STATEMENT OF

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ON

"MEDICARE PROGRAM INTEGRITY: SCREENING OUT ERRORS, FRAUD AND ABUSE"

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
ENERGY & COMMERCE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JUNE 25, 2014

U.S. House Committee on Energy & Commerce
Subcommittee on Oversight & Investigations
Hearing on
"Medicare Program Integrity: Screening Out Errors, Fraud and Abuse"
June 25, 2014

Chairman Murphy, Ranking Member DeGette, Vice Chairman Burgess and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts to strengthen provider enrollment. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee's commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. We have made important strides in reducing waste, fraud and abuse across our programs with the strong support of this Committee and the Congress, and I appreciate the opportunity to detail the tangible results from these improvements.

CMS is using a multi-faceted strategy to target all causes of waste, abuse and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. Thanks in part to the authorities and resources provided by the Affordable Care Act and the Small Business Jobs Act of 2010, CMS has powerful tools to ensure that only legitimate providers are enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). CMS has enhanced the provider enrollment and screening process, which includes risk-based screening that increases the level of scrutiny for providers designated to the moderate and high screening levels. CMS is revalidating all of the Medicare program's existing providers to ensure that only qualified and legitimate providers can provide health care items and services to Medicare beneficiaries. As result of these efforts, over 20,218 providers and suppliers have had their billing privileges revoked, preventing these entities from billing Medicare.

In 2014, as program integrity efforts mature, CMS is applying three key operational principles to guide all of our initiatives. First, we aim to achieve operational excellence in addressing the full spectrum of program integrity causes, in taking swift administrative actions, and in the performance of audits, investigations and payment oversight. Second, CMS will provide leadership and coordination in program integrity efforts across the healthcare system. Finally, we

will focus on impacting the cost and appropriateness of care across healthcare programs. Fraud can inflict real harm to Medicare patients. When fraudulent providers steal a beneficiary's identity and bill for services or goods never received, the beneficiary may later have difficulty accessing needed and legitimate care. Medicare beneficiaries are at risk when fraudulent providers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity. Our efforts are focused on ensuring that beneficiaries receive appropriate health care services, protecting both beneficiaries and taxpayers from unnecessary costs. In addition to CMS's ongoing program integrity efforts, the President's Fiscal Year (FY) 2015 Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years.

Strengthening provider enrollment

A critical component to preventing waste, fraud and abuse is to ensure that only legitimate providers have the ability to bill Medicare in the first place. 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.

Risk-based screening of providers

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. All Medicare providers undergo a baseline screening, including confirmation of the provider'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 Office of Inspector General (OIG) exclusion list for all individuals listed on the application.

Under section 1128 of the Social Security Act, the Secretary, through 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 Death Master File 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 respective plea or conviction, and if the provider 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. 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 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 that has been subject to certain adverse actions, including prior revocation, payment suspension, or licensure suspension or revocation.

State Medicaid agencies may rely on the screening done by CMS for dually-enrolling providers to assist them in complying with the requirement to terminate any provider that has been terminated by Medicare or another state Medicaid program for cause. Additionally, CMS has the discretionary authority to revoke Medicare billing privileges where a state has terminated or revoked a provider's or supplier's Medicaid billing privileges. [1] CMS established a process for

[1] Note: This authority was created by: http://www.gpo.gov/fdsys/pkg/FR-2011-02-02/pdf/2011-1686.pdf

states to report and share information about Medicaid termination. States have been instructed to report all "for cause" Medicaid terminations, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. Over the past seven months, CMS has reviewed 400 Medicaid terminations, and CMS has revoked nearly 50 Medicare providers based on this information. This prevents bad actors from jumping from program to program.

Revalidation of existing Medicare providers

The Affordable Care Act also required CMS to revalidate all existing 1.5 million Medicare suppliers and providers under the new 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.[2] As previously noted, since the implementation of these requirements, CMS has 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 a licensure requirements.

Expanding and strengthening provider enrollment requirements

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.

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

In May 2014, CMS issued a final rule that requires prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file by June 2015. CMS also established a new revocation authority for abusive prescribing patterns that will be effective in July 2014. Additionally, Medicare enrollment could be revoked if a prescriber's Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked or the applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.[3]

Enrollment Moratoria

CMS has used the authority provided to the Secretary in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In July 2013, CMS announced temporary moratoria on the enrollment of new HHAs and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.[4] In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.[5] CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

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

[3] http://oig.hhs.gov/oei/reports/oei-02-09-00608.pdf
[4] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[5] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

put into place. Additionally, law enforcement made arrests in a $48 million Miami home health scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies in the last 12 months, and 92 revocations occurring after the moratorium was put into place in Houston.

