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

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTEENTH CONGRESS

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

WEDNESDAY, JULY 19, 2017

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:02 a.m., in Room 1100, Longworth House Office Building, Hon. Vern Buchanan [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

Chairman Buchanan Announces Hearing on Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program

House Ways and Means Oversight Subcommittee Chairman Vern Buchanan (R-FL) announced today that the Subcommittee will hold a hearing entitled "Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program." The hearing will focus on how the Centers for Medicare and Medicaid Services (CMS) identifies and combats waste, fraud, and abuse in both traditional Medicare and the Medicare Advantage program. Reducing improper payments is critical for protecting the integrity of the program and ensuring that taxpayer dollars are well spent. **The hearing will take place on Wednesday, July 19, 2017 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 Wednesday, August 2, 2017**. 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

announced charges of more than 400 individuals who claim more than $1.3 billion in fraudulent payments. Bad actors are real, and it is important that we continue to provide support for the effort to combat fraud.

However, errors other than fraud require different approaches. This makes efforts to distinguish between fraud and improper payments important. In the end, we need to look for ways to reduce all types of errors and ensure that the mechanisms created to do this are working as intended.

Today, we are looking at how CMS addresses improper payments to Medicare. Over the past decade, enrollment in Medicare Advantage has tripled. A third of all seniors on Medicare rely on it, and this number continues to grow. Because of this, we need to better understand the processes in place to oversee the program and what we can do to improve it.

To that end, I look forward to the hearing and the witnesses today. I now yield to the distinguished Ranking Member from Georgia, Mr. Lewis, for the purposes of an opening statement.

Mr. Lewis. Good morning. Thank you, Mr. Chairman, for holding this hearing. I also would like to thank our witnesses for being here today and for taking the time to be here.

As you know, Mr. Chairman, this subcommittee's work touches many areas, and protecting and preserving Medicare is one of our most important duties. Last year, Medicare paid nearly $700 billion for health services -- $700 billion for health services.

This program is a lifeline for over 57 million elderly and disabled beneficiaries, and we must ensure that Medicare remains sound and strong for all who rely on it. I deeply believe that preventing fraud is key to this mission.

In 2016, the Medicare fee-for-service program paid an estimated $41 billion in improper payments, and the Medicare Advantage program paid about $16 billion in improper payments. We must work together to bring these numbers down. We cannot let the bad actions of a few ruin the promise and commitment of Medicare for generations yet unborn.

Yet as we recommit to fighting fraud, we should be cautious. Our first priority should be to ensure that beneficiaries have access to quality and life-saving services.

As Medicare transforms to reward quality instead of quantity, this administration must continue President Obama's work to fight new forms of fraud, and we must continue to act. We all must continue the Affordable Care Act investment and innovation in preventing fraud before it happens. Reducing fraudulent, wasteful, and improper payments is a critically important part to keeping the promise to protect the life of the Medicare Trust Fund for all who rely on it.

Chairman BUCHANAN. The Subcommittee will come to order.

Welcome to the Ways and Means Oversight Subcommittee hearing on "Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program."

Nearly 60 million Americans, including four million in my home state of Florida, rely on Medicare programs to provide care. We have a responsibility to all of them and to the taxpayers to ensure that care is high quality and that CMS is paying accurate and appropriate amounts to those providing the care. As it stands now, the Center for Medicare Services has not been in a position to ensure that that is the case.

A couple of weeks ago, I had a very helpful discussion with staff from CMS Center for Program Integrity about their efforts to address improper payments. One issue we discussed is the 10 percent error in the rate. So just to put that in perspective, the way I look at it, when you have a large program, 600 billion—650 billion, 10 percent is over a billion dollars a week in improper payments, and that is really what we are talking about, how can we drive that down.

So 10 percent error rate that is reported includes fraud, as well as overpayments, as well as underpayments. Put directly, that 10 percent number doesn't really tell us much about the program's integrity. The problem with accurate and complete documentation makes up a substantial portion, and it is impossible to extrapolate how much of the payments are actually lost to trust funds and how much merely represent administrative errors. CMS treats them the same.

When we try to understand how much fraud is in Medicare, the answer: We simply don't know. Understanding payment errors is important, as every dollar reported lost in error serves to undermine the good works of the program and could represent a dollar that should be spent providing care to beneficiaries.

However, different types of errors require different analytics and different solutions. Last week, the Department of Justice and the Department of Health and Human Services announced charges of more than 400 individuals who claim more than $1.3 billion in fraudulent payments. Bad actors are real, and it is important that we continue to provide support for the effort to combat fraud.

However, errors other than fraud require different approaches. This makes efforts to distinguish between fraud and improper payments important. In the end, we need to look for ways to reduce all types of errors and ensure that the mechanisms created to do this are working as intended.

Today, we are looking at how CMS addresses improper payments to Medicare. Over the past decade, enrollment in Medicare Advantage has tripled. A third of all seniors on Medicare rely on it, and this number continues to grow. Because of this, we need to better understand the processes in place to oversee the program and what we can do to improve it.

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Mr. LEWIS. Good morning. Thank you, Mr. Chairman, for holding this hearing. I also would like to thank our witnesses for being here today and for taking the time to be here.

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Yet as we recommit to fighting fraud, we should be cautious. Our first priority should be to ensure that beneficiaries have access to quality and life-saving services.

As Medicare transforms to reward quality instead of quantity, this administration must continue President Obama's work to fight new forms of fraud, and we must continue to act. We all must continue the Affordable Care Act investment and innovation in preventing fraud before it happens. Reducing fraudulent, wasteful, and improper payments is a critically important part to keeping the promise to protect the life of the Medicare Trust Fund for all who rely on it.

This is not a partisan matter. It is a question of preserving the sacred trust of our seniors, families in need, and people living with disabilities. It is a question of doing what is right and what is just.

And again, Mr. Chairman, thank you for holding this hearing. I look forward to the testimony of our witnesses. And I yield back.

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

Today's witnesses panel includes two experts, John Cosgrove, Director of Health Care at the Government Accountability Office; Jonathan Morse, Acting Director, Center for Program Integrity, Center for Medicare and Medicaid Services.

