Hearing on Combating Fraud in Medicare: A Strategy for Success

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HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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Hearing on Combating Fraud in Medicare: A Strategy for Success

U.S. House of Representatives,
Subcommittee on Oversight,
Committee on Ways and Means,
Washington, D.C

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Seto J. Bagdoyan
Director, Forensic Audits & Investigative Service, Government Accountability Office
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Gloria L. Jarmon
Deputy Inspector General for Audit Services, Office of Inspector General, U.S. Department of Health and Human Services
Witness Statement

Alec Alexander
Director, Center for Program Integrity, Centers for Medicare and Medicaid Services
Witness Statement

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

Chairman Jenkins Announces Hearing on Combating Fraud in Medicare: A Strategy for Success

House Ways and Means Oversight Subcommittee Chairman Lynn Jenkins (R-KS) announced today that the Subcommittee will hold a hearing entitled "Combating Fraud in Medicare: A Strategy for Success." The hearing will focus on how the Centers for Medicare and Medicaid Services (CMS) identifies and manages the risk of fraud in the Medicare program. **The hearing will take place on Tuesday, July 17, 2018 in 1100 Longworth House Office Building, beginning at 10:00 AM.**

In view of the limited time to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, July 31, 2018**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines

listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/

COMBATING FRAUD IN MEDICARE:
A STRATEGY FOR SUCCESS
Tuesday, July 17, 2018
House of Representatives,
Subcommittee on Oversight,
Committee on Ways and Means,
Washington, D.C.

The Subcommittee met, pursuant to call, at 10:01 a.m., in Room 1100, Longworth House Office Building, Hon. Lynn Jenkins [Chairman of the Subcommittee] presiding.

Chairman Jenkins. Good morning. We are going to get started this morning. And thank you all for being here.

Nearly 60 million individuals in the United States rely on Medicare for their healthcare. And in my home state of Kansas alone, almost one in five Kansans depends on the Medicare program.

As one of the government's largest and most complex programs, Medicare is highly susceptible to fraud, waste, and abuse. And because of this, Medicare has been designated as a high-risk program for almost three decades. In 2017 alone, improper payments accounted for nearly $52 billion of Medicare spending.

Fraud, in particular, is often challenging to identify and measure due to its deceptive nature. Fraud may also be nonfinancial, making it even more difficult to measure.

The Centers for Medicare and Medicaid Services, or CMS, measures improper payments, some of which may result from fraud. However, while CMS identifies improper payments through the Comprehensive Error Rate Testing, or CERT program, it is difficult to get a clear understanding of which improper payments are a result of fraud and which are simply a mistake.

So how much fraud is in the Medicare program? Right now there are varying opinions but the bottom line is it is too much.

Currently Medicare anti-fraud efforts focus on identifying fraud after it has occurred in a pay-and-chase format. Instead, CMS should focus on identifying and assessing where there is risk of fraud before it happens, which I understand CMS is starting to do.

Fraud risk exists when there is the incentive, opportunity, or pressure to commit fraud. By focusing on and mitigating fraud risk in Medicare, CMS can reduce the likelihood and impact of fraud in the program, preventing it before it occurs.

The Government Accountability Office, or GAO, developed the Fraud Risk Framework in 2015 in order to guide agencies' efforts to combat fraud. Congress liked the Framework so much that we passed the Fraud Reduction and Data Analytics Act of 2015 requiring Federal agencies to incorporate leading practices from the Fraud Risk Framework.

As it stands now, there is no comprehensive risk-based strategy for combating fraud in Medicare, and CMS has not conducted an assessment of Medicare using the Framework that would allow it to develop such a strategy. Without a strategy in place, it is very difficult to address fraud.

Today's hearing will cover ways in which CMS can continue to improve its anti-fraud efforts, including the development of a comprehensive anti-fraud strategy. The witness panel will provide helpful updates on CMS's current anti-fraud efforts and where there is room for improvement.

Our goal here today is to better understand what needs to be done to more effectively combat fraud in Medicare and to support those efforts, however we can.

Unfortunately, at CMS there seems to be some level of acceptance of the improper payment amount. However, I know this is something that every Member of this Subcommittee wants to improve, particularly given that every dollar lost to fraud is a dollar that could be spent on patients.

I want to thank our witnesses for being here today, and I look forward to their testimony.

And now I would like to yield to the distinguished Ranking Member, Mr. Lewis, for the purpose of an opening statement.

Mr. Lewis. Thank you, Madam Chair, for holding this hearing. I apologize for being a little late. You know, these elevators move slowly, and I was trying to move faster. But I am delighted to be here.

Thank you, Madam Chair, again. Thank you for holding this hearing. And thank you to our witnesses for taking time to be with us today.

You are a good-looking group, and I look forward to hearing words from you.

Madam Chair, this Subcommittee's work touches many areas, but protecting and preserving Medicare is perhaps our most sacred obligation. The fight against fraud, waste, and abuse is not a partisan matter. Medicare covers 58 million elderly and disabled beneficiaries from every state, from every section, from every corner of our great country.

This Subcommittee has a long and historic track record of bipartisan work, preserving the sacred trust of our seniors, families in need, and people with disabilities.

I deeply believe that the fight against fraud, waste, and abuse is essential to keep the promise of Medicare for all who rely on it.

Yet as we recommit to fighting fraud, let us take care. Our first priority should be to ensure that beneficiaries have access to quality and lifesaving services.

As Medicare adopts new payment models, this administration must continue President Obama's work to fight new forms of fraud. They must continue the Affordable Care Act's investment in innovation in preventing fraud before it happens.

Madam Chair, I will always welcome the opportunity to work with you to strengthen and protect Medicare, just as I did almost 1 year ago today when this Committee held the exact same hearing with essentially the exact same agencies at the witness table this morning.

Little time remains in this Congress, and each day the news continues troubling reports about the state of our health systems. For the past 18 months the Committee on Ways and Means has made little mention about patient access to care, social determinants of health, the closure of rural hospitals, or the price of prescription drugs.

I hope that we can find more areas in which to work and continue our Committee's bipartisan commitment to Medicare beneficiaries.

Thank you. And Madam Chair, with that, I yield back.

Chairman Jenkins. Thank you, Mr. Lewis.

Without objection, other Members' opening statements will be made part of the record.

Today's witness panel includes three experts. Seto Bagdoyan, Director of Forensic Audits and Investigative Service at the Government Accountability Office; Gloria Jarmon, Deputy Inspector General for Audit Services at the Department of Health and Human Services, Office of the Inspector General; Alec Alexander, Director of the Center for Program Integrity at the Centers for Medicare and Medicaid Services.

The Subcommittee has received your written statements, and they will all be made a part of the formal hearing record. You will each have 5 minutes to deliver oral remarks.

And so we will get started. We will begin with Mr. Bagdoyan.

You may begin when you are ready.

STATEMENT OF SETO J. BAGDOYAN, DIRECTOR, FORENSIC AUDITS AND INVESTIGATIVE SERVICE, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. Bagdoyan. Thank you, Madam Chairman.

Chairman Jenkins, Ranking Member Lewis, and Members of the Subcommittee, I am pleased to appear before you this morning to discuss GAO's December 2017 report on how CMS manages fraud risk in its programs, including Medicare.

In 2017, Medicare expenditures totaled $702 billion, or about 18 percent of all Federal outlays, covering over 58 million beneficiaries.

Reflecting an aging population and rising per capita healthcare costs, CBO projects these expenditures to rise to about $1.5 trillion by 2028 or the

equivalent of about 21 percent of all Federal outlays. This is an annual average growth rate of 7 percent.

The current and projected levels of spending for Medicare highlight what is at risk from potential fraud and why it is imperative for CMS to comprehensively address would-be fraud risks to the program.

Illustrating the magnitude and reach of potential risks, recently the Attorney General and HHS Secretary announced a major healthcare enforcement action involving 601 defendants across 58 Federal districts, including 165 doctors, nurses, and other licensed medical professionals, for their alleged participation in healthcare fraud schemes totaling more than $2 billion in false billings for, among other things, medically unnecessary treatments and prescription drugs.

Relating to Medicare, 124 defendants were charged with offenses relating to various fraud schemes totaling over $337 million in false billings for services such as pharmacy fraud.

With this in mind, I will now focus on four central points from the December 2017 report.

First, consistent with GAO's Fraud Risk Framework, CMS has demonstrated commitments to combating fraud by creating a dedicated entity, the Center for Program Integrity, to lead overall anti-fraud efforts with a direct reporting line to executive-level CMS management.

Second, CMS has taken steps to establish a culture conducive to fraud risk management, although it could expand its anti-fraud training to include all employees.

Consistent with the Framework, CMS has promoted an anti-fraud culture by, for example, coordinating with internal stakeholders to incorporate anti-fraud features into new program design.

To increase awareness of fraud risk in Medicare, CMS requires training for stakeholder groups such as providers, but does not require the same training for most of its own workforce. The Framework identifies training as one way of demonstrating an agency's commitment to combating fraud. Training and education intended to increase fraud awareness among employees serves as a key preventative measure to help create an agency culture of integrity.

Third, CMS has taken some steps to identify fraud risks in Medicare. For example, it has identified fraud risks through control activities that target areas the agency has designated as high risk, such as home healthcare providers. However, CMS has not conducted a fraud risk assessment for Medicare as a whole or developed a risk-based anti-fraud strategy.

Four, CMS has established monitoring and evaluation mechanisms for its program integrity activities that, if aligned with anti-fraud strategy, could enhance the effectiveness of fraud risk management in Medicare.

CMS uses a metric called return-on-investment and savings estimates to measure the effectiveness of its program integrity activities. In developing an anti-fraud strategy CMS could include plans for refining and building on existing methods, such as the ROI measure, to evaluate the effectiveness of all of its anti-fraud efforts.

In closing, I would underscore that CMS has already agreed with the three recommendations in our report, and it is essential for the agency to place a high priority on implementing them in a timely fashion to help better manage fraud risk in Medicare.

Doing so would provide reasonable assurance that the program's expenditures, totaling hundreds of billions of dollars annually, will be adequately safeguarded. Otherwise, dollars lost to fraud could significantly detract from CMS' ability to ensure that individuals who rely on Medicare are provided adequate care.

Chairman Jenkins, Ranking Member Lewis, this concludes my remarks. I look forward to the Subcommittee's questions.

United States Government Accountability Office

Testimony

Before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

For Release on Delivery
Expected at 10 a.m. ET
Tuesday, July 17, 2018

MEDICARE

Actions Needed to Better Manage Fraud Risks

Statement of Seto J. Bagdoyan, Director
Forensic Audits and Investigative Service

July 17, 2018

MEDICARE

Actions Needed to Better Manage Fraud Risks

GAO Highlights

Highlights of GAO-18-660T, a testimony before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Medicare covered over 58 million people in 2017 and has wide-ranging impact on the health-care sector and the overall U.S. economy. However, the billions of dollars in Medicare outlays as well as program complexity make it susceptible to improper payments, including fraud. Although there are no reliable estimates of fraud in Medicare, in fiscal year 2017 improper payments for Medicare were estimated at about $52 billion. Further, about $1.4 billion was returned to Medicare Trust Funds in fiscal year 2017 as a result of recoveries, fines, and asset forfeitures.

In December 2017, GAO issued a report examining how CMS managed its fraud risks overall and particularly the extent to which its efforts in the Medicare and Medicaid programs aligned with GAO's Framework. This testimony, based on that report, discusses the extent to which CMS's management of fraud risks in Medicare aligns with the Framework. For the report, GAO reviewed CMS policies and interviewed officials and external stakeholders.

What GAO Recommends

In its December 2017 report, GAO made three recommendations, namely that CMS (1) require and provide fraud-awareness training to its employees; (2) conduct fraud risk assessments; and (3) create an antifraud strategy for Medicare, including an approach for evaluation. The Department of Health and Human Services agreed with these recommendations and reportedly is evaluating options to implement them. Accordingly, the recommendations remain open.

View GAO-18-660T. For more information, contact Seto Bagdoyan at (202) 512-6722 or bagdoyans@gao.gov.

What GAO Found

In its December 2017 report, GAO found that the Centers for Medicare & Medicaid Services' (CMS) antifraud efforts for Medicare partially align with GAO's 2015 *A Framework for Managing Fraud Risks in Federal Programs* (Framework). The Fraud Reduction and Data Analytics Act of 2015 required OMB to incorporate leading practices identified in this Framework in its guidance to agencies on addressing fraud risks.

Fraud Risk Framework's Components

Commit
Commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management.

Assess
Plan regular fraud risk assessments and assess risks to determine a fraud risk profile.

Design and Implement
Design and implement a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation.

Evaluate and Adapt
Evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management.

Source: GAO. | GAO-18-660T

- Consistent with the Framework, GAO determined that CMS had demonstrated *commitment* to combating fraud by creating a dedicated entity to lead antifraud efforts; the Center for Program Integrity (CPI) serves as this entity for fraud, waste, and abuse issues in Medicare. CMS also promoted an antifraud culture by, for example, coordinating with internal stakeholders to incorporate antifraud features into new program design. To increase awareness of fraud risks in Medicare, CMS offered and required training for stakeholder groups such as providers of medical services, but it did not offer or require similar fraud-awareness training for most of its workforce.
- CMS took some steps to identify fraud risks in Medicare; however, it had not conducted a fraud risk *assessment* or *designed and implemented* a risk-based antifraud strategy for Medicare as defined in the Framework. CMS identified fraud risks through control activities that target areas the agency designated as higher risk within Medicare, including specific provider types, such as home health agencies. Building on earlier steps and conducting a fraud risk assessment, consistent with the Framework, would provide the detailed information and insights needed to create a fraud risk profile, which, in turn, is the basis for creating an antifraud strategy.
- CMS established *monitoring and evaluation* mechanisms for its program-integrity control activities that, if aligned with an antifraud strategy, could enhance the effectiveness of fraud risk management in Medicare. For example, CMS used return-on-investment and savings estimates to measure the effectiveness of its Medicare program-integrity activities. In developing an antifraud strategy, consistent with the Framework, CMS could include plans for refining and building on existing methods such as return-on-investment, to evaluate the effectiveness of all of its antifraud efforts.

Chairman Jenkins, Ranking Member Lewis, and Members of the Subcommittee:

I am pleased to appear before you today to discuss ways to better manage Medicare fraud risks that we identified in a recent report.[1] Although there are no reliable estimates of fraud in Medicare, in fiscal year 2017 improper payments for Medicare were estimated at about $52 billion.[2]

A recent example illustrates the scope and scale of fraud risks. The Department of Health and Human Services (HHS) Office of Inspector General's (OIG) latest Semiannual Report to Congress highlighted the recent activities of the Medicare Fraud Strike Force (Strike Force).[3] During the period from October 1, 2017, through March 31, 2018, Strike Force efforts resulted in the filing of charges against 77 individuals or entities, 107 criminal actions, and more than $100.3 million in investigative receivables. In one example, a Strike Force investigation led to the conviction of two owners of a medical billing company, who were both found guilty of conspiracy and health-care fraud, for fraudulently billing Medicare for services that were never provided. They also conspired to circumvent Medicare's fraud investigation of one of the owners by creating sham companies. The owners were sentenced to 10 years in prison, and 15 years in prison, respectively, and ordered to pay nearly $9.2 million in restitution.

Overall, HHS OIG and the Department of Justice report annually on monetary and other results of their efforts against health-care fraud and

[1]GAO, *Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework*, GAO-18-88 (Washington, D.C.: Dec. 5, 2017).

[2]An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. See 31 U.S.C. § 3321 note. OMB guidance also instructs agencies to report as improper payments any payment for which insufficient or no documentation was found.

[3]Medicare Fraud Strike Force, a joint Department of Justice (DOJ) and HHS OIG program, consists of investigators and prosecutors who use data-analysis and traditional law-enforcement techniques to identify, investigate, and prosecute potentially fraudulent billing patterns in geographic areas with high rates of health-care fraud.

abuse: in fiscal year 2017, about $1.4 billion was returned to Medicare Trust Funds as a result of recoveries, fines, and asset forfeitures.[4]

Medicare, which is administered within HHS by its Centers for Medicare & Medicaid Services (CMS), has been on our high-risk list since 1990[5] because of the size and complexity of the program, and its susceptibility to fraud, waste, and abuse. Medicare covered over 58 million people in 2017 and it has wide-ranging current and long-term effects beyond beneficiaries, the health-care sector, and the overall U.S. economy. The following statistics illustrate the program's impact.

- According to the Congressional Budget Office (CBO), in 2017 Medicare outlays totaled $702 billion. Under current law, the outlays are projected to rise to $1.5 trillion in 2028, growing at about 7 percent a year; that is, faster than the economy, as the population ages and health-care costs rise.[6]
- In 2017, these expenditures accounted for 3.7 percent of gross domestic product (GDP) and 17.6 percent of federal outlays. CBO estimates that, in 2028, under current law, Medicare will account for 5.1 percent of GDP and 21.9 percent of federal outlays.
- Over 1 million health-care providers, contractors, and suppliers from across the health sector—including private health plans, physicians, hospitals, skilled-nursing facilities, durable medical equipment suppliers, ambulance providers, and many others—receive payments from Medicare.

Given the size and impact of Medicare on the health-care sector and U.S. economy overall, we recently reported on CMS's fraud risk management efforts relative to GAO's 2015 *A Framework for Managing Fraud Risks in Federal Programs* (Fraud Risk Framework).[7] The Fraud Risk Framework describes key components and leading practices for agencies to proactively and strategically manage fraud risks. Our objectives in the

[4]Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program: Annual Report for Fiscal Year 2017*.

[5]GAO, *High-Risk Series: Progress on Many High-Risk Areas, While Substantial Efforts Needed on Others*, GAO-17-317 (Washington, D.C.: Feb. 15, 2017).

[6]Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028* (April 2018).

[7]GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 2015).

December 2017 report were to determine: (1) CMS's approach for managing fraud risks across its four principal programs (including Medicare) and (2) how CMS's efforts for managing fraud risks in Medicare and Medicaid align with the Fraud Risk Framework.

Drawing from the December 2017 report, my testimony today discusses the extent to which CMS's management of fraud risks in Medicare aligned with the Fraud Risk Framework and the actions needed to better manage fraud risks.

We performed our work on CMS antifraud efforts in Medicare and Medicaid for the December 2017 report under the authority of the Comptroller General to assist Congress with its oversight. The report provides further detail on our scope and methodology. Because this statement focuses on Medicare, we have omitted references to Medicaid in some instances when discussing organizational structure and agency-wide efforts.

We conducted the work in the December 2017 report in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Medicare is one of four principal health-insurance programs administered by CMS; it provides health insurance for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease.[8] See table 1 for information about Medicare's component programs.

[8]Other CMS programs are Medicaid, the Children's Health Insurance Program (CHIP), and the health-insurance marketplaces.

Table 1: Summary of Medicare Parts

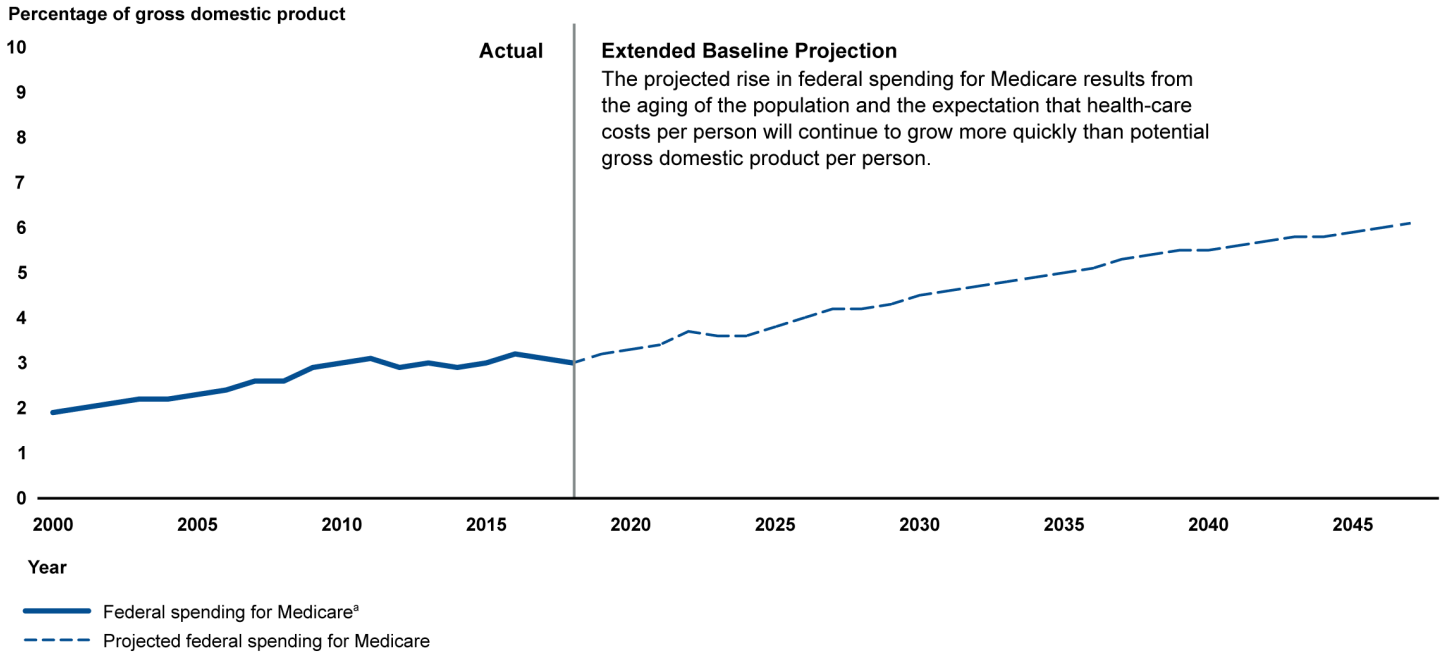
Medicare program	Program description
Medicare Fee-for-Service (FFS) (Parts A and B)	Providers submit claims for reimbursement after services have been rendered. Medicare pays providers for each service delivered (e.g., office visit, test, or procedure). Part A—hospital insurance Part B—outpatient care
Medicare Advantage (Part C)	Alternative to Parts A and B that allows beneficiaries to receive Medicare benefits through a private health plan[a]
Medicare Prescription Drug (Part D)	Voluntary, outpatient prescription-drug coverage through stand-alone drug plans or Medicare Advantage drug plans

Source: GAO. | GAO-18-660T

[a]Health-insurance plans are paid a predetermined, fixed periodic amount per enrollee. The payment is risk-adjusted based on enrollee diagnoses, but that does not vary based on number or cost of health-care services an enrollee uses.

Medicare is the largest CMS program, at $702 billion in fiscal year 2017. As discussed earlier, according to CBO, Medicare outlays are projected to rise to $1.5 trillion in 2028 (see fig. 1).

