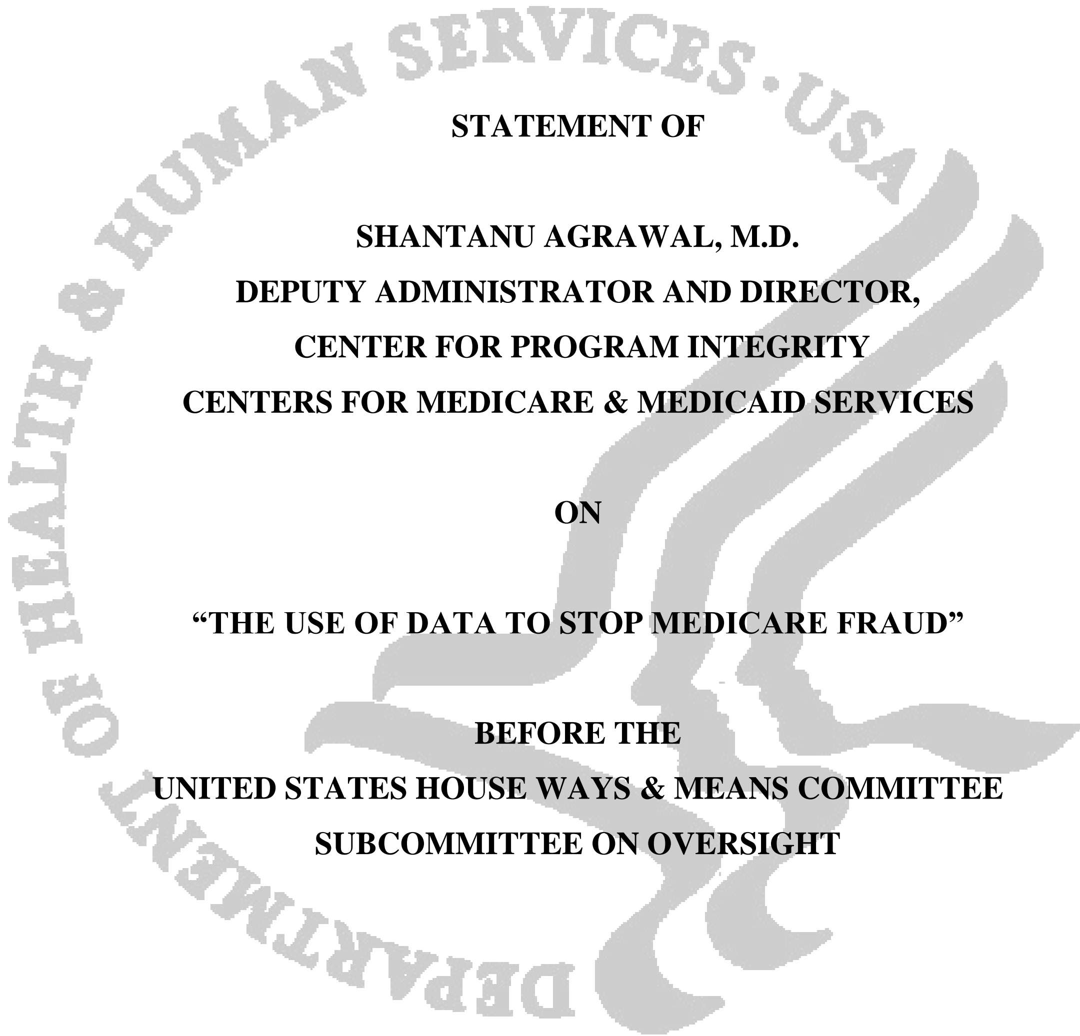

STATEMENT OF

SHANTANU AGRAWAL, M.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"THE USE OF DATA TO STOP MEDICARE FRAUD"

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

MARCH 24, 2015

U.S. House Ways & Means Committee
Subcommittee on Oversight
Hearing on
"The Use of Data to Stop Medicare Fraud"
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Chairman Roskam, Ranking Member Lewis, and members of the Subcommittee, 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 CMS' program integrity 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 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 dependent upon "pay and chase" activities, by working to identify and recoup fraudulent payments after claims were paid. Now, CMS is using a variety of tools, including innovative data analytics, to keep fraudsters out of our programs and to uncover fraudulent schemes and trends 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. Fraud can inflict real harm on beneficiaries. 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. 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. When we prevent fraud, we ensure that beneficiaries are less exposed to risks and harm from fraudulent providers, and are provided with

improved access to quality health care from legitimate providers while preserving Trust Fund dollars.

We have seen important success from these efforts. CMS is using a multi-faceted approach to strengthen Medicare by more closely aligning payments with the costs of providing care, encouraging health care providers to deliver better care and better outcomes for their patients, and improving access to care for beneficiaries. We have instituted many program improvements and are continuously looking for ways to refine and improve our program integrity activities.

