

STATEMENT OF

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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”
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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 Framework¹, 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 entities² 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 guidance⁴ 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.