STATEMENT OF

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ON

"IDEAS TO IMPROVE MEDICARE OVERSIGHT TO
REDUCE WASTE, FRAUD AND ABUSE"

BEFORE THE
UNITED STATES HOUSE WAYS & MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH

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Chairman Brady, Ranking Member McDermott, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We have made important strides in reducing fraud, waste, and abuse across our programs and I appreciate the opportunity to discuss the priorities of CMS' Center for Program Integrity.

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 improve our efforts to detect and prevent fraud, waste, and abuse in Medicare. The fundamental change in the Administration's approach to fraud-fighting is a stronger focus on prevention. Historically, CMS and our law enforcement partners have been forced to use "pay and chase" by paying claims and then working to identify and recoup fraudulent payments. Now, CMS is using a variety of tools to keep fraudsters out of our programs, and to uncover fraudulent schemes quickly, before they drain valuable resources from our Trust Funds. Our efforts in Medicare and Medicaid strike an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers and suppliers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.

Earlier this year, the government announced that in fiscal year (FY) 2013, its fraud, waste, and abuse 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.[1] 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

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

investment 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.

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 health care system. Finally, we will focus on impacting the cost and appropriateness of care across health care 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.

Operational Excellence

CMS is working 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. To support these efforts, CMS is launching an improved contracting approach, the Unified Program Integrity Contractors (UPIC) to integrate the program integrity functions for audits and investigations across Medicare and Medicaid from work currently performed by several existing contractors.

Strengthening Provider Enrollment

The Affordable Care Act required CMS to implement categorical 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 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. Categories of providers and suppliers designated as limited risk undergo verification of licensure and a wide range of database checks to ensure compliance with any provider or supplier-specific requirements. Categories of providers and suppliers designated as moderate or high categorical risk are subject to all the requirements in the limited screening level, plus additional screening including unannounced site visits. In April 2014, CMS announced that upon notification, providers assigned to the high screening level will begin fingerprint-based background checks.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. CMS embarked on an ambitious project to revalidate the enrollment information of all existing providers and suppliers, and these efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.[2] Since implementation of these requirements, CMS has also revoked 17,534 providers' and suppliers' ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions, were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

CMS is collaborating with our State partners to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one State will not be able to replicate their scams in another State's Medicaid program. Specifically, the Affordable Care Act and CMS's implementing regulations require States to terminate from Medicaid and the State Children's Health Insurance Program (CHIP) those providers whose Medicare billing privileges have been revoked for cause or that another State's Medicaid or CHIP agency has terminated for cause. Similarly, under current authority, the Medicare program may also revoke

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

the billing privileges of its providers or suppliers that were terminated by State Medicaid or CHIP agencies.

<u>Enrollment Moratoria</u>

The Affordable Care Act provides the Secretary the authority to impose a temporary moratorium on the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines the moratorium is necessary to prevent or combat fraud, waste, or abuse under these programs. States affected are required to determine whether the imposition of a moratorium would adversely affect Medicaid beneficiaries' access to medical assistance and may refuse the moratorium if there would be an adverse effect. When a moratorium is imposed, existing providers and suppliers may continue to deliver and bill for services, but no new applications will be approved for the designated provider or supplier-types in the designated areas. The moratoria enable CMS to pause provider entry or re-entry into markets that CMS has determined have a significant potential for fraud, waste or abuse while working with law enforcement to use other tools and authorities to remove bad actors from the program. CMS is required to re-evaluate the need for such moratoria every six months.

In the last year, CMS has used this authority to fight fraud, waste, and abuse, and to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (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.[3] 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.[4]

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. In each moratoria area, CMS is

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[3] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html
[4] http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html

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. During the first six-month period of the moratorium, for example, CMS has revoked or deactivated billing privileges of 21 Miami HHAs in the first 60 days of the moratorium. Additionally, law enforcement made arrests in a $48 million 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 $8 million fraud scheme.

Before taking these actions, CMS consulted with HHS OIG, the Department of Justice (DOJ), and the relevant State Medicaid Agencies, and found that fraud trends warranted moratoria on certain types of providers in these geographic areas. CMS also reviewed key factors of potential fraud risk including a disproportionately high number of providers and suppliers relative to the number beneficiaries, and extremely high utilization. All the geographic areas included in the moratoria ranked as high-risk in these fraud risk factors.