Figure 1: Federal Spending on Medicare Is Projected to Increase



Source: Congressional Budget Office (CBO). | GAO-18-660T

[a]Spending for Medicare refers to net spending for Medicare, which accounts for offsetting receipts that are credited to the program. Those offsetting receipts are mostly premium payments made by beneficiaries to the government.

Fraud Vulnerabilities and Improper Payments in Medicare

Fraud involves obtaining something of value through willful misrepresentation. There are no reliable estimates of the extent of fraud in the Medicare program, or in the health-care industry as a whole. By its very nature, fraud is difficult to detect, as those involved are engaged in intentional deception. Further, potential fraud cases must be identified, investigated, prosecuted, and adjudicated—resulting in a conviction—before fraud can be established.

As I mentioned earlier, we designated Medicare as a high-risk program in 1990 because its size, scope, and complexity make it vulnerable to fraud, waste, and abuse. Similarly, the Office of Management and Budget (OMB) designated all parts of Medicare a "high priority" program because they each report $750 million or more in improper payments in a given year.[9] We also highlighted challenges associated with duplicative payments in Medicare in our annual report on duplication and opportunities for cost savings in federal programs.[10]

Improper payments are a significant risk to the Medicare program and may include payments made as a result of fraud. However, I would note that improper payments are not a proxy for the amount of fraud or extent of fraud risk in a particular program as improper payment measurement does not specifically identify or estimate such payments due to fraud. Improper payments are those that are either made in an incorrect amount (overpayments and underpayments) or those that should not have been made at all.

CMS's Fraud Risk Management Approach

Our December 2017 report found that CMS manages its fraud risks as part of a broader program-integrity approach working with a broad array of stakeholders. CMS's program-integrity approach includes efforts to address waste, abuse, and improper payments as well as fraud across its

[9]Starting in fiscal year 2018, the threshold for high-priority program determinations is $2 billion in improper payments regardless of the improper payment rate.

[10]GAO, *2017 Annual Report: Additional Opportunities to Reduce Fragmentation, Overlap, and Duplication and Achieve Other Financial Benefits*, GAO-17-491SP (Washington, D.C.: April 2017).

four principal programs. In Medicare, CMS collaborates with contractors, health-insurance plans, and law-enforcement and other agencies to carry out its program-integrity responsibilities. According to CMS officials, this broader program-integrity approach can help the agency develop control activities to address multiple sources of improper payments, including fraud.

Fraud Risk Management Standards and Guidance

According to federal standards and guidance, executive-branch agency managers are responsible for managing fraud risks and implementing practices for combating those risks. Federal internal control standards call for agency management officials to assess the internal and external risks their entities face as they seek to achieve their objectives. The standards state that as part of this overall assessment, management should consider the potential for fraud when identifying, analyzing, and responding to risks.[11] Risk management is a formal and disciplined practice for addressing risk and reducing it to an acceptable level.[12]

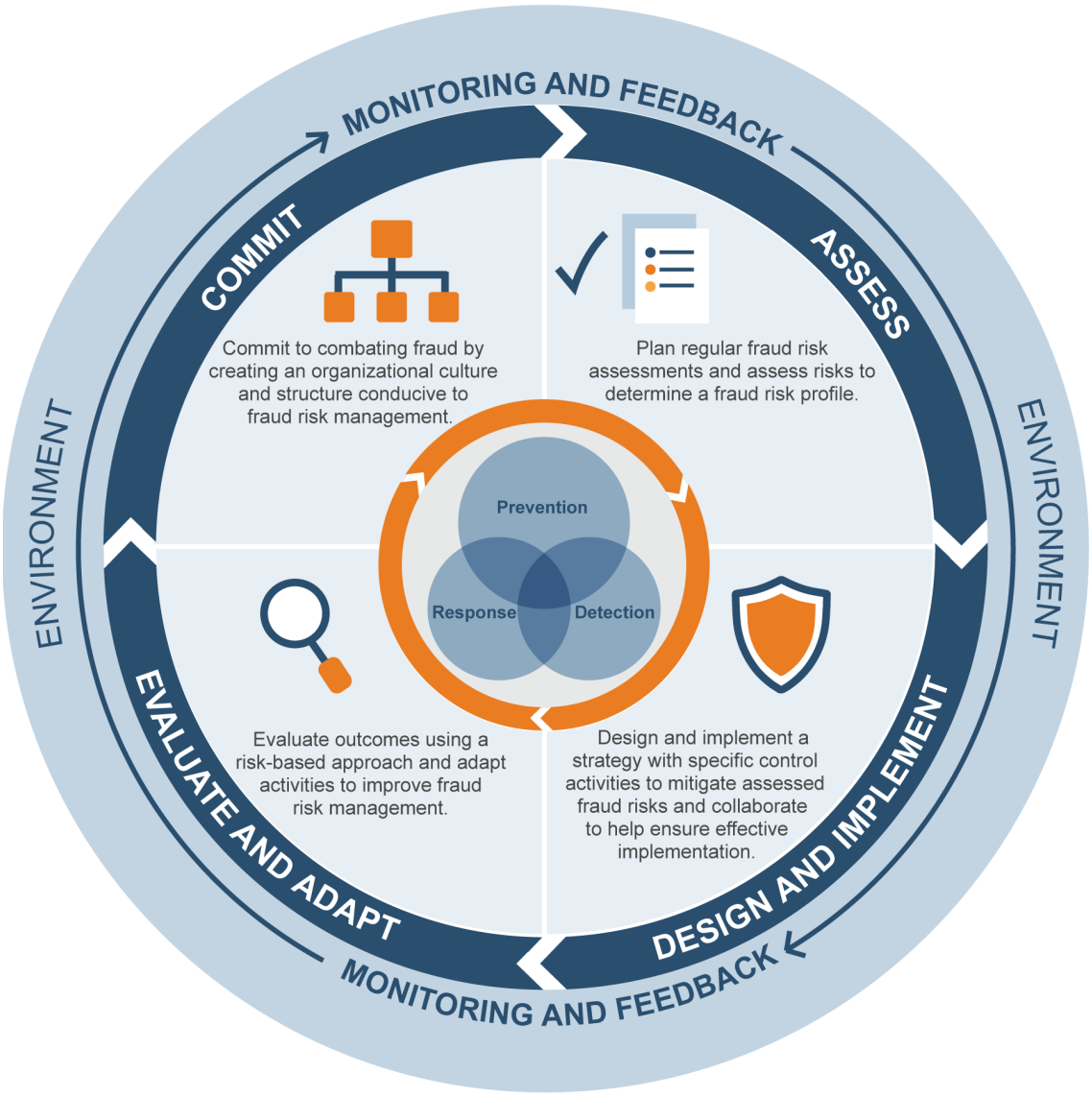
In July 2015, GAO issued the Fraud Risk Framework, which provides a comprehensive set of key components and leading practices that serve as a guide for agency managers to use when developing efforts to combat fraud in a strategic, risk-based way.[13] The Fraud Risk Framework describes leading practices in four components: commit, assess, design and implement, and evaluate and adapt, as depicted in figure 2.

[11]GAO, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 2014).

[12]MITRE, *Government-wide Payment Integrity: New approaches and Solutions Needed* (McLean, Va.: February 2016).

[13]See GAO-15-593SP.

Figure 2: The Fraud Risk Management Framework



Source: GAO. | GAO-18-660T

The Fraud Reduction and Data Analytics Act of 2015, enacted in June 2016, requires OMB to establish guidelines for federal agencies to create controls to identify and assess fraud risks and design and implement antifraud control activities. The act further requires OMB to incorporate the leading practices from the Fraud Risk Framework in the guidelines. In July 2016, OMB published guidance about enterprise risk management

and internal controls in federal executive departments and agencies.[14] Among other things, this guidance affirms that managers should adhere to the leading practices identified in the Fraud Risk Framework. Further, the act requires federal agencies to submit to Congress a progress report each year for 3 consecutive years on the implementation of the controls established under OMB guidelines, among other things.[15]

CMS's Efforts Managing Fraud Risks in Medicare Were Partially Aligned with the Fraud Risk Framework

CMS's antifraud efforts partially aligned with the Fraud Risk Framework. Consistent with the framework, CMS has demonstrated commitment to combating fraud by creating a dedicated entity to lead antifraud efforts. It has also taken steps to establish a culture conducive to fraud risk management, although it could expand its antifraud training to include all employees. CMS has taken some steps to identify fraud risks in Medicare; however, it has not conducted a fraud risk assessment or developed a risk-based antifraud strategy for Medicare as defined in the Fraud Risk Framework. CMS has established monitoring and evaluation mechanisms for its program-integrity control activities that, if aligned with a risk-based antifraud strategy, could enhance the effectiveness of fraud risk management in Medicare.

CMS's Organizational Structure Includes a Dedicated Entity for Program-Integrity and Antifraud Efforts

The *commit* component of the Fraud Risk Framework calls for an agency to commit to combating fraud by creating an organizational culture and structure conducive to fraud risk management. This component includes establishing a dedicated entity to lead fraud risk management activities.[16]

Within CMS, the Center for Program Integrity (CPI) serves as the dedicated entity for fraud, waste, and abuse issues in Medicare, which is consistent with the Fraud Risk Framework. CPI was established in 2010, in response to a November 2009 Executive Order on reducing improper payments and eliminating waste in federal programs.[17] This formalized

[14]Office of Management and Budget, *Management's Responsibility for Enterprise Risk Management and Internal Control*, Circular No. A-123 (Washington, D.C.: July 15, 2016).

[15]Pub. L. No. 114-186, § 3, 130 Stat. 546 (2016).

[16]See GAO-15-593SP.

[17]*Reducing Improper Payments*, Exec. Order No. 13520, 74 Fed. Reg. 226 (Nov. 20, 2009).

role, according to CMS officials, elevated the status of program-integrity efforts, which previously were carried out by other parts of CMS.

As an executive-level Center—on the same level with five other executive-level Centers at CMS, such as the Center for Medicare—CPI has a direct reporting line to executive-level management at CMS. The Fraud Risk Framework identifies a direct reporting line to senior-level managers within the agency as a leading practice. According to CMS officials, this elevated organizational status offers CPI heightened visibility across CMS, attention by CMS executive leadership, and involvement in executive-level conversations.

CMS Has Taken Steps to Create a Culture Conducive to Fraud Risk Management but Could Enhance Antifraud Training for Employees

The *commit* component of the Fraud Risk Framework also includes creating an organizational culture to combat fraud at all levels of the agency. Consistent with the Fraud Risk Framework, CMS has promoted an antifraud culture by, for example, coordinating with internal and external stakeholders.

Consistent with leading practices in the Fraud Risk Framework to involve all levels of the agency in setting an antifraud tone, CPI has worked collaboratively with other CMS Centers. In addition to engaging executive-level officials of other CMS Centers through the Program Integrity Board, CPI has worked collaboratively with other Centers within CMS to incorporate antifraud features into new program design or policy development and established regular communication at the staff level. For example:

- **Center for Medicare and Medicaid Innovation (CMMI).** When developing the Medicare Diabetes Prevention Program, CMMI officials told us they worked with CPI's Provider Enrollment and Oversight Group and Governance Management Group to develop risk-based screening procedures for entities that would enroll in Medicare to provide diabetes-prevention services, among other activities. The program was expanded nationally in 2016, and CMS determined that an entity may enroll in Medicare as a program supplier if it satisfies enrollment requirements, including that the

supplier must pass existing high categorical risk-level screening requirements.[18]

- **Center for Medicare (CM).** In addition to building safeguards into programs and developing policies, CM officials told us that there are several standing meetings, on monthly, biweekly, and weekly bases, between groups within CM and CPI that discuss issues related to provider enrollment, FFS operations, and contractor management. A senior CM official also told us that there are ad hoc meetings taking place between CM and CPI: "We interact multiple times daily at different levels of the organization. Working closely is just a regular part of our business."

CMS has also demonstrated its commitment to addressing fraud, waste, and abuse to its stakeholders. Representatives of CMS's extensive stakeholder network whom we interviewed—contractors and officials from public and private entities—generally recognized the agency's commitment to combating fraud. In our interviews with stakeholders, officials observed CMS's increased commitment over time to address fraud, waste, and abuse and cited examples of specific CMS actions. CMS contractors told us that CMS's commitment to combating fraud is incorporated into contractual requirements, such as requiring (1) data analysis for potential fraud leads and (2) fraud-awareness training for providers. Officials from entities that are members of the Healthcare Fraud Prevention Partnership (HFPP), specifically, a health-insurance plan and the National Health Care Anti-Fraud Association, added that CMS's effort to establish the HFPP and its ongoing collaboration and information sharing reflect CMS's commitment to combat fraud in Medicare.[19]

The Fraud Risk Framework identifies training as one way of demonstrating an agency's commitment to combating fraud. Training and

[18]82 Fed. Reg. 52,976 (Nov. 15, 2017) (codified at 42 C.F.R. Parts 405, 410, 414, 424, and 425). For additional information about CMS provider-enrollment activities for Medicare, see GAO, *Medicare: Initial Results of Revised Process to Screen Providers and Suppliers, and Need for Objectives and Performance Measures*, GAO-17-42 (Washington, D.C.: Nov. 15, 2016).

[19]In 2012, CMS created the HFPP to share information with public and private stakeholders and to conduct studies related to health-care fraud, waste, and abuse. According to CMS, as of October 2017, the HFPP included 89 public and private partners, including Medicare- and Medicaid-related federal and state agencies, law-enforcement agencies, private health-insurance plans, and antifraud and other health-care organizations.

education intended to increase fraud awareness among stakeholders, managers, and employees serve as a preventive measure to help create a culture of integrity and compliance within the agency. The Fraud Risk Framework discusses requiring all employees to attend training upon hiring and on an ongoing basis thereafter.

To increase awareness of fraud risks in Medicare, CMS offers and requires training for stakeholder groups such as providers, beneficiaries, and health-insurance plans. Specifically, through its National Training Program and Medicare Learning Network, CMS makes available training materials on combating Medicare fraud, waste, and abuse.[20] These materials help to identify and report fraud, waste, and abuse in CMS programs and are geared toward providers, beneficiaries, as well as trainers and other stakeholders. Separately, CMS requires health-insurance plans working with CMS to provide annual fraud, waste, and abuse training to their employees.[21]

However, CMS does not offer or require similar fraud-awareness training for the majority of its workforce. For a relatively small portion of its overall workforce—specifically, contracting officer representatives who are responsible for certain aspects of the acquisition function—CMS requires completion of fraud and abuse prevention training every 2 years. According to CMS, 638 of its contracting officer representatives (or about 10 percent of its overall workforce) completed such training in 2016 and 2017. Although CMS offers fraud-awareness training to others, the agency does not require fraud-awareness training for new hires or on a regular basis for all employees because the agency has focused on providing process-based internal controls training for its employees.

While fraud-awareness training for contracting officer representatives is an important step in helping to promote fraud risk management, fraud-awareness training specific to CMS programs would be beneficial for all employees. Such training would not only be consistent with what CMS offers to or requires of its stakeholders and some of its employees, but

[20]The CMS National Training Program provides support for partners and stakeholders, not-for-profit professionals and volunteers who work with seniors and people with disabilities, and others who help people make informed health-care decisions. The program offers an online training library with materials to conduct outreach and education sessions. The Medicare Learning Network provides free educational materials for health-care professionals on CMS programs, policies, and initiatives.

[21]For example, 42 C.F.R. § 422.503(b)(4)(vi)(C).

would also help to keep the agency's entire workforce continuously aware of fraud risks and examples of known fraud schemes, such as those identified in successful HHS OIG investigations. Such training would also keep employees informed as they administer CMS programs or develop agency policies and procedures. Considering the vulnerability of Medicare and Medicaid programs to fraud, waste, and abuse, without regular required training CMS cannot be assured that its workforce of over 6,000 employees is continuously aware of risks facing its programs.

In our December 2017 report, we recommended that the Administrator of CMS provide fraud-awareness training relevant to risks facing CMS programs and require new hires to undergo such training and all employees to undergo training on a recurring basis. In its March 2018 letter to GAO, HHS stated that CMS is in the process of developing Fraud, Waste, and Abuse Training for all new employees, to be presented at CMS New Employee Orientations. Additionally, CMS is also developing training to be completed by current CMS employees on an annual basis. As of July 2018, this recommendation remains open.

CMS Has Taken Steps to Identify Fraud Risks but Has Not Conducted a Fraud Risk Assessment for Medicare

The *assess* component of the Fraud Risk Framework calls for federal managers to plan regular fraud risk assessments and to assess risks to determine a fraud risk profile.[22] Identifying fraud risks is one of the steps included in the Fraud Risk Framework for assessing risks to determine a fraud risk profile.

In our December 2017 report, we discussed several examples of steps CMS has taken to identify fraud risks as well as control activities that target areas the agency has designated as higher risk within Medicare, including specific provider types and specific geographic locations. These examples include

- data analytics to assist investigations in Medicare FFS, including Medicare's Fraud Prevention System (FPS),[23]

[22]According to the Fraud Risk Framework, a fraud risk profile documents the findings from a fraud risk assessment. We discuss this concept later in the report.

[23]The FPS is a data-analytic system that analyzes Medicare fee-for-service claims to identify health-care providers with suspect billing patterns for further investigation and to prevent improper payments. See GAO, *Medicare: CMS Fraud Prevention System Uses Claims Analysis to Address Fraud*, GAO-17-710 (Washington, D.C.: Aug. 30, 2017).

- prior authorization for Medicare FFS services or supplies,[24]
- revised provider screening and enrollment processes for Medicare FFS,[25] and
- temporary provider enrollment moratoriums for certain providers and geographic areas for Medicare FFS.

CMS officials told us that CPI initially focused on developing control activities for Medicare FFS and consider these activities to be the most mature of all CPI efforts to address fraud risks.

CMS Has Not Conducted a Fraud Risk Assessment for Medicare

The assess component of the Fraud Risk Framework calls for federal managers to plan regular fraud risk assessments and assess risks to determine a fraud risk profile. Furthermore, federal internal control standards call for agency management to assess the internal and external risks their entities face as they seek to achieve their objectives. The standards state that, as part of this overall assessment, management should consider the potential for fraud when identifying, analyzing, and responding to risks.[26]

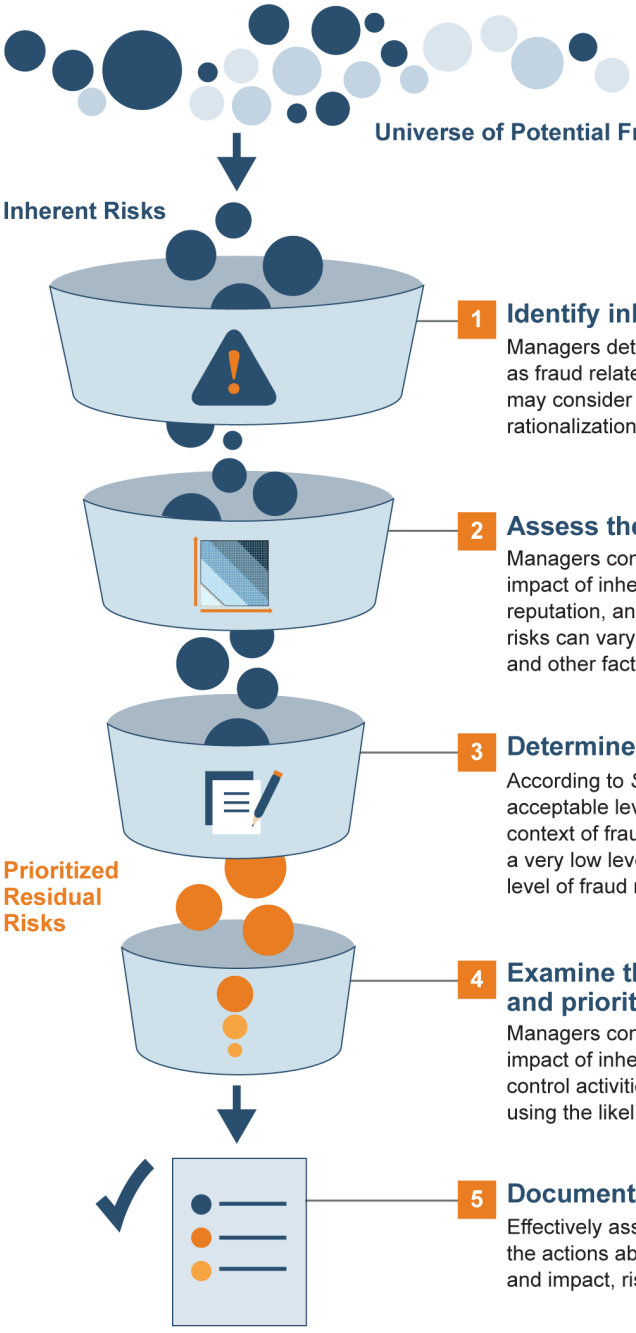
The Fraud Risk Framework states that, in planning the fraud risk assessment, effective managers tailor the fraud risk assessment to the program by, among other things, identifying appropriate tools, methods, and sources for gathering information about fraud risks and involving relevant stakeholders in the assessment process. Fraud risk assessments that align with the Fraud Risk Framework involve (1) identifying inherent fraud risks affecting the program, (2) assessing the likelihood and impact of those fraud risks, (3) determining fraud risk tolerance, (4) examining the suitability of existing fraud controls and prioritizing residual fraud risks, and (5) documenting the results (see fig. 3).

[24]Prior authorization is a payment approach that generally requires health-care providers and suppliers to first demonstrate compliance with coverage and payment rules before certain items or services are provided to patients, rather than after the items or services have been provided. See GAO, *Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending*, GAO-18-341 (Washington, D.C.: Apr. 20, 2018).

[25]GAO-17-42.

[26]GAO-14-704G.

Figure 3: Key Elements of the Fraud Risk Assessment Process



1 Identify inherent fraud risks affecting the program

Managers determine where fraud can occur and the types of fraud the program faces, such as fraud related to financial reporting, misappropriation of assets, or corruption. Managers may consider factors that are specific to fraud risks, including incentives, opportunity, and rationalization to commit fraud.

2 Assess the likelihood and impact of inherent fraud risks

Managers conduct quantitative or qualitative assessments, or both, of the likelihood and impact of inherent risks, including the impact of fraud risks on the program's finances, reputation, and compliance. The specific methodology managers use to assess fraud risks can vary by program because of differences in missions, activities, capacity, and other factors.

3 Determine fraud risk tolerance

According to *Standards for Internal Control in the Federal Government*,[a] risk tolerance is the acceptable level of variation in performance relative to the achievement of objectives. In the context of fraud risk management, if the objective is to mitigate fraud risks—in general, to have a very low level of fraud—the risk tolerance reflects managers' willingness to accept a higher level of fraud risks, and it may vary depending on the circumstances of the program.

