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“Provider Screening”
United States House Committee On Energy & Commerce
Subcommittee On Oversight & Investigations
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Attachment 1—Additional Questions for the Record

The Honorable Tim Murphy

- 1. What percentage of Recovery Audit Contractors (RAC) appeal cases in FY 2013 were decided on the record?**
- 2. Who are the top ten administrative law judges that are deciding RAC cases on the record?**
- 3. What is being done to implement Office Inspector General (OIG) recommendations to improve the Administrative Law Judge (ALJ) process, including better training and clarification of Medicare policies, so ALJ RAC rulings are more in line with those made at the two earlier levels of appeal, the Medicare Administrative Contractors (MAC) and the Qualified Independent Contractors (QIC)?**
- 4. What plans are in place to hire additional judges at the ALJ level to deal with the Office of Medicare Hearings and Appeals (OMHA) appeal backlog?**

Answer to #1 - #4: The Office of Medicare Hearings and Appeals (OMHA) is independent from CMS, so CMS cannot speak to these issues.

- 5. Dr. Agrawal said “We want to get the RACs up and running as quickly as possible.” What is delaying the award of new RAC contracts that are not under protest?**

Answer: Recovery Audit Regions 1, 2, and 4 are subject to a bid protest in the Court of Federal Claims. Recovery Audit Regions 3 and 5 are based on the same statement of work. Therefore, we believe it is prudent to receive the Judge’s decision prior to moving forward on the procurement.

- 6. What is being done to monitor the quality of the Administrative Law Judges' decisions and ensure they consistently adhere to current Medicare policy?**

Answer: Because OMHA is independent from CMS, I cannot speak to their efforts to monitor decisions made by ALJs.

7. What is being done to insure the RACs are notified of the ALJ hearings?

Answer: In accordance with the regulation in 42 CFR 405.1020(c), Notice of Hearing, Administrative Law Judges issue a Notice of Hearing to all the parties to the initial determination and the Qualified Independent Contractor (QIC) that issued the reconsideration decision if a hearing is held. The QICs are contractually required to forward the Notice of Hearing to the Medicare Administrative Contractors, Recovery Auditors, and Zone Program Integrity Contractors. The current Joint Operating Agreements between the QICs and these entities establish timeframes and transmission mechanisms.

When issues arise, such as delays or non-receipt of Notices of Hearings, CMS brings them to OMHA's attention during a regularly scheduled bi-weekly meeting.

8. CMS is expanding the savings for the FPS to include savings associated with payment suspensions and savings associated with revocations. CMS' traditional Medicare Integrity Program (MIP) Return On Investment (ROI) does not include these types of savings. Why is CMS making a change with this methodology?

Answer: The Small Business Jobs Act of 2010 requires the Secretary of HHS to submit reports for each of the first three years of Fraud Prevention System (FPS) implementation. The law also requires the Office of Inspector General (OIG) to certify the actual and adjusted savings with respect to improper payments recovered and avoided and the return on investment related to the Department's use of the FPS for each of its first three implementation years. Including payment suspensions and savings associated with revocations was the result of consultation with the OIG on the actual and adjusted savings resulting from the FPS. This methodology currently only applies to the FPS, and has not been expanded to the Medicare Integrity Program return on investment methodology.

9. The Small Business Jobs Act of 2010 provided CMS with \$100 million to implement the Fraud Prevention System (FPS). If I recall correctly, the initial contract with option years was \$70 M. Based on the information in the first report and in this report, CMS has or is about to spend the initial \$100 million. What is the burn rate and the funding plan moving forward? Please provide a detailed chart with all costs (technology, manpower, legal, actual savings return based on enhanced edits, etc.).

Answer: CMS implemented the FPS on June 30, 2011. In the first implementation year, the FPS stopped, prevented, or identified an estimated \$115.4 million in improper payments. In the second implementation year, the FPS identified or prevented more than \$210 million in improper Medicare fee-for-service (FFS) payments, double the previous year.

The funding for FPS is associated with two main contractors, Northrup Grumman (Development Contractor) and IBM (Modeling Contractor). In addition to these contractors, National Government Services (NGS) and Verizon are actively involved as sub-contractors. The table below represents funding amounts associated with development and modeling efforts:

Period Of Performance	Total Funding (Development + Modeling)
05/11 - 07/11	\$7,209,714
07/11 - 07/12	\$23,282,595
07/12 - 07/13	\$34,848,069
07/13 - 07/14	\$35,213,285
07/14 - 07/15	\$22,700,383
Total Funding: 05/11 - 07/15	\$123,254,046

The funding includes the following categories:

Type of Contractor	Category	Included
Development	Hardware/Software/System	Hardware infrastructure, Hardware hosting, Software Licenses, System Patches, Software Development/Implementation
Development	User/Business Oversight	Model Development, Vulnerability Identification, Testing, Training, Help Desk Support
Development	Monitoring	Model/Edit Monitoring, System Performance
Modeling	User/Business Oversight	Model Development, Testing, Vulnerability Identifications, and Model Monitoring
Modeling	Monitoring	Model Monitoring, System Performance

The costs above the initial \$100 million appropriated for the Fraud Prevention System are funded through Medicare Integrity Program resources.

10. The Small Business Jobs Act [says](#) that “the Secretary shall expand the use of predictive analytics technologies, beginning April 1, 2015, to apply to Medicaid and CHIP. To the extent the Secretary determines appropriate, such expansion may be made on a phased-in basis.” Will you commit to keep this Committee updated on what CMS is thinking as that date approaches?

Answer: CMS is happy to work with the Committee to provide updates on the progress of the FPS. The Small Business Jobs Act requires that CMS include in the Third Implementation Year Report an analysis of the cost-effectiveness and feasibility of expanding the use of predictive analytics technologies to Medicaid and CHIP. Section 4241(c)(5) of the Small Business Jobs Act does refer to expanding the use of predictive analytics technologies to Medicaid and CHIP, but only “[b]ased on the results of the report and recommendation required under subsection (e)(3).”