The Subcommittee has your written statements, and they will be made part of the formal hearing record. You have five minutes to deliver your oral remarks, and we will begin with you, Mr. Cosgrove.

STATEMENT OF JAMES COSGROVE, DIRECTOR, HEALTHCARE, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. COSGROVE. Chairman Buchanan, ranking member——

Chairman BUCHANAN. Turn on your mike.

Mr. COSGROVE. Is it on now? Sorry.

Chairman Buchanan, Ranking Member Lewis, members of the subcommittee, I am pleased to be here today as you discuss Medicare program integrity issues.

In 1990, GAO first designated Medicare as a high-risk program, in part due to the risk of improper payments. These are payments

that were either made in error or for incorrect amounts. Sometimes they may be the result of fraud, and according to HHS' most recent estimate, Medicare improper payments totaled nearly $60 billion.

My remarks today will focus on program integrity in Medicare part C, also known as Medicare Advantage, the private health plan alternative to the fee-for-service program.

Chairman BUCHANAN. Could you speak up just a little bit, please.

Mr. COSGROVE. Absolutely.

Back in 1990, relatively few Medicare beneficiaries were enrolled in such plans. Since then, enrollment has grown substantially, and Medicare Advantage is a popular option. Today, one in three beneficiaries are enrolled, and payments to plan total about $200 billion. These magnitudes underscore the importance of addressing the 10 percent of plan payments that HHS estimates are improper.

In Medicare Advantage, improper payments largely stem from beneficiary diagnoses that are unsupported by beneficiaries' medical records. That is because CMS uses these diagnoses to adjust plan payments up or down, a process known as risk adjustment, to pay plans more for sick beneficiaries and less for healthy ones. If the beneficiary diagnoses that plans report to CMS are wrong, then plans can be paid too little or too much.

To identify and recover improper payments from plans, CMS conducts audits known as risk adjustment data validation, or RADV audits. In a RADV audit, a contractor checks the medical records for a sample of plan beneficiaries to see if the plan reported diagnoses are accurate and supported.

The first RADV audits checked payments from 2007 for 32 plan contracts. CMS' intention is to conduct about 30 annual audits that would identify any improper payments to a plan based on a sample of beneficiaries, then extrapolate the finding to estimate the total amount of improper payments made to that plan, and finally, recover the overpayments. CMS has now additional RADV audits underway for payment years 2011, 2012, and 2013.

We believe, based on our work, that fundamental changes are necessary to improve the RADV audits and recover additional substantial amounts of improper payments. First, RADV audits should be better focused on those plans with the highest potential for improper payments. Second, the RADV process must speed up for a variety of reasons, including a lengthy appeals process. None of the RADV audits has been completed. Third, recovery audit contractors, known as RACs, called for in the Affordable Care Act should be incorporated into the audit process. The RACs would work on a contingency basis and extend the resources available to conduct RADV audits.

HHS agreed with our recommendations, and CMS has begun considering steps to address them, but the details of how the agency will address our recommendations have yet to be filled in.

I also want to describe our concerns about the shortcomings in CMS' efforts to validate and use the encounter data that plans must now submit to the agency. For years, MA plans have been somewhat of black boxes. We knew how much the plans were paid and who they enrolled, but very little about the services that they actually provided. Before 2012, plans simply submitted the bene-

ficiary diagnoses needed for risk adjustment. However, starting in 2012, CMS required plans to submit encounter data, which are similar to fee-for-service claims data, and contain information on all diagnoses and the medical services and items provided to the beneficiaries. In 2015, CMS began using diagnoses from these encounter data, along with other plan submitted data on diagnosis to risk adjust plan payments.

In January of this year, we reported that CMS had made some progress in validating plans encounter data, but that certain important steps identified in our earlier report had not yet been fully addressed. For example, CMS had not fully established benchmarks for the completeness and accuracy of the data or it conducted analyses to compare submitted data with established benchmarks. We also found that CMS had not yet established specific plans for using the data for program integrity or other purposes that had been outlined, except for risk adjustment.

We, therefore, continue to believe that CMS should implement our July 2014 recommendations by thoroughly assessing the data for completeness and accuracy and by establishing specific plans and timeframes for using these data for other purposes.

This concludes my prepared remarks. I would be happy to answer any questions.

[The prepared statement of James Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony

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

For Release on Delivery
Expected at 10:00 a.m. ET
Wednesday, July 19, 2017

MEDICARE ADVANTAGE PROGRAM INTEGRITY

CMS's Efforts to Ensure Proper Payments and Identify and Recover Improper Payments

Statement of James Cosgrove
Director, Health Care

GAO-17-761T

GAO Highlights

Highlights of GAO-17-761T, a testimony before the Subcommittee on Oversight, Committee on Ways and Means, House of Representatives

July 19, 2017

MEDICARE ADVANTAGE PROGRAM INTEGRITY

CMS's Efforts to Ensure Proper Payments and Identify and Recover Improper Payments

Why GAO Did This Study

GAO has designated Medicare as a high-risk program because of its size, complexity, and susceptibility to mismanagement and improper payments, which reached an estimated $60 billion in fiscal year 2016.

CMS contracts with MAOs to provide services to about one-third of all Medicare beneficiaries, and paid MAOs about $200 billion for their care in 2016. CMS's payments to the MAOs vary based on the health status of beneficiaries. For example, an MAO receives a higher risk-adjusted payment for an enrollee with a diagnosis of diabetes than for an otherwise identical enrollee without this diagnosis. Improper payments in MA arise primarily from diagnosis information unsupported by medical records that leads CMS to increase its payments.

This testimony is based on GAO's 2016 and 2017 reports addressing MA improper payments and highlights (1) factors that have hindered CMS's efforts to identify and recover improper payments through payment audits and (2) CMS's progress in validating encounter data for use in risk adjusting payments to MAOs. For these reports, GAO reviewed research and agency documents, analyzed data from ongoing RADV audits, and compared CMS's activities with the agency's protocol for validating Medicaid encounter data and federal internal control standards. GAO interviewed CMS officials for both reports, and also asked for updates on the status of GAO's prior recommendations for this statement.