4 Examine the suitability of existing fraud controls and prioritize residual fraud risks

Managers consider the extent to which existing control activities mitigate the likelihood and impact of inherent risks. The risk that remains after inherent risks have been mitigated by existing control activities is called residual risk. Managers then rank residual fraud risks in order of priority, using the likelihood and impact analysis, as well as risk tolerance, to inform prioritization.

5 Document the program's fraud risk profile

Effectively assessing fraud risks involves documenting the key findings and conclusions from the actions above, including the analysis of the types of fraud risks, their perceived likelihood and impact, risk tolerance, and the prioritization of risks.

Source: GAO. | GAO-18-660T

Although CMS had identified some fraud risks posed by providers in Medicare FFS, the agency had not conducted a fraud risk assessment for the Medicare program as a whole. Such a risk assessment would provide the detailed information and insights needed to create a fraud risk profile, which, in turn, is the basis for creating an antifraud strategy.

According to CMS officials, CMS had not conducted a fraud risk assessment for Medicare because, within CPI's broader approach of preventing and eliminating improper payments, its focus has been on addressing specific vulnerabilities among provider groups that have shown themselves particularly prone to fraud, waste, and abuse. With this approach, however, it is unlikely that CMS will be able to design and implement the most-appropriate control activities to respond to the full portfolio of fraud risks.

A fraud risk assessment consists of discrete activities that build upon each other. Specifically:

- **Identifying inherent fraud risks affecting the program.** As discussed earlier, CMS took steps to identify fraud risks. However, CMS has not used a process to identify inherent fraud risks from the universe of potential vulnerabilities facing Medicare, including threats from various sources. According to CPI officials, most of the agency's fraud control activities are focused on fraud risks posed by providers. The Fraud Risk Framework discusses fully considering inherent fraud risks from internal and external sources in light of fraud risk factors such as incentives, opportunities, and rationalization to commit fraud. For example, according to CMS officials, the inherent design of the Medicare Part C program may pose fraud risks that are challenging to detect.[27] A fraud risk assessment would help CMS identify all sources of fraudulent behaviors, beyond threats posed by providers, such as those posed by health-insurance plans, contractors, or employees.
- **Assessing the likelihood and impact of fraud risks and determining fraud risk tolerance.** CMS has taken steps to prioritize fraud risks in some areas, but it had not assessed the likelihood or

[27]In Medicare Part C, health-insurance plans may pose a fraud risk, as shown by a recent legal settlement. See the Freedom Health case at Department of Justice, *Medicare Advantage Organization and Former Chief Operating Officer to Pay $32.5 Million to Settle False Claims Act Allegations*, May 30, 2017, accessed May 31, 2017, https://www.justice.gov/opa/pr/medicare-advantage-organization-and-former-chief-operating-officer-pay-325-million-settle.

impact of fraud risks or determined fraud risk tolerance across all parts of Medicare. Assessing the likelihood and impact of inherent fraud risks would involve consideration of the impact of fraud risks on program finances, reputation, and compliance. Without assessing the likelihood and impact of risks in Medicare or internally determining which fraud risks may fall under the tolerance threshold, CMS cannot be certain that it is aware of the most-significant fraud risks facing this program and what risks it is willing to tolerate based on the program's size and complexity.

- **Examining the suitability of existing fraud controls and prioritizing residual fraud risks.** CMS had not assessed existing control activities or prioritized residual fraud risks. According to the Fraud Risk Framework, managers may consider the extent to which existing control activities—whether focused on prevention, detection, or response—mitigate the likelihood and impact of inherent risks and whether the remaining risks exceed managers' tolerance. This analysis would help CMS to prioritize residual risks and to determine mitigation approaches. For example, CMS had not established preventive fraud control activities in Medicare Part C. Using a fraud risk assessment for Medicare Part C and closely examining existing fraud control activities and residual risks, CMS could be better positioned to address fraud risks facing this growing program and develop preventive control activities.[28] Furthermore, without assessing existing fraud control activities and prioritizing residual fraud risks, CMS cannot be assured that its current control activities are addressing the most-significant risks. Such analysis would also help CMS determine whether additional, preferably preventive, fraud controls are needed to mitigate residual risks, make adjustments to existing control activities, and potentially scale back or remove control activities that are addressing tolerable fraud risks.
- **Documenting the risk-assessment results in a fraud risk profile.** CMS had not developed a fraud risk profile that documents key findings and conclusions of the fraud risk assessment. According to

[28]We have reported about concerns with improper payments in Part C. For example, we examined CMS's audits of Medicare Advantage organizations—which help CMS recover improper payments in cases where beneficiary diagnoses are unsupported by medical records—and recommended that CMS improve the timeliness of, and processes for, selecting contracts to include in its audits. We have also recommended that CMS develop specific plans for incorporating a recovery auditor into the agency's Part C audit program. Both recommendations remain open. See GAO, *Medicare Advantage Program Integrity: CMS's Efforts to Ensure Proper Payments and Identify and Recover Improper Payments*, GAO-17-761T (July 19, 2017).

the Fraud Risk Framework, the risk profile can also help agencies decide how to allocate resources to respond to residual fraud risks. Given the large size and complexity of Medicare, a documented fraud risk profile could support CMS's resource-allocation decisions as well as facilitate the transfer of knowledge and continuity across CMS staff and changing administrations.

Senior CPI officials told us that the agency plans to start a fraud risk assessment for Medicare after it completes a separate fraud risk assessment of the federally facilitated marketplace. This fraud risk assessment for the federally facilitated marketplace eligibility and enrollment process is being conducted in response to a recommendation we made in February 2016.[29] In April 2017, CPI officials told us that this fraud risk assessment was largely completed, although in September 2017 CPI officials told us that the assessment was undergoing agency review. CPI officials told us that they have informed CM officials that there will be future fraud risk assessments for Medicare; however, they could not provide estimated timelines or plans for conducting such assessments, such as the order or programmatic scope of the assessments.

Once completed, CMS could use the federally facilitated marketplace fraud risk assessment and apply any lessons learned when planning for and designing fraud risk assessments for Medicare. According to the Fraud Risk Framework, factors such as size, resources, maturity of the agency or program, and experience in managing risks can influence how the entity plans the fraud risk assessment. Additionally, effective managers tailor the fraud risk assessment to the program when planning for it. The large scale and complexity of Medicare as well as time and resources involved in conducting a fraud risk assessment underscore the importance of a well-planned and tailored approach to identifying the assessment's programmatic scope. Planning and tailoring may involve decisions to conduct a fraud risk assessment for Medicare as a whole or divided into several subassessments to reflect their various component parts (e.g., Medicare Part C).

CMS's existing fraud risk identification efforts as well as communication channels with stakeholders could serve as a foundation for developing a

[29]GAO, *Patient Protection and Affordable Care Act: CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk*, GAO-16-29 (Washington, D.C.: Feb. 23, 2016).

fraud risk assessment for Medicare. The leading practices identified in the Fraud Risk Framework discuss the importance of identifying appropriate tools, methods, and sources for gathering information about fraud risks and involving relevant stakeholders in the assessment process. CMS's fraud risk identification efforts discussed earlier could provide key information about fraud risks and their likelihood and impact. Furthermore, existing relationships and communication channels across CMS and its extensive network of stakeholders could support building a comprehensive understanding of known and potential fraud risks for the purposes of a fraud risk assessment. For example, the fraud vulnerabilities identified through data analysis and information sharing with health-insurance plans, law-enforcement organizations, and contractors could inform a fraud risk assessment. CPI's Command Center missions—facilitated collaboration sessions that bring together experts from various disciplines to improve the processes for fraud prevention in Medicare[30]—could bring together experts to identify potential or emerging fraud vulnerabilities or to brainstorm approaches to mitigate residual fraud risks.

As CMS makes plans to move forward with a fraud risk assessment for Medicare, it will be important to consider the frequency with which the fraud risk assessment would need to be updated. While, according to the Fraud Risk Framework, the time intervals between updates can vary based on the programmatic and operating environment, assessing fraud risks on an ongoing basis is important to ensure that control activities are continuously addressing fraud risks. The constantly evolving fraud schemes, the size of the programs in terms of beneficiaries and expenditures, as well as continual changes in Medicare—such as development of innovative payment models and increasing managed-care enrollment—call for constant vigilance and regular updates to the fraud risk assessment.

In our December 2017 report we recommended that the Administrator of CMS conduct fraud risk assessments for Medicare and Medicaid to include respective fraud risk profiles and plans for regularly updating the assessments and profiles. In its March 2018 letter to GAO, HHS stated

[30]According to CMS, the Command Center opened in July 2012 and provides an opportunity for Medicare and Medicaid policy experts, law-enforcement officials from the HHS OIG and the Federal Bureau of Investigation, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads in real time. In fiscal year 2015, CMS conducted 41 Command Center missions.

that it is currently evaluating its options with regards to implementing this recommendation. As of July 2018, the recommendation remains open.

CMS Needs to Develop a Risk-Based Antifraud Strategy for Medicare, Which Would Include Plans for Monitoring and Evaluation

The *design and implement* component of the Fraud Risk Framework calls for federal managers to design and implement a strategy with specific control activities to mitigate assessed fraud risks and collaborate to help ensure effective implementation.

According to the Fraud Risk Framework, effective managers develop and document an antifraud strategy that describes the program's approach for addressing the prioritized fraud risks identified during the fraud risk assessment, also referred to as a risk-based antifraud strategy. A risk-based antifraud strategy describes existing fraud control activities as well as any new fraud control activities a program may adopt to address residual fraud risks. In developing a strategy and antifraud control activities, effective managers focus on fraud prevention over detection, develop a plan for responding to identified instances of fraud, establish collaborative relationships with stakeholders, and create incentives to help effectively implement the strategy. Additionally, as part of a documented strategy, management identifies roles and responsibilities of those involved in fraud risk management activities; describes control activities as well as plans for monitoring and evaluation; creates timelines; and communicates the antifraud strategy to employees and stakeholders, among other things.

As discussed earlier, CMS had some control activities in place to identify fraud risk in Medicare, particularly in the FFS program.[31] However, CMS had not developed and documented a risk-based antifraud strategy to guide its design and implementation of new antifraud activities and to better align and coordinate its existing activities to ensure it is targeting and mitigating the most-significant fraud risks.

Antifraud strategy. CMS officials told us that CPI does not have a documented risk-based antifraud strategy. Although CMS has developed

[31]The individual CMS fraud control activities and other antifraud efforts described in the December 2017 report serve as examples of CMS activities; we did not evaluate the effectiveness of these efforts.

several documents that describe efforts to address fraud,[32] the agency had not developed a risk-based antifraud strategy for Medicare because, as discussed earlier, it had not conducted a fraud risk assessment that would serve as a foundation for such strategy.

In 2016, CPI identified five strategic objectives for program integrity, which include antifraud elements and an emphasis on prevention.[33] However, according to CMS officials, these objectives were identified from discussions with CMS leadership and various stakeholders and not through a fraud risk assessment process to identify inherent fraud risks from the universe of potential vulnerabilities, as described earlier and called for in the leading practices. These strategic objectives were presented at an antifraud conference in 2016,[34] but were not announced publicly until the release of the Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015 in June 2017.

Stakeholder relationships and communication. CMS has established relationships and communicated with stakeholders, but, without an antifraud strategy, stakeholders we spoke with lacked a common understanding of CMS's strategic approach. Prior work on practices that can help federal agencies collaborate effectively calls for a strategy that is shared with stakeholders to promote trust and understanding.[35] Once an antifraud strategy is developed, the Fraud Risk Framework calls for managers to collaborate to ensure effective implementation. Although some CMS stakeholders were able to describe various CMS program-integrity priorities and activities, such as home health being a fraud risk

[32]Centers for Medicare & Medicaid Services, *New Strategic Direction and Key Antifraud Activities* (Nov. 3, 2011); *Comprehensive Medicaid Integrity Plan: Fiscal Years 2014-2018*; *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015*; *Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Years 2013 and 2014*; *CMS Medicare and Medicaid Program Integrity Strategy* (Mar. 3, 2013).

[33]The five strategic objectives are: (1) address the full spectrum of fraud, waste, and abuse; (2) proactively manage provider screening and enrollment; (3) continue to build states' capacity to protect Medicaid; (4) extend work in Medicare Parts C and D, Medicaid managed care, and the Marketplace; and (5) provide greater transparency into program-integrity issues.

[34]National Health Care Anti-Fraud Association conference in Atlanta, Georgia, November 15–18, 2016.

[35]GAO, *Results-Oriented Cultures: Implementation Steps to Assist Mergers and Organizational Transformations*, GAO-03-669 (Washington, D.C.: July 2, 2003).

priority, the stakeholders could not communicate, articulate, or cite a common CMS strategic approach to address fraud risks in its programs.

Incentives. The Fraud Risk Framework discusses creating incentives to help ensure effective implementation of the antifraud strategy once it is developed. Currently, some incentives within stakeholder relationships may complicate CMS's antifraud efforts. Among contractors, CMS encourages information sharing through conferences and workshops; however, competition for CMS business among contractors can be a disincentive to information sharing. CMS officials acknowledged this concern and said that they expect contractors to share information related to fraud schemes, outcomes of investigations, and tips for addressing fraud, but not proprietary information such as algorithms to risk-score providers.

Without developing and documenting an antifraud strategy based on a fraud risk assessment, as called for in the *design and implement* component of the Fraud Risk Framework, CMS cannot ensure that it has a coordinated approach to address the range of fraud risks and to appropriately target and allocate resources for the most-significant risks. Considering fraud risks to which Medicare is most vulnerable, in light of the malicious intent of those who aim to exploit the programs, would help CMS to examine its current control activities and potentially design new ones with recognition of fraudulent behavior it aims to prevent. This focus on fraud is distinct from a broader view of program integrity and improper payments by considering the intentions and incentives of those who aim to deceive rather than well-intentioned providers who make mistakes. Also, continued growth of the program, such as growth of Medicare Part C, calls for consideration of preventive fraud control activities across the entire network of entities involved.

Furthermore, considering the large size and complexity of Medicare and the extensive stakeholder network involved in managing fraud in the program, a strategic approach to managing fraud risks within the programs is essential to ensure that a number of existing control activities and numerous stakeholder relationships and incentives are being aligned to produce desired results. Once developed, an antifraud strategy that is clearly articulated to various CMS stakeholders would help CMS to address fraud risks in a more coordinated and deliberate fashion. Thinking strategically about existing control activities, resources, tools, and information systems could help CMS to leverage resources while continuing to integrate Medicare program-integrity efforts along functional lines. A strategic approach grounded in a comprehensive assessment of

fraud risks could also help CMS to identify future enhancements for existing control activities, such as new preventive capabilities for its Fraud Prevention System (FPS) or additional fraud factors in provider enrollment and revalidation, such as provider risk-scoring, to stay in step with evolving fraud risks.

CMS Has Established Monitoring and Evaluation Mechanisms That Could Inform a Risk-Based Antifraud Strategy for Medicare

The *evaluate and adapt* component of the Fraud Risk Framework calls for federal managers to evaluate outcomes using a risk-based approach and adapt activities to improve fraud risk management. Furthermore, according to federal internal control standards, managers should establish and operate monitoring activities to monitor the internal control system and evaluate the results, which may be compared against an established baseline.[36] Ongoing monitoring and periodic evaluations provide assurances to managers that they are effectively preventing, detecting, and responding to potential fraud.

CMS has established monitoring and evaluation mechanisms for its program-integrity activities that it could incorporate into an antifraud strategy.

As described in the Fraud Risk Framework, agencies can gather information on the short-term or intermediate outcomes of some antifraud initiatives, which may be more readily measured. For example, CMS has developed some performance measures to provide a basis for monitoring its progress towards meeting the program-integrity goals set in the HHS Strategic Plan and Annual Performance Plan. Specifically, CMS measures whether it is meeting its goal of "increasing the percentage of Medicare FFS providers and suppliers identified as high risk that receive an administrative action."[37] CMS does not set specific antifraud goals for other parts of Medicare; other CMS performance measures relate to measuring or reducing improper payments in the various parts of Medicare.

[36]See GAO-14-704G.

[37]This performance metric refers to providers identified by FPS whose behavior is aberrant and potentially fraudulent. CMS can take a variety of administrative actions against those providers, from payment suspensions to revoking providers' billing privileges. CMS has met this goal from 2013 to 2015; the 2016 data were pending at the time of the writing of the December 2017 report.

CMS uses return-on-investment and savings estimates to measure the effectiveness of its Medicare program-integrity activities and FPS.[38] For example, CMS uses return-on-investment to measure the effectiveness of FPS[39] and, in response to a recommendation we made in 2012, CMS developed outcome-based performance targets and milestones for FPS.[40] CMS has also conducted individual evaluations of its program-integrity activities, such as an interim evaluation of the prior-authorization demonstration for power mobility devices that began in 2012 and is currently implemented in 19 states.

Commensurate with greater maturity of control activities in Medicare FFS compared to other parts of Medicare and Medicaid, monitoring and evaluation activities for Medicare Parts C and D and Medicaid are more limited. For example, CMS calculates savings for its program-integrity activities in Medicare Parts C and D, but not a full return-on-investment. CMS officials told us that calculating costs for specific activities is challenging because of overlapping activities among contractors. CMS officials said they continue to refine methods and develop new savings estimates for additional program-integrity activities.

According to the Fraud Risk Framework, effective managers develop a strategy and evaluate outcomes using a risk-based approach. In developing an effective strategy and antifraud activities, managers consider the benefits and costs of control activities. Ongoing monitoring and periodic evaluations provide reasonable assurance to managers that they are effectively preventing, detecting, and responding to potential fraud. Monitoring and evaluation activities can also support managers' decisions about allocating resources, and help them to demonstrate their continued commitment to effectively managing fraud risks.

[38]We previously found flaws with CMS's return-on-investment calculation and made two recommendations regarding the methodology. CMS has implemented both of the recommendations. See GAO, *Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*, GAO-11-592 (Washington, D.C.: July 29, 2011).

[39]HHS OIG has reviewed CMS's methodology and calculations and certified the use of adjusted savings, which in 2014 yielded the FPS return-on-investment of approximately 3 to 1.

[40]GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

As CMS takes steps to develop an antifraud strategy, it could include plans for refining and building on existing methods such as return-on-investment or savings measures, and setting appropriate targets to evaluate the effectiveness of all of CMS's antifraud efforts. Such a strategy would help CMS to efficiently allocate program-integrity resources and to ensure that the agency is effectively preventing, detecting, and responding to potential fraud. For example, while doing so would involve challenges, CMS's strategy could detail plans to advance efforts to measure a potential fraud rate through baseline and periodic measures. Fraud-rate measurement efforts could also inform risk assessment activities, identify currently unknown fraud risks, align resources to priority risks, and develop effective outcome metrics for antifraud controls. Such a strategy would also help CMS ensure that it has effective performance measures in place to assess its antifraud efforts beyond those related to providers in Medicare FFS, and establish appropriate targets to measure the agency's progress in addressing fraud risks.

In our December 2017 report we recommended that the Administrator of CMS should, using the results of the fraud risk assessments for Medicare, create, document, implement, and communicate an antifraud strategy that is aligned with and responsive to regularly assessed fraud risks. This strategy should include an approach for monitoring and evaluation. In its March 2018 letter to GAO, HHS stated that it is currently evaluating its options with regards to implementing this recommendation. As of July 2018, the recommendation remains open.

Chairman Jenkins and Ranking Member Lewis, this concludes my prepared statement. I look forward to the subcommittee's questions.

GAO Contacts and Staff Acknowledgments

If you or your staff have any questions concerning this testimony, please contact Seto J. Bagdoyan, who may be reached at (202) 512-6722 or bagdoyans@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to this testimony include Tonita Gillich (Assistant Director), Irina Carnevale (Analyst-in-Charge), Colin Fallon, Scott Hiromoto, and Maria McMullen.

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Chairman Jenkins. Thank you.

Ms. Jarmon, you are recognized.

STATEMENT OF GLORIA L. JARMON, DEPUTY INSPECTOR GENERAL FOR AUDIT SERVICES, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. Jarmon. Good morning, Chairman Jenkins, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Gloria Jarmon, Deputy Inspector General for Audit, Office of Inspector General, Department of Health and Human Services. I appreciate the opportunity to appear before you today to discuss OIG's strategy to combat fraud and promote program integrity in Medicare.

Medicare represented more than 15 percent of all Federal spending in 2017. Expenditures can be expected to rise further as the number of beneficiaries increases and if per capita healthcare costs continue to increase.

This makes it more important than ever to protect Medicare's financial integrity by fighting fraud and reducing improper payments, a central component of OIG's mission.

OIG's multidisciplinary team conducts audits, evaluations, and investigations that identify improper payments, assess internal controls and payment vulnerabilities, and build cases against those who seek to defraud the Medicare program.

This work has led to numerous fraud convictions and has generated recommendations for improper payment recovery and prevention of future improper payments.

OIG has long been in the forefront of measuring, monitoring, and recommending actions to prevent improper payments. We developed the first Medicare payment error rate in 1996 at a time when there were few error rate models in government.

In this context, it is important to stress that while all monetary losses from fraud constitute improper payments, not all improper payments are fraud. A

comprehensive program integrity strategy helps to address multiple sources of improper payments, including fraud.

Today, I would first like to highlight OIG's three-pronged approach that focuses on prevention, detection, and enforcement.

CMS' Fraud Prevention System, or FPS, serves as an important tool for preventing fraud and other types of improper payments. However, OIG recommends improvements to the FPS that would increase its effectiveness.

Specifically, we have recommended that CMS ensure that its redesigned FPS can track savings from administrative actions back to individual FPS models. We have also recommended that contractors report only FPS-related savings amounts to CMS. Finally, we have recommended that evaluations of FPS model performance consider not only identified savings, but also the amount that is likely to be recovered.

To help increase the effectiveness of our fraud detection efforts, OIG uses advanced data analytics to scrutinize millions of claims and billions of data points. Once suspected fraud is detected, we thoroughly investigate the facts and aggressively enforce the law when warranted.

OIG partners with the Department of Justice and HHS on Medicare Strike Force teams and other healthcare fraud enforcement activities through the Health Care Fraud and Abuse Control, or HCFAC program.

Just last month, OIG, along with our State and Federal law enforcement partners, participated in an unprecedented nationwide healthcare fraud takedown. The takedown represented the largest multi-agency enforcement operation in history, both in terms of the number of defendants charged and total loss amount.

I would also like to speak today about OIG's use of risk management practices to improve decision making. We integrate these practices into all aspects of our work.

The risk assessment process for our audit work considers a variety of factors, including fraud-related risk factors that are based on GAO's Framework for Managing Fraud Risk in Federal Programs. The information we obtain from ongoing risk assessments helps us prioritize our work and guides the development of our work plan. While OIG historically published an annual

work plan, we now maintain a dynamic work plan that is updated throughout the year to keep the public better informed.

Each year we also identify the top management and performance challenges facing HHS. While these challenges cover a wide range of critical departmental responsibilities, ensuring program integrity in Medicare remains a top management challenge for HHS.