Although Medicaid is administered and organized in a distinctly different way than Medicare, CMS anticipates that there are opportunities to transfer the knowledge and lessons learned about Medicare through the FPS to states for uses applicable to Medicaid. CMS will report to the Congress as required by section 4241(e)(3) on the cost-effectiveness and feasibility of expanding

use of predictive analytics technologies to Medicaid and CHIP. However, data provided to CMS on Medicaid payments are post-payment, so it will be important to consider whether prepayment analytics may best be implemented by the states.

11. CMS has said “the Fraud Prevention System now has the capability to stop payment of certain improper claims, without human intervention, by communicating a denial message to the claims payment system.” This sounds promising. Has CMS actually used this capability yet? If so, how many claim denials has it resulted in?

Answer: CMS launched an Ambulatory Surgical Center edit in one state as a proof of concept to test the functionality of rejecting claims directly through the Fraud Prevention System. CMS successfully rejected 125 claims for 52 providers during the proof of concept, totaling over \$40,000. While the savings may be small for this single edit in one state, CMS intends to expand the number of edits in the third implementation year.

12. CMS said it “has pilot projects underway evaluating the expansion of programs that provide waste, fraud and abuse leads to Medicare Administrative Contractors for early intervention.” Two questions on this:

- a. Please explain the duration of the pilot, the evaluation process, and the timeframe in which this Committee can expect to know from you what actions you may take as a pilot.**
- b. How would this effort to work with MACs duplicate – or not duplicate – the work of the other program integrity contractors?**

Answer: CMS completed the pilot during the second implementation year, and CMS has begun additional pilot testing, and results will be included in the report to Congress on the third implementation year. The purpose of the pilot was to determine whether providers identified in the FPS that were not currently in the workload of the Zone Program Integrity Contractors were submitting a high number of likely improper payments. The first phase that was completed during the second implementation year had positive results.

CMS identified eight providers and suppliers (“providers”) for the pilot, and the Medicare Administrative Contractors (MACs) implemented a two-phase intervention. First, the MAC contacted individual providers to discuss their billing data. If the provider did not have a satisfactory explanation for their aberrant billing pattern or did not change their billing pattern, the provider’s claims were placed on prepayment review. Four of the eight providers the MAC contacted changed their billing within one month. Two others were instructed to complete a self-audit, and the remaining two did not change their billing patterns. One of those providers is now on prepayment review, and the other is subject to post pay review.

The MACs cited the speed with which the billing behavior was changed and the low cost of the intervention as positive outcomes of the pilot. The cost of the intervention is reduced because there were no additional costs for the analysis and 4 providers changed their behaviors based on a conversation rather than the traditional approach of reviewing medical records first, which must be completed by clinical staff. Since this was a small, short-term project the long-term impact cannot be quantified, however the initial results are promising.

Another value of expanding the use of the FPS tool is that the MAC and Zone Program Integrity Contractor (ZPIC) may be able to better coordinate audit activity on a specific provider, rather than duplicating work. This will reduce burden on providers and provide a forum for collaboration across contractors.

13. CMS said the FPS “resulted in CMS taking action against 938 providers and suppliers.” Can you give us a breakdown of the types of actions taken against different types of providers?

Answer:

Administrative action	Number of Providers Unduplicated Oct 2012 – Sept 2013
Prepayment Review Denials	423
Denials from Auto-Denial Edits	254
Payment Suspension	35*
Overpayments Referred to the MAC for Recovery	235
Referred to Law Enforcement	75
Revocation	48
Total	938

* These 35 providers were on active payment suspension as of the last day of the reporting period. An additional 20 providers were on payment suspension during the reporting period but were terminated from payment suspension prior to the end of the reporting period.

14. In tallying the adjusted (\$54 million) or unadjusted (\$210 million) Medicare dollars, how did CMS account for the role of its ZPICs, PSCs, or other program integrity contractors? Were the findings of the contractors counted toward the dollar amount identified? If so, how was the PSC’s normal work disaggregated from its work for the FPS?

Answer: CMS accounted for the role of the contractors in the methodology certified by the HHS Office of Inspector General. CMS requires its contractors to track the recoveries that result from FPS leads, and OIG then determined that our methodology for tracking was reasonable, and certified those savings. In addition to identifying new leads and new issues, FPS information may corroborate, augment or expedite investigations. CMS identified or prevented an additional \$39.4 million using information in the FPS to corroborate, augment, or expedite existing investigations but for which documentation was insufficient to be included by the OIG in the certified savings.

An estimated portion of the contractor time is included since a portion of time is spent acting on FPS leads. These costs are estimated by calculating the percentage of total investigation created from FPS leads, including the new leads in the second year, new leads in the first year that were also worked in the second year and existing investigations where administrative action was taken due to FPS, and multiplying that percentage by their total investigator costs.

15. Before the creation of the FPS that Congress mandated CMS adopt, CMS was reluctant to adopt more forward leaning, predictive tools. I am not asking you to agree with this characterization, but it was the perception of many in Congress that CMS did not think they needed the FPS, and resisted being told how to do this program. However, Congress mandated it, and here you are today explaining the achievements of FPS. Do you think the FPS has been a positive step for CMS and taxpayers? Mr. Chairman, I would note the role of former Florida Republican Senator George LeMieux, who, as author of the provision creating FPS, deserves credit for helping nudge CMS's fraud-fighting efforts forward to adopt the FPS.