CMS carefully examined Medicare beneficiary access to services in all of these areas, and concluded that the moratoria will not affect access to care. The Agency also worked closely with each of the affected states to evaluate patient access to care, and these states reported that Medicaid and CHIP beneficiaries will continue to have access to services. During the moratoria period, CMS and the affected states will continue to monitor access to care to ensure that Medicare, Medicaid, and CHIP beneficiaries are receiving the services they need.

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 fee-for-service Medicare 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. CMS designed the FPS to accommodate different analytic model types to address a variety of fraud schemes. The most important indicator of success is that the models in the FPS have led to administrative action – we have used our revocation authority to remove bad actors from the Medicare program, which is the surest way to protect Trust Fund dollars and

beneficiaries, suspended potentially fraudulent payments from going out the door, and referred leads and cases to law enforcement.

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). When suspect behavior or billing activity is identified, the ZPICs 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. The FPS also gives CMS a provider-level view of ZPIC activities and administrative actions.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS FY 2012 Report to Congress,[5] in its first year of implementation, the FPS stopped, prevented or identified an estimated $115.4 million in improper payments. These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the suspension of payments, and changes in behavior that result from CMS actions. The FPS achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; CMS anticipates that the ability of FPS to identify bad actors and focus investigative resources on most egregious schemes will continue to expand.

National Correct Coding Initiative

CMS has developed the National Correct Coding Initiative (NCCI), which consists of edits designed to reduce improper payments in Medicare Part B and Medicaid. This program was originally implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.[6] In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for

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[5] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf
[6] Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.

Medicare Part B claims as part of the NCCI program.[7] NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national health care 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.[8] The use of the NCCI procedure-to-procedure edits saved the Medicare program $483 million in FY 2012, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $5 billion since 1996 based on savings reports from claims-processing contractors.

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 enhanced its data analysis and improved coordination with law enforcement to get a more comprehensive view of activities in Medicare Advantage and Part D. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans design and implement a comprehensive plan to detect, correct and prevent fraud, waste and abuse.

CMS also contracts with the Medicare Drug Integrity Contractor (MEDIC) to perform analysis to identify fraud, waste and abuse as well as identifies vulnerabilities in MA and Part D. In September 2013, CMS directed the MEDIC to increase its focus on proactive data analysis in Part D. As a result, the MEDIC identified vulnerabilities and then performed analysis that resulted in notification to plan sponsors to remove records associated with inaccurate data leading to improper payments made in FYs 2011 and 2012. This increased focus on proactive analysis resulted in savings of $4.8 million from decreased provider payments, $21 million for unallowable charges for medications during a hospice stay, 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 proposed rule that would provide CMS, the

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[7] MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single data of service.

[8] Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

MEDIC, OIG and GAO the ability to request and collect information directly from pharmacy benefit managers, pharmacies and other downstream entities of Part D Plans.

The rule also proposes to require prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file in order to ensure that only qualified individuals are prescribing for Medicare beneficiaries. This proposed enrollment requirement would work in conjunction with another proposed requirement that would allow CMS to revoke a Part D prescriber's enrollment based on abusive prescribing practices and patterns. This proposal would provide CMS the authority to revoke a physician's or eligible professional's Medicare enrollment if CMS determines that he or she has a pattern or practice of prescribing Part D drugs that is abusive and represents a threat to the health and safety of Medicare beneficiaries, or otherwise fails to meet Medicare requirements. Additionally, prescribing authority 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.

Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the Attorney General announced a historic 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 35 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.

Health Care Fraud Prevention & Enforcement Action Team

In addition to CMS's commitment to collaboration, the sustained success of Health Care Fraud Prevention & Enforcement Action Team (HEAT) demonstrates the effectiveness of the Cabinet-level commitment between HHS and DOJ to prevent and prosecute health care fraud. Since its

creation in May 2009, HEAT has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud, waste, and abuse data intelligence sharing workgroup. A key component of HEAT is the presence of Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as providers or suppliers.

In the six and a half years since its inception,[9] Strike Force prosecutors have filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than $5.5 billion; 1,137 defendants pleaded guilty and 148 others were convicted in jury trials; 1087 defendants were sentenced to imprisonment for an average term of about 47 months.