Thank you again for the opportunity to testify this morning, and I am happy to answer any questions you may have.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony Before the United States House Committee on Ways and Means
Subcommittee on Oversight

Combating Fraud in Medicare: A Strategy for Success

Testimony of:

Gloria L. Jarmon
Deputy Inspector General for Audit Services
Office of Inspector General
U.S. Department of Health and Human Services

July 17, 2018
10:00 a.m.
Longworth House Office Building, Room 1100

Testimony of: **Gloria L. Jarmon**
Deputy Inspector General for Audit Services
U.S. Department of Health and Human Services, Office of Inspector General

Good morning, Chairman Jenkins, Ranking Member Lewis, and distinguished Members of the Subcommittee. I am Gloria Jarmon, Deputy Inspector General for Audit Services, U.S. Department of Health and Human Services (HHS or the Department). Thank you for your longstanding commitment to ensuring that Medicare's 59 million beneficiaries are well served and the taxpayers' approximately $700 billion annual investment is well spent. I appreciate the opportunity to discuss the Office of Inspector General's (OIG's) strategy to promote program integrity and combat fraud in Medicare.

Introduction

Congress created OIG in 1976 as an independent body to oversee HHS programs. A key component of OIG's mission is to promote integrity and efficiency in Medicare and other Federal health care programs. Our multidisciplinary team of auditors, investigators, evaluators, and attorneys strategically focuses on fraud prevention, detection, and enforcement efforts. Our work generates specific recommendations to the Centers for Medicare & Medicaid Services (CMS) for mitigating or eliminating program vulnerabilities and improving program operations.

Medicare spending represented more than 15 percent of all Federal spending in 2017.[1] As the number of beneficiaries continues to rise, and if per capita health care costs continue to increase, Medicare spending can be expected to increase. The 2018 Annual Report by Medicare's Board of Trustees estimated that the Trust Fund for Medicare Part A will be depleted by 2026. The Annual Report also projected that spending for Medicare Part B will grow by more than 8 percent over the next 5 years, outpacing the U.S. economy, which is projected to grow by 4.7 percent during that same time.

My testimony today discusses Medicare fraud and improper payments. I will also discuss ways in which OIG is engaged in prevention, detection, and enforcement activities related to Medicare. Finally, I will describe how OIG uses risk assessment to ensure efficient use of our resources and effective oversight of the Medicare Program.

Fraud and Improper Payments in Medicare

We must foster sound financial stewardship to ensure that Medicare continues to serve a growing population of senior citizens and individuals with disabilities well into the future.

[1] Henry J Kaiser Family Foundation, "The Facts on Medicare Spending and Financing," https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/. Accessed July 12, 2018.

Combating fraud and reducing improper payments are critical to protecting the financial integrity of Medicare. It is important to stress that while all monetary loss from fraud constitutes improper payments, not all improper payments are fraud. A comprehensive program integrity strategy that focuses on prevention, detection, and enforcement helps address multiple sources of improper payments, including fraud.

While the full extent of fraud is not known, the Improper Payments Information Act of 2002 requires Federal agencies to report to the President and Congress information on the agencies' improper payments each year. Medicare and Medicaid accounted for $88.6 billion, or about 98 percent, of the $90.1 billion in improper payments that HHS reported in its fiscal year (FY) 2017 Agency Financial Report. Traditional Medicare fee-for-service accounted for $36.2 billion, or about 40 percent, of the improper payments that HHS reported. As a percentage of total Medicare fee-for-service payments, about 9.5 percent was improper. HHS attributed about 66 percent of Medicare fee-for-service improper payments to errors associated with insufficient or no documentation. For these claims, the medical records do not support that the billed services were actually provided, were provided at the level billed, or were medically necessary. Medical necessity errors accounted for about 18 percent of the errors. Medical necessity errors occur when the billed services were not reasonable and necessary as required by Medicare coverage and payment policies. Although improper payments may occur in all types of health care, home health, skilled nursing facility (SNF), and inpatient rehabilitation facility (IRF) are areas of particular concern, representing 33 percent of the overall estimated improper payment rate for Medicare fee-for-service in FY 2017.

OIG has long been at the forefront of measuring, monitoring, and recommending actions to prevent improper payments, including developing the first Medicare payment error rate in 1996 at a time when there were few error rate models in Government. In addition to OIG's reviewing and reporting on HHS's annual improper payment information, our audits, evaluations, and investigations identify improper payments for specific services and items, assess internal control and payment vulnerabilities, and make recommendations to prevent future improper payments. The Department's annual financial report, which is reviewed by our office, plays a significant role when we plan our oversight work, which I will discuss in the context of our approach to risk assessment. The high error rates associated with home health, SNF, and IRF claims have caused us to devote substantial resources to conducting work on those areas of the program. This work has resulted in fraud convictions as well as recommendations to collect improper payments and take corrective action to prevent future improper payments.

OIG drives positive change by not only identifying risks, problems, abuses, and deficiencies, but also by recommending solutions to address them. OIG identifies opportunities to promote economy and efficiency and offers recommendations to the agencies that operate HHS programs. We follow up with those agencies to get such recommendations implemented. We actively track recommendations that remain unimplemented, and each year we include the most significant recommendations in our *Compendium of Unimplemented Recommendations*.

We systematically follow up on our recommendations with the relevant HHS management officials. We frequently plan work related to unimplemented recommendations to update the results of a prior review or to provide further evidence of a vulnerability in the program. We also follow up on implemented recommendations to verify that corrective action was successful in addressing the problem.

A Focus on Prevention, Detection, and Enforcement

OIG takes a three-pronged approach to fighting fraud, waste, and abuse. This approach focuses on prevention, detection, and enforcement. With respect to preventing fraud and other types of improper payments, CMS's Fraud Prevention System (FPS) serves as an important tool that should be improved to increase its effectiveness. Data analytics and predictive analytics can help increase the effectiveness of fraud-detection programs. Once suspected fraud is identified, OIG special agents and other professionals thoroughly investigate the facts and, when indicated, OIG and our law enforcement partners aggressively pursue enforcement to hold perpetrators accountable and recover misspent taxpayer dollars. I discuss these prevention, detection, and enforcement efforts in more detail below.

Improvement of CMS's Fraud Prevention System Is Key to Preventing Improper Payments in Medicare

In June 2011, HHS launched FPS. Following a law that required HHS to use predictive modeling and other analytics technologies to identify and prevent fraud, waste, and abuse in the Medicare fee-for-service program, the Department designated CMS to develop FPS. FPS is a key component in CMS's strategy to go beyond detecting fraudulent and other types of improper payments and recovering the lost funds to preventing those claims from being paid in the first place.

Although OIG remains optimistic about FPS's future role in preventing fraud and improper payments, we have performed several audits that have identified ways to improve FPS. For example, when performing work to certify the actual and projected savings and the return on investment related to HHS's use of FPS, we discovered that HHS might not have the capability to trace the savings from administrative actions back to the specific FPS model that generated the savings. CMS could not track those savings because, according to CMS, that capability was not built into FPS. In addition, CMS did not make use of all pertinent performance results because it did not ensure that contractors' adjusted savings reported to CMS reflected the amounts certified by OIG, and CMS did not evaluate FPS model performance on the basis of the amounts actually expected to be prevented or recovered. As a result, FPS is not as effective as it could be in preventing fraud, waste, and abuse in Medicare.

CMS concurred with our recommendations that it make better use of its performance results to refine and enhance the predictive analytics technologies of the FPS models by ensuring that (1) the redesigned FPS allows CMS to track savings from administrative actions back to individual FPS models, (2) contractors adjust savings reported to CMS to reflect only FPS-

related savings amounts, and (3) evaluations of FPS model performance consider not only the identified savings but also the amount that is likely to be recovered.

OIG will continue to monitor CMS's implementation of predictive analytics technologies and will assess HHS's reporting of actual and projected savings for improper payments avoided and recovered and the related return on investment. In addition, we will follow up on corrective actions made in response to past OIG recommendations.

OIG Uses Sophisticated Data Analytics

The schemes to steal money from Medicare take many forms. They can be as simple as billing for services not provided or as complex as identity theft, kickbacks, and money laundering. The perpetrators of fraud schemes range from highly respected physicians to individuals with no prior experience in the health care industry and organized criminal enterprises. Regardless, they are all motivated by greed and often put profit before patients' health and safety, creating potentially dangerous patient care environments.

OIG's use of advanced data analytics helps us to more effectively assess risk and pinpoint our oversight efforts. We use data analytics to analyze millions of claims and billions of data points. At the macro level, OIG analyzes data patterns to assess fraud and other types of risk across Medicare services, provider types, and geographic locations to prioritize our work and more effectively deploy our resources. At the micro level, OIG uses data analytics, including near-real-time data, to identify potential fraud suspects for more in-depth analysis and to efficiently target investigations.

We are mindful that, even as our program integrity efforts have become more technology driven, the nature of health care fraud has become more technologically sophisticated. Therefore, technology is not a silver bullet. Even the most cutting-edge fraud-prevention technologies are of little value if not effectively implemented, used, and overseen.

Enforcement Efforts Hold Wrongdoers Accountable and Maximize Recovery of Public Funds

OIG partners with the Department of Justice and HHS on Medicare Strike Force teams and other health care fraud enforcement activities through the Health Care Fraud and Abuse Control (HCFAC) program. Over its 22-year history, the HCFAC program has recovered billions of dollars and has further protected Federal health care programs by convicting criminals, excluding providers from participation in Medicare and other Federal health care programs, and recovering audit disallowances.

Just last month, OIG, along with our State and Federal law enforcement partners, participated in an unprecedented nation-wide health care fraud takedown aimed at combating health care fraud and the opioid epidemic. Enforcement activities took place across the Nation, representing the largest multiagency enforcement operation in history, both in terms of the number of defendants charged and total loss amount. More than 600 defendants in 58 Federal

districts were charged for their alleged participation in schemes involving approximately $2 billion in losses to vital health care programs, including Medicare. Of those subjects charged, 165 are medical professionals—including 32 doctors who were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. More than 1,000 law enforcement personnel took part in this operation, including more than 350 OIG special agents.

We will continue to use enforcement activities to hold fraud perpetrators accountable and recover stolen or misspent funds. In addition, we will continue to share information about prescription-drug fraud schemes, trends, and other matters related to health care fraud with our partners in the Healthcare Fraud Prevention Partnership and the National Healthcare Anti-Fraud Association.

A Risk-Based Approach to Oversight

Integrating risk management practices improves decision making in governance, strategy, objective setting, and day-to-day operations. It helps to enhance performance and provides a path to creating, preserving, and realizing value. OIG uses risk assessments to develop and prioritize our oversight work to maximize our positive impact for HHS beneficiaries and taxpayers. With particular respect to OIG's audit work, our risk assessment process considers specific risk factors related to the potential liability and level of exposure of Medicare and other HHS programs to fraud, waste, and abuse. The risk factors related to fraud are based on the Government Accountability Office's *A Framework for Managing Fraud Risks in Federal Programs*[2] and the Committee of Sponsoring Organizations of the Treadway Commission's (COSO's) *Fraud Risk Management Guide*. We consider other areas based on COSO's updated *Enterprise Risk Management—Integrated Framework,* including:

- governance and culture;
- strategy and objective setting;
- performance;
- review and revision of practices to enhance entity performance; and
- information, communication, and reporting.

To assess the severity of identified risks, we generally evaluate the likelihood of a risk occurring and the potential impact or result of the risk. For example, rapid growth in program authority or spending may signal a greater likelihood of fraud, waste, or abuse. The number of beneficiaries affected by the rapid growth may be an indicator of impact. Risks may be categorized in a variety of ways. For example, the tool we developed to manage reported recommendations uses strategic, financial, informational, operational, and compliance risks to assist us in evaluating the potential impact. An audit ranked as high risk may be the target for a followup audit to ensure management has taken corrective action. An analysis of the high-risk

[2] U.S. Government Accountability Office, *A Framework for Managing Fraud Risks in Federal Programs*, July 2015. Accessed July 12, 2018. https://www.gao.gov/assets/680/671664.pdf.

recommendations for an HHS agency or program may lead us to new audit areas.

Our office uses a variety of other information to help identify and prioritize audits, including an environmental scan that considers the expectations of external stakeholders (including statutory mandates), OIG's strategic goals, and an analysis of Department operations and previous audits (including analyses to identify recurring audit findings and control deficiencies).

We use the information we obtain throughout the year from risk assessments and stakeholders to prioritize our work and develop our *Work Plan*. While we have traditionally published a static annual *Work Plan*, this document now reflects our dynamic ongoing process, and we update the plan throughout the year to keep the public informed of our currently planned work. It is critical that we appropriately plan an agenda of audits, investigations, and evaluations given the limited resources we have to oversee more than 100 programs and over $1 trillion in Federal spending. To focus the Department's attention on the most pressing issues, each year OIG identifies the top management and performance challenges facing the Department. These challenges can affect one or many HHS programs and cover a range of critical HHS responsibilities that include delivering quality services and benefits, exercising sound fiscal management, safeguarding public health and safety, and enhancing cybersecurity. Ensuring program integrity in Medicare remains a top management challenge for HHS.

Conclusion

As discussed earlier, the schemes used to steal money from Medicare range from straightforward false billings by physicians to complex schemes perpetrated by organized criminal enterprises. OIG will continue to develop and use cutting-edge tools and technology to provide Medicare oversight that prevents and detects fraud, waste, and abuse, and we will take appropriate action when they occur. Specifically, we will continue to perform audits and evaluations aimed at recommending improvements to the Medicare Program and reducing improper payments. With an eye on prevention, we will monitor CMS's efforts to implement our previous recommendations and to improve the FPS. By leveraging advanced data analytic techniques and using risk assessments in our work planning, we will detect potential vulnerabilities and fraud early and better target our resources to those areas and individuals most in need of oversight. Finally, we will continue to focus on the principle of enforcement, holding accountable those who commit fraud and building on successes such as the takedown that occurred in late June.

Thank you for your ongoing leadership and for affording me the opportunity to testify on this important topic.

Chairman Jenkins. Thank you.

Mr. Alexander, you are recognized.

STATEMENT OF ALEC ALEXANDER, DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. Alexander. Good morning, Chairman Jenkins, Ranking Member Lewis, and Members of the Subcommittee. Thank you for the invitation and the opportunity to discuss CMS' ongoing efforts to protect taxpayer dollars by protecting the integrity of the Medicare program.

CMS takes very seriously our responsibility to make sure that we are paying the right amount to the right party for the right beneficiary in accordance with all applicable laws and regulations.

As a former assistant United States attorney who was responsible for prosecuting healthcare fraud, I have seen firsthand how Medicare fraud can inflict real harm on beneficiaries.

When fraudulent providers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity, program beneficiaries are put at risk.

When fraudulent providers steal a beneficiary's identity and bill for services or goods never rendered, that beneficiary may later have difficulty accessing care.

Strengthening our program integrity efforts protects beneficiaries from harm that fraudulent providers and bad actors might otherwise cause, and at the same time it safeguards trust fund dollars.

While we are not a law enforcement agency, we do collaborate closely and on a regular basis with our law enforcement partners. Most recently, CMS began and is leading an important new process improvement we call Major Case Coordination.

This innovative initiative provides an opportunity for CMS policy experts, law enforcement, including HHS OIG, the Department of Justice, the Healthcare Fraud Strike Force, as well as CMS fraud investigators, to collaborate before, during, and after the development of fraud leads. This involves weekly

meetings to discuss and prioritize new leads and coordinate and assign appropriate paths for resolution.

This early and frequent collaboration and coordination maximizes our joint ability to identify, investigate, and pursue fraudsters who might otherwise endanger program beneficiaries or steal from Federal programs.

Just last month, as was mentioned, HHS, along with the Department of Justice OIG and other law enforcement partners, announced the largest ever healthcare fraud enforcement action by the Medicare Fraud Strike Force. More than 600 defendants were charged with participating in fraud schemes involving approximately $2 billion in losses to Medicare and Medicaid.

Only 45 days after being referred to the Strike Force as part of this new coordination effort that I have described, one of those reviewed cases was charged as part of the June 28th healthcare fraud takedown.

CMS has been working to identify and prevent fraud for decades, and we truly appreciate the extensive work of the GAO to provide a systemic conceptual framework within which we can assess areas at risk of fraud across our programs.

CMS is also strengthening our efforts to ingrain fraud risk assessment principles throughout the agency to cultivate a culture of program integrity and to ensure that this critical work does not occur in a silo.

We will continue to work closely with GAO and other stakeholders as we take steps to expand our capacity to conduct fraud risk assessments and make the process more standardized and more efficient.

CMS is also using a number of other tools to identify and prevent fraud, waste, and abuse in our programs. As was mentioned, the Fraud Prevention System allows us to implement prepayment edits and stop payments before they go out the door.

Through advanced data analytics and modeling, it also allows us to better target investigative resources toward suspect claims and providers and swiftly impose either administrative action or make law enforcement referrals when they are warranted.

Additionally, when one of the Fraud Prevention System's approximately 100 predictive models identifies egregious, suspect, or aberrant activity, the system automatically generates lead for further review and investigation.

The FPS helped CMS identify or prevent $527 million in inappropriate payments during fiscal year 2016. This reflects a return on investment of $6.30 for every dollar spent on that effort.

Recent work of the OIG is helping us in our efforts to continually improve the Fraud Prevention System.

In addition to our efforts to identify and prevent fraud, waste, and abuse, we are also taking a number of steps to lower the improper payment rate across our programs. It is important to remember that while all payments resulting from fraud are improper, most improper payments are not fraud.

Under the leadership of Administrator Verma, CMS is reexamining existing corrective actions and exploring new and innovative approaches to reducing improper payments while minimizing burden. And because of the actions we have put into place, we are glad to point out that the Medicare fee-for-service improper payment rate fell from 11 percent in 2016 to 9.5 percent in 2017, which represents about a $5 billion decrease in estimated improper payments.

Going forward, we must continue our effort to identify vulnerabilities in the program and in our payment systems and develop mitigation strategies to proactively help reduce fraud, waste, and abuse.

CMS shares the subcommittee's commitment to protecting the safety and health of beneficiaries and to safeguarding taxpayer and trust fund dollars and to strengthening the Medicare program to ensure its long-term sustainability for the millions of beneficiaries we are honored to serve.

We thank you for your interest in our work. And I look forward to any questions you may have.

STATEMENT OF

ALEC ALEXANDER,
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"COMBATTING FRAUD IN MEDICARE: A STRATEGY FOR SUCCESS"

BEFORE THE

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

JULY 17, 2018

U.S. House Ways and Means Committee,
Subcommittee on Oversight
"Combating Fraud in Medicare: A Strategy for Success"
July 17, 2018

Chairman Jenkins, Ranking Member Lewis, and members of the Subcommittee, thank you for the invitation and the opportunity to discuss the ongoing efforts of the Centers for Medicare & Medicaid Services (CMS) to protect taxpayer dollars by protecting the integrity of the Medicare and Medicaid programs. We share this Subcommittee's commitment to protecting beneficiaries, ensuring taxpayer dollars are spent appropriately, and identifying and correcting improper payments. CMS makes it a top priority to protect the health and safety of millions of beneficiaries who depend on vital federal healthcare programs. CMS's Center for Program Integrity (CPI) collaborates closely with our law enforcement partners to safeguard precious taxpayer dollars. Under CMS Administrator Seema Verma, we will continue to strengthen this partnership with law enforcement in order to ensure the integrity and sustainability of these essential programs that serve millions of Americans. Most recently, CPI has begun a Major Case Coordination initiative which includes the Department of Health & Human Services Office of Inspector General (HHS-OIG), the United States Department of Justice (DOJ), and all components of CPI. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads. Through early coordination, CMS is able to direct potential fraud matters to law enforcement partners quickly. This serves to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs. Just last month, HHS, along with DOJ, announced the largest ever health care fraud enforcement action by the Medicare Fraud Strike Force. More than 600 defendants in 58 federal districts were charged with participating in fraud schemes involving about $2 billion in losses to Medicare and Medicaid.

CMS efforts across our programs strive to 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.

Through the work of CPI, we're focusing on making sure CMS is paying the right provider the right amount for the right services. This Administration has instituted many program improvements, and CMS is continuously looking for ways to refine and improve our program integrity activities. In addition to CMS's ongoing program integrity efforts, the President's Fiscal Year (FY) 2019 Budget reflects the Administration's commitment to strong program integrity initiatives. The Budget includes 17 legislative proposals that provide additional tools to further enhance program integrity efforts in the Medicare and Medicaid programs. For example, one proposal would provide CMS with the authority to better ensure providers that violate Medicare's safety requirements and have harmed patients cannot quickly re-enter the program. Another would expand CMS's authority to require prior authorization for specified Medicare fee for service (FFS) items and services to include additional items at high risk of fraud, waste, and abuse. Together the program integrity investments in the Budget will yield an estimated $915 million in savings for Medicare and Medicaid over 10 years.

CMS Uses a Variety of Tools to Fight Fraud, Waste, and Abuse

CMS is taking a number of steps to reduce fraud, waste, and abuse and lower the improper payment rate across our programs. To inform our efforts, we rely on input from stakeholders, such as Congress, providers, patients, and law enforcement, as well as the work done by the Government Accountability Office (GAO) and HHS-OIG. For example, following the GAO's Fraud Risk Framework[1], CMS has begun to initiate the GAO fraud risk assessment for some programs in Medicare, including the Medicare Diabetes Prevention Program expanded model. We are also continuing to draft Fraud Risk Profiles for the Comprehensive ESRD Care model, the Comprehensive Primary Care Plus model, the permanent Medicare Shared Savings Program,

[1] https://www.gao.gov/products/GAO-15-593SP

and the new Medicare Beneficiary Identifier. We are also assessing the Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), utilizing the GAO fraud risk assessment. CMS has been working to identify and prevent fraud for decades, and we greatly appreciate the work of the GAO to provide a systematic way to assess areas at risk of fraud across our programs.

Medicare is a large, complex program comprised of numerous different payment systems with different incentives for providers and suppliers, and we are working hard to incorporate lessons learned across our programs and making sure our fraud risk assessments are tailored to accurately reflect the fraud risks of each program and payment system. The fraud risk assessments will help CMS identify vulnerabilities in our programs and payment systems, and develop mitigation strategies to proactively help reduce the risk of fraud. CMS is also strengthening our efforts to ingrain fraud risk assessment principles throughout the Agency to ensure that this critical work is not completed in a silo – for example, CMS is developing a training video, module, and curriculum to train staff agency-wide on fraud risks. We are greatly appreciative of the GAO's work in this area, and we will continue to work closely with them and other stakeholders as we take steps to expand our capacity to conduct fraud risk assessments and make the process more standardized and efficient.