Answer: Yes, I agree that the FPS has been a positive step. It's part of CMS's comprehensive program integrity strategy and its implementation has resulted in a positive return on investment for Medicare and taxpayers. For example, the FPS is used as part of an agency focus on home health services in South Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. The FPS led to investigations and administrative actions, which ultimately led to the revocation of the billing privileges of home health agencies, with potential savings worth more than \$26 million. CMS expects that future activities will substantially increase savings by expanding the use of the innovative technology beyond the initial focus on identifying fraud into areas of waste and abuse.

16. What number of full-time-equivalent (FTE) personnel are at CMS or its contractors, who are charged with identifying, reducing, or recovering improper payments attributable to fraud, waste, or abuse? Could you please provide the Committee with this number? Please include the personnel at Office of Financial Management who oversee the Recovery Audit Contractors, the contract staff of program integrity contractors, the FTE at the Center for Program Integrity, and any other relevant personnel.

Answer: CMS has 512 full-time employees whose work includes identifying, reducing, or recovering improper payments. Additionally, CMS contractors employ 1,265 full-time employees for this work.

17. Almost two years ago exactly, with a press release, HHS and DOJ announced a public private partnership to help prevent health care fraud. I think collaboration with industry and the private sector is the kind of initiative most members would support. However, it's been two years, and what we have heard from many in the industry is that CMS has been moving, but moving slowly. Can you please outline for the Committee what the partnership has accomplished to date, and what are the metrics for success? Could you please provide the Committee—in as much detail as possible—with the following:

- a. The number of cases shared between plans and CMS**
- b. The number of trends shared between plans and CMS**
- c. What types of corrective actions CMS may have taken as a result of the partnership?**
- d. Has CMS identified any real or perceived legal barriers to plans and CMS sharing information?**

e. In your view, are there any outstanding legal barriers to plans and CMS sharing needed information to prevent fraud, waste, or abuse?

Answer: The Healthcare Fraud Prevention Partnership (HFPP) is a ground-breaking initiative that is designed to work with the private sector to fight fraud, waste, and abuse across the health care system. The HFPP's ultimate goal is to exchange facts and information to identify trends and patterns that will uncover fraud, waste and abuse that could not otherwise be identified. CMS is working through the legal requirements for data sharing with private health plans, and has made significant progress in the development of the HFPP.

Until CMS receives approval for its new information collection effort under the HFPP from the Office of Management and Budget, the data sharing has been limited to nine participants. Current information collection activities are limited to a specified number of participants per pilot study under Paperwork Reduction Act requirements. In addition, because claims data contains both personally identifiable information and protected health information subject to many constraints on sharing, these early HFPP proof of concept pilots have used non identifiable data such as payment codes which may be associated with fraud, waste or abuse, or information about known non-operational group practices and other organizational data. Once the legal agreements are put in place to allow for the maximum legally allowable data sharing, the partnership will be able to share provider-level information that should result in joint investigations and sharing of active and past cases.

That said, the HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. The HFPP has conducted 4 data and information sharing studies over the past two years. Several studies are still being analyzed by the partners and they will report outcomes in the future. CMS has established over 150 payment edits to address improper billing identified through the information shared within the partnership. We have also put several providers on payment suspension, revoked several providers, as well as revoked provider practice locations that we have identified as false store fronts.

18. What do you believe are the top five vulnerabilities with regard to the integrity of Medicaid payments?

Answer: CMS measures Medicaid and CHIP improper payments annually through the Payment Error Rate Measurement (PERM) program, using a 17-state three-year rotation so that CMS measures each state once every three years. Through PERM, CMS samples state Medicaid FFS and managed care payments, collects documentation from providers, conducts a data processing review on sampled FFS and managed care payments, and performs a medical record review on sampled FFS claims.

Based on a compilation of Medicaid improper payments identified in Fiscal Years (FYs) 2011, 2012, and 2013, the PERM program reported FFS payment errors by service type. The top five service areas for FYs 2011-2013, based on projected dollar amount, were found to be in the following services (in decreasing order of dollars in error):

- Habilitation and Waiver Programs
- Nursing Facility/Intermediate Care Facilities

- Prescribed Drug
- Personal Support Services
- ICF for the Mentally Retarded and Group Homes¹

Through PERM, the identification of service types and other predictors of high payment errors inform corrective actions by CMS and states. CMS works closely with states to review their error rates, determine root causes of errors, and develop corrective actions to address the major causes of errors.

19. Please provide the Committee with an update on the status of using RACs in Medicaid, as required by the ACA.

Answer: State Medicaid agencies contract with Medicaid Recovery Audit Contractors (RACs), to identify and recover overpayments, and identify underpayments made to Medicaid providers. CMS implemented section 6411(a) of the Affordable Care Act in a Final Rule published on September 16, 2011 requiring states to implement Medicaid RAC programs by January 1, 2012, unless granted an exception.

By the end of FY 2013, 45 states and the District of Columbia had implemented Medicaid RAC programs, and CMS had granted five U.S. Territories complete exceptions from implementing RAC programs. Additionally, CMS granted five states time-limited exceptions from implementing Medicaid RAC programs during FY 2013, due to either high rates of Medicaid managed care penetration (two states), small Medicaid beneficiary population and low Medicaid payment error rate (one state), or re-procurement of new State Medicaid RACs (two states). For FY 2013, 19 states reported recoveries totaling \$124.3 million in the Federal and state share combined amount (Total Computable) and returned a total of \$74.5 million (Federal share).²

¹ 2013 PERM Report Appendix 2, Figure S12, available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2013PERMREPORTAPPENDICES.pdf>.

² RAC recoveries include overpayments collected, adjusted, and refunded to CMS, as reported by states on the CMS-64.