In addition to CMS' ongoing program integrity efforts, the President's Fiscal Year (FY) 2016 Budget reflects the Administration's commitment to strong program integrity initiatives. Together the program integrity investments in the Budget will yield $21.7 billion in savings for Medicare and Medicaid over 10 years. The Budget also includes 16 legislative proposals that provide additional tools to further enhance program integrity efforts in the Medicare and Medicaid programs. In addition, to better protect seniors and the Medicare program against the risks associated with identity theft,[1] the Budget proposes $50 million in FY 2016 to support the removal of Social Security Numbers from Medicare cards so that millions of beneficiaries will no longer have to fear that their personal identification numbers could be used against them due to a lost, stolen, or misused Medicare card.

Using Data to Identify New Trends in Fraud and Enhance Prevention

CMS is working to achieve operational excellence in addressing the full spectrum of program integrity issues, 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.

[1] MEDICARE INFORMATION TECHNOLOGY: Centers for Medicare and Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards. GAO-13-761: Published: Sep 10, 2013. Publicly Released: Oct 17, 2013.

Strengthening Provider Enrollment

Provider enrollment is the gateway to billing within the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers and suppliers are enrolling in the Medicare program. 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 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 Health and Human Services (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. CMS routinely revokes billing privileges from enrolled providers and suppliers based on the Social Security Administration's complete death master file and CMS' repository of information contained in the OIG's exclusion list, the Medicare Exclusion Database (MED). Revocations are retroactive to the date of a provider'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, beginning in September 2014 and on a phased-in basis, providers and suppliers who were designated to the high screening level must also undergo a fingerprint-based criminal history check 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 are required to terminate the enrollment of 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. CMS established a process for 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. CMS has revoked 290 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 required CMS to revalidate all 1.5 million existing Medicare providers and suppliers under new risk-based screening requirements. CMS is on track to request the revalidation of all providers and suppliers by the end of this month. Since March 25, 2011, more than one million providers and suppliers have been subject to the new screening requirements, over 470,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and almost 28,000 provider and supplier enrollments were revoked.[2]

CMS continues to make improvements in its oversight of provider enrollment. In December 2014, CMS issued a Final Rule that permits revocation of providers or suppliers that demonstrate patterns or practices of abusive billing, permits CMS to deny the enrollment of providers, suppliers, or owners affiliated with an entity that has unpaid debt to the Medicare

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

program, and expands the list of felony convictions that could prevent a provider or supplier from participating in Medicare.

Enrollment Moratoria

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 are not required to comply with 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.

In July 2013, CMS announced temporary moratoria on new HHAs in and around Miami and Chicago, and ground‑based ambulances in and around Houston. In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in Philadelphia. CMS is required to re-evaluate the need for such moratoria every six months and on January 29, 2015, CMS extended these existing moratoria for an additional six months. In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of billing privileges of HHAs and ambulance companies, as well as working with law enforcement to support investigations and prosecutions.

Fraud Prevention System

CMS is leading the government and healthcare industry in systematically applying advanced analytics to claims on a nationwide scale. Since 2011, CMS has been using its Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming,

national basis by using predictive algorithms and other sophisticated analytics to analyze every Medicare fee-for-service claim against billing patterns. The system also incorporates other data sources, including information on compromised Medicare cards and complaints made through 1-800-MEDICARE. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS' 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 in their designated region, making our program integrity strategy more data-driven.

The Small Business Jobs Act requires the OIG to certify the projected and actual savings from the FPS, and also to determine whether CMS should continue, modify or expand the use of the FPS. Since the implementation of the FPS, CMS has demonstrated a positive return on its investment and the OIG found that CMS' ongoing use of the FPS will strengthen efforts to prevent fraud, waste and abuse in the Medicare fee-for-service program. In its second year of operation, the OIG certified CMS' identified and adjusted savings, and the FPS identified or prevented more than $210 million in improper Medicare fee-for-service payments, double the previous year. It also resulted in CMS taking action against 938 providers and suppliers. 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.

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. Another value of expanding the use of the FPS tool is that the MAC and ZPIC may be able to better coordinate audit activity on a specific provider in the same system, reducing burden on the provider and providing a forum for collaboration between contractors.