Fraud Prevention System (FPS)

One of the most important improvements CMS has made in its approach to program integrity over the last several years is our enhanced focus on prevention. Historically, CMS and our law enforcement partners were 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. Since June 30, 2011, the Fraud Prevention System (FPS) has run predictive algorithms and other sophisticated analytics nationwide against Medicare FFS claims on a continuous basis prior to payment in order to identify, prevent, and stop potentially fraudulent claims. The FPS helps CMS target potentially fraudulent providers and suppliers, reduce the administrative and compliance burden on legitimate providers and suppliers, and prevent potential fraud so that funds are not diverted from providing beneficiaries with access to quality health care. In March

2017, CMS launched an updated version of FPS, called "FPS 2.0," which modernizes system and user interface, improves model development time and performance measurement, and aggressively expands CMS's program integrity capabilities.

The FPS helped CMS identify or prevent $527.1 million in inappropriate payments during FY 2016, which resulted in a return on investment (ROI) of $6.3 to $1. Since CMS implemented the original FPS technology in June 2011, the FPS has identified or prevented almost $2 billion in inappropriate payments by discovering new leads or contributing to existing investigations. During FY 2016, the FPS models generated 688 leads that were included in the Zone Program Integrity Contractor's workload, resulting in 476 new investigations and augmented information for 212 existing investigations.

Prior Authorization

As part of CMS's program integrity strategy, CMS implemented several prior authorization programs, including one permanent program and three demonstrations/models. Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for review before an item or service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization helps to make sure that applicable coverage, payment, and coding rules are met before items and services are furnished. CMS also implemented one pre-claim review program. Pre-claim review is a process through which a request for provisional affirmation of coverage is submitted for review before a final claim is submitted for payment. Pre-claim review helps make sure that applicable coverage, payment, and coding rules are met before the final claim is submitted.

Two of the Medicare prior authorization programs (repetitive, scheduled non-emergent ambulance transport and non-emergent hyperbaric oxygen therapy) were models developed to reduce expenditures, while maintaining or improving quality of care. One of the Medicare prior authorization programs (power mobility devices) and the Medicare pre-claim review program (home health services) were demonstrations that helped develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services. CMS also implemented a permanent Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

(DMEPOS) prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization.

CMS has been closely monitoring the impact of the prior authorization and pre-claim review programs on beneficiaries, suppliers, providers, and Medicare expenditures to evaluate the results of each program and help inform next steps.

Provider Screening and Enrollment

Provider enrollment is the gateway to the Medicare program and is the key to preventing ineligible providers and suppliers from entering the program. CMS is committed to maintaining operational excellence in its provider enrollment screening process. Through risk-based provider screening and enrollment, CMS continues to prevent and reduce fraud, waste, and abuse within Medicare and ensure that only eligible providers are caring for beneficiaries and receiving payment.

CMS's regulations establish three levels of provider and supplier enrollment risk-based screening: "limited," "moderate," and "high," and each provider and supplier type is assigned to one of these three screening levels. Providers and suppliers designated in the "limited" risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider- or supplier-specific requirements. Providers and suppliers designated in the "moderate" risk category are subject to all the requirements in the "limited" screening level, in addition to unannounced site visits.

Providers and suppliers in the "high" risk category are subject to all of the requirements in the "limited" and "moderate" screening levels, in addition to fingerprint-based criminal background checks (FCBCs). For Medicare, CMS began phasing in the fingerprinting requirements on August 6, 2014. In FY 2017, CMS denied approximately 1,259 enrollments and revoked 19 enrollments as a result of the FCBCs or a failure to respond. The Advanced Provider Screening system (APS) automatically screens all current and prospective providers and suppliers against a number of data sources, including provider and supplier licensing and criminal records to identify and highlight potential program integrity issues for proactive investigation by CMS. In FY 2017, APS resulted in more than 2.6 million screenings. These screenings were composed of

more than 21,700 actionable License Continuous Monitoring alerts, and more than 60 actionable Criminal Continuous Monitoring alerts, which resulted in approximately 176 Criminal revocations and over 590 Licensure revocations.

Site visits are a screening mechanism used to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The CMS-authorized site-visit contractors validate that the provider or supplier complies with Medicare enrollment requirements during these visits. In FY 2017, the initiative resulted in 75,568 site visits conducted by the National Site Visit Contractor (NSVC), which conducts site visits for most Medicare FFS providers and suppliers, and 17,745 conducted by the National Supplier Clearinghouse (NSC), which conducts site visits for Medicare DME suppliers. This work resulted in 227 revocations due to non-operational site visit determinations for all providers and suppliers.

CMS's provider screening and enrollment initiatives in Medicare have had a significant impact on removing ineligible providers from the program. In FY 2017, CMS deactivated 177,525 enrollments, and revoked 2,831 enrollments. Site visits, revalidation, and other initiatives have contributed to the deactivation and revocation of more than one million enrollment records since CMS started implementing these screening and enrollment requirements.

In addition, in FY 2017, CMS continued its use of statutory authority to suspend Medicare payments to providers during investigations of a credible allegations of fraud. CMS also has authority to suspend Medicare payment if there is reliable information that an overpayment exists. During FY 2017, there were 551 payment suspensions that were active at some point during the fiscal year. Of the 551 payment suspensions, 252 new payment suspensions were imposed during FY 2017.

Medicare Part D Preclusion List

In an effort to strike a better balance between program integrity and prescriber and provider burden, CMS announced that it would compile a "Preclusion List" of prescribers, individuals,

and entities[2] that should not receive payments through Medicare Part C or have their prescriptions covered under Medicare Part D. Effective January 1, 2019, Part D sponsors will be required to reject a pharmacy claim (or deny a beneficiary request for reimbursement) for a Part D drug that is prescribed by an individual on the Preclusion List and MA plans will be required to deny payment for a health care item or service furnished by an individual or entity on the Preclusion List.

Removing Social Security Numbers from Medicare Cards

To protect the safety and security of people with Medicare benefits, CMS is removing Social Security numbers from Medicare cards and is replacing it with a unique, randomly-assigned Medicare Beneficiary Identifier (MBI), or Medicare number. This fraud prevention initiative aims to protect the identities of people with Medicare, reduce fraud and offer better safeguards of important health and financial information. Through MACRA, Congress provided CMS with the resources to achieve this important goal. All newly eligible people with Medicare are now receiving a Medicare Card with the MBI. Starting in April 2018, CMS began mailing new Medicare cards to all people with Medicare on a flow basis, based on geographic location and other factors. CMS expects to complete this important work by April 2019, as required by MACRA. To ensure the integrity of the card mailing process and prevent new cards from falling into fraud schemes, CMS is conducting enhanced beneficiary address verification. The goal of this effort is to ensure cards are mailed only to correct beneficiary addresses.

With the introduction of the MBI, for the first time, CMS will have the ability to terminate a Medicare number and issue a new number to a beneficiary, in instances in which they are the victim of medical identity theft or their Medicare number has been compromised. Transitioning to the MBI will help beneficiaries better safeguard their personal information by reducing the exposure of their SSNs. CMS has already removed SSNs from many types of communications,

[2] Individuals and entities could be added to the "Preclusion List" if they: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. For more information please visit: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/PreclusionList.html

including Medicare Summary Notices mailed to beneficiaries on a quarterly basis. We have prohibited private Medicare Advantage and Medicare Part D prescription drug plans from using SSNs on enrollees' insurance cards.

Unified Program Integrity Contractors (UPIC)

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 previously performed by several contractors. All five UPIC contracts have been awarded and are operational. UPICs consolidate Medicare and Medicaid program integrity functions, phasing out the Zone Program Integrity Contractors and the Audit Medicaid Integrity Contractors. The UPICs merge these separate contracting functions into a single contractor, in a geographic area, with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations. This means that the same contractor can conduct audits and investigations of providers enrolled in both Medicare and Medicaid, and can more easily make connections across the two programs.

As part of the UPICs' work, collaborative audits are conducted to augment a state's audit capacity by leveraging the resources of CMS and its UPICs, resulting in more timely and accurate audits. These audits combine the resources of CMS and the UPICs, including algorithm development, data mining, auditors, and medical review staff, to assist states in addressing suspicious payments. The collaborative process includes discussions between the states and CMS regarding potential audit issues and the states' provision of Medicaid Management Information System data for data mining. The states, together with CMS, determine the audit processes the UPICs follow during the collaborative audit.

Healthcare Fraud Prevention Partnership (HFPP)

While not a law enforcement agency, CMS partners with law enforcement to provide data they need to pursue investigations of alleged fraud. Since FY 2012, HHS and 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, a voluntary, collaborative partnership, includes the federal government, state officials, many of the leading private health insurance organizations, and other healthcare anti-fraud groups. It currently consists of over 100 members, 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 HFPP has completed several studies associated with fraud, waste or abuse that have yielded successful results for participating partners. Studies have examined such subjects as billing for "the impossible day" (billing for more hours than possible in one day) and excessive weekends and holidays, and services that are ordered by providers with deactivated National Provider Identifiers (NPIs). The HFPP also leverages in-person information sharing sessions and the Partner Portal as mechanisms to share fraud schemes with all Partners. The HFPP's most important goal is to generate comprehensive approaches and strategies that materially impact each Partner's effort to combat healthcare fraud, waste, and abuse. Collectively, membership represents over 70 percent of covered lives in the United States and is continuously growing.

Improper Payment Rate Measurements and Prevention

In addition to our ongoing efforts to fight fraud, waste, and abuse within our program, CMS is taking action to reduce improper payments. 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. 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).[3] 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 or item was medically

[3] https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf

necessary. For example, one common claim error within Medicare FFS – a missing physician's signature – is not necessarily indicative of fraud where it is otherwise clear that a physician did in fact perform the service or order the test at issue.

Clarifying and streamlining documentation requirements is a key component of our efforts to lower the Medicare FFS improper payment rate. For example, we simplified documentation requirements for providers and clarified the medical review process by releasing guidance[4] for contractors such as Medicare Administrative Contractors (MACs). This will allow providers to spend more time with patients and less time on complex claims documentation that is confusing and can lead to errors. In addition, when performing a medical review as part of CMS's Targeted Probe and Educate (TPE) program, MACs focus on specific providers/suppliers that bill a particular item or service, rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Through TPE, MACs work directly with providers and suppliers to identify errors. Many common errors are simple – such as a missing physician's signature – and, in some situations, are easily corrected. So far, CMS has seen promising results from this program – the majority of those that have participated in the TPE process increased the accuracy of their claims. In addition to medical reviews and audits, CMS uses automated edits to help prevent improper payment without the need for manual intervention. The National Correct Coding Initiative (NCCI) program consists of edits designed to reduce improper payments in Medicare Part B. In just the first nine months of FY 2017, NCCI edits saved the Medicare program $546.7 million.[5] Our efforts to reduce improper payments, including efforts to reduce administrative burden, appear to be working – the Medicare FFS improper payment rate decreased from 11.0 percent, or $41.1 billion, in FY 2016 to 9.51 percent, or $36.2 billion, in FY 2017.[6]

[4] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/SimplifyingRequirements.html
[5] https://oig.hhs.gov/publications/docs/hcfac/FY2017-hcfac.pdf
[6] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2017-Medicare-FFS-Improper-Payment.pdf

Moving Forward

CMS's goal is to make sure our programs pay the right amount, to the right party, for the right beneficiary. Preventing fraud, waste, and abuse and reducing improper payments helps to safeguard trust fund dollars and to make sure that the Medicare program is strong and available to the beneficiaries we serve. 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 identify fraud trends and prevent harm to the Trust Fund 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. CMS shares 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.

Chairman Jenkins. Thank you for your testimony, each and every one of you.

We will now proceed to the question and answer session. And I would like to direct my first question to Mr. Bagdoyan.

Can you expand on the purpose of a risk-based anti-fraud strategy? What are the benefits of being able to assess and mitigate the risk of fraud?

Mr. Bagdoyan. Thank you for your question, Madam Chairman.

A strategy is basically a roadmap that allows an agency, in this case CMS, to meet its mission. It has objectives within that mission, and it has a capacity. There is an asymmetry usually between the two. And an anti-fraud strategy is designed to close the gap in terms of meeting the mission while also achieving fraud management.

Now, a strategy is the best way to organize and target the disparate measures that CMS and CPI have in place already, plus any new ones that might be needed to target those against prioritized risks. You certainly cannot address each and every risk, so you have to prioritize them, and a strategy provides the best roadmap to do so.

Chairman Jenkins. Okay. What would an effective anti-fraud strategy look like? And can you talk a little bit about what other agencies or entities have successfully conducted a fraud risk assessment using the Fraud Risk Framework and how that has informed a risk-based anti-fraud strategy?

Mr. Bagdoyan. Sure. Just to follow up, a strategy is basically the result of performing a risk assessment in which you identify all the risks that are facing a particular program. Then you create a risk profile, which is essentially a documentation from the assessment, and there could be various assessments certainly. And the profile identifies in priority order what the risks are that need to be addressed.

And then the strategy comes in with identifying the existing controls that are in place and also identifies any new ones that are needed, any new controls, how they might be sequenced in a particular program, how they work with each other. And essentially, the strategy also has performance measures to see whether any of these activities actually move the needle, so to speak, in terms of achieving reduction in fraud or better management of fraud.

And in terms of the other subpart to your question, the Framework has been around for about 3 years now, and we have applied it to various agencies. And to be candid, most of them are still struggling to come up to speed in terms of fully utilizing the capabilities that are within the Framework.

So there is a lot of good faith effort we have seen, as I described, within CMS. They have lots to build on. It just needs to be better organized and focused and targeted.

Chairman Jenkins. Thank you.

Mr. Alexander, CMS has a number of anti-fraud initiatives in place. Can you describe CMS's efforts to align its anti-fraud initiative with GAO's Framework, the Fraud Risk Framework?

Mr. Alexander. Thank you, Madam Chairman.

Of course, we are grateful to have the GAO guidance with respect to the Fraud Risk Framework, and we use it and are using it every day. We assess fraud risk in all of our programs every day. This is a continuous effort because fraud and fraud risk evolves day-to-day.

We are also standing up right now, and will be integrally associated with our use of the framework, a vulnerability management process that we are at the end of putting into place which we will do and incorporate essentially all of the elements of the Fraud Risk Framework that the GAO has outlined.

Specifically, this is enterprise-wide, look across the horizon at emerging fraud risk, bring them together with the entire team, prioritize them, analyze them, score them for likelihood of occurrence and impact if they do occur, attach action plans to them to ensure, as my colleague indicated, that we move the needle from red to green, and then attach an outcomes assessment tool at the back.

We do that not only at payment-system level on a regular basis, not only with respect to, for example, the marketplace and the exchanges we have done it, we are doing it in modeling from CMMI, but we do it at the program level. And more particularly and more granularly, we do it at the issue level.

So when one of these vulnerabilities are identified, we put it into this vulnerability management process, we will be doing a version of exactly what is recommended in each of those.

Now, the GAO report was also very thoughtful in observing that because of the size of our program, it probably makes sense not to try to eat the elephant all at once, but instead to break it into it some sub-assessments, which is essentially what we are trying to do. But I want the committee to be aware and GAO to be aware that we are following exactly those protocols. And in fact, they mirror pretty standard enterprise risk management practices that were described a moment ago.

Chairman Jenkins. Okay. Thank you.

And finally, Ms. Jarmon, what role does the Inspector General have in managing fraud risk in Medicare?

Ms. Jarmon. We have a significant role in managing fraud risk in Medicare as part of our oversight role in OIG, and due to the large size of the Medicare program. Like I think was mentioned, it was about $700 billion.

So we are continually overseeing how the Department is managing Medicare and even in determining what work we do, whether we are doing audits, evaluations, or investigations. We have to do our own risk assessment to determine what areas to focus on.

And we have what we call priority outcomes because of the size of the programs that we are responsible for, and that continues to evolve. We determine what areas we are focusing on.

Like in Medicare, the improper payments have been higher in the noninstitutional settings, like home health agencies. And so we have additional focus on Medicare work in looking at claims in those areas, and we are continuing to do advanced data analytics to look at areas we should focus on.

So we use our own risk assessment in deciding what work we do and in overseeing the Department.

Chairman Jenkins. Okay. Thank you.

Now I will recognize Ms. DelBene for 5 minutes.

Ms. DelBene. Thank you, Madam Chair.

And thanks to all of you for joining us this morning.

The Affordable Care Act included dozens of new requirements and enhanced authorities for CMS to combat waste, fraud, and abuse in Medicare and Medicaid and the Children's Health Insurance Program.

And now, as you know, several States are suing to have the ACA overturned. And their argument is that the law is not severable, meaning that if they are successful, the enhanced fraud-fighting capabilities of CMS would be repealed as well.

So, Mr. Alexander, I wanted to ask you, if those States prevail in their argument and the ACA is overturned in its entirety, then would providers, suppliers, Medicaid managed care plans, Medicare Advantage plans and Medicare prescription drug plans be required to report and return any overpayment in 60 days?

Mr. Alexander. Thank you very much for the question.

First of all, I would like to assure the Subcommittee that the Secretary and the Administrator have made very clear that we are committed to performing --

Ms. DelBene. But if this is overturned, that requirement goes away. Isn't that true? It is a simple yes-or-no question.

Mr. Alexander. Well, the 60-day rule is a little bit beyond the purview of what I was going to discuss today.

Ms. DelBene. Okay.

Mr. Alexander. But, yes, it would have an impact.

Ms. DelBene. Okay. Thank you.

I just also wanted to ask, would physicians be required to provide documentation on referrals to programs which contain a high risk of waste and abuse, something else that was required under the Affordable Care Act?

Mr. Alexander. We have many different sources of information on vulnerabilities in the program. That is certainly one of them.

Ms. DelBene. But that would go away.

Mr. Alexander. Not necessarily.

Ms. DelBene. The requirement would go away.

And then would CMS have the authority -- the authority -- to impose an administrative penalty if a Medicare beneficiary or a Medicaid recipient knowingly participated in a healthcare fraud scheme?

Mr. Alexander. We have multiple authorities upon which to revoke provider billing privileges or put payment suspension into place or take other administrative action.

Ms. DelBene. But the administrative penalty, that is an authority that was provided under the Affordable Care Act.

And I want to highlight these because I think it is safe to say that a fair number of important fraud prevention tools would be taken out of the CMS toolbox if the ACA were overturned in its entirety. And those are just a few of them. I know there are others that would also be removed that we probably don't have time to mention right here.

Almost exactly a year ago, this Subcommittee held this same hearing, and I submitted a question to the record and I haven't received a response, so I wanted to ask it here today for you, Mr. Alexander.

Certain value-based models, such as accountable care organizations, are uniquely positioned to help identify and ultimately report fraud to the Center for Program Integrity. On average, Medicare ACO's cover 17,000 lives and comprise hundreds of clinicians, and their success depends on continuously monitoring their expenditures.

So ACOs have asked for a fast-track platform so they can report fraud to the agency, but it is my understanding that CMS has not done this or responded to their request. And so I wanted to ask you if you can commit to creating a platform for large value-based providers so that they can report fraud to your department.

Mr. Alexander. Thank you very much.

We have multiple ways to receive concerns of vulnerabilities from all of the payment structures and payment programs and payment systems that we have.

Yes, we would make that available. We want to know from every source we can what are the emerging vulnerabilities so that we can place it within the vulnerability management process I have just described and address it.

Ms. DelBene. Okay. We will follow up with you on that too. Thank you.

Mr. Alexander. Thank you.

Ms. DelBene. And then lastly to you, Ms. Jarmon, President Trump came into office saying that he was going to drain the swamp, but it didn't take long for his appointees to waste taxpayer dollars, in particular on lavish trips on costly chartered jets.

Last week, the OIG found that Secretary Price wasted 341,000 taxpayer dollars on trips that did not comply with Federal policies and the OIG recommended that HHS begin recouping these funds.

I wanted to ask you, has HHS supplied you a timeframe to recoup the $341,000, taxpayer dollars, that were wasted?

Ms. Jarmon. I don't believe we have a timeframe yet. The report, like you mentioned, was just issued last week. And as part of our process, we will be following up with the Department on how they are implementing those recommendations.

And so we will be following up with them over the next few months on how they are implementing the recommendations. And then at some point we probably will get a timeframe. But we don't have one now.

Ms. DelBene. Okay. Thank you. I would be interested in knowing when you have one.

Thank you very much for your time.

I yield back.

Chairman Jenkins. Thank you.

I would like to recognize Mrs. Walorski for 5 minutes.

Mrs. Walorski. Thank you, Madam Chairman.

Mr. Bagdoyan, it is my understanding that in order to implement a strategy for Medicare in line with GAO's Framework, a fraud assessment must be first conducted. Can you talk about that?

Mr. Bagdoyan. Yes, sure. An assessment is basically a bottom-up build-out, if you will, looking at all the, in this case, Medicare's various parts and identifying risks that are known and perhaps speculating on ones that are emerging.

Fraud risk is not static. It is very dynamic. It shifts from region to region, State to State, city to city. As program design or counter fraud measures take effect, those schemes evolve.

So an assessment is essentially a thoughtful process from all stakeholders to determine essentially a portfolio of risks, and then also determine their likelihood and their impact. And those assessments, as I mentioned earlier, feed into a risk profile which is the more formal documentation of an assessment.

Mrs. Walorski. Okay. Thank you.

And, Mr. Alexander, Mr. Bagdoyan mentioned earlier a lot of good faith effort going on around all these systems. And I am just curious, what steps is CMS taking to determine what order Medicare programs should develop a fraud risk assessment.

And then, to his point, if you could talk about the fact, is there a full timeline when each of these fraud risk assessments are going to be completed? I imagine there is a master grid by which all these things are going to be completed.

So can you just talk about that, of the Medicare programs, how they should develop, and then the timeline that we are looking at for all these programs?

Mr. Alexander. Sure. Thank you for the question.

As I mentioned earlier, we have been and do fraud risk and risk profiling as has been described for a long time. We, for example, have done it in the marketplace and the exchanges. We are doing it in the modeling. And with each of those steps, we are learning and bringing those learnings forward to each subsequent program.

I would point out as well that each of the programs and each of the payment systems that you would do a risk assessment on has unique peculiarities to it. The way we pay for critical access hospitals is very different than the way we pay for acute care hospitals. And therefore each presents a different table or plate full of risks that need to be assessed differently and independently.

So they each break into a separate brick, if you would. So if you would imagine, we are building under the framework GAO has given us a monolithic program integrity wall that would cover the whole program, it is going to be comprised of many, many different bricks, each containing within it a risk assessment of its own.

So we are in the process of doing that.

Mrs. Walorski. Sure.

Mr. Alexander. As to the timeline, I am not sure exactly when that all gets done. But I would assure the Committee that we do these, as I mentioned, on a vulnerability-by-vulnerability, issue-by-issue basis each and every day as we see these.

Mrs. Walorski. Can you just ballpark it, though, just for the sake of -- are we looking at 2 years, 5 years, 10 years?