The Honorable Michael C. Burgess

- 1. CMS has not adopted all of the recommendations from HHS OIG to prevent and detect fraud. What recommendations have and have not been adopted? Why have these recommendations not been adopted? What is the timeline for implementing these provisions?**

Answer:

	OIG Recommendation	Status
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.
2	Strengthen the Medicare contractor’s monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	Implemented In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies. On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors’ downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS’ and its anti-fraud contractors’ investigative processes. Currently, it can take a long time for CMS’ contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human

		Services (HHS) Office of Inspector General.
3	Require Part D plans to verify that prescribers have the authority to prescribe	<p>Implemented</p> <p>Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013.</p> <p>On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, if a Drug Enforcement Administration (DEA) certificate of registration is suspended or revoked, or if the applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider’s ability to prescribe drugs.</p>
4	Increase monitoring of Medicare claims for home health services	<p>Implemented</p> <p>CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.</p>
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	<p>Unimplemented</p> <p>CMS is evaluating whether or not a form will help resolve the issues identified in OIG’s</p>

		report. However, a standardized form would eliminate some of the current flexibilities that providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.
7	Implement the surety bond requirement for HHAs	<p>Unimplemented</p> <p>CMS has not scheduled for publication new regulations under this authority.</p> <p>CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about \$1.6 million directly from surety companies, and has collected an additional \$18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame.</p>
8	Monitor hospices that depend heavily on nursing facility residents	<p>Implemented</p> <p>CMS has provided this information to the Recovery Auditors and to the Medicare Administrative Contractors, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.</p>
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	<p>Ongoing</p> <p>Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care.</p> <p>In May 2014, CMS released additional analysis to inform hospice payment reforms.</p>
10	Consider whether additional controls are needed are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	<p>CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.</p>
11	Take action to provide states with	After the information in # 10 above is

	data suitable for identifying payments for PCS claims when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.	gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	<p>Unimplemented</p> <p>CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud.</p> <p>Plan sponsors report and share information related to potential fraud, waste and abuse (FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.</p>
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	<p>Implemented</p> <p>In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.</p>

2. What databases is CMS currently using to screen provider or fund recipients or to detect other types of fraud in the system? What other databases could CMS be using?

Answer: 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 CHIP, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid and CHIP 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. All Medicare providers and suppliers undergo a baseline screening, including confirmation of the provider's or supplier's Social Security Number through the Social Security Administration, license and certification through the state licensing boards, as well as searches in the System for Award Management, operated by the General Services Administration (GSA), in terms of Government contracting exclusion (suspension and debarments) and the HHS OIG exclusion list for all individuals listed on the application.

Under section 1128 of the Social Security Act, HHS OIG must exclude individuals and entities from Federal health care programs based on felony or misdemeanor convictions related to the Medicare or Medicaid programs, or related to the abuse or neglect of patients, and has discretionary authority to exclude individuals on a number of grounds, including misdemeanor convictions related to health care fraud. Once approved, enrolled providers are systematically compared weekly to the Social Security Administration's complete file of death information and the Medicare Exclusion Database (MED), CMS's repository of information contained in the OIG's exclusion list, and CMS routinely revokes billing privileges based on this information. Revocations are retroactive to the date of a provider's or supplier's respective plea or conviction, and if the provider or supplier submitted claims after that date, CMS demands those payments be repaid.

CMS has historically relied on the MED and GSA list to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony convictions of Medicare providers and suppliers. CMS is currently working on a process to match enrollment data against public and private databases to receive timely felony conviction data. Additionally, in April 2014, CMS announced that upon notification, providers and suppliers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare. The requirement applies to individuals with a five percent or greater ownership interest in a newly-enrolling durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) supplier or a newly-enrolling home health agency (HHA), as well as any provider and supplier that has been subject to certain adverse actions, including prior revocation, payment suspension, or licensure suspension or revocation.

3. Through the Sunshine Act, CMS is required to include “background information on industry-physician relationships.” While access to information about physician-industry relationships is important, the proper context is needed to understand these legitimate interactions between physicians and industry. Will CMS be putting out draft context proposals for public comment? If so, when? If not, why not?

Answer: CMS agrees that both context and access to information about physician-industry relationships is important to help the consumer understand the information presented. In the preamble to the February 2013 Final Rule implementing the Open Payments program, CMS provided extensive background information on industry-physician relationships. This information discussed how the financial relationships can be beneficial to the advancement of medicine and innovation, however they can also create the opportunity for conflicts of interest. The preamble and the Final Rule discussed that CMS will remain neutral in its representation and presentation of the data, and will not label any reported interactions as legitimate or

inappropriate. CMS solicited and addressed comments to the Final Rule, including the request that CMS allow applicable manufacturers to voluntarily report contextual information about each payment or other transfer of value and make the information publicly available. CMS has provided manufacturers with the opportunity to report such information, but they are not required to do so. CMS also requested and received comments on the structure of the public website in the Final Rule. CMS is not formally issuing additional material for public comments but will continue to consider any stakeholder feedback it receives upon the launch of the site.

The Honorable Renee Ellmers

1. Please describe in detail the proposals from CMS to reform MAC and RAC audits to ensure they are not unduly burdensome on medical equipment suppliers and providers.

Answer: CMS is committed to reducing improper payments but must be mindful of provider and supplier burden because medical review is a resource-intensive process for both the healthcare provider and the Medicare review contractor. In many cases, the only way to identify improper payments is to request medical records from providers and suppliers and review the records along with the claim. This requires providers and suppliers to fax, mail or electronically send many pages of documentation to CMS contractors which can be time consuming and burdensome. The CMS hopes to lessen provider burden by instituting changes that will help providers and suppliers better comply with Medicare policies and documentation requests.