One of the most important advances FPS brings to CMS' fraud identification capabilities is that the FPS is uniquely capable of evaluating claims for episodes of care that span multiple legacy claims processing systems as well as those that span multiple visits over a period of time. What this means is that FPS can identify billing patterns and claim aberrancies that would be undetectable or difficult to detect by CMS' current claim edit modules or a single contractor reviewing on a claim by claim basis. In addition, FPS now has the capability to stop payment of certain improper and non-payable claims by communicating a denial message to the claims payment system. As recommended by the Government Accountability Office (GAO), CMS successfully enhanced the integration of the FPS and the claims processing system during the second implementation year.[3]

Leadership and coordination across the health care system

CMS remains committed to identifying and taking timely, appropriate action against emerging forms of fraud, waste, and abuse. Prescription drug abuse is a quickly growing problem that has touched providers, pharmacies, and beneficiaries in the Part D program. While the Part D program is strong, CMS knows it must continually improve the program and address vulnerabilities. Based on input from the HHS OIG, GAO, and stakeholders, over the past several years, CMS has broadened its initial focus of strengthening beneficiary access to prescribed drugs to also address fraud and drug abuse by making sure Part D sponsors implement effective safeguards and provide coverage for drug therapies that meet safety and efficacy standards. 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 compliance program guidelines to assist Medicare Advantage plans and prescription drug plans in designing and implementing a comprehensive plan to detect, correct and prevent fraud, waste and abuse.

CMS also contracts with the Medicare Drug Integrity Contractor (MEDIC), which is charged with identifying and investigating potential fraud and abuse, and developing cases for referral to

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[3] Government Accountability Office Report, "CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness." (GAO-13-104) See http://www.gao.gov/assets/650/649537.pdf.

law enforcement agencies. 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.

CMS also issued a Final Rule that both establishes a new revocation authority for abusive prescribing patterns and requires prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file. Additionally, CMS may now also revoke a prescriber's Medicare enrollment if his or her 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.

The President's FY 2016 Budget includes a proposal to give the Secretary the authority to establish a requirement that high-risk Medicare beneficiaries only use certain prescribers and/or pharmacies to obtain controlled substance prescriptions, similar to many state Medicaid programs. Currently, CMS requires Part D sponsors to conduct drug utilization reviews, which assess the prescriptions filled by a particular enrollee. These efforts can identify overutilization that results from inappropriate or even illegal activity by an enrollee, prescriber, or pharmacy. However, CMS' statutory authorities to take preventive measures in response to this information presently are limited. Under the President's FY 2016 Budget proposal, the Medicare program would be required to ensure that beneficiaries retain reasonable access to needed medication.

Collaborating with law enforcement and the private sector

Since its inception in 1997, the waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the recovery of $27.8

billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers. Over the last three years, the average return on investment (ROI) of the HCFAC program is $7.70 for every dollar spent, which is an $2 higher than the average ROI for the life of the HCFAC program.

CMS is committed to working with our law enforcement partners, who take a lead role in investigating and prosecuting alleged fraud. CMS provides support and resources to the Strike Forces, which investigate and track down individuals and entities defrauding Medicare and other government health care programs. Since 2006, CMS has been building the Integrated Data Repository (IDR), a data warehouse to integrate Medicare and Medicaid data so CMS and our partners can access data from a single source. The IDR provides a comprehensive view of Medicare and Medicaid data including claims, beneficiary, and drug information. The IDR provides greater information sharing, broader and easier access to data, enhanced data integration, and increased security and privacy of data, while strengthening our analytical capabilities. The IDR makes fraud prevention and detection efforts more effective by eliminating duplicative efforts. CMS has been working closely with law enforcement to provide training and support in the use of One PI for their needs.

Importantly, these joint efforts have also led to a measurable decrease in expenditures in areas of focus. For example, there has been a dramatic decline in payment for home health care in Miami and throughout Florida. In 2009, claims to Medicare for home health services in Florida were $3.4 billion, and Medicare paid approximately $2.9 billion for home health care services. Just two years later, in 2011, billings to Medicare had dropped to $2.3 billion, a difference of $1.1 billion.

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 38 partner organizations from the public

and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. We are continuing to grow strategically by adding new partners and identifying additional overlapping fraud schemes. The HFPP has completed the following four studies to date – Misused Codes and Fraud Schemes, Non-Operational Providers (or "false store fronts"), Revoked and Terminated Providers, and Top-Billing and High Risk Pharmacies – that have enabled partners, including CMS, to take substantive actions to stop payments from going out the door. The HFPP is now in the process of launching three new studies based on successful identification of continuing challenges faced by current and new members.

The President's FY 2016 Budget proposal includes additional support for the HFPP collaboration. The proposal would give CMS the authority to accept gifts made to the Trust Funds for particular activities funded through the Health Care Fraud and Abuse Control Account, including the HFPP. Currently, the account can only receive gifts that are made for an unspecified purpose. This proposal would allow for gifts to be made to support the HFPP directly, and allow both public and private partners to support the anti-fraud program.

Moving Forward

Medicare fraud, waste, and abuse affect every American by draining critical resources from taxpayers and 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 and identify trends in fraud before it happens, provide leadership and coordination to address these issues across the health care system, and ensure that we take appropriate administrative action as swiftly as possible to stop suspected instances of waste, fraud, and abuse. I look forward to

working with you and the Congress to protect the integrity of our health care programs and safeguarding taxpayer resources.