Mr. Alexander. I think that by the fall of next year, I think we should have a general idea where we are. I believe that we are steadily making progress.

And, again, I want to reiterate that as the vulnerability process I mentioned that we are standing up comes into fruition, we will be taking each of those vulnerabilities on a daily, weekly basis, performing exactly this process and then assessing it to make sure we are addressing it and measuring the outcome on how we are doing moving the needle.

But generally speaking, probably the fall of next year, I would think we should have something, something in terms of the overall plan.

Mrs. Walorski. Sure. And back to your point, you talked about ACA. Can you talk about the ACA marketplace for fraud risk assessment and how that may inform a fraud risk assessment for Medicare?

Mr. Alexander. Oh, absolutely.

We, of course, take marketplace exchange integrity as a top priority for us, for all of us. We are following the recommendation that GAO has given us, have performed and are performing a risk assessment specific to the exchanges.

I am happy to tell you that that very process has identified a particular vulnerability around agents and brokers. That vulnerability has led to a referral.

We have also stood up a contractor, a marketplace program integrity contractor, that has the sole responsibility of working with us as part of our major case coordination process to look into that.

We have referred the first of those cases. There is a criminal trial in September on that first referral, and there are more that are coming.

So we are making very, very important progress there. And expect we will be identifying additional vulnerabilities in the near future.

Mrs. Walorski. Thank you, sir.

And, Madam Chairman, I yield back.

Chairman Jenkins. Thank you.

Mr. Blumenauer, you are recognized for 5 minutes.

Mr. Blumenauer. Thank you, Madam Chair.

I appreciate the opportunity for us to come together dealing with these important oversight issues.

One item I would just mention as a side point is that another area of potential oversight would be our Committee's responsibility dealing with the integrity of the American infrastructure system.

Today marks the 397th hearing that we have had as a committee in the 7-1/2 years that my Republican friends have been in charge, and we have had but one 5-minute witness testify about the responsibilities we have dealing with infrastructure. And that has significant impacts in terms of the health of our country, the economy.

And it is sad to me the Ways and Means Committee has shirked that responsibility. There will be a wide range of opportunities to exercise oversight in that area, and I hope at some point we own up to the responsibility we have in that regard.

I appreciate the focus on Medicare integrity. You have referenced here that we are already talking about over $700 billion in the next 10 years. If I understand it correctly, that is going to double. And so the integrity of the program is absolutely essential.

Part of the problem we have in this country where we pay more than anybody else in the world for mediocre results overall, for on average Americans get sick more often, they take longer to get well, and they die sooner than other countries, is simply inefficiency, and waste is a part of that.

I appreciate the effort here to look at comprehensive efforts moving forward. My friend, Ms. DelBene, pointed out a number of the tools that were available under the Affordable Care Act, which is a comprehensive approach to dealing with America's health. And embedded in that were some elements to be able to have more efficient ways of monitoring, guaranteeing program integrity. And we have a long way to go, but there are tools there.

We hope that the administration will take those seriously, unlike some of the other areas where they appear to be taking apart the Affordable Care Act bolt by bolt, destabilizing the system and making things worse.

I appreciated the reference here, I believe $4.20 was returned for each dollar that was invested in terms of program integrity. And, Mr. Alexander, I think you mentioned one example where it was $6 for every dollar invested.

I am curious if you have some sense here of whether or not we are making adequate investment. If we have the rate of return that is 4-1, 5-1, 6-1, are we making the appropriate investments through the budgetary process and within the administration to be able to fully capitalize on the power of these approaches?

Mr. Alexander.

Mr. Alexander. Thank you for the question.

First of all, I believe it is important to note that the Committee and the Subcommittee have been particularly good at providing resources, whether it is

CARA or the Small Business Jobs Act or MACRA or any of the tools that you have provided. All of these have served the program integrity functions exceedingly well.

I am not in a position at this moment to request any particular funds. I would point out that the President's budget proposal does contain, I believe, it is 17 specific program integrity-focused proposals, all of which have the capacity to advance our efforts considerably.

A couple, just to mention one or two of them, we regularly see problems with what we call affiliated entities. There is a proposal that would allow revocation and denial of provider enrollment based on an affiliation with a previously sanctioned entity.

As a person who was honored to participate in one of the very first Healthcare Fraud Strike Force training classes back in 2009, I believe, I am very familiar with the fact that fraud organizations will disappear and reappear, reorganize themselves, in different but clearly related corporate structures that are then untouchable.

So this particular authority is one. There are several others. I would just ask the Committees to pay attention to those.

Mr. Blumenauer. Thank you, Mr. Alexander.

Madam Chair, I would ask unanimous consent to enter into the record a statement concerning the failure of the committee to deal with its responsibilities of American infrastructure.

Chairman Jenkins. Without objection, so ordered.

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Congressman Earl Blumenauer
Statement for the Record before the Ways and Means Committee's Subcommittee on Oversight
July 17, 2018

Chairman Jenkins, I would like to draw attention to one of the most pressing health, economic, and safety issues our seniors face today: infrastructure. The Ways and Means Committee has held 397 hearings and markups since 2011, but only devoted five minutes to infrastructure—five minutes of testimony in more than seven and a half years. In every American community, there are deep concerns about the state of our roads, bridges, transit, water systems, ports, airports, and broadband connectivity. Today, one in five miles of highway pavement is in poor condition, and two of five urban highway miles are congested,[1] forcing our constituents to spend more money fixing their car and more time sitting in traffic rather than being with their loved ones.

This Committee's inaction on infrastructure has also resulted in degrading health and safety outcomes across generations. In 2016, 37,461 Americans were killed in fatal automobile crashes. More than two million Americans are routinely injured in traffic accidents every year[2]—costing our economy over $63 billion from the cost medical care and lost productivity[3]. The health impacts of long commutes and traffic congestion are also clear: physical inactivity, increased risk of depression and anxiety, chronic stress, and higher blood pressure. Aging Americans are especially harmed by chronic underinvestment, with their independence and freedom of movement at stake without increased investment in multimodal transportation options.

There is no area of greater political consensus than on the need to rebuild and renew America. Most recently, Oklahoma demonstrated the broad, bipartisan support for infrastructure by raising its transportation revenues—one of 32 states to do so since 2012. On Capitol Hill, countless stakeholder groups from across the political spectrum stand ready and willing to testify on the importance of infrastructure investment; a list of some of these groups is attached. It is past time that the Ways and Means Committee takes an active role on providing the leadership and courage to rebuild and renew America. I look forward to partnering with my colleagues to get this done.

[1] American Society of Civil Engineers, 2017 Infrastructure Report Card—Roads.
[2] National Highway Traffic Safety Administration, "USDOT Releases 2016 Fatal Traffic Crash Data," October 6, 2017.
[3] Center for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System, 2013.

Supporters of renewing the federal partnership on infrastructure

- AAA
- Airports Council International
- American Association of Port Authorities (AAPA)
- American Association of State Highway and Transportation Officials (AASHTO)
- American Association of Airport Executives
- American Bus Association
- American Coal Ash Association
- American Concrete and Pavement Association
- American Concrete Pipe Association
- American Council of Engineering Companies (ACEC)
- American Highway Users Alliance
- American Iron and Steel Institute
- American Public Transportation Association (APTA)
- American Public Works Association (APWA)
- American Road & Transportation Builders Association (ARTBA)
- American Short Line and Regional Railroad Association
- American Society of Civil Engineers (ASCE)
- American Subcontractors Association
- American Traffic Safety Services Administration (ATSSA)
- American Trucking Associations
- American Water Works Association
- American Waterway Operators
- Associated General Contractors of America (AGC)
- Associated Equipment Distributors
- Association for Commuter Transportation
- Association of Equipment Manufacturers
- Association of Metropolitan Planning Organizations
- Association of Regional Water Organizations
- Asphalt Emulsion Manufacturers Association
- Asphalt Recycling & Reclaiming Association
- Bay Area Rapid Transit (BART)
- Building America's Future
- Commercial Vehicle Safety Alliance
- Concrete Reinforcing Steel Institute
- Geosynthetic Materials Association
- Getting America to Work Coalition
- Highway Materials Group
- International Slurry Surfacing Association
- International Association of Bridge, Structural, Ornamental and Reinforcing Iron Workers
- International Brotherhood of Electrical Workers (IBEW)
- International Brotherhood of Teamsters
- International Union of Operating Engineers
- ITS America
- Laborers-Employers Cooperation and Education Trust
- Laborers International Union of North America (LIUNA)
- League of American Bicyclists
- Los Angeles County Metropolitan Transportation Authority
- National Asphalt Pavement Association
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- National Association of Counties
- National Association of Manufacturers
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- National Association of Surety Bond Producers

- National Association of Truck Stop Operators
- National Association of Water Companies
- National Electrical Contractors Association
- National League of Cities
- National Ready Mixed Concrete Association
- National Steel Bridge Alliance
- National Stone, Sand, and Gravel Association
- National Utility Contractors Association
- North America's Building Trades Unions
- NTCA – The Rural Broadband Association
- Owner Operator Independent Drivers Association (OOIDA)
- Portland Cement Association
- Precast/Pre-stressed Concrete Institute
- Railroad Cooperation and Education Trust
- The Road Information Program
- Sound Transit
- Transportation for America
- United Association of Plumbers and Pipefitters
- United Brotherhood of Carpenters and Joiners of America
- United Parcel Service (UPS)
- U.S. Chamber of Commerce
- U.S. Conference of Mayors
- Water Environment Federation
- Waterways Council, Inc.

Mr. Blumenauer. Thank you very much.

Chairman Jenkins. Thank you.

Mr. Wenstrup, you are recognized for 5 minutes.

Mr. Wenstrup. Thank you, Madam Chairman.

And thank you all for being here today.

As we look at this whole process and the trends that you may be trying to find, it is kind of like looking at crime stats, right? It is very similar.

And so I am curious and I want to ask you a little bit about the types of fraud that you see and are we looking at breakdowns of the types of fraud, because you have mentioned several different ways that people can go about committing fraud, whether it is from the provider or people that pretend to be providers, et cetera.

And so I am curious as to where does most of the fraud occur. In other words, are you looking at trends like is most of it in urban areas or is it in rural areas? Is it in certain states or in certain cities? The number of occurrences that occur and the amount of dollars that are involved with these occurrences, say, per capita and where. Do you look at trends like this?

And I am always curious to know, how does Medicare fraud compare with fraud in the private healthcare sector of insurance, if you will?

Mr. Alexander. Thank you, Congressman.

The answer is yes. We, in collaboration with our law enforcement partners, who in the Strike Force are particularly adept and focused on doing exactly what you just said, we look at high concentrations of fraud geographically and high concentrations both as a monetary and fiscal matter as well. So where the dollar is going and is that geography particularly prone for fraud or susceptible to it.

And you might see that of the, I think, 9 or 10 or 11 now current Strike Force jurisdictions, as we call them, they are located in places where that is occurring, high volume and a particular concentration.

So that is where these 75 or so very elite prosecutors and equal number of agents from the Bureau and OIG focus their work.

Our case coordination process is locked in with them once a week. We are sitting down with them looking at the newest leads that are being brought in to assess them. And we make quick decisions as to what proper path they should be in.

Is this a matter that, based on the conduct we see, should go straight into a criminal referral? Is it one that perhaps there is an administrative action we should take or is there more investigation this year? Or very importantly, is it one where a provider is exhibiting a high error rate with respect to their claims but it is through, apparently, through error, there is no indicia of fraud, no indicia of mal-intent.

And in that case, we want that provider to not have a burdensome, onerous referral. We want that provider to have the benefit of what we call Targeted Probe and Educate, which is a chance to one-on-one education.

Mr. Wenstrup. Well, I do want to go back in a second to how you compare to the private sector, but what you just brought up is key. I can remember a time, you know, I saw a patient and one of her lower extremities was a prosthetic.

And I circled it, one extremity is what I treated. Staffer didn't notice that, saw the lady walk out fine, and billed for two extremities, which I noticed later. Called Medicare right away and said: We are going to reimburse the $12 because it was miscoding, innocent miscoding, right?

Because what I am worried about is the headline that there was some misdeed here, right? And that has happened to people that I know. You know there are cases out there.

I had someone who they didn't like one code that he was using. They went into his office, raided his office in the middle of the day, led to headlines, led to a divorce, led to a tremendous amount of money in legal fees, to end up fining him $60 for one occurrence.

Now, there is a difference between innocent miscoding and intentional overcoding. And I hope you are addressing that in a more proper way. I am going back a few years from when this happened, so it is not a recent event. But I think that is important, too, from the standpoint of our providers.

Can we be a little more parental with someone, "Hey, you are not exactly doing this right, let's correct it now," rather than raiding their office without any type of warning?

But if you could, in the time I have left, talk about how you might compare to the private sector as far as fraud and abuse.

Mr. Alexander. Sure. Thank you, Congressman. And of course that process I described I will follow up with you about, called Targeted Probe and Educate, does exactly what you just described for a provider who needs that education.

With respect to the private sector analogy, I would point out that really the goal there is to be as quick as we possibly can, not to chase, pay and then chase, but instead, to prevent a payment from going out.

And I believe I hear in your question, are we as good as the private sector at doing that? I am not sure about how they measure that, but I do know that we have several tools that we use that give us the capability of stopping payments before they go out if they are improper.

For example, our Fraud Prevention System allows us to place edits that immediately will deny a claim if it violates a policy. We have the ability to do prior authorization. And one of the President's budget proposals that I referred to is to expand prior authorization, and I would ask that you consider that.

We also have provider enrollment, payment suspension, and prepayment review, among other tools, that are designed to stop those payments before they are made.

Mr. Wenstrup. Well, if I could, and if I could indulge for just a second, I would like to be able to get the statistics that you gather about the geographic findings that you have.

Mr. Alexander. Sure.

Mr. Wenstrup. I would like to be able to get those from you. And then, again, also compare to private sector the amount of fraud that occurs, is there less fraud occurring in the private sector, and why, if that is the case.

And I yield back.

Chairman Jenkins. Mr. Lewis, you are now recognized.

Mr. Lewis. Well, thank you very much, Madam Chair.

I want to thank each of you for being here and for your great work.

I would like to ask each of you, are we doing enough as a Nation and as agencies to protect our Nation's seniors from Medicare fraud? If we are not doing enough, what should be our next steps?

Mr. Alexander. Thank you very much, Congressman Lewis.

I believe that we have resources. I tell my team all the time we have a $1.3 billion budget to protect a trillion dollars in Medicare and Medicaid spending. I believe we have the financial resources to do it, although there are always emerging responsibilities that are required.

But I think we have to bring greater insight to the process. And I believe that what I have described in this new coordination process is where we bring the insight of all relevant parties along, what I call the enforcement continuum, which starts with education on one end and ends with criminal prosecution and sentencing hopefully at the high end of the guidelines on the other end, and everything in between. We need to be assessing these issues holistically at the beginning, together, to make sure we are making insightful and proper decisions from the beginning.

So I think we can definitely improve there, and we are working to do that.

Ms. Jarmon. I would say that there has been some progress. Like Mr. Alexander mentioned, the decrease in the error rate for Medicare. But still the numbers are still large. He mentioned, I think, it went from 11 percent in 2016 to 9.5 percent in 2017. But there is still a lot of Medicare fraud out there.

So I think we have made some progress, but there is still a whole lot that needs to be done. And I think some of the things that Mr. Alexander mentioned is going in the right direction. The coordination with law enforcement and the meetings that he mentioned that he has weekly. And I think better use of the data analytics information and targeting areas where we need to use our resources, I think we need to make better use of all of that.

And we have made several recommendations related to the Fraud Prevention System that I know CMS is working on. And we just feel like more needs to be done in that area. We talked about the recoveries, but the recoveries that

Mr. Alexander talked about is the identified recoveries. But what actually gets returned to the trust fund is a different amount.

So the adjusted recoveries are the ones that need to be looked at to determine how effective the Fraud Prevention System is, and that is different from the 6.3-1.

Mr. Bagdoyan. Thank you, Mr. Lewis, for your question. It is a really good question to bring it all together, basically picking up on points that Mr. Alexander made and Ms. Jarmon as well.

There is certainly a lot going on from the GAO perspective. As I mentioned before, it just needs to be better organized and better focused on prioritized risks. We cannot fight all of them all the time. So that is very important.

And then assessments will yield also additional actions that may be required. I think Mr. Alexander mentioned the President's budget request, for example, outlining, I think, 17 or so programs or activities. That would certainly come into the mix.

But a comprehensive, forward-looking strategy is imperative to make sure that fraud risks are identified and managed at the most effective level possible.

Mr. Lewis. Are you discovering what I would like to call bad actors, people engaged in something in Georgia, then they go to Florida, or to some other State, and try to get away with doing the same thing?

Mr. Alexander. Yes, Congressman, we are. In only the 8 or so weeks that we have run this new coordination process with law enforcement, we are seeing emerging risks that are both geographically disparate and tied together.

So we are seeing through what we call link analysis that a behavior over here that is particularly problematic is also showing itself here. And through this process, we are putting together, we, along with our law enforcement partners, are linking those together.
We also have a contractor that we are able to bring to bear, we call them the Supplemental Medical Review Contractor, for matters that require investigative resources and have multijurisdictional connections.

So the answer is yes, and we are working those very, very aggressively.

Mr. Lewis. Thank you.

Madam Chair, I would like to submit for the record a recent story from my hometown newspaper, the Atlanta Journal-Constitution. The story tells of a provider who was defrauding taxpayers and harming the elderly who are already struggling to make ends meet.

Chairman Jenkins. Without objection, so ordered.

Pending court ruling could be pivotal in health care fraud cases

ATLANTA-NEWS By Lois Norder

Medicare pays for hospice services for patients expected to live six months or less if their disease takes its normal course. Photo: The Centers of Medicare & Medicaid Services

Posted: 1:52 p.m. Tuesday, March 06, 2018

Elderly people were the target, and wherever they might congregate, the company dispatched recruiters.

Workers rode along on Meals on Wheels deliveries and went door-to-door in government-subsidized housing. Then they'd pitch what sounded like home care services paid for by the government. Instead, the elderly were being enrolled in Medicare-funded hospice based on what the government says were bogus determinations that they were close to death.

Those are allegations in a whistleblower lawsuit against hospice provider AseraCare. Federal prosecutors want the company to pay more than $200 million in reimbursement, fines and fees for running what they said was little more than a money-making scheme.

A federal jury agreed, finding that AseraCare had committed fraud by filing false claims for Medicare reimbursement. But the presiding U.S. district court judge threw out the jurors' verdict. She ruled, in part, that the case boiled down to a battle of medical experts, and differences in professional medical judgment alone couldn't prove the case.

Now, attorneys around the country are awaiting a decision from the 11th Circuit, which heard arguments a year ago on the government's appeal of that ruling. The appeals court decision could tie the hands of prosecutors in a wide range of health care fraud cases. Or, it could spell continued trouble not only for hospices, but also for nursing homes, hospitals, dentists and other health care providers. The issue of medical necessity has been at the heart of many health care fraud cases.

"This is going to be a pivotal case," said Justin Linder, a New Jersey attorney who concentrates on hospice and home health care and the federal False Claims Act.

If the court upholds the district judge's ruling, "then you have some very far-ranging ramifications, not only to hospices but to any health care providers whose health care reimbursement is conditioned on providing medically necessary services," he said.

More fraud cases will likely proceed to trial, rather than settle out of court, he said.

"It could also wipe out a number of cases that already have been filed," said Linder, with the firm of Dughi, Hewit & Domalewski, who represents the health care industry in cases involving the False Claims Act.

The government says that some hospice providers have sought out patients who aren't close to death because they don't need as intense of services as terminally ill patients require. And by keeping patients on hospice longer, a company can continue to collect payments for each patient – around $200 every day for routine home care, whether the hospice agency provides services

on any given day or not. Payments for other levels of care can top $800 a day. Hundreds of millions of dollars are drained from the Medicare trust fund as a result of fraud, the government has found.

Hospice fraud has other consequences as well. When patients enter hospice, Medicare pays only for services that help alleviate pain or suffering and help them cope as they die — not for medical treatments to cure them. Some patients don't understand that. A Mississippi woman who went in for a yearly mammogram was denied Medicare-funded service because she was on hospice, a federal investigator said.

In other cases, such as a recent one out of California, patients were led to believe that they had life-ending illnesses when they did not.

In Mississippi, fraud involving "mom and pop" hospices has been epidemic, said Mike Loggins, a special agent with the Office of the Inspector General of the Department of Health and Human Services in the Southeast Region. Patient recruiters there would go door to door looking for elderly people to sign up, getting paid $300 to $500 for each patient they got, he said.

One recruiter – a gang member and convicted sex offender – told investigators it was easier and less risky than dealing drugs, Loggins said.

Doctors who got kickbacks from hospices then would certify that the patients had only a few months to live, sometimes without even seeing the patients.

To prove the cases, federal investigators would knock on the doors of hospice patients to ask if they were dying. "And they immediately laugh or get angry and say, 'Who told you I'm dying?' " Loggins said.

Proving cases against corporate providers, though, is more complex. "The medical necessity issue is what's killing us with some of these corporate hospices," said Derrick Jacobson, special agent in charge with the inspector general's office for the region.

In the AseraCare case, originally brought by former employees in Georgia, Alabama and Wisconsin, the government had a physician review medical records of hospice patients. He found that most were not within six months of dying – the criterion for enrolling in Medicare-funded hospice. In a two-month trial, jurors heard from both him and defense experts, then found that in the majority of cases presented, the patients were not terminally ill.

Many AseraCare patients lived for years on hospice or were discharged from hospice alive.

In setting aside the jury's verdict in March 2016, U.S. District Judge Karon Bowdre of the Northern District of Alabama said a mere difference of opinion among physicians is not enough to establish that the claims were false. "The government has presented no evidence of an objective falsehood for any of the patients at issue," she wrote.

If her ruling stands, Linder said, the government would have to look for other evidence to show there was an intent to defraud the government, such as kickbacks to physicians to certify that patients were dying.

If the 11th Circuit overturns the judge's ruling, it may not signal an immediate change for health care providers, said attorney Jay Mitchell with King & Spalding in Atlanta. But, he said, "it certainly could embolden the government to go after more medical necessity cases."

That is a concern because, ultimately, the case is about physicians making decisions based on their judgments and medical experience, said Mitchell, who works with health care clients at the law firm and formerly was chief legal officer at Piedmont Healthcare. "We never want to make physicians feel like they are somehow being called into question," he said.

"You have all sides of the legal community looking at this case," Mitchell said. "I think it is a case that will be looked at…and cited in the future."

Attorneys involved in the AseraCare case declined comment.

In recent years, a number of hospices have settled cases that involved allegations they enrolled patients who were not dying, though the companies didn't admit fraud. Among the cases involving companies with services in Georgia was a $2.4 million settlement last year by Compassionate Care Hospice Group. Nurses who worked for the hospice in Atlanta said the company marketed itself to patients with the promise of free drugs, supplies and services, paid kickbacks to doctors to refer patients, and used imprecise diagnoses such as "general debility" or "failure to thrive" to make it difficult for the government to detect fraud.