Recent Initiatives

- Require Medicare Administrative Contractors (MACs) to issue **“no findings” letters** at the conclusion of postpayment review. Previously, CMS only required that MACs send results letters when an overpayment was identified. Now, providers and suppliers will receive a letter at the conclusion of review even if no overpayments are identified.
Effective Date: January 28, 2014
- Require contractors to **accept documentation** from providers via fax, CD/DVD and Electronic Submission of Medical Documentation system. Previously, CMS only required MACs to accept hard copy documentation.
Effective Date: October 21, 2013
- Post a **review contractor directory on CMS’ website** so that providers and suppliers can easily identify all Medicare review contractors in their state. This interactive map can be found at the link to the left called “Review Contractor Directory – Interactive Map”.
Effective Date: August 1, 2012

Planned Initiatives

- Require MACs to **post issues selected for focused review to their websites**. Currently, it is optional for MACs to post what they are reviewing to their websites.
Estimated timeframe: Summer 2014

Recovery Audit Program Improvements

The CMS announced a number of changes to the Recovery Audit program in response to industry feedback. The CMS is confident that these changes will result in a more effective and efficient program, including improved accuracy, less provider and supplier burden, and more program transparency. These changes will be effective with the next Recovery Audit program contract awards.

- **More time for providers and suppliers to engage with the Recovery Auditors.**
Recovery Auditors will be required to wait 30 days (to allow for a discussion period) before sending the claim to the MAC for adjustment. Today, in some cases, providers and suppliers must delay filing an appeal in order to initiate a discussion period with the RAC.

- **Improved customer service.** Recovery Auditors will be required to confirm receipt of a discussion request within three days.
- **More time before Recovery Auditors receive contingency fee if there is an appeal.** Recovery Auditors will be required to wait until the 2nd level appeal is exhausted before the CMS will pay them any contingency fee.
- **More claim diversity across a facility (e.g., inpatient, outpatient).** CMS is establishing revised additional document request limits, so that they can be diversified across claim types.
- **Number of additional document requested during Recovery Auditors review proportional to denial rates.** CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's or supplier's denial rate. Providers and suppliers with low denial rates will have lower additional document request limits while providers and suppliers with high denial rates will have higher additional document request limits.
- **Central point of contact for complaints/concerns about claim reviews.** CMS has established a Provider Relations Coordinator that can assist with Recovery Auditor review process concerns/suggestions and other contractor review process concerns/suggestions

2. I've heard from several Durable Medical Equipment, Prosthetics, Orthotics and Suppliers (DMEPOS) providers in my district about CMS changing the auditing rules and penalizing a company before they were aware of the change. Will CMS set a real guideline for a grace period for changes to the audit rules before auditors can penalize company?

Answer: CMS agrees that providers should have current information regarding payment and audit policies. Every Local Coverage Determination (LCD) has a public comment period and an effective date. In addition, policy changes that go into a CMS manual have an implementation date that is at least 30 days beyond the publication date allowing for public notice. When an audit is conducted, the payment and coverage policy that was in place at the time the service was delivered is used to make audit determinations.

3. What specific metrics does CMS use to target entities for audits? In particular, what metrics does CMS use to target DMEPOS companies for audits?

Answer: The MACs and the RACs analyze claims to determine provider and supplier compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant. The goal of MAC and RAC administrative actions is to correct the behavior in need of change and prevent future inappropriate billing.

When improper behavior is detected, the priority for MACs is to minimize potential future losses to the Medicare Trust Funds through targeted claims review and education while using resources efficiently and treating providers, suppliers, and beneficiaries fairly.

The CMS provides instructions to its contractors through the Program Integrity Manual. The following is an excerpt from the Program Integrity Manual 3.2.1 – Setting Priorities and Targeting Reviews:

The MACs have the authority to review any claim at any time, however, the claims volume of the Medicare Program doesn't allow for review of every claim. The MACs shall target their efforts at error prevention to those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR focuses on areas with the greatest potential for improper payment.

The MACs shall develop a problem-focused, outcome-based MR strategy and Strategy Analysis Report (SAR) that defines what risks to the Medicare trust fund the MAC's MR programs will address and the interventions that will be implemented during the fiscal/option year as addressed in PIM chapter 7.

The MACs shall focus their edits where the services billed have significant potential to be non-covered or incorrectly coded. Medical review staff may decide to focus review on problem areas that demonstrate significant risk to the Medicare program as a result of inappropriate billing or improper payments. The MACs shall have in place a program of systematic and ongoing analysis of claims and data from Recovery Auditors and CERT, among other sources, in order to focus intervention efforts on the most significant errors.

The MACs shall initiate a targeted provider-specific prepayment review only when there is the likelihood of sustained or high level of payment error. MACs are encouraged to initiate targeted service-specific prepayment review to prevent improper payments for services identified by CERT or Recovery Auditors as problem areas, as well as, problem areas identified by their own data analysis.

The MACs have the discretion to select target areas because of:

- High volume of services;
- High cost;
- Dramatic change in frequency of use;
- High risk problem-prone areas; and/or,
- Recovery Auditor, CERT, Office of Inspector General (OIG) or Government Accounting Office (GAO) data demonstrating vulnerability. Probe reviews are not required when targeted areas are based on data from these entities.

In an effort to identify the claims most likely to contain improper billing, MACs are encouraged to use prepayment and postpayment screening tools or natural language coding software. MACs shall not deny a payment for a service simply because the claim fails a single screening tool criterion. Instead, the reviewer shall make an individual determination on each claim. MACs have the discretion to post the screening tools in use to their Web site or otherwise disclose to the provider community. Recovery Auditors shall use screening tools and disclose their use to the provider community consistent with the requirements in their statements of work (SOWs).

MACs and Recovery Auditors shall NOT target a provider for review solely based on the provider's preferred method of maintaining or submitting documentation. For example, a MAC or Recovery Auditor shall NOT choose a provider for review based only on the fact that the provider uses an electronic health record or responds to documentation

requests using the Electronic Submission of Medical Documentation mechanism. (More information about esMD can be found in Section 3.2.3.5)

Attachment 2—Member Requests for the Record

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. For your convenience, descriptions of the requested information are provided below.