View GAO-17-761T. For more information, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) estimated that about $16 billion—nearly 10 percent—of Medicare Advantage (MA) payments in fiscal year 2016 were improper. To identify and recover MA improper payments, CMS conducts risk adjustment data validation (RADV) audits of prior payments. These audits determine whether the diagnosis data submitted by Medicare Advantage organizations (MAOs), which offer private plan alternatives to fee-for-service (FFS) Medicare, are supported by a beneficiary's medical record. CMS pays MAOs a predetermined monthly amount for each enrollee. CMS uses a process called risk adjustment to project each enrollee's health care costs using diagnosis data from MAOs and demographic data from Medicare. In its 2016 report, GAO found several factors impeded CMS's efforts to identify and recover improper payments, including:

- RADV audits were not targeted to contracts with the highest potential for improper payments. The agency's method of calculating improper payment risk for each contract, based on the diagnoses reported for the contract's beneficiaries, had shortcomings, and CMS did not use other available data to select the contracts with the greatest potential for improper payment recovery.
- Substantial delays in RADV audits in progress jeopardize CMS's goal of eventually conducting annual RADV audits. CMS had RADV audits underway for payment years 2011, 2012, and 2013.
- CMS had not expanded the use of Recovery Audit Contractors (RAC) to the MA program as required by law in 2010. RACs have been used in other Medicare programs to recover improper payments for a contingency fee.

GAO recommended that CMS improve the accuracy of its methodology for identifying contracts with the greatest potential for improper payment recovery, modify the processes for selecting contracts to focus on those most likely to have improper payments, and improve the timeliness of the RADV audit process. CMS reported in July 2017 that it had taken initial actions to address these recommendations, but none had been fully implemented. GAO also recommended that CMS develop specific plans for incorporating a RAC into the RADV program. In July 2017, CMS reported that the agency is evaluating its strategy for the MA RAC with CMS leadership.

CMS has begun to use encounter data, which are similar to FFS claims data, along with diagnosis data from MAOs to help ensure the proper use of federal funds by improving risk adjustment in the MA program. Encounter data include more information about the care and health status of MA beneficiaries than the data CMS uses now to risk adjust payments. In its January 2017 report, GAO found CMS had made progress in developing plans to use encounter data for risk adjustment. However, CMS had made limited progress in validating the completeness and accuracy of MA encounter data, as GAO recommended in 2014. GAO continues to believe that CMS should establish plans for using encounter data and thoroughly assess the data for completeness and accuracy before using it to risk adjust payments.

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

I am pleased to be here today to discuss program integrity in Medicare, particularly ongoing efforts to reduce and recover improper payments in Medicare Advantage (MA). GAO has designated Medicare as a high-risk program since 1990, because of its size, complexity, and susceptibility to mismanagement and improper payments. Improper payments, which are payments that either were made in incorrect amounts, such as over- or underpayments, or were made in error, are a significant risk for Medicare. In fiscal year 2016, improper payments in Medicare reached an estimated $60 billion.[1] Some improper Medicare payments are due to fraud, which involves willful misrepresentation. The Centers for Medicare & Medicaid Services (CMS), within the Department of Health and Human Services, faces many challenges related to implementing payment methods that encourage efficient service delivery and safeguarding the program from loss as a result of improper payments.

In 2016, Medicare was projected to finance health services for more than 57 million elderly and disabled beneficiaries with expenditures of $696 billion. About two-thirds of Medicare beneficiaries are enrolled in traditional, fee-for-service (FFS) Medicare, with the remaining third enrolled in MA. In 2016, Medicare paid about $200 billion to MA organizations (MAOs), which are entities that offer a private plan alternative to FFS Medicare. CMS estimates that improper payments in MA totaled about $16.2 billion in fiscal year 2016, nearly 10 percent of CMS's payments to MAOs that year.[2]

Under MA, CMS contracts with MAOs to provide services to beneficiaries. MAOs may have multiple contracts with CMS; for example, plans with varying benefit levels would each have a separate contract. CMS pays MAOs a predetermined monthly amount for each beneficiary, no matter how many services are provided or how much they cost. CMS adjusts payments to MAOs to reflect enrollees' projected health care costs—a process known as risk adjustment. CMS pays MAOs more for enrollees

[1]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).

[2]See Department of Health and Human Services, *FY 2016 Agency Financial Report* (Washington, D.C.: Nov. 2016). In fiscal year 2016, CMS estimated that the net overpayments in MA (overpayments minus underpayments) were about $7 billion, or 4 percent.

who are projected to have higher medical costs, based on prior-year diagnoses and demographics (such as age and gender), and less for those projected to have lower costs. For example, a MAO receives a higher risk-adjusted payment for an enrollee with a diagnosis of diabetes or heart disease than for an otherwise identical enrollee without those diagnoses. The purpose of risk adjustment is to pay MAOs fairly and accurately, thereby decreasing incentives for MAOs to avoid enrolling sicker beneficiaries. MAOs can incur losses if their aggregate spending exceeds payments, but they can retain savings if their aggregate spending is less than payments. Because MAOs are paid a predetermined amount for each enrollee that is based on prior diagnoses, improper payments primarily result from unsupported diagnosis information from MAOs that lead to increased payments.[3] CMS conducts risk adjustment data validation (RADV) audits of past payments to verify the accuracy of the diagnosis information submitted by MAOs. Additionally, CMS has begun to use encounter data, which are similar to FFS claims data, to help ensure that CMS appropriately risk adjusts MAO payments.[4]

My testimony summarizes the findings and recommendations of two of our recent reports relevant to MA improper payments. In particular, I will describe (1) factors that have hindered CMS's ability to identify and recover MA improper payments through payment audits, and (2) progress CMS has made in validating encounter data for use in risk adjusting payments to MAOs.

