

STATEMENT OF

**JONATHAN MORSE
ACTING DIRECTOR OF THE CENTER FOR PROGRAM INTEGRITY,
CENTERS FOR MEDICARE & MEDICAID SERVICES**

ON

**“EFFORTS TO COMBAT WASTE, FRAUD, AND
ABUSE IN THE MEDICARE PROGRAM”**

BEFORE THE

**U. S. HOUSE WAYS AND MEANS COMMITTEE,
SUBCOMMITTEE ON OVERSIGHT**

JULY 19, 2017

**U.S. House Ways and Means Committee,
Subcommittee on Oversight
“Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program”
July 19, 2017**

Chairman Buchanan, Ranking Member Lewis, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services’ (CMS) Medicare program integrity efforts, including in Medicare Part C. We share this Subcommittee’s commitment to protecting beneficiaries, ensuring taxpayer dollars are spent appropriately, and identifying and correcting improper payments. These efforts are at the forefront of our program integrity mission. Medicare Advantage (MA) has been successful in allowing innovative approaches that give Medicare enrollees options that best fit their individual health needs. Maintaining a strong Medicare program is critical for the over 57 million beneficiaries enrolled in Medicare fee-for-service (Parts A and B) and MA.

CMS uses a multi-faceted approach to strengthen Medicare by more closely aligning payments with the costs of providing care, encouraging healthcare 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.

Under the MA program (also known as Medicare Part C), Medicare beneficiaries have the option of enrolling in a private health plan to receive coverage for medical care. Beneficiaries can also enroll in a Medicare Advantage Prescription Drug (MA-PD) plan to receive prescription drug benefits. More than 18 million individuals (over 32 percent of those enrolled in the Medicare program) are enrolled in Medicare Advantage plans as of June 2017. CMS data confirms that about 99 percent of Medicare beneficiaries have access to at least one Medicare Advantage plan in 2017. Additionally, while average premiums have remained stable, access to most Medicare Advantage supplemental benefits has increased, and enrollment is growing faster than in original Medicare. Medicare Advantage plans may offer additional benefits and cost-sharing arrangements that are at least as generous as the standard Parts A and B benefits under original Medicare. In addition to the regular Part B premium, beneficiaries who choose to participate in

MA may pay monthly plan premiums, which vary based on the services offered by the plan and the efficiency of the plan.

Unlike original Medicare, CMS makes prospective, monthly per-capita payments to MA organizations. Each per-person payment is based in part on a bid amount, approved by CMS, that reflects the plan's estimate of average revenue required to provide coverage of original Medicare (Parts A and B) benefits to an enrollee with an average risk profile. CMS risk-adjusts these payments to take into account expected costs for enrolled beneficiaries based on the individual enrollee's health status and demographic factors. In general, the current risk adjustment methodology relies on enrollee diagnoses to prospectively adjust capitation payments for a given enrollee based on the enrollee's health status. Diagnosis codes submitted by MA organizations and encounter data from claims are used to determine beneficiary risk scores, which in turn determine risk adjustment payments. This methodology is designed to compensate MA organizations appropriately so they can provide needed benefits for patients enrolled in their plans.

Medicare FFS Improper Payment Rate Measurements and Prevention

Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare, Medicaid, and Children's Health Insurance Program (CHIP).¹ CMS takes seriously our responsibility to make sure our programs pay the right amount, to the right party, for the right beneficiary, in accordance with the law and agency policies. It is important to remember that while all payments made as a result of fraud are considered improper payments, improper payments typically do not involve fraud. Rather, for CMS' programs, improper payments are most often payments for which there is no or insufficient supporting documentation to determine whether the service of item was medically necessary.

CMS uses the Comprehensive Error Rate Testing (CERT) program to review a stratified random sample of Medicare fee-for-service (FFS) claims to estimate an improper payment rate. The CERT methodology is based on results from both data processing and medical record reviews for a national random sample of claims and primarily identifies payments that did not meet Medicare

¹ <https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf>

coverage, coding, and billing rules. The Medicare FFS improper payment rate decreased from 12.1 percent in 2015 to 11.0 percent, or \$41.08 billion, in 2016. The decrease from the prior year's reported error estimate was primarily driven by a reduction in improper payments for inpatient hospital claims. However, improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims were the largest contributors to the 2016 Medicare FFS improper payment rate.