Educating Beneficiaries: A Key Tool in Preventing Fraud

Beneficiary involvement is a key component of all of CMS's anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to suspect providers and suppliers for inappropriate services or items, and prevent further abuses in the program. In June 2013, CMS began sending redesigned Medicare Summary Notices (MSNs),[10] the explanation of benefits for people with Medicare fee-for-service, to make it easier for beneficiaries to spot fraud or errors. The new MSNs include clearer language, descriptions and definitions, and have a dedicated section that tells beneficiaries how to spot potential fraud, waste, and abuse. Beneficiaries are encouraged to report fraud, waste, and abuse to 1-800-MEDICARE, and this is promoted in the re-designed MSN. CMS has an incentive reward program that currently offers a reward of 10 percent of the amount recovered up to $1,000 paid to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds. Last year, CMS released a proposed rule that if finalized, would increase these rewards to 15 percent of the amount recovered up to $10 million.[11]

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[9] Specifically, the period from May 7, 2007, through September 30, 2013.
[10] http://blog.medicare.gov/2013/06/06/redesigned-with-you-in-mind-your-medicare-summary-notice/
[11] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-04-24.html

CMS has also been partnering with the Administration for Community Living (ACL) to lend support to the Senior Medicare Patrol (SMP) program, a volunteer-based national program that educates Medicare beneficiaries, their families, and caregivers to prevent, detect, and report Medicare fraud, waste and abuse. The SMP program empowers Medicare beneficiaries through increased awareness and understanding of health care programs and educates them on how to recognize and report fraud. During 2012, SMP program grantees' staff and more than 5000 volunteers reached nearly 1.5 million people with group education sessions and one-on-one counseling.[12] SMP projects also work to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control and consumer protection entities, including Medicare contractors, State Medicaid fraud control units, State attorneys general, HHS OIG, and the Federal Trade Commission.

Impact on Cost and Appropriateness of Care

CMS is implementing program integrity activities that will prevent improper payments while ensuring that only appropriate care is provided. Such efforts targeting target waste, fraud and abuse have already helped extend the life of the Medicare Trust Fund, and it is critical in doing more to protect Medicare for years to come. Fraud can also inflict real harm on Medicare beneficiaries. By preventing fraud, we ensure that beneficiaries are less exposed to risks and harm from fraudulent providers, and providing them reliable access to quality health care from legitimate providers while preserving Trust Fund dollars.

Proposals to Improve the Prevention of Waste, Fraud, and Abuse

The FY 2015 President's Budget reflects the Administration's commitment to strong program integrity initiatives. For FY 2015, the Budget invests a total of $428 million in new HCFAC funds and the Medicaid Integrity Program. Together with program integrity investments in the Budget will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years. The Budget also includes 17 legislative proposals that provide additional tools to further enhance program integrity efforts in the Medicare and Medicaid programs, as well as authority to retain recoveries from certain program integrity activities to help correct vulnerabilities and administer

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[12] http://oig.hhs.gov/oei/reports/oei-02-13-00170.pdf.

the programs. The Budget includes additional investments and flexibility for the Medicaid Integrity Program.

The Budget proposes new authorities to prevent improper payments from ever being made. One proposal builds on the success of the Power Mobility Device (PMD) Prior Authorization Demonstration by giving CMS the authority to require prior authorization for all Medicare fee-for-service items, particularly those items at the highest risk for improper payment. Based on claims submitted as of September 30, 2013, spending for PMDs has decreased by $117 million (assuming that the month expenditures for PMDs would have remained constant).[13] 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.

The Budget also aims to improve payment accuracy by allowing the Secretary to create a Medicare claims ordering system requiring electronic submission of orders prior to payment for certain high risk products and services, like durable medical equipment and home health, to validate that a physician or other eligible practitioner ordered the service. Many existing systems do not automatically validate the elements of an order prior to payment of a claim. This new system would ensure that the supplier billing for the service or equipment has received all necessary components from the ordering physician or the eligible practitioner prior to payment.

New data transparency initiatives
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 will serve a significant public interest by increasing transparency of Medicare payments to physicians, which are governed by statutory requirements, and shed light on Medicare fraud, waste, 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

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[13] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-CompliancePrograms/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf

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 will be possible to conduct a wide range of analyses that compare 6,000 different 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 national 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

Medicare fraud, waste, and abuse affect every American by draining critical resources from our health care system. 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 cost alone. It is fundamentally about protecting our beneficiaries – our patients – and ensuring we have the resources to provide for their care. Although we have made significant progress in stopping fraud and improper payments, more work remains to be done.

Going forward, we must continue our efforts to move beyond "pay and chase" to prevent fraud before it happens, provide leadership and coordination to address these issues across the health care system, and ensure that we take administrative action as swiftly as possible to stop suspected instances of waste, fraud, and abuse. We appreciate committee members' high level of interest in program integrity, many of whom have introduced or sponsored legislation in this

area. I look forward to working with you and the Congress on your ideas to continue making improvements in protecting the integrity of our health care programs and safeguarding taxpayer resources.