My remarks on factors that have hindered CMS's ability to recover MA improper payments are based on our 2016 report examining the extent to

[3]Intentional manipulation of diagnostic information may be subject to the False Claims Act (FCA), which prohibits certain actions, including the knowing presentation of a false claim for payment by the federal government. The Department of Justice (DOJ) is responsible for enforcement of the FCA. FCA claims may also be brought by private parties on behalf of the federal government, which DOJ may elect to join, and these "whistleblowers" can receive a share of a monetary settlement or recovery plus expenses and attorneys' fees and costs. Some whistleblowers have filed FCA claims against health plans alleging they manipulated data to overbill the MA program and improperly boost profits. For example, in one lawsuit joined by the DOJ in May 2017, an MAO was accused of knowingly ignoring information in medical charts that did not support invalid diagnoses that it submitted to CMS to increase payments.

[4]Encounter data are detailed information about the care and health status of MA enrollees.

which CMS has addressed improper payments in the MA program.[5] For that report, we reviewed research and agency documents, and we analyzed data from ongoing RADV audits of 2007 and 2011 payments, which were CMS's two initial contract-level RADV audits. We also interviewed CMS officials. My remarks on the progress CMS has made in validating encounter data and its plans to use the data are based on our 2017 report examining these issues.[6] For that report, we compared CMS's activities with the agency's protocol for validating Medicaid encounter data, which are comparable data collected and submitted by entities similar to MAOs, and federal internal control standards. We also reviewed relevant agency documents and interviewed CMS officials about MA encounter data collection and reporting. More detailed information on our objectives, scope, and methodology for this work can be found in the issued reports. For this statement, we also asked CMS officials for updates on the status of our prior recommendations.

We conducted the work on which this statement is based 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

FFS Medicare generally pays providers directly for the services they perform—such as paying physicians for office visits—based on predetermined payment formulas. FFS payments are based on claims data received directly from providers. CMS relies primarily on prepayment automated checks and postpayment medical reviews to identify and recover FFS improper payments. Under the Improper Payments Information Act of 2002 (IPIA), as amended, CMS reported that the FFS

[5]GAO, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, GAO-16-76 (Washington, D.C.: April 8, 2016).

[6]GAO, *Medicare Advantage: Limited Progress Made to Validate Encounter Data Used to Ensure Proper Payments*, GAO-17-223 (Washington, D.C.: Jan. 17, 2017). For this report, we updated findings from our 2014 report on the same subject. See GAO, *Medicare Advantage: CMS Should Fully Develop Plans for Encounter Data and Assess Data Quality before Use*, GAO-14-571 (Washington, D.C.: July 31, 2014). In the 2014 report, we found that CMS had taken some, but not all, appropriate actions to ensure the completeness and accuracy of MA encounter data.

improper payment rate was 11 percent for fiscal year 2016.[7] Two-thirds of the FFS improper payment rate, according to CMS, was a result of insufficient documentation.[8]

CMS and its contractors engage in a number of activities to prevent, identify, and recover improper payments in FFS. The Patient Protection and Affordable Care Act of 2010 included provisions designed to strengthen Medicare's provider enrollment and screening requirements. Subsequently, CMS implemented a revised screening process for new and existing providers and suppliers based on the potential risk of fraud, waste, and abuse. In November 2016, we evaluated this revised screening process and found that CMS used the new process to screen and revalidate over 2.4 million unique applications and existing enrollment records.[9] As a result of this process, over 23,000 new applications were denied or rejected, and over 703,000 existing enrollment records were deactivated or revoked. CMS estimates that this process saved $2.4 billion in Medicare payments to ineligible providers and suppliers from March 2011 to May 2015.

Also in FFS, CMS uses different types of contractors to conduct prepayment and postpayment reviews of Medicare claims at high risk for improper payments. We examined the review activities of these contractors and in April 2016 reported that using prepayment reviews to deny improper claims and prevent overpayments is consistent with CMS's goal to pay claims correctly the first time. In addition, prepayment reviews can better protect Medicare funds because not all overpayments can be collected.[10] We recommended that CMS seek legislation to allow

[7]IPIA, as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012, requires executive branch agencies to annually identify programs and activities susceptible to significant improper payments, estimate the amount of improper payments, and report these estimates along with actions planned or taken to reduce them.

[8]Insufficient documentation occurs in FFS when the claim reviewers cannot conclude that the billed services were actually provided, were provided at the level billed, or were medically necessary. Claims are also placed into this category when a specific documentation element that is required is missing, such as a physician signature on an order, or a form that is required to be completed in its entirety.

[9]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).

[10]See GAO, *Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data*, GAO-16-394 (Washington, D.C.: April 13, 2016).

Recovery Auditors, who are currently paid on a postpayment contingency basis from recovered payments, to conduct prepayment reviews. Although CMS did not concur with this recommendation, we continue to believe CMS should seek legislative authority to allow Recovery Auditors to conduct these reviews.

Medicare Administrative Contractors (MACs) process Medicare claims, identify areas vulnerable to improper billing, and develop general education efforts focused on these areas. In March 2017, we evaluated MACs' provider education efforts to help reduce improper billing.[11] We found that CMS collects limited information about how the efforts focus on the areas MACs identify as vulnerable to improper billing, and recommended that CMS require MACs to report in sufficient detail to determine the extent to which their provider education efforts focus on vulnerable areas. According to CMS, the agency has updated its reporting guidance and MACs will begin reporting more detailed information beginning in July 2017.

Whereas Medicare pays FFS providers for services provided, Medicare pays MAOs a fixed monthly amount per enrollee regardless of the services enrollees use. To identify and recover MA improper payments resulting from unsupported data submitted by MAOs for risk adjustment purposes, CMS conducts two types of RADV audits: national RADV activities and contract-level RADV audits. Both types determine whether the diagnosis codes submitted by MAOs are supported by a beneficiary's medical record. CMS conducts national RADV activities annually to estimate the national IPIA improper payment rate for MA. For 2016, CMS estimated that 71 percent of the improper payments resulted from the insufficient medical record documentation MAOs submitted to CMS that did not support diagnoses they had previously submitted to CMS.[12] The second type of RADV audit, contract-level audits, seeks to identify and recover improper payments from MAOs, and thus deter MAOs from submitting inaccurate diagnosis information. CMS conducted contract-level audits of 2007 payments for a sample of enrollees in 32 MA contracts. CMS's goal is to conduct contract-level audits annually to

[11]See GAO, *Medicare Provider Education: Oversight of Efforts to Reduce Improper Billing Needs Improvement*, GAO-17-290 (Washington, D.C.: March 10, 2017).