CMS achieved significant savings through activities aimed at preventing improper payments before they go out the door.²³ The Fraud Prevention System (FPS) resulted in \$604.7 million in fraudulent payments being stopped, prevented, or identified during FY 2015. In March 2017, CMS launched an updated version of the Fraud Prevention System (called, "FPS 2.0"), which modernizes system and user interface, improves model development time and performance measurement, and aggressively expands CMS' program integrity capabilities.

CMS also saved the Medicare program \$393.9 million in FY 2016 using National Correct Coding Initiative (NCCI) edits. The NCCI is intended to promote national correct coding methodologies and control improper coding in Medicare Part A, Part B, and durable medical equipment (DME) claims. In addition, CMS had 435 active payment suspensions during FY 2015.

Medicare Administrative Contractors (MACs) request and review medical documentation from providers and suppliers on a prepayment and post-payment basis. In FY 2015, MAC prepayment medical review resulted in nearly \$5.0 billion in improper payments being prevented. These efforts avoid "pay and chase," as well as promote provider compliance.

Medicare Advantage Improper Payment Rate Measurements and Prevention

Due to the capitated payment structure of the MA program, CMS uses a different methodology to calculate the Medicare Part C improper payment rate. The 2016 Medicare Part C gross improper payment estimate was 9.99 percent, or \$16.18 billion. The Part C payment error rate reflects errors in risk adjustment data (clinical diagnosis data) submitted by Part C plans to CMS

² <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>

³ <https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf>

for payment purposes. Specifically, the estimate reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

The largest component of a beneficiary's risk score is currently based on clinical diagnoses submitted by plans. If the diagnoses submitted to CMS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C improper payment estimate is based on medical record reviews conducted under CMS' annual National Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

CMS uses several tools to address the Part C improper payment rate: contract-level Risk Adjustment Data Validation (RADV) audits, requirements that MA organizations report and return overpayments, and program and financial audits.

Contract-level RADV audits verify whether the diagnosis codes submitted for payment by MA organizations are supported by medical record documentation. RADV audits are CMS' primary corrective action to recoup improper payments. These audits recover overpayments identified by RADV; encourage accurate coding; increase the incentive for MA organizations to submit valid and accurate diagnosis codes; and encourage MA organizations to self-identify, report, and return overpayments they have received.

RADV audits consist of multiple steps including plan selection, document review, error calculation, appeals, and recoupment. During the annual RADV audit, CMS reviews a sample of approximately 30 MA organization contracts based on diagnosis coding intensity, or the average change in the risk score component specifically associated with the reported diagnoses for the beneficiaries covered by the contract. CMS ranks all contracts by coding intensity and divides them into three categories: high, medium, and low. CMS then randomly selects contracts for audit: 20 from the high coding intensity category, 5 from the medium category, and 5 from the low category. CMS then selects beneficiaries whose medical records will be the focus of the review based on their risk scores. Once beneficiaries are selected, CMS requests supporting medical record documentation for all diagnoses submitted to adjust risk in the payment year. CMS contractors then review the medical records to determine if the MA organization submitted the correct diagnoses.

CMS works closely with plans as part of the RADV audit process. When submitting a record for RADV, CMS encourages plans to consider a number of factors. As an example, for conditions that warrant an inpatient hospitalization (such as septicemia, cardio respiratory failure, or shock), an inpatient record, a stand-alone inpatient consultation record, or a stand-alone discharge summary may be appropriate for submission. When possible, plans are encouraged to obtain a record from the specialist treating the condition, e.g. an oncologist for a cancer diagnosis. Otherwise, a notation indicating “history of cancer,” without an indication of current cancer treatment, may not be sufficient documentation for validation.