Proper and Accurate Claims Payment

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

Prior Authorization

CMS also develops targeted demonstrations related to areas that have been consistently problematic, such as the Powered Mobility Device (PMD) benefit, where CMS found that over

80 percent of claims for PMDs did not meet Medicare coverage requirements.[6] CMS implemented the Medicare 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 the PMDs included in the demonstration decreased from $20 million in September 2012 to $6 million in December 2013 in the non-demonstration states and from $12 million to $3 million in the 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 fee-for-service items, particularly those items at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and preventing potential improper payments before they are made.

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[6] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

[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.

Medical Review

The detection of improper payments can sometimes require an evaluation of the medical record – to identify documentation errors for example – which is not submitted with claims. CMS and its Medicare Administrative Contractors (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 to encouraging providers to conduct self-audits or targeting medical review of specific providers. Comparative reports educate providers about their billing practices by showing the provider in comparison to his or her state and national peers. The MACs reported that medical review resulted in $5.6 billion in savings for FY 2013.[12]

Fraud Prevention System

Under the Small Business Jobs Act of 2010, CMS is required to use predictive modeling and other analytic technologies to identify and prevent fraud, waste, and abuse in our Medicare fee-for-service program. Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS's Zone Program Integrity Contractors (ZPICs). The ZPICs then identify administrative actions that can be implemented swiftly, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS is also an important management tool, as it prioritizes leads for ZPICs to review and investigate Medicare fraud in their designated region, making our program integrity strategy more data-driven.

Results from the FPS demonstrate a positive return on CMS's investment, and in its first year of implementation, the FPS stopped, prevented, or identified an estimated $115.4 million in improper payments.[13] These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the

[12] http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf
[13] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

suspension of payments, and changes in behavior that result from CMS actions. The administrative actions and associated savings increased substantially in the second implementation year, indicating the FPS is getting better at identifying fraud, waste, and abuse.

CMS is also piloting the use of the tool with the MACs to see if they can change aberrant billing behavior by directly contacting providers flagged in the FPS. Based on the small pilot, CMS has seen changes in billing behavior in half of the providers contacted within one month, and of the remaining, additional actions were taken, including self-audit and prepayment review.

Leadership and Coordination Across the Health Care System

CMS is coordinating a variety of efforts with Federal and state partners, as well as the private sector to better share information to combat fraud. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans in designing and implementing a comprehensive plan to detect, correct and prevent waste, abuse, and fraud. In September 2013, CMS directed the Part C and D program integrity contractor to increase its focus on proactive data analysis. As a result, the contractor performed analyses that identified the following improper payments: $4.8 million from deceased provider payments, $21 million for unallowable charges for medication during hospice stays, and $80 million for Transmucosal Immediate Release Fentanyl drugs without a medically-acceptable indication. To increase the impact of the proactive analysis, CMS issued a final rule that allows CMS, the OIG and the Government Accountability Office to request and collect information directly from pharmacy benefit managers, pharmacies and other downstream entities of Part D plans.

Collaborating with law enforcement and the private sector

Earlier this year, the Government announced that in FY 2013, its waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.3 billion in taxpayer dollars from

individuals trying to defraud Federal health care programs serving seniors and taxpayers.[14] Over the last five years, the Administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Over the last three years, the average return on investment (ROI) of the HCFAC program is $8.10 for every dollar spent, which is an increase of $2.70 over the average ROI for the life of the HCFAC program since 1997. As a result of these and other efforts, there has been a measurable decrease in Medicare payments for certain medical services that have also been targeted by the Medicare Strike Force.

Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the Attorney General announced a ground-breaking partnership with the private sector to fight fraud, waste, and abuse across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover fraud, waste and abuse that could not otherwise be identified. The HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop payments from going out the door.

Improving Data Transparency

CMS recently released new, privacy-protected data on services and procedures provided to Medicare beneficiaries by physicians and other health care professionals. Release of physician-identifiable payment information serves a significant public interest by increasing transparency of Medicare payments to physicians, which are governed by statutory requirements, and shed light on potential Medicare waste, fraud, and abuse. The new data also show payment and submitted charges, or bills, for those services and procedures by provider. The new data set has information for over 880,000 distinct health care providers who collectively received $77 billion in Medicare payments in 2012, under the Medicare Part B fee-for-service program. With this data, it is possible for the public to conduct a wide range of analyses that compare 6,000 different

[14] http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf

types of services and procedures provided, as well as payments received by individual health care providers.

Later this year, CMS will release additional data to help consumers make informed choices under the Open Payments program. As required by the Affordable Care Act, the data will provide information about payments to physicians made by certain manufacturers of covered drugs and devices. This program is a resource for beneficiaries, consumers, and providers to better understand relationships between physicians, teaching hospitals, and industry. Collaboration among physicians, teaching hospitals, and industry manufacturers can contribute to the design and delivery of life-saving drugs and devices. However, while some collaboration is beneficial, payments from manufacturers to physicians and teaching hospitals can also introduce conflicts of interests.

Moving Forward

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive, or fraudulent services. But the importance of program integrity efforts extends beyond dollars and health care costs alone. It is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care. Although we have made significant progress by implementing important policies to improve provider screening, we are continually refining our policies and processes. 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.