The Honorable Tim Murphy

1. Can someone with a foreign address be a Medicare provider?

Answer: A provider or supplier must have a practice location within the United States; however, an owner may have an address outside the United States.

2. With each recommendation made by the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) that has not been implemented, please explain the reason they have not been implemented.

Answer:

	GAO recommendation	Status
1	Implement Surety Bonds	<p>Unimplemented</p> <p>CMS has not scheduled for publication new regulations under this authority.</p> <p>CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about \$1.6 million directly from surety companies, and has collected an additional \$18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame.</p>
C2	Implement providers and suppliers disclosure	<p>Unimplemented</p> <p>On April 24, 2013, CMS issued a proposed rule that would implement a piece of this provision. The proposal would permit CMS to deny Medicare enrollment if the provider, supplier or current owner thereof was the owner of another provider or supplier that had a Medicare debt when the latter’s enrollment was voluntarily or involuntarily terminated or revoked.</p> <p>CMS is considering potential provider burden in the development of additional disclosure requirements under this section.</p>

3	Implement compliance plans	<p>Unimplemented</p> <p>CMS solicited comments on compliance plans in the September 2010 proposed rule (CMS 6028-P). CMS analyzed comments and is studying issues associated with implementation of compliance plan requirements.</p> <p>The Office of Inspector General conducted compliance training around the country and posted video and audio podcasts of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training Initiative on its website.</p>
4	Collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions.	<p>Ongoing</p> <p>CMS has instituted an enhanced evaluation process for its contractors, but has not yet fully integrated it into the process.</p>
5	Develop reliable schedules to incorporate all types of data into the Integrated Data Repository.	Ongoing
6	Establish deadlines for program integrity contractors to begin using One PI.	Ongoing
7	Select an approach for removing Social Security numbers from Medicare cards that best protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries and CMS.	<p>Unimplemented</p> <p>CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.</p>

	OIG Recommendation	Status
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	<p>Unimplemented</p> <p>CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.</p>
2	Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	<p>Implemented</p> <p>In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies.</p>

		<p>On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors' downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS' and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS' contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human Services (HHS) Office of Inspector General.</p>
3	<p>Require Part D plans to verify that prescribers have the authority to prescribe</p>	<p>Implemented</p> <p>Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013.</p> <p>On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, is a Drug Enforcement Administration (DEA) certificate of registration is suspended or revoked, or if the applicable licensing or</p>

		administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider's ability to prescribe drugs.
4	Increase monitoring of Medicare claims for home health services	<p>Implemented</p> <p>CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.</p>
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	<p>Unimplemented</p> <p>CMS is evaluating whether or not a form will help resolve the issues identified in OIG's report. However, a standardized form would eliminate some of the current flexibilities that providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.</p>
7	Implement the surety bond requirement for HHAs	<p>Unimplemented</p> <p>CMS has not scheduled for publication new regulations under this authority.</p> <p>CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about \$1.6 million directly from surety companies, and has collected an additional \$18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame</p>
8	Monitor hospices that depend heavily on nursing facility residents	<p>Implemented</p> <p>CMS has provided this information to the Recovery Auditors and to the Medicare</p>

		Administrative Contractors, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	<p>Ongoing</p> <p>Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care.</p> <p>In May 2014, CMS released additional analysis to inform hospice payment reforms.</p>
10	Consider whether additional controls are needed are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.
11	Take action to provide states with data suitable for identifying payments for PCS claims when beneficiaries are receiving institutional care paid for by Medicare or Medicaid.	After the information in # 10 above is gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	<p>Unimplemented</p> <p>CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud.</p> <p>Plan sponsors report and share information related to potential fraud, waste and abuse</p>

		(FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	Implemented In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.

3. What additional data would be valuable to help you prescreen for Medicare fraud?

Answer: CMS is currently in the process of procuring a contractor to perform fingerprint-based criminal history record checks of the Federal Bureau of Investigation databases. CMS believes this new data source will provide information about providers, suppliers and their direct or indirect owners that would permit CMS to take action when appropriate on the requirement that such individuals be free of certain federal and state felony convictions.

The Honorable Michael C. Burgess

- 1. Please provide the Committee with a list of the recommendations made by GAO and the OIG that have not been implemented yet.**

Answer:

	OIG Recommendation	Status
1	Remove Social Security Numbers from Medicare cards to help protect personally identifiable information of Medicare beneficiaries	Unimplemented CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.
2	Strengthen the Medicare contractor's monitoring of pharmacies and its ability to identify for further review of pharmacies with questionable billing patterns	Implemented In June 2013, CMS sent its first pharmacy risk assessment to Part D plans, and CMS has released two other assessments in December 2013 and April 2014 to seek industry comments about the methodology used to help identify high risk pharmacies. On May 19, 2014, CMS issued a Final Rule that permits CMS to direct access to Part D sponsors' downstream entities: This provision will provide CMS, its antifraud contractors, and other oversight agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other entities that contract or subcontract with Part D Sponsors to administer the Medicare prescription drug benefit. The provision will streamline CMS' and its anti-fraud contractors' investigative processes. Currently, it can take a long time for CMS' contractors who are often assisting law enforcement to obtain important documents like invoices and prescriptions directly from pharmacies, because they must work through the Part D plan sponsor to obtain this information. This provision is designed to provide more timely access to records, including for investigations of Part D fraud and abuse, and responds to recommendations from the Department of Health and Human Services (HHS) Office of Inspector General.
3	Require Part D plans to verify	Implemented