[12]CMS also estimated that 29 percent of MAO's improper payments in 2016 were due to administrative or process errors.

recover improper payments efficiently, among other things.[13] It plans to recoup overpayments by calculating a payment error rate for a sample of enrollees in each audited contract and extrapolating the error rate to estimate the total amount of improper payments made under the contract. CMS has RADV audits underway for three payment years—2011, 2012, and 2013. In general, CMS audits about 5 percent of contracts for each year, or roughly 30 contracts.[14]

CMS calculates a beneficiary's risk score—a relative measure of projected Medicare spending—based on both demographic characteristics and health status (diagnoses). The agency uses Medicare data to determine a beneficiary's demographic characteristics; however, it must rely on data submitted by MAOs for health status information. CMS requires MAOs to submit diagnosis codes for each beneficiary in a contract in order to calculate risk scores. Since 2004, CMS has used the Risk Adjustment Processing System (RAPS) to collect diagnosis information from MAOs. In 2012, CMS began requiring MAOs to submit encounter data. Such data include diagnosis and treatment information for all medical services and items provided to an enrollee, with a level of detail similar to FFS claims. Since 2015, CMS has used both RAPS and encounter data submitted by MAOs to risk adjust MA payments.[15]

When CMS proposed collecting encounter data in 2008, the agency stated it would use the data for risk adjustment and may also use them for specified additional payment and oversight purposes. CMS has recognized the importance of ensuring that the data collected are complete—representing all encounters for all enrollees—and accurate—representing a correct record of all encounters that occurred—given the important functions for which the data will be applied.

[13]CMS also expects that the RADV audits will have a sentinel effect on the quality of risk adjustment data submitted by the MAOs.

[14]In fiscal year 2016, CMS selected contracts for audit to initiate contract-level RADV audits of 2013 payments. See Department of Health and Human Services, *FY 2016 Agency Financial Report* (Washington, D.C.: Nov. 2016).

[15]For 2015 MAO payments, CMS used encounter data diagnoses as an additional source of diagnoses to compute risk scores. CMS supplemented the diagnoses from each enrollee's RAPS data file with the diagnoses from each enrollee's MA encounter data file. For 2016, CMS used a different process that increased the importance of encounter data in computing risk scores. CMS intends to increase the weight of encounter data in the risk score calculation in the next 4 years so that encounter data will be the sole source of diagnoses by 2020.

Several Factors Hinder CMS's Efforts to Recover MA Improper Payments

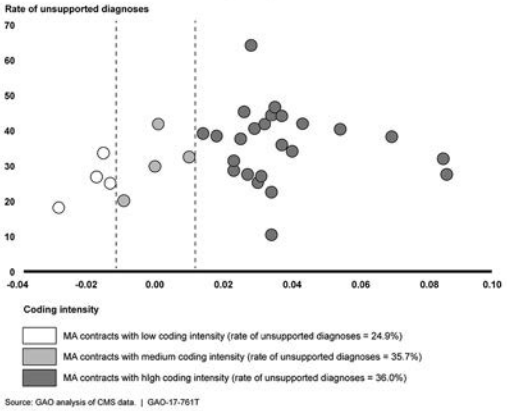
In our 2016 report, we found several factors that hamper CMS's recovery activities, including its failure to select contracts for audit that have the greatest potential for payment recovery, delays in conducting CMS's first two RADV payment audits, and its lack of specific plans or a timetable for incorporating Recovery Audit Contractors (RACs) into the MA program to identify improper payments and help with their recovery.[16]

CMS Did Not Focus RADV Audits on Contracts with Highest Potential for Improper Payments

Our 2016 report found that the results from the RADV audits of 2007 payments indicated that the scores CMS calculates to identify contracts that are candidates for audit, called coding intensity scores, were not strongly correlated with the percentage of unsupported diagnoses. CMS defines coding intensity as the average change in the risk score component specifically associated with the reported diagnoses for the beneficiaries in each contract. Increases in coding intensity measure the extent to which the estimated medical needs of the beneficiaries in a contract increase from year to year; thus, contracts whose beneficiaries appear to be getting "sicker" at a relatively rapid rate, based on the information submitted to CMS, will have relatively high coding intensity scores. Figure 1 shows, for example, that CMS reported that the percentage of unsupported diagnoses among the high coding intensity contracts it audited (36 percent) was nearly identical to the percentage among the medium coding intensity contracts (35.7 percent). Our report also found that the RADV audits were not targeted to contracts with the highest potential for improper payments.

[16]RACs have been used in various industries, including health care programs, to identify and collect overpayments. Medicare RACs are paid on a contingency fee basis from recovered overpayments.

Figure 1: Percentage of Unsupported Diagnoses within Medicare Advantage (MA) Contracts by the Centers for Medicare & Medicaid Services (CMS) Coding Intensity, 2007 Risk Adjustment Data Validation (RADV) Audits



Source: GAO analysis of CMS data. | GAO-17-761T

We identified two reasons that the RADV audits were not targeted on the contracts with the greatest potential for recoveries. The first reason is that the coding intensity scores have shortcomings. For example, our report found that CMS's calculation may be based on scores that are not comparable across contracts, because the years of data used for each contract may differ, and there are known year-to-year differences in coding intensity scores. In addition, CMS's calculation does not distinguish between diagnoses likely coded by providers and diagnoses subsequently coded by MAOs. Medical records that providers create from diagnoses are apt to support the diagnoses better than diagnoses subsequently coded by the MAO through medical record review. CMS has a method available to it—the Encounter Data System—that will distinguish between the two diagnoses. Although using encounter data would help target the submitted diagnoses that may be most likely related to improper payments, CMS has not outlined plans for using it. Furthermore, CMS follows contracts that are renewed or consolidated

under a different existing contract within the same MAO, but CMS's coding intensity calculation does not incorporate prior risk scores from an earlier contract into the MAO's renewed contract. This could result in an improper payment risk if MAOs move beneficiaries with higher risk scores, such as those with special needs, into one consolidated contract.[17]

The second reason audits are not targeted to the contracts with the greatest potential for recovery is that CMS does not always use the information available to it to select audit contracts with the highest potential for improper payments. CMS did not always target the contracts with the highest coding intensity scores, use results from prior contract-level RADV audits, account for contract consolidation, or account for contracts with high enrollment. For example, only four of the contracts selected for the 2011 RADV audit had coding intensity scores at the 90th percentile or above. Even though we found that coding intensity scores are not strongly correlated with diagnostic discrepancies, they are still somewhat correlated. Also, CMS's 2011 contract selection methodology did not consider results from the agency's prior RADV audits, potentially overlooking information indicating contracts with known improper payment risk. Finally, even though the potential dollar amount of improper payments to MAOs with high rates of unsupported diagnoses is likely greater when contract enrollment is large, CMS officials stated that the 2011 contract-level RADV audit contract selection did not account for contracts with high enrollment.