The nation's largest for-profit hospice chain, Vitas – owned by the company that owns and operates Roto-Rooter Group plumbing services – also settled last year, agreeing to pay $75 million in a case that involved ineligible patients and other violations.

In 2016, Optum Palliative and Hospice Care agreed to pay some $18 million for enrolling patients

who were not terminally ill. In 2015, Guardian Hospice/AccentCare agreed to pay $3 million. In 2014, Hospice Compassus agreed to pay $3.9 million, and Serenity Hospice of Dublin agreed to pay more than a half-million dollars. In 2013, America Hospice Management, agreed to pay $12 million.

Many fraud cases against hospices settle out of court. That's largely because if a hospice loses at trial, it can face having to pay triple damages along with penalties under provisions of the federal False Claims Act.

What you need to know about Medicare hospice

Determining when someone will die is not an exact science, so Medicare requires that both a patient's doctor and the hospice's medical director certify that a patient is expected to live six months or less if a disease takes its normal course.

Doctors are not allowed to take payments for referring patients to a particular hospice — such kickbacks are illegal. And patients cannot be forced into hospice if they want to continue medical treatment in hopes of a cure. Patients also have the right to leave hospice at any time.

Medicare covers two initial 90-day periods of service from a hospice, then subsequent 60-day periods if a patient continues to be certified as terminally ill. If patients stabilize or improve, though, they are supposed to be discharged from hospice.

Hospices are paid a set amount per day for each patient, whether or not services are provided every day. That payment is to cover all the palliative services a patient might need, such as medications to ease pain or manage chronic symptoms, home health services to maintain a healthy environment, physical or occupational therapy for symptom control or to allow the patient to maintain basic functional skills, and visits by grief counselors and social workers to ease mental stress. Hospice also will provide some medical equipment, such as walkers or wheelchairs.

Hospice patients no longer are covered by Medicare for treatment to cure their terminal illness. For example, Medicare would no longer cover chemotheraphy for cancer patients.

Hospices are responsible for other medical care a patient might need. For example, if a patient suffering from heart failure breaks a hip, the hospice would be responsible for arranging hospital care related to the fracture.

Many patients receive hospice care in their homes, although patients in nursing homes or hospitals also may receive such services.

About the Author

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Mr. Lewis. Thank you. And I yield back, Madam Chair. Thank you.

Chairman Jenkins. Thank you.

I now recognize Mr. LaHood for 5 minutes.

Mr. LaHood. Thank you, Madam Chair.

And I want to thank the witnesses for your testimony and your service.

I understand under the Fraud Prevention System at CMS there have been some steps taken to develop evaluation and monitoring mechanisms to determine return on investment and other savings when combating fraud, but that CMS is unable to evaluate all preventive activities without a comprehensive fraud assessment and strategy.

Recognizing that there are a number of anti-fraud efforts happening at CMS that we have heard today, I want to focus on the Health Fraud Prevention Partnership.

The Health Fraud Prevention Partnership is a voluntary public-private partnership between the Federal Government, States, law enforcement, health insurance plans, and others, that analyzes and studies multiple-payer claims data to identify providers with suspect billing patterns.

I know, for example, in my home state of Illinois the Illinois Department of Healthcare and Family Services' Office of Inspector General is a member of that partnership.

I think that, used in the right way, public-private partnerships are an effective tool for the Federal Government to harness the expertise of the private sector in helping to identify challenges like improper payments and fraud.

Mr. Alexander, I wanted to know if you can elaborate a little bit more on some of the successes in fraud prevention related to the HFPP. And then secondly, maybe talk a little bit about, I mentioned earlier it is a voluntary program, how the process to join HFPP works.

Mr. Alexander. Thank you very much.

Of course, as you mentioned, this is a very important collaboration that includes Federal, State, and private entities. And the purposes of it are to

facilitate information sharing and to identify and manage fraud risks that pervade across payers, for example, or across systems.

Currently, the Partnership has, I believe, 102 members. I was honored to participate in the last board meeting. Inspector General Levinson was there. Joe Beemsterboer, the chief of the Health Care Fraud Unit's Criminal Division and Strike Force, was there as well. We were there, many of the State representatives. And we talked a great deal about how this data sharing can reveal the sorts of fraud schemes that we are looking for.

For example, if the Federal Government is aware of a particular provider billing an excessive amount of time in day for a particular thing, and then we are able, through de-identified data shared through the Partnership, to compare that to the same provider that may have billed multiple private payers on the same day at the same rate, then what emerges there is an impossible time scenario that is something that can be pursued.

So that is a simple example of the sort of fruit that we see from the data sharing that is a critical component of identifying risk not just for the Federal programs, but for, as you mentioned, for the State Medicaid fraud units, for the administrative programs, as well, and for the private entities who are exposed to these sorts of frauds also.

Mr. LaHood. What about -- do you anticipate growth in the program?

Mr. Alexander. Yes. I noticed that just from last year as I prepared for this I believe the number last year for this kind of prepared answer to the extent it might have come up again was 79 last year. I am pretty sure I heard 102 recently at the board meeting.

So I know it is growing. I know it makes a lot of sense. And we are honored to be part of it and to actually coordinate it, and I expect additional growth.

Mr. LaHood. And what about any deficiencies or challenges that you have with the program that need to be worked out?

Mr. Alexander. Well, I have only had the honor of working in this capacity for 6 months. I am not aware of any at this moment. But I will be glad to follow up and make you aware if I do become aware of any shortcomings or any needs that we have.

Mr. LaHood. Thank you.

And those are all my questions. Thank you, Madam Chair.

Chairman Jenkins. Thank you.

Mr. Curbelo, you are recognized for 5 minutes.

Mr. Curbelo. Thank you, Madam Chair.

And I thank the witnesses for their time here today.

"South Florida still No. 1 for healthcare fraud, following massive takedown across the nation." That was the headline last month in the Miami Herald following the unveiling by the Department of Justice that 600 defendants are being accused of fraudulently billing $2 billion to Medicare, TRICARE, and private insurance.

It has been reported that over $300 million of those fraudulent claims by south Floridians were treatment for opioids, home health, and prescription drugs.

Madam Chairman, I would like to submit into the record the referenced Miami Herald article published in June regarding healthcare fraud in south Florida.

Chairman Jenkins. So ordered.

Federal agents with Health and Human Services, the FBI and IRS carried out a nationwide takedown of healthcare fraud offenders on Thursday. U.S. Department of Health and Human Services-Office of Inspector General

SOUTH FLORIDA

South Florida still No. 1 for healthcare fraud, following massive takedown across nation

BY JAY WEAVER
jweaver@miamiherald.com

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No surprise: South Florida is still the nation's capital of healthcare fraud.

On Thursday, the Department of Justice unveiled an array of new healthcare fraud cases accusing about 600 defendants nationwide of submitting $2 billion in false bills to the Medicare program for the elderly, the TRICARE system for military members and private insurance companies.

Of that staggering total, about 125 defendants were charged in South Florida with filing nearly $340 million in fraudulent claims for opioid addiction treatment, home healthcare and prescription drugs covered by taxpayer-funded programs and other insurance plans.

"The sustained losses are astronomical," U.S. Attorney Benjamin Greenberg said during a news conference in Miami, pointing out that South Florida was responsible for 20 percent of the defendants charged in the healthcare fraud takedowns across the country. "It really shows the problem is quite severe down here."

Greenberg focused on the theme of fighting scofflaw drug treatment centers and sober homes for opioid addicts during his presentation, which echoed a news conference led by U.S. Attorney General Jeff Sessions in Washington, D.C. Sessions has made fighting the nation's opioid crisis, fueled by an average of 115 overdose deaths every day, a top priority of the Trump administration.

Over the past decade, both the Justice Department and U.S. Attorney's Office have coordinated yearly efforts to spotlight the latest crackdown on healthcare fraud offenders from Miami to West Palm Beach by agents with the FBI, Health and Human Services and Internal Revenue Service.

Among dozens of new cases in South Florida, Greenberg zeroed in on Good Decisions Sober Living in West Palm Beach, whose operators recruited patients and paid kickbacks in order to bill $106 million for widespread fraudulent urine testing that was not medically necessary between 2011 and 2015, according to an indictment. The so-called sober home, which houses patients with addiction problems, was paid more than $31 million by private insurers.

The indictment, prosecuted by Justice Department attorney James Hayes, accused owner Kenneth Bailynson, 45, medical director Mark Agresti, 55, and employees Stephanie Curran, 35, and Matthew Noel, 32, with conspiracy to commit healthcare and wire fraud

Authorities also highlighted a major healthcare fraud case against a Delray Beach sober home, Halfway There Florida, and a substance abuse treatment facility, Real Life Recovery Delray. The treatment facility's CEO, Paul R. Materia, 43, and patient brokers Joseph Lubowitz, 29, and Christopher Fuller, 33, were charged with illegally recruiting patients, paying kickbacks and defrauding healthcare programs by billing for urine testing and substance abuse treatment that were medically unnecessary.

Both the sober home and treatment center billed more than $58 million to insurance plans and were paid $20 million, according to an indictment.

"We are seeing a disturbing reality — doctors, medical directors, clinicians, treatment center owners and employees are actually fueling the opioid crisis rather than doing something to reduce it," Greenberg said.

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Mr. Curbelo. Last year in a hearing before this Subcommittee I asked why we are always chasing so much fraud. We learned that one of the biggest challenges is understanding the cause behind improper payments, since it isn't always fraud but also clerical and technical errors that contribute to improper payment statistics.

While I am grateful for the work to bring bad actors to justice, as evidenced by the most recent takedown, we still need to do more to cut down on pay-and-chase methods and focus on prevention measures.

I agree with Deputy Inspector General Jarmon that a comprehensive program integrity strategy that focuses on prevention, detection, and enforcement helps address the sources of improper payments.

I worked on a bill with my colleagues, Representatives Thompson and Fitzpatrick, to introduce the REACH OUT Act, which recently passed the House. This bill would direct CMS to work with certain entities, including quality improvement organizations, to engage in educational outreach with prescribers to prevent prescription drug abuse. This bill is specifically directed toward educating outlier opioid prescribers to help change their behavior and prevent overprescribing.

Mr. Alexander -- and by the way, this issue is in many ways personal to me because it is no secret that south Florida is the Medicare fraud capital of the United States, and my constituents no longer want for that to be the case.

So my question to you is, how does the administration view prescriber education as fitting into an overall anti-fraud strategy?

Mr. Alexander. Thank you for the question.

As you know, first of all, the Secretary and the Administrator and the President have made it absolutely clear that fighting the opioid crisis is a top priority for the administration, and we are working very closely with law enforcement to do that.

We are bringing a number of tools to that fight, specific tools from the program integrity perspective. That would include the MEDIC, the Medicare Drug Integrity Contractor, which provides investigative work and referrals for fraud and other problematic behaviors in that space.

And the MEDIC is part of the UPIC, MEDIC, MPEC major case coordination process I have described. So once every 7 weeks, and more frequently if needed, the MEDIC is in the Center for Program Integrity reporting in real time on its current investigation. We are making sure they get where they need to go.

We also have projects like the TRIO Project where we are monitoring the prescribing of this particularly deadly trio of substances that are very, very dangerous for beneficiaries. We have comparative billing reports that we provide that are generated and that are provided to help us with this.

We also will be standing up what is called the Preclusion List which is going to place certain problematic prescribers on the list and require the programs to deny payment for claims associated with those particular prescribers.

And finally, the new lock-in authority that we have, thanks to the Congress. We now have the authority to limit high-risk beneficiaries to specific pharmacies and specific prescribers.

All very, very important tools that we are bringing to that important work.

Mr. Curbelo. Well, thank you, Mr. Alexander. I appreciate CMS's commitment.

And I am very grateful to the Chair, to the Ranking Member.

Because this is all very demoralizing to American taxpayers, and obviously it is unfair to Medicare beneficiaries. Every dollar that goes into one of these fraudulent schemes is one dollar less that we have for those who have earned Medicare by working hard in our country.

And, again, in south Florida it is particularly personal and painful. Our community does not want to be known as a place where Medicare fraud is prevalent. And we look forward to working with you, with all of you, to root out this horrible situation in our country.

Thank you.

Chairman Jenkins. Thank you.

And I want to thank our witnesses for appearing before us today. Please be advised that Members have two weeks to submit written questions to be

answered later in writing. Those questions and your answers will be made part of the formal hearing record.

And with that, the Subcommittee stands adjourned.

[Whereupon, at 11:08 a.m., the Subcommittee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

Alec Alexander's Questions for the Record
Hearing on
"Combating Fraud in Medicare: A Strategy For Success"
Ways & Means Subcommittee on Oversight
July 17, 2018

Lynn Jenkins, Chairman

1. **During your testimony, you described the Centers for Medicare and Medicaid Services' (CMS) efforts to implement the Government Accountability Office's (GAO) recommendations to conduct a fraud risk assessment of Medicare and create a risk-based antifraud strategy by first conducting "sub-assessments" of smaller programs.[1] Please list the sub-assessments that (1) are in the process of being conducted, (2) are completed, and (3) have a resulting Fraud Risk Profile (identifying whether each is a draft or final product).**
    a. **How can these assessments inform a comprehensive fraud risk assessment and resulting antifraud strategy for Medicare?**
    b. **What is the status of the fraud risk assessment of the federally facilitated marketplace?**
    c. **What metrics does CMS use to measure the success of the fraud risk assessments for programs such as the Medicare Diabetes Prevention Program (MDPP) expanded model?**
    d. **What challenges, if any, has CMS encountered when implementing policies and procedures on the front end to reduce fraud risk in programs such as the MDPP expanded model?**
    e. **As part of CMS's antifraud initiatives, GAO recommended that CMS provide and require fraud-awareness training for all employees. Your testimony mentions that CMS is developing a training video, module, and curriculum to train staff agency-wide on fraud risks.**
        i. **What is the status of the implementation of this recommendation?**
        ii. **Have any CMS employees received this fraud risk training? If so, how many and in which offices?**

Response: CMS is using GAO's Fraud Risk Assessment Framework to build on our existing efforts to fight fraud, waste, and abuse. CMS has been working to identify and prevent fraud for decades, and we greatly appreciate the work of the GAO to provide a systematic way to assess areas at risk of fraud across our programs.

[1] U.S. Government Accountability Office, Medicare and Medicaid: CMS Needs to Fully Align Its Antifraud Efforts with the Fraud Risk Framework (December 2017)

As recommended by the GAO, CMS has completed a fraud risk assessment of the federally facilitated marketplace. This process has helped CMS identify risks that we are now working to mitigate. For example, CMS tightened regulations related to special enrollment periods. Issuers are now allowed to require individuals to pay back past due premiums before enrolling into a plan with the same issuer the following year. In addition, individuals are required to submit sufficient supporting documentation at the time of enrollment for certain special enrollment periods to ensure that only those who are eligible are able to enroll.

Medicare is a large, complex program comprised of numerous payment systems with different incentives for providers and suppliers. For example, the way Medicare covers and reimburses hospital inpatients services varies greatly from the way Medicare covers and reimburses Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Instead of waiting until our alternative payment models are operational before assessing the risks for fraud, we are taking a thoughtful, proactive approach and incorporating these assessments into the development of models where we can. An important part of this process will be incorporating adequate metrics to measure the impact of these assessments in order to accurately measure their success.

Across our programs, we are working hard to incorporate lessons learned and tailor our fraud risk assessments to accurately reflect the fraud risks of each program and payment system. CMS is also in the process of conducting a fraud risk assessment for: the Medicare Diabetes Prevention Program, the Comprehensive ESRD Care Model, the Comprehensive Primary Care plus Model, the Medicare Shared Savings Program, and the new Medicare Beneficiary Identifier. We are also currently assessing the Quality Payment Program, established by the Medicare Access and CHIP Reauthorization Act of 2015, utilizing the GAO fraud risk assessment.

Assessing programs for risk and improving our activities to identify and prevent fraud, waste, and abuse is an ongoing responsibility. That's why we are incorporating lessons learned on an ongoing basis, addressing risks as they are identified. For example, in response to a risk profile, CMS incorporated lessons learned from provider enrollment requirements in order to thoroughly screen coaches and suppliers providing services to beneficiaries through the Medicare Diabetes Prevention Program.

That's why we are strengthening our efforts to ingrain fraud risk assessment principles throughout the Agency to ensure that this critical work is not completed in a silo. For example, in response to a GAO recommendation, CMS is developing a training video, module, and curriculum to train staff agency-wide on fraud risks. In addition, through the Program Integrity Board, CMS engages leadership across the organization on the development of fraud risk assessments.

As we move forward with our efforts, we will continue to work closely with GAO and other stakeholders as we take steps to expand our capacity to conduct fraud risk assessments and make the process more standardized and more efficient.

2. **In a September 2017 report, the Office of the Inspector General (OIG) for the U.S. Department of Health and Human Services (HHS) recommended that CMS implement three improvements to the Fraud Prevention System (FPS).[2] Given that CMS agreed with the recommendations, but has since developed an updated FPS 2.0, what is the status of the implementation of HHS OIG's three recommendations?**
   a. **Is FPS 2.0 able to allow CMS to track savings from administrative actions back to individual FPS models?**
   b. **Are Unified Program Integrity Contractors adjusting savings reported to CMS to only reflect FPS-related savings amounts?**
   c. **Are evaluations of FPS model performance considering adjusted savings?**
   d. **Given that a main benefit of the FPS is its ability to speed up contractor investigations, does CMS assess the FPS' s effect on timeliness?**
   e. **Please describe CMS's efforts to increase the number of prepayment edits implemented into the FPS.**
      i. **To date, what is the number of implemented prepayment edits?**
   f. **CMS reported that FPS identified $454 million in potential savings, but estimated only $133 million in actual savings in calendar year 2014.**
      i. What is the reason for this large discrepancy?
      ii. Please provide (1) the most updated number of identified savings and actual savings as a result of FPS, and (2) the steps CMS is taking to decrease such discrepancies and increase the amount of actual savings.

Response: 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. Since June 30, 2011, the Fraud Prevention System (FPS) has run predictive algorithms and other sophisticated analytics nationwide against Medicare FFS claims on a continuous basis prior to payment in order to identify, prevent, and stop potentially fraudulent claims. The FPS helps CMS target potentially fraudulent providers and suppliers, reduce the administrative and compliance burden on legitimate providers and suppliers, and prevent potential fraud so that funds are not diverted from providing beneficiaries with access to quality health care.

In an effort to enhance CMS's ability to prevent and reduce improper payments, in March 2017, CMS launched an updated version of the Fraud Prevention System (FPS 2.0) that modernizes the system and user interface; improves model development time and performance measurement; and expands CMS' program integrity capabilities addressing the full spectrum of fraud, waste, and abuse. FPS 2.0 is designed to provide CMS with the capability of tracking an administrative

[2] U.S. Department of Health & Human Services, Office of Inspector General, The Centers for Medicare & Medicaid Services Could Improve Performance Measures Associated With the Fraud Prevention System (September 2017)

action back to the models that generated the lead and attribute savings accordingly. FPS 2.0 also provides better real-time insight into the performance of models and edits; allows more of CMS's program integrity stakeholders to use FPS data; and helps CMS more effectively target provider education efforts. CMS has continued to work to increase the number of prepayment edits within FPS 2.0, and as of September 12, 2018, FPS 2.0 included 34 prepayment edits in operation.

CMS uses two different metrics to measure savings from FPS: identified and adjusted savings. Identified savings come from payments being stopped, prevented, or referred for recovery. The FPS helped CMS identify or prevent $527.1 million in inappropriate payments during FY 2016, which resulted in a return on investment (ROI) of $6.3 to $1. Since CMS implemented the original FPS technology in June 2011, the FPS has identified or prevented almost $2 billion in inappropriate payments by generating new leads or contributing to existing investigations. The adjusted savings number is an attempt to estimate the dollars of identified savings that CMS has already returned, or from a financial auditing perspective, is likely to return to the Treasury in the future. CMS considers identified savings to be an important metric when evaluating a model's performance. With Fraud Prevention System 2.0, CMS will also use adjusted savings to internally evaluate models. The combination of identified and actual savings will allow CMS to evaluate how well various administrative actions perform in terms of prevention and recovery.

Last year, OIG completed a report on FPS that included three recommendations for CMS. CMS concurred with these recommendations included in OIG's report, "The Centers for Medicare & Medicaid Services Could Improve Performance Measures Associated with the Fraud Prevention System" [3.] CMS is currently working to implement them.

To better ensure that Unified Program Integrity Contractors report savings to CMS that only reflect FPS-related savings amounts, CMS issued a Technical Direction Letter in April 2016 clarifying FPS attribution, and the incidence of UPIC-submitted savings that should not be attributable to FPS dropped dramatically. CMS also has an internal quality assurance process to identify and exclude UPIC-submitted administrative actions that are not FPS attributable from savings.

Since this testimony in July 2018, CMS has continued to make progress on the OIG recommendations. In August 2018, CMS further refined its FPS savings calculation process and provided FPS attribution information back to the UPICs. While the capability to track savings from administrative actions back to individual FPS models was already available in UCM as of July 2018, the next step for CMS was to issue guidance to the UPICs on when to attribute savings from administrative actions to FPS models. CMS issued a Technical Direction Letter in September 2018 providing this guidance.

3. CMS recently reported that the Medicare Fee-for-Service improper payment rate dipped below 10 percent for the first time since 2013.
   a. What reasons or actions led to this occurrence?
   b. What additional efforts can CMS undertake to ensure that the improper payment rate continues to decrease?

[3] https://oig.hhs.gov/oas/reports/region1/11500509.asp

Response: Clarifying and streamlining documentation requirements is a key component of our efforts to lower the Medicare FFS improper payment rate. For example, we simplified documentation requirements for providers and clarified the medical review process by releasing guidance for contractors such as Medicare Administrative Contractors (MACs). This will allow providers to spend more time with patients and less time on complex claims documentation that is confusing and can lead to errors. In addition, when performing a medical review as part of CMS's Targeted Probe and Educate (TPE) program, MACs focus on specific providers/suppliers that bill a particular item or service, rather than all providers/suppliers billing a particular item or service. MACs will focus only on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Through TPE, MACs work directly with providers and suppliers to identify errors. Many common errors are simple – such as a missing physician's signature – and, in some situations, are easily corrected. So far, CMS has seen promising results from this program – the majority of those that have participated in the TPE process increased the accuracy of their claims. In addition to medical reviews and audits, CMS uses automated edits to help prevent improper payment without the need for manual intervention. The National Correct Coding Initiative (NCCI) program consists of edits designed to reduce improper payments in Medicare Part B. In just the first nine months of FY 2017, NCCI edits saved the Medicare program $546.7 million. Our efforts to reduce improper payments, including efforts to reduce administrative burden, appear to be working – the Medicare FFS improper payment rate decreased from 11.0 percent, or $41.1 billion, in FY 2016 to 9.51 percent, or $36.2 billion, in FY 2017.