	that prescribers have the authority to prescribe	<p>Through rulemaking finalized in 2012, CMS required Part D sponsors to submit Prescription Drug Events (PDEs – Part D claims data) with active and valid individual prescriber National Provider Identifiers (NPIs) beginning January 1, 2013. CMS began to apply edits to any PDE without an active and valid individual NPI on May 6, 2013.</p> <p>On May 19, 2014, CMS issued a Final Rule that requires prescribers of Part D drugs to enroll in Medicare to help ensure CMS that Part D drugs are only prescribed by qualified individuals. CMS also finalized authority to revoke Medicare enrollment if CMS determines there is a pattern or practice of prescribing Part D drugs that is abusive, is a Drug Enforcement Administration certificate of registration is suspended or revoked, or if the applicable licensing or administrative body for any state in which a physician or eligible professional practices has suspended or revoked the provider’s ability to prescribe drugs.</p>
4	Increase monitoring of Medicare claims for home health services	<p>Implemented</p> <p>CMS has implemented the FPS, which runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment, including home health claims. For example, FPS is used as part of an agency focus on home health services, particularly in Florida. CMS identified this type of service in South Florida as an area of high risk to our programs. CMS is monitoring the activity of home health agencies across Florida through the FPS to identify changes in billing patterns and the potential migration of fraud schemes to other parts of the state or Nation.</p>
6	Create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements	<p>Unimplemented</p> <p>CMS is evaluating whether or not a form will help resolve the issues identified in OIG’s report. However, a standardized form would eliminate some of the current flexibilities that</p>

		providers are afforded. Providers are allowed to use existing information in the medical record, rather than completing a separate form, to document a face to face encounter.
7	Implement the surety bond requirement for HHAs	<p>Unimplemented</p> <p>CMS has not scheduled for publication new regulations under this authority.</p> <p>CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about \$1.6 million directly from surety companies, and has collected an additional \$18.5 million directly from suppliers immediately after their debts were referred to their respective sureties for payment for the same time frame</p>
8	Monitor hospices that depend heavily on nursing facility residents	<p>Implemented</p> <p>CMS has provided this information to the RACs and MACs, emphasizing the importance of this issue when prioritizing medical review strategies and other interventions.</p>
9	Modify the payment system for hospice care in nursing facilities, seeking statutory authority if necessary	<p>Ongoing</p> <p>Section 3132 of the Affordable Care Act requires CMS to revise Medicare's payments system for hospice care no earlier than October 1, 2013, and allows CMS to collect additional data and information as the Secretary determines appropriate to revise payments for hospice care.</p> <p>In May 2014, CMS released additional analysis to inform hospice payment reforms.</p>
10	Consider whether additional controls are needed to ensure that Personal Care Services are allowed under the program rules and are provided.	<p>CMS will conduct an analysis of personal care services' requirements and identify potential risks and vulnerabilities relating to the delivery of personal care services. CMS will gather additional data on best practices to better inform states. This information will be used to address the recommendations.</p>
11	Take action to provide states with data suitable for identifying payments for PCS claims when beneficiaries are receiving	<p>After the information in #10 above is gathered and reviewed, CMS will determine the appropriate policy and evaluate the best vehicle to communicate the information.</p>

	institutional care paid for by Medicare or Medicaid.	
12	Amend regulations to require MA and Part D plans to report to CMS, or its designee, their identification of and response to potential fraud and abuse.	<p>Unimplemented</p> <p>CMS does not concur with this recommendation. Part D sponsors are held accountable for detecting and preventing fraud and abuse. Amending the regulation to require reporting directly to CMS itself could be considered a duplication that would require Part D sponsors to expend unnecessary additional resources and would have the potential to inundate the agency and our contractors with an unwieldy amount of information that would not necessarily yield a better outcome in terms of stopping Part D fraud.</p> <p>Plan sponsors report and share information related to potential fraud, waste and abuse (FWA) through several means which includes the FWA Work Group meetings where information is shared with CMS, law enforcement and other plan sponsors; directly contacting the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC); and by contacting 1-800-MEDICARE which will refer the case to the NBI MEDIC.</p>
13	Establish a deadline for when complete, accurate and timely T-MSIS data will be available.	<p>Implemented</p> <p>In August 2013, CMS issued a State Medicaid Director letter that established a compliance date of July 1, 2014.</p>

	GAO recommendation	Status
1	Implement Surety Bonds	<p>Unimplemented</p> <p>CMS has not scheduled for publication new regulations under this authority.</p> <p>CMS does currently require DMEPOS suppliers to post a surety bond at the time of enrollment, and has collected about \$1.6 million directly from surety companies, and has collected an additional \$18.5 million directly from suppliers immediately after their debts were referred to their respective</p>

		sureties for payment for the same time frame.
2	Implement providers and suppliers disclosure	<p>Unimplemented</p> <p>On April 24, 2013, CMS issued a proposed rule that would implement a piece of this provision. The proposal would permit CMS to deny Medicare enrollment if the provider, supplier or current owner thereof was the owner of another provider or supplier that had a Medicare debt when the latter's enrollment was voluntarily or involuntarily terminated or revoked.</p> <p>CMS is considering potential provider burden in the development of additional disclosure requirements under this section.</p>
3	Implement compliance plans	<p>Unimplemented</p> <p>CMS solicited comments on compliance plans in the September 2010 proposed rule (CMS 6028-P). CMS analyzed comments and is studying issues associated with implementation of compliance plan requirements.</p> <p>HHS OIG conducted compliance training around the country and posted video and audio podcasts of the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Provider Compliance Training Initiative on its website.</p>
4	Collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions.	<p>Ongoing</p> <p>CMS has instituted an enhanced evaluation process for its contractors, but has not yet fully integrated it into the process.</p>
5	Develop reliable schedules to incorporate all types of data into the Integrated Data Repository.	Ongoing
6	Establish deadlines for program integrity contractors to begin using One PI.	Ongoing
7	Select an approach for removing Social Security numbers from Medicare cards that best protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries and CMS.	<p>Unimplemented</p> <p>CMS has performed a cost analysis of options to remove the Social Security number from the Medicare card.</p>

The Honorable Renee Ellmers

- 1. You suggested CMS is making changes in the next RAC audit time period so that providers who have a low denial rate are rewarded. What is the percentage of providers who are rewarded, if they have a low denial rate?**

Answer: CMS plans to require RACs to adjust the Additional Documentation Request limits in accordance with a provider's denial rate, under the new Recovery Audit contracts. Providers with low denial rates will have lower additional document request limits while providers with high denial rates will have higher additional document request limits. More information will be available when the next contract procurement is finalized.