We made two recommendations to address these issues:

- We recommended that (1) CMS improve the accuracy of coding intensity calculations, and (2) modify its processes for selecting contracts for RADV audit to focus on those most likely to have improper payments. In July 2017, CMS officials told us that the

[17]To help beneficiaries select an MA plan, CMS rates MAO contracts on a five-star scale. A contract's rating indicates its performance relative to that of all other plans on about 50 measures of clinical quality, patient experience, and contractor performance. CMS permits MAOs to move enrollees from a contract with a low rating to a contract with a higher rating. The Medicare Payment Advisory Commission has reported that contracts with low quality ratings tend to disproportionately serve beneficiaries with special needs, including those under age 65 who are disabled. Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy: Online Appendixes, Chapter 14* (Washington, D.C.: March 2013), 6 and *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2015), 337.

agency is working to implement these recommendations regarding the selection of contracts for audit. These officials said that CMS is reevaluating the design of the RADV audits to ensure its rigor in the context of all the payment error data acquired since the original design of the RADV audits, including an examination of whether coding intensity is the best criterion to use to select contracts for audit.

RADV Process Incurred Substantial Delays Completing Contract-level Audits and Appeals

Our 2016 report found that prior contract-level RADV audits have been ongoing for years, and CMS lacks an annual timetable to conduct and complete audits.[18] CMS officials reported at that time that the current and previous contract-level RADV audits had been ongoing for several years. CMS has audits for payment years 2011, 2012, and 2013 underway. We concluded that this slow progress in completing audits conflicted with CMS's goal of conducting contract-level RADV audits annually, and slowed recovery of improper payments. CMS lacked a timetable that would help the agency complete these contract-level audits annually. In this regard, CMS had not followed established project management principles, which call for developing an overall plan to meet strategic goals and to complete projects in a timely manner.[19]

In addition to the lack of a timetable, we found other factors that lengthened the time frame of the contract-level audit process. The sequential notification of MAOs that identify contracts selected for audit and then, sometimes months later, identify the beneficiaries under these contracts creates a time gap that hinders the agency from conducting annual audits.[20] Technology problems with CMS's system for receiving medical records are the main cause of the delay in completing CMS's contract-level audits of 2011 payments. Additional technical issues with other systems led CMS to more than triple the medical record submission time frame for the 2011 audits.

Our report found that disputes and appeals of contract-level RADV audits have also continued for years, and CMS has not incorporated measures to expedite the process. Nearly all of the MAOs whose contracts were

[18]GAO-16-76.

[19]GAO, *GAO Cost Estimating and Assessment Guide: Best Practices for Developing and Managing Capital Program Costs*, GAO-09-3SP (Washington, D.C.: March 2, 2009).

[20]According to CMS officials, once MAO contracts are notified of selection for RADV audit, the agency prevents the MAO from submitting any additional payment data that could affect CMS's selection of beneficiaries for audit.

included in the 2007 contract-level RADV audit cycle disputed at least one diagnosis finding following medical record review. CMS stated that MAOs disputed a total of 624 (4.3 percent) of the 14,388 audited diagnoses, and that the determinations on these disputes, which were submitted from March through May 2013, were not complete until July 2014. In addition, because the dispute process took a year and a half to complete, CMS officials stated that it did not receive all 2007 appeal requests for hearing officer review until August 2014. The hearing officer adjudicated or received a withdrawal request for 377 of the 624 appeals from August 2014 through September 2015.

For the 2011 audit cycle, CMS officials stated that the medical record dispute process will be incorporated into the appeal process. Thus, MAOs can request reconsideration of medical record review determinations concurrent with the appeal of payment error calculations, rather than sequentially, as was the case for the 2007 cycle. While this change may help, the new process does not set time limits for when reconsideration decisions must be issued. Lack of explicit time frames for appeal decisions at reconsideration hinders CMS's collection of improper payments because the agency cannot recover extrapolated overpayments until the MAO exhausts all levels of appeal, and the lack of time frames is inconsistent with established project management principles.[21]

We made two recommendations to address these issues:

- We recommended that CMS take steps to improve the timeliness of the RADV audit process. In July 2017, CMS officials told us that, as part of the agency's efforts to consolidate program integrity initiatives into one center, the decision was made to transition RADV contract-level audits to the CMS Center for Program Integrity (CPI) at the end of 2016. With the transition, CMS is implementing a formal project management structure to facilitate the timeliness of the audit process.
- We also recommended that CMS require that reconsideration decisions be rendered within a specified number of days, similar to other time frames in the Medicare program. In July 2017, CMS officials told us that the agency is actively considering options for expediting the appeals process.

[21]GAO-09-3SP.

CMS Made Little Progress toward Incorporating a Recovery Audit Contractor in MA

Our 2016 report found that CMS had not expanded the RAC program to MA, as it was required to do by the end of 2010 by the Patient Protection and Affordable Care Act. Implementing an MA RAC would help CMS address the resource requirements of conducting contract-level audits. In 2014, CMS issued a request for proposals for an MA RAC, which would audit improper payments in three areas of MA, but CMS officials told us that CMS did not receive any proposals to do the work in those audit areas, and that its goal was to reissue the MA RAC solicitation in 2015. CMS reconsidered the audit work in the request for the MA RAC. In December 2015, CMS issued a request for information seeking industry comment on how an MA RAC could be incorporated into CMS's existing contract-level RADV audit framework.[22] In the request, CMS stated that it was seeking an MA RAC to help the agency expand the number of MA contracts subject to audit each year, and stated that its ultimate goal is to have all MA contracts subject to either a contract-level RADV audit or another audit that would focus on specific diagnoses determined to have a high probability of being erroneous. Officials from three Medicare FFS RACs all told us their organizations had the capacity and willingness to conduct contract-level RADV audits.