Rep. Earl Blumenauer

Please describe the role that the use of high-level data analytics plays in allowing CMS to identify potentially fraudulent providers and claims. To what extent does CMS rely on the expertise of outside, private sector contractors to develop these tools and execute follow up investigations and referrals for criminal prosecution? Do you think such strategies and expertise could also be useful in other federal health programs?

Response: Across our programs, data analytics is playing an increasingly critical role in our efforts to identify and prevent fraudulent providers and claims. Within Medicare Fee-For-Service, the Fraud Prevention System (FPS) is a key part of our work to utilize data analytics.

Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against Medicare FFS claims on a continuous basis prior to payment in order to identify, prevent, and stop potentially fraudulent claims. The FPS helps CMS target potentially fraudulent providers and suppliers, reduce the administrative and compliance burden on legitimate providers and suppliers, and prevent potential fraud so that funds are not diverted from providing beneficiaries with access to quality health care. In March 2017, CMS launched an updated version of FPS, called "FPS 2.0." CMS developed the next generation of the FPS with a contractor and their partners, and built on FPS' previous successes. Working with our contractor on FPS 2.0, CMS modernized FPS' system and user interface, improved model performance measurement, optimized model development time to production, and aggressively expanded our program integrity capabilities addressing the full spectrum of fraud, waste and abuse.

The FPS helped CMS identify or prevent $527.1 million in inappropriate payments during FY 2016, which resulted in a return on investment (ROI) of $6.3 to $1. Since CMS implemented the original FPS technology in June 2011, the FPS has identified or prevented almost $2 billion in inappropriate payments by discovering new leads or contributing to existing investigations. During FY 2016, the FPS models generated 688 leads that were included in the Zone Program Integrity Contractor's workload, resulting in 476 new investigations and augmented information for 212 existing investigations.

Data analytics also plays a critical role within Medicaid, and we are working to expand states' access to Medicare data. In June, we announced that CMS will be implementing data analytics pilots to help states apply algorithms and insights to analyze Medicaid state claim data and identify potential areas to target for investigation. Part of these pilots could include sharing FPS algorithms when appropriate.

In addition, while CMS is not a law enforcement agency, we collaborate closely with our law enforcement partners to safeguard taxpayer dollars. Under CMS Administrator Seema Verma, we will continue to strengthen this partnership with law enforcement in order to ensure the integrity and sustainability of these essential programs that serve millions of Americans.

Since FY 2012, HHS and the 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 voluntary, collaborative partnership that includes the federal government, state officials, many of the leading private health insurance organizations, and other healthcare anti-fraud groups. It currently consists of over 108 members, and 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.

Most recently, CMS has begun a Major Case Coordination initiative which includes the Department of Health & Human Services Office of Inspector General (HHS-OIG), the DOJ, and all components of CMS's Center for Program Integrity. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads. Through early coordination, CMS is able to direct potential fraud matters to law enforcement partners quickly. This serves to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs. In June, HHS, along with DOJ, announced the largest ever health care fraud enforcement action by the Medicare Fraud Strike Force. More than 600 defendants in 58 federal districts were charged with participating in fraud schemes involving about $2 billion in losses to Medicare and Medicaid.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

The Honorable Lynn Jenkins, CPA
Chairman, Committee on Ways and Means
Subcommittee on Oversight
United States House of Representatives
Washington, DC 20515-6348

Dear Chairman Jenkins:

I am writing in response to questions for the record following my testimony before the Committee on Ways and Means, Subcommittee on Oversight on July 17, 2018, at the hearing entitled " Combating Fraud in Medicare: A Strategy for Success."

If you have any questions, please contact me, or your staff may contact Christopher Seagle, Director of External Affairs, at 202-260-7006 or Christopher.Seagle@oig.hhs.gov.

Sincerely,

Gloria L. Jarmon
Deputy Inspector General

Enclosure:
Responses to Questions for the Record

FPS 2.0 – Q&A's for the U.S. House Ways and Means Committee

Question 1:

In a September 2017 report, HHS OIG recommended that CMS implement three improvements to the Fraud Prevention System (FPS). Given that CMS agreed with the recommendations, but has since developed an updated FPS 2.0, does HHS OIG plan to evaluate the new FPS? Keeping in mind the initial recommendations for the FPS, has the HHS OIG assessed whether:

a. *the redesigned FPS is effective in allowing CMS to track savings from administrative actions back to individual FPS models;*
b. *Unified Program Integrity Contractors (UPICs) adjust savings reported to CMS to only reflect FPS-related savings amounts; and*
c. *evaluations of FPS 2.0 model performance consider not only the identified savings but also the adjusted savings?*

Answer 1:

The OIG is considering a review to evaluate the new FPS 2.0 during FY 2019 or FY 2020. We may defer to FY 2020 to provide the FPS 2.0 an opportunity to mature before we assess its performance.

a. OIG has not, to date, verified whether the redesigned FPS 2.0 is effective in allowing CMS to track savings from administrative actions back to individual models.

b. OIG has not, to date, verified whether the UPICs adjust savings reported to CMS to only reflect FPS-related savings amounts.

c. OIG has not, to date, verified whether evaluations of FPS 2.0 model performance consider not only the identified savings but also the adjusted savings.

Question 2:

Given that a main benefit of the FPS is its ability to speed up contractor investigations, does HHS OIG plan to assess the FPS's effect on timeliness?

Answer 2:

If we conduct a review to evaluate the FPS 2.0 during FY 2019 or FY 2020, we would consider assessing the FPS's ability to expedite contractor investigations. We recognize the importance of "timeliness" as it relates to FPS's ability to enhance its "detect the bad claim and prevent the payment from being made" types of administrative actions as well as its "pay-and-chase" types of administrative actions.

PUBLIC SUBMISSIONS FOR THE RECORD

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Comments of the

American Physical Therapy Association

Oversight Subcommittee of the House Committee on Ways and Means

Tuesday, July 17, 2018

For a hearing titled

"Combating Fraud in Medicare: A Strategy for Success**"**

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) appreciates the opportunity to submit comments to the Oversight Subcommittee of the House Ways and Means Committee as the committee evaluates how the Centers for Medicare and Medicaid Services (CMS) identifies and manages the risk of fraud in the Medicare program. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for otherwise avoidable health care services. Physical therapists' roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

In 2015, APTA launched Integrity in Practice, a comprehensive campaign to promote the delivery of high-quality care and help combat fraud, waste, and abuse within the health care system. The campaign helps physical therapists navigate complex regulations and payment systems by making tools and resources available to encourage and promote evidence-based practice; ethics; professionalism; prevention of fraud, waste, and abuse; and more. As part of the Integrity in Practice campaign, APTA developed a multipronged approach to promoting compliance with documentation, billing, coverage, and other requirements.

APTA is committed to protecting and preserving resources within the health care system through several initiatives. APTA is also partnering with associations, academic programs, state licensing boards, and private payers to root out fraud, waste, and abuse. As the association of a diverse profession, with providers in a variety of health care settings, APTA recognizes the need to work with other organizations to reach all physical therapy providers regardless of setting and experience.

We are committed to protecting and preserving resources within the health care system through several Integrity in Practice initiatives, including but not limited to:

- Choosing Wisely: The Right Care at the Right Time: APTA has partnered with the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely® campaign to provide specific, evidence-based recommendations that encourage both patients and physical therapists to make wise decisions about the most appropriate care. APTA was the first nonphysician group to join more than 50 medical specialty societies that have produced a list of 5 things members of their profession and patients should question.

- Partnering to Prevent Fraud, Waste and Abuse: APTA is working with the American Occupational Therapy Association (AOTA) and the American Speech-Language-Hearing Association (ASHA) to analyze the conditions treated by therapists to provide APTA members and others with information to ensure appropriate care based on ethical and professional standards. Together AOTA, APTA, and ASHA have published a Consensus Statement on Clinical Judgment in Health Care Settings (see below).

- Educating Current and Future Physical Therapists: APTA has published new resources to help physical therapists comply with relevant laws and regulations. The first of these documents, *Preventing Fraud, Abuse, and Waste: A Primer for Physical Therapists*, is a free guide that examines not only relevant laws and regulations but the physical therapist's relationship with payers, referral sources, and patients. The second document, the Consensus Statement on Clinical Judgment in Health Care Settings, underscores the importance of clinical judgment in achieving optimum patient care, provides examples of unacceptable practices that interfere with clinical judgment, and emphasizes the importance of knowing all rules and regulations, following proper evaluation and treatment protocols, and completing all documentation. Clinicians are encouraged to take action if they encounter a billing process or practice that may be suspect and are provided with possible steps to take in response to employer policies or practices that conflict with clinical judgment.

APTA supports efforts by CMS to address payment, billing, and service integrity in the Medicare program, and we are eager to work with CMS, as well as Congress, in advancing initiatives that improve procedures for the identification, investigation, and prosecution of Medicare fraud while also reducing redundancies, eliminating administrative burden, and increasing efficiency. However, we strongly object to widespread institution of prepayment and postpayment audit initiatives, including National Correct Coding Initiative (NCCI) edits, Medically Unlikely Edits (MUEs), and medical review, including pre-claim review. Such processes impose access barriers

to timely, medically necessary health care services; increase costs to patients, providers, and taxpayers; fail to sufficiently target fraudulent behavior; and are excessively burdensome.

Please find our detailed recommendations below:

Targeted Program Integrity Efforts

CMS's program integrity efforts fail to consider Medicare providers' compliance record and other factors. The agency unfairly and arbitrarily scrutinizes providers, even those who have a long-established record of compliance with existing rules and regulations and may already be scrutinized by retrospective audits from other entities. Medicare providers and suppliers are under pressure to comply with various complex and burdensome Medicare program integrity initiatives. Rather than continue to impose additional integrity programs on already burdened providers, such as the Review Choice Demonstration for Home Health Services—a demonstration that attempts to prevent fraud by assessing compliance with documentation—CMS should allocate its time and resources to target specific providers whose behavior suggests fraudulent activity, such as fraudulent billing, false cost reports, credit balances, and noncompliance with the Stark law. Broadly penalizing Medicare providers with time-consuming, burdensome medical review, nonmedical record review, and automated review wastes both provider and governmental resources and will only serve to harm Medicare beneficiaries' access to high-quality, safe, effective care. **Therefore, APTA recommends that Congress direct CMS to allocate its time and resources to target specific providers whose behavior suggests fraudulent activity, such as aberrant utilization, rather than penalizing all providers in specific jurisdictions with time-consuming and costly audits and reviews.**

Targeted Provider Education

The majority of Medicare providers currently exert a sincere effort to comply with Medicare's laws, regulations, and standards. Many of the instances in which a provider or supplier may be involved in a violation of a statute or regulation, the provider has no knowledge or intent to violate the law. Given the significant number of initiatives with which CMS requires conformity, CMS should offer providers with the appropriate education and other tools necessary to support provider compliance. We urge CMS to explore solutions to situations in which violations may arise that the provider or supplier has no knowledge of or specific intent to violate the law. **Specifically, APTA recommends that Congress direct CMS to increase its education efforts at the local, regional, and national levels to better ensure compliance with Part A and Part B documentation requirements, and offer tools and resources that will help providers obtain the requisite documentation from others involved in the delivery of care to Medicare beneficiaries.**

Avoid Duplicative Oversight

CMS has many existing tools and auditing entities at its disposal to address Medicare integrity issues, including Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), Unified Program Integrity Contractors (UPICs), Supplemental Medical Review Contractor (SMRC), and Medicare Administrative Contractors (MACs), among others, to address the numerous vulnerabilities of the Medicare program, including fraudulent billing. CMS relies on ZPICs/UPICS to address any potentially fraudulent, wasteful, or abusive billing practices based on the various leads they receive. These contractors are expected to take prompt action after scrutinizing billing practices, patterns, or trends that may indicate fraudulent billing,

such as billing for services not furnished; billing that appears to be deliberate for duplicate payment; altering claims or medical records to obtain a higher payment amount; soliciting, offering, or receiving a kickback or rebate for patient referrals; and/or billing noncovered or nonchargeable services as covered.

CMS continues to implement new initiatives to reduce and control Medicare fraud and abuse; however, these endeavors merely impose greater administrative and financial burdens on providers, ineffectively spend the Medicare funds they are designed to protect, and fall short of what it takes to be effective program integrity tools sufficient to offset the downside risks to Medicare beneficiaries and providers. For instance, prepayment and postpayment audit and review processes do not necessarily address the current vulnerabilities of the Medicare program. **Moreover, such endeavors fail to address the increasing pressure on individual health care practitioners from practice or facility administrators who dictate excessive or unwarranted services to Medicare beneficiaries or any other patient.** Such programs also are likely to result in many additional requests for administrative appeals from providers, which will not only increase administrative burdens and delay payment, but also expound upon the already significant backlog of appeals pending with the US Department of Health and Human Services (HHS) Office of Medicare Hearings and Appeals, thereby further increasing the administrative and financial burden on HHS.

The systemic issues and failures of the Medicare benefit structure are what should be addressed and corrected, rather than the imposition of additional burdensome processes on providers caring for some of the nation's most vulnerable patient populations. Further, such endeavors are contradictory to CMS's top priorities—to put patients first and streamline rules and regulations. **We strongly encourage Congress to instruct CMS to assess the agency's current program integrity processes and the resulting administrative and financial burdens that plague providers, and instruct the agency to halt any new program integrity initiatives that duplicate already-implemented efforts.**

<u>Safeguarding the Provision of Physical Therapy and Other Medicare Covered Services</u>
APTA strongly believes that rather than continue to impose additional program integrity initiatives, Congress should direct CMS to adopt streamlined approaches that hold Medicare providers accountable for the delivery of appropriate, medically necessary care. CMS may believe that Medicare Quality Reporting Programs, Conditions of Participation, and/or Value-Based Purchasing Programs are sufficient to hold providers accountable and to ensure that the most qualified health care professionals are delivering services they are trained to provide; however, none are sufficient, or timely, for ensuring the delivery of appropriate care.
To better ensure the appropriate provision of therapy and other health care services, APTA recommends that CMS be required to adopt quantitative and qualitative metrics that currently exist in the public domain, including meaningful performance-based and patient-reported outcome measures, by which it can ensure that coordinated, patient-specific, outcome-based care is being delivered safely by properly qualified professionals.

APTA also offers the following suggestions for consideration:

1. Assess provider adherence to clinical practice guidelines.

2. Require the completion of patient-reported satisfaction surveys.

3. Require the collection of patient-reported outcome measures that have clinical utility and importance. Such measures should be meaningful to a diverse set of providers. For example, CMS could require physical therapists within the model to use the Patient-Reported Outcomes Measurement Information System (PROMIS).

4. Require the use of specific performance-based (observation-based) outcome measures.

Rather than continue to impose burdensome auditing procedures on Medicare providers, we encourage CMS to pursue mechanisms that allow it to effectively monitor providers to detect inappropriate behavior within the Medicare program, including the withholding of therapy services, selectively admitting patients based on profitability, generating unnecessary care, and premature discharges.

Additionally, CMS could encourage and incentivize Medicare providers to submit their data to a registry. For example, APTA's Physical Therapy Outcomes Registry is the sole vehicle for physical therapists that permits standardized data collection across all settings, diagnoses, and lifespan that is compatible with other registries, discipline data collection, and functional assessment tools. Moreover, registry participation will facilitate CMS data collection on functional measures at the start and conclusion of care. CMS could use registries and other mechanisms to track providers participating in Medicare and take measured action based upon the data. However, providers also should be granted the opportunity to remediate and use the data iteratively to improve practice patterns and patient communications. Further, quarterly performance reports that include benchmarks (once available) will reinforce and facilitate behavior change and practice improvements. To assist CMS in its efforts, APTA welcomes the opportunity to serve as a resource and share data results at the clinician, practice, and national levels for the measures included in the Physical Therapy Outcomes Registry, a Qualified Clinical Data Registry.

Medicare Contractor Education

APTA recommends that CMS contractors be required to institute ongoing continuing education for its medical reviewers. APTA's members and nonmembers, in addition to the facilities in which physical therapists and physical therapists work, experience significantly high rates of denial due to medical reviewers' flawed application of Medicare statutes, regulations, and billing and coding guidance. These providers are nearly always required to complete continuing education, and those responsible for reviewing their claims should be as well. There must be a greater effort to ensure that CMS's contractors receive ongoing, detailed education and training on Medicare Part A, B, and D regulations, guidance, and coding. Contractors erroneously apply Medicare statutes and regulations to Parts A and B claims, and lack sufficient knowledge of guidance included in the Medicare Internet-Only Manuals. Medicare providers are experiencing unfair denials of claims for skilled services provided, delayed claims processing, and the burden of additional investments of time and labor to engage in the tedious, complicated appeals process, notwithstanding their success rate in overturned claims. These unnecessary denials not only cost providers valuable resources, but also contribute to administrative cost for the contractors themselves. Educating medical reviewers would produce more efficient and less costly claims review for all parties. **Therefore, APTA recommends that Congress instruct**

FPS

The CMS statistical system is named Fraud Prevention System. As Mr. Alexander stated in his testimony, it contains edits that may prevent certain payments from being made. It cannot address a "clean claim" where a stolen identity is used to obtain payments. Since there are 50% more Electronic Health Records systems in the US than there were in 2009, stealing those identities has been an easy and lucrative practice. Which begs another questions the Committee should ask:

- What information, besides claim information (which is inherently flawed) does CMS or its contractors use to help prevent and identity fraud?

Statistical systems of any kind work better with multiple data sources. I do not believe CMS or its contractors recognize or take advantage of this. Further, it cannot differentiate even fraudulent or suspicious claims in the example brought up by Mr. Alexander:

- If a provider's claims submission history indicates a pattern of potential fraud, how does CMS, law enforcement or contractors determine which ones are legitimate and which ones are fraudulent and how much does that cost?

Return on Investment

As I understand, the Return on Investment methodology has been retrofitted to meet the capabilities or shortcomings of the FPS. I have been told it works something like this:

For a provider who has been removed from the Medicare system, the Return on Investment is calculated as the present value of future claims that provider would have submitted to Medicare.

If that, or something similar reflects the ROI methodology it is deeply flawed. Extrapolating these data to some point in the future ignores the reality of retirement, death, other fraud reduction efforts, future billing behaviors or any other truth. Congress needs to determine what the methodology is and whether it includes the costs of investigation and prosecution.

As an examplar, look at how much States spend on their MFCUs and how much they recover in criminal fraud. https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2016-statistical-chart.pdf. Most don't cover their costs.

Congressman Lewis asked what more can be done. Addressing the root causes of fraud, bringing in additional, independent data sources which will help pinpoint fraud, and preventing the use of stolen identities to submit claims (both provider and beneficiary) – none of which is done now- will go a long way in reducing fraud and its enabling conditions.

I would be happy to speak with the Members of the Committee at any time.

CMS to identify the level of competence that needs to be achieved by medical review staff and require Medicare contractors to furnish their personnel with timely, relevant, and regularly updated training on Medicare Part A and Part B statutes, regulations, and guidance. CMS also should institute an "internal" audit process that is intended to provide independent assurance that each contractor's interpretation and application of the law, governance, and internal control processes are operating appropriately and effectively.

Solicit Stakeholder Feedback

Many of the current methods to prevent fraud, waste, and abuse fall short of what it takes to be an effective program integrity tool sufficient to offset the downside risks to Medicare beneficiaries and providers. **APTA recommends that Congress instruct CMS to solicit input and engage in meaningful dialogue with stakeholders through roundtables, open-door forums, conference calls, and meetings, to discuss how to better identify and prevent Medicare fraud.** CMS should conduct provider-specific and patient-specific open door forums on a quarterly basis and invite stakeholders to provide feedback on CMS's various program integrity initiatives. In addition, CMS should develop an email box that allows the public to submit questions or provide recommendations on how to better identify and prevent Medicare fraud without imposing additional administrative and financial burdens on providers.

APTA fully supports efforts to mitigate fraudulent and abusive behaviors under the Medicare program, and we look forward to working with Congress to craft fair and balanced program integrity policies that promote the delivery of quality health care for all Medicare beneficiaries. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547. Thank you for your consideration of these comments from APTA.

Submission for the Record
Jeff Leston, Founder of Castlestone, LLC
House Ways and Means Oversight Subcommittee
Hearing on Combating Fraud in Medicare: A Strategy for Success
Tuesday, July 17, 2018

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House Ways and Means Committee

I am founder of Castlestone, which created anti-fraud technology.

Most of the efforts described in the hearing were coordination initiatives between CMS and law enforcement. Mr. Alexander discussed better ways of getting "new leads" and how they would "investigate and pursue." This, and other tools discussed, perpetuate the "pay and chase" approach to fraud reduction.

None of the Committee members asked any of the panelists what CMS is doing to address the root causes of fraud, as the GAO reported recently,"CMS' efforts do not address the ***root causes*** of (Office of Inspector General Report A-17-17-52000)."

While the annual large nationwide 'takedown' or 'enforcement action' is both laudable and predictable, Congress should be asking the following questions:

- How does the amount of fraud get so large if we have a "predictive modeling" system to 'prevent' it?

- What percentage of the amount of fraud detailed in the press releases of this and prior annual national takedowns is *recovered and returned to the Trust Fund*?

- How is Return on Investment measured and are the costs of investigation, prosecution and the amounts recovered included in those calculations?

- Much of the fraud cases (and I keep a data base of them) are for, as Mr. Alexander pointed out, stolen identities or for services never rendered- and are preventable.

And a self-reflective question for the Committee and Congress:

Why has Congress required Electronic Visit Verification for home healthcare which is 3% of Medicare Spending, and not for non-inpatient charges, which are 75% of spending?

Respectfully

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Submission for the Record
Micki Nozaki, California Senior Medicare Patrol State Director
House Ways and Means Oversight Subcommittee
Hearing on Combating Fraud in Medicare: A Strategy for Success
Tuesday, July 17, 2018

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I am the State Director for the California Senior Medicare Patrol (SMP). We are a grantee of the Department of Health and Human Services, Administration for Community Living. There are 53 other SMPs in the U.S. Our mission is to educate Medicare beneficiaries, their families and caregivers about healthcare fraud prevention so older adults and persons with disabilities are not victims of criminals, fraudsters and scammers.

Thank you for holding hearings on Medicare Fraud. There are many opportunities to mitigate the estimated $60 to $90 Billion in losses to Medicare from fraud, waste, errors and abuse. And we are proud to do our part. We believe educating our communities results in informed, aware consumers who are less likely to be tricked into divulging personal Medicare information and other personal health information.

I look forward to reading the results of the July 17 hearing. Thank you again,
Micki Nozaki
State Director
California Senior Medicare Patrol
www.cahealthadvocates.org