The Honorable Diana DeGette

- 1. How much will CMS spend this year on Medicare and Medicaid program integrity efforts?**

Answer: CMS has available funding for program integrity in FY 2014 of approximately \$1.4 billion after sequestration, including funds from the following sources: Healthcare Fraud and Abuse Control (HCFAC) accounts, user fees for Medicare provider enrollment and oversight, and the Medicaid Integrity Program under section 1936 of the Social Security Act. Of this amount, approximately \$176.6 million is for Medicaid program integrity.

- 2. Please explain your plans for the money if Congress appropriates the requested funding for your agency.**

Answer: The President's FY 2015 Budget proposes to build on recent progress by increasing support for the HCFAC program through both mandatory and discretionary funding streams. The HCFAC investment supports efforts to reduce the Medicare FFS improper payment rate and initiatives of the joint HHS-DOJ HEAT task force, including Strike Force teams in cities where intelligence and data analysis indicate high levels of fraud, and the HFPP between the Federal Government, private insurers, and other stakeholders. CMS will also make further investments in innovative prevention initiatives, such as the FPS that analyzes all Medicare FFS claims using sophisticated algorithms to identify suspicious behavior. In FY 2015 and beyond, CMS will continuously refine these technologies to better combat fraud, waste, and abuse in Medicare, Medicaid, and CHIP. Finally, these funds will support more rigorous data analysis and an increased focus on civil fraud, such as off-label marketing and pharmaceutical fraud. A complete breakdown of allocations for the FY 2015 HCFAC Budget proposal is attached.

FY 2015 CMS HCFA Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
I. Strengthening Program Integrity Activities in Medicare Advantage and Medicare Part D			
Medicare Drug Integrity Contractors (MEDICs)	\$25,300	\$0	\$25,300
Part C & D Contract/Plan Oversight	\$28,314	\$0	\$28,314
Monitoring, Performance Assessment, and Surveillance	\$55,117	\$0	\$55,117
Program Audit	\$39,283	\$0	\$39,283
Compliance and Enforcement	\$21,377	\$0	\$21,377
Total	\$169,391	\$0	\$169,391
II. Program Integrity Staffing & Support			
Field Offices/Rapid Response/and Oversight Staffing	\$10,726	\$23,473	\$34,199
Total	\$10,726	\$23,473	\$34,199
III. Program Integrity Special Initiatives			
Automated Provider Screening	\$3,519	\$6,481	\$10,000
1-800 Medicare Integration	\$0	\$3,200	\$3,200
Case Management System	\$0	\$5,000	\$5,000
Technology and Strategic Decision Support	\$0	\$2,000	\$2,000
Beneficiary Fraud Outreach	\$0	\$4,000	\$4,000
Joint Hospice Project	\$0	\$2,000	\$2,000
Southern California Rapid Response	\$0	\$2,000	\$2,000
Total	\$3,519	\$24,681	\$28,200
IV. Prevent Excessive Payments			
Fraud Prevention System	\$24,000	\$0	\$24,000
Fraud System Enhancements	\$0	\$2,000	\$2,000
Command Center	\$0	\$2,000	\$2,000
Benefits Integrity	\$0	\$29,880	\$29,880
Medical Review	\$0	\$17,250	\$17,250
Total	\$24,000	\$51,130	\$75,130
V. Program Integrity Oversight Efforts			
Overpayment/Payment Suspension	\$0	\$5,000	\$5,000
Compromised Numbers Checklist	\$0	\$1,400	\$1,400
National Supplier Clearinghouse	\$0	\$27,822	\$27,822
One PI Data Analysis	\$0	\$18,869	\$18,869
HEAT Support / Strike Force	\$0	\$2,000	\$2,000
Appeals Initiatives	\$0	\$4,654	\$4,654
Healthcare Fraud Prevention Partnership	\$0	\$29,500	\$29,500
Probable Fraud Study Database & Analysis	\$0	\$3,500	\$3,500
Total	\$0	\$92,745	\$92,745

FY 2015 CMS HCFAC Funding Request
(Dollars in Thousands)

Project or Activity	FY 2015 Base Request	FY 2015 Additional Funding	FY 2015 Total Request
VI. Medicaid Program Integrity Initiatives			
Payment Error Rate Measurement (PERM)	\$21,000	\$0	\$21,000
Correct Coding Initiative	\$0	\$1,500	\$1,500
State Readiness, Enrollment and Eligibility	\$0	\$4,000	\$4,000
Medicaid and CHIP Business Information Solutions (MACBIS)	\$0	\$7,236	\$7,236
Physician Transparency	\$4,000	\$0	\$4,000
Healthcare Fraud Prevention Partnership	\$0	\$4,500	\$4,500
IT Shared Services	\$4,708	\$4,730	\$9,438
Total	\$29,708	\$21,966	\$51,674
VII. Private Insurance Program Integrity			
Private Insurance PI	\$0	\$25,000	\$25,000
Total	\$0	\$25,000	\$25,000
HCFAC Summary			
Total Medicare Integrity	\$207,636	\$192,029	\$399,665
Total Medicaid Integrity	\$29,708	\$21,966	\$51,674
Total Private Insurance Integrity	\$0	\$25,000	\$25,000
Total CMS Funding Request	\$237,344	\$238,995	\$476,339