- We recommended that CMS develop specific plans for incorporating a RAC into the RADV program. In July 2016, CMS described to us its initial steps to meet this goal. In July 2017, CMS officials told us that the agency is evaluating its strategy for the MA RAC with CMS leadership.

[22]Centers for Medicare & Medicaid Services, Medicare Advantage Part C Recovery Auditor Request for Information, December 22, 2015, RFI-CMS-2016-RADV-RAC, accessed July 14, 2017, https://www.fbo.gov/index?s=opportunity&mode=form&id=83f1ec085c52a81a6a6ce7cba3ffbc5d&tab=core&_cview=0.

CMS Has Made Limited Progress Validating Encounter Data Used to Ensure Proper Payments

In July 2014, we recommended that CMS complete all the steps necessary to validate encounter data, including performing statistical analyses, reviewing medical records, and providing MAOs with summary reports on CMS's findings, before using the data to risk adjust payments or for other intended purposes.[23] In our 2017 report, we found that CMS had made limited progress toward validating encounter data.[24] (See fig. 2.) As of January 2017, CMS had begun compiling basic statistics on the volume and consistency of data submissions and preparing automated summary reports for MAOs indicating the diagnosis information used for risk adjustment; however CMS had not yet taken other important steps identified in its Medicaid protocol, which we used for comparison.[25]

Figure 2: Change in Status of the Centers for Medicare & Medicaid Services' Actions to Validate Medicare Advantage (MA) Encounter Data, from July 2014 to October 2016

Activity	July 2014 status	October 2016 status
Establish requirements for collecting and submitting MA encounter data	◐	◐
Review MA organizations' capability to collect and submit encounter data	●	●
Perform automated checks on submitted data for completeness and accuracy	●	●
Conduct statistical analyses for completeness and accuracy	○	◐
Review medical records to verify encounter data	○	○
Summarize findings on encounter data completeness and accuracy to provide recommendations to MA organizations	○	◐

● Addressed
◐ Partially addressed
○ Not addressed

Source: GAO. | GAO-17-761T

[23]GAO-14-571.

[24]GAO-17-223.

[25]We compared CMS's activities to the principal activities identified in its 2012 protocol for validating Medicaid encounter data that states receive from managed care organizations—entities that provide Medicaid benefits in exchange for a fixed monthly payment. The protocol specifies a procedure for assessing the completeness and accuracy of encounter data that Medicaid managed care organizations are required to submit to state agencies. See Centers for Medicare & Medicaid Services, *EQR Protocol 4: Validation of Encounter Data Reported by the MCO* (Baltimore, Md: September 2012).

The steps CMS had not yet taken as of our January 2017 report are:

- **Establish benchmarks for completeness and accuracy.** This step would establish requirements for collecting and submitting MA encounter data. Without benchmarks, CMS does not have objective standards against which to hold MAOs accountable for complete and accurate data reporting.
- **Conduct analyses to compare with established benchmarks.** This would help ensure accuracy and completeness. Without such analyses, CMS has limited ability to detect potentially inaccurate or unreliable data.
- **Determine sampling methodology for medical record review and obtain medical records.** Medical record review would help ensure the accuracy of encounter data. Without these reviews, CMS cannot substantiate the information in MAO encounter data submissions and lacks evidence for determining the accuracy of encounter data.
- **Summarize analyses to highlight individual MAO issues.** This step would provide recommendations to MAOs for improving the completeness and accuracy of encounter data. Without actionable and specific recommendations from CMS, MAOs might not know how to improve their submissions.

In July 2014, we also recommended that CMS establish specific plans and time frames for using the data for all intended purposes in addition to risk adjusting payments to MAOs. We found in our 2017 report that CMS had made progress in defining its objectives for using MA encounter data for risk adjustment and in communicating its plans and time frames to MAOs. CMS reported it plans to fully transition to using MA encounter data for risk adjustment purposes by 2020. However, even though CMS had formed general ideas of how it would use MA encounter data for purposes other than risk adjustment, as of January 2017 it had not specified plans and time frames for most of the additional purposes for which the data may be used. These other purposes include activities to support program integrity.[26]

[26]Although CMS had not specified plans or time frames for using encounter data for program integrity activities, CMS officials told us at the time that they anticipate including MA encounter data in the Fraud Prevention System to help identify abusive billing practices and that, to date, CPI has begun using encounter data to determine improper payments to providers, among other things.

In July 2017, CMS officials told us that the agency had not taken any further actions in response to our July 2014 recommendations. Because CMS is making payments that are based on data that have not been fully validated for completeness and accuracy, the soundness of billions of dollars in Medicare expenditures remains unsubstantiated. In addition, without planning for all of the authorized uses, the agency cannot be assured that the amount and types of data being collected are necessary and sufficient for specific purposes. Given CMS's limited progress in planning and time frames for all authorized uses of the data, we continue to believe CMS should implement our July 2014 recommendations that CMS should establish specific plans for using MA encounter data and thoroughly assess data completeness and accuracy before using the data to risk adjust payments or for other purposes. In response to our 2014 recommendations, the Department of Health and Human Services did not specify a date by which CMS would develop plans for all authorized uses of the data and did not commit to completing data validation before using the data for risk adjustment in 2015. CMS began using encounter data for risk adjustment in 2015, although it had not completed activities to validate the data.

In conclusion, Medicare remains inherently complex and susceptible to improper payments. Therefore, actions CMS takes to ensure the integrity of the MA program by identifying, reducing, and recovering improper payments would be critical to safeguarding federal funds.

Chairman Buchanan, Ranking Member Lewis, and Members of the Subcommittee, this concludes my prepared statement. I would be pleased to respond to any questions that you may have.