CMS began the RADV initiative by conducting two sets of audits starting with the 2007 payment year: Pilot 2007, which involved 5 MA contracts, and Targeted 2007, which involved 32 contracts. CMS reviewed medical record documentation provided by each audited Medicare Advantage organization to substantiate conditions reported by the Medicare Advantage organization for beneficiaries in each audit sample. CMS’ findings are reported to each Medicare Advantage organization. Medicare Advantage organizations that disagree with CMS’ error determinations may challenge them through a three-stage administrative process established in the RADV Appeals regulation. For the 2007 RADV audits, CMS recouped \$13.7 million in overpayments associated with sampled beneficiaries. CMS is currently conducting the appeals process for plan year 2007. CMS is currently conducting RADV audits for plan years 2011, 2012, and 2013. The 2011 RADV audits have completed the payment error calculation phase; the 2012 RADV audits are in the payment error calculation phase; and the 2013 RADV audits are in the medical record review phase.

RADV and other program integrity efforts can have a sentinel effect on the quality of risk adjustment data submitted for payment and may help reduce the Part C improper payment rate.⁴ The impact of the RADV audits on enhancing program integrity should be examined not only in terms of RADV recoveries, but also through changes in the behavior of MA organizations.

CMS appreciates the work of the Government Accountability Office (GAO) and their recommendations on ways to improve the RADV audit program. As GAO has recommended, CMS is working to enhance the timeliness of our RADV audits and our RADV appeals process.

⁴ <https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf>

CMS is also reviewing our contract-level RADV methodology to determine other data sources that can be used to help us conduct a more targeted approach to our audits.

As required by the Social Security Act, CMS regulations specify that MA organizations report and return overpayments that they identify no later than 60 days after the date on which it identified it received an overpayment. The MA organization must notify CMS of the amount and reason for the overpayment. In FY 2016, MA organizations reported and returned approximately \$317 million in self-reported overpayments. MA organizations have reported and returned just over \$2 billion in self-identified overpayments for payment years 2006 through 2014.

Fighting Fraud, Waste, and Abuse through the Healthcare Fraud Prevention Partnership

Since FY 2012, HHS and Department of Justice (DOJ) have developed a partnership that unites public and private organizations in the fight against healthcare fraud, known as the Healthcare Fraud Prevention Partnership (HFPP). The HFPP is a platform for sharing skills, assets, and data among partners in accordance with applicable laws to address fraud issues of mutual concern. The HFPP provides visibility into the larger universe of healthcare claims and claimants beyond those encountered by any single partner. The ultimate goal of the HFPP is to exchange data and information to improve detection and prevention of healthcare fraud.

The voluntary, collaborative partnership includes the federal government, state officials, many of the leading private health insurance organizations, and other healthcare anti-fraud groups. The Partnership has completed several studies associated with fraud, waste or abuse that have yielded successful results for participating partners. Studies have examined such subjects as “false store fronts” or “phantom providers” and top billing pharmacies. Additional studies are underway and the Partnership has established a Trusted Third Party (TTP) which conducts HFPP data exchanges, research, data consolidation and aggregation, reporting, and analysis. Partners participated in the HFPP’s first case information sharing session in 2015, resulting in an average of seven new fraud leads per partner. The HFPP currently has 79 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In all, HFPP Partner data includes nearly 70 percent of covered lives in the United States.

Given the HFPP's broad membership encompassing a variety of players interested and involved in detection of fraud, waste, and abuse in the healthcare system, it is uniquely positioned to examine emerging trends and develop key recommendations and strategies to address them.

Today, with the authorities and resources provided by Congress, CMS has more tools than ever before to move beyond "pay and chase" and to implement important strategic changes in preventing fraud, waste, and abuse.

Conclusion

CMS' goal is to empower Medicare enrollees to choose options that best fit their individual health needs. CMS also strives to provide appropriate payment to Medicare Advantage organizations that serve those enrollees. Reducing improper payments helps to safeguard trust fund dollars and to make sure that the fee-for-service Medicare program and Medicare Advantage are strong and available to the beneficiaries we serve. 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.