GAO Contact and Staff Acknowledgments

For questions about this statement, please contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

Individuals who made key contributions to this testimony include Martin T. Gahart (Assistant Director), Aubrey Naffis (Analyst-in-Charge), Manuel Buentello, Elizabeth T. Morrison, Jennifer Rudisill, and Jennifer Whitworth.

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Chairman BUCHANAN. Thank you.
Mr. Morse, you are recognized.

STATEMENT OF JONATHAN MORSE, ACTING DIRECTOR, CENTER FOR PROGRAM INTEGRITY, CMMS

Mr. MORSE. Chairman Buchanan, Ranking Member Lewis, and members of the subcommittee, thank you for the invitation and the opportunity to discuss the Centers for Medicare & Medicaid Services program integrity efforts in the Medicare program.

We share this subcommittee's commitment to protecting beneficiaries, ensuring taxpayer dollars are spent appropriately, and identifying and correcting improper payments.

As required by statute, each year, CMS estimates the improper payment rate and projected dollar amount of improper payments for the Medicare program. 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 laws and regulations.

It is important to remember that while all payments made as a result of fraud are considered to be improper payments, improper payments typically do not involve fraud. Rather, for CMS programs, improper payments most often occur when there is insufficient documentation to determine whether the service was medically necessary.

CMS' approach to program integrity in the Medicare fee-for-service and Medicare Advantage programs are determined by inherent differences in the programs themselves. I want to spend some time highlighting our program integrity work in Medicare fee-for-service and our approach to Medicare Advantage, and also the cross-cutting work we do with the help of our public and private partners, including our colleagues at the GAO and the Justice Department.

To estimate the Medicare fee-for-service improper payment rate, CMS reviews a statistically valid random sample of Medicare fee-for-service claims. Most recently, the Medicare fee-for-service improper payment rate was 11 percent in 2016. Unlike Medicare fee-for-service in Medicare Advantage, CMS makes prospective monthly per capita payments to the MA organizations. As a result, CMS uses a different methodology to calculate the Medicare Part C improper payment rate. In 2016, the Medicare Part C improper payment rate was 9.9 percent.

The Part C improper payment rate estimate is based on medical record review conducted by the CMS' annual risk adjustment data validation, or RADV, process, where the unsupported diagnoses are identified and corrected as risk scores are recalculated.

In an effort to reduce the Medicare improper payment rates, CMS has instituted many program improvements, and is continuously looking for ways to refine and improve our program integrity activities. We are always working to more closely align payments with the cost of providing care, encouraging healthcare providers to deliver better care, and improving access to care for our beneficiaries.

CMS estimates that, through our program integrity activities, Medicare prevented or recovered $17 billion in fiscal year 2015. For example, our fraud prevention system resulted in $604 million in

fraudulent payments being stopped, prevented, or identified last year. CMS also recently updated the version of the FPS, which is now called FPS 2.0, which improves our model development time and expands CMS predictive analytics capabilities.

CMS also saved Medicare approximately $400 million in 2016, using the National Correct Coding Initiative, or NCCI edits, which promote correct coding methodologies and control improper payments in Medicare Part A, Part B, and for durable medical equipment.

CMS also conducts various medical review activities to help prevent improper payments. For example, CMS uses Medicare Administrative Contractors, or MACs, to review claims submitted by providers and suppliers on a prepayment basis. In fiscal year 2015, MAC prepayment medical review resulted in nearly $5 billion in improper payments being prevented. Overall, these efforts help us to avoid pay and chase, as well as promote provider compliance.

CMS and the Justice Department have also developed a partnership with private health plans and State Medicaid programs to fight healthcare fraud, known as the Healthcare Fraud Prevention Partnership. The partnership provides visibility into the larger universe of healthcare claims beyond those encountered by any single payer. The goal of the partnership is to exchange data and identify trends and patterns that will uncover fraud, waste, and abuse.

CMS now has 79 public-private and State organizations as part of the partnership. And just last week, HHS, along with the Justice Department, announced the largest ever healthcare fraud enforcement action by the Medicare Fraud Strike Force. The takedown involved 412 charged defendants across 41 Federal districts for their alleged participation in healthcare fraud schemes involving approximately $1.3 billion in false billings. Over 120 defendants, including doctors, nurses, and pharmacists, were charged for their roles in prescribing and distributing opioids and other dangerous narcotics. In addition, HHS suspended the Medicare payments of 295 providers.

CMS also takes seriously our commitment to combatting the opioid epidemic, and works to address abusive prescribing through data monitoring, information sharing with Medicare Part D, and law enforcement.

CMS appreciates the work of the GAO on their recommendations of ways to improve Medicare program integrity. We look forward to continuing to work with them to improve and protect the Medicare Trust Fund, while providing beneficiaries with high quality care. I look forward to answering the subcommittee's questions on how we can improve our commitment to protecting taxpayer funded dollars, while also protecting beneficiaries' access to care.

[The prepared statement of Jonathan Morse follows:]

STATEMENT OF

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

ON

"EFFORTS TO COMBAT WASTE, FRAUD, AND ABUSE IN THE MEDICARE PROGRAM"

BEFORE THE

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

JULY 19, 2017

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

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

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

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

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

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

Medicare FFS Improper Payment Rate Measurements and Prevention

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

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

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

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

CMS achieved significant savings through activities aimed at preventing improper payments before they go out the door.[2][3] The Fraud Prevention System (FPS) resulted in $604.7 million in fraudulent payments being stopped, prevented, or identified during FY 2015. In March 2017, CMS launched an updated version of the Fraud Prevention System (called, "FPS 2.0"), which modernizes system and user interface, improves model development time and performance measurement, and aggressively expands CMS' program integrity capabilities.

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

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

Medicare Advantage Improper Payment Rate Measurements and Prevention

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

[2] https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf
[3] https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusion

CMS' goal is to empower Medicare enrollees to choose options that best fit their individual health needs. CMS also strives to provide appropriate payment to Medicare Advantage organizations that serve those enrollees. Reducing improper payments helps to safeguard trust fund dollars and to make sure that the fee-for-service Medicare program and Medicare Advantage are strong and available to the beneficiaries we serve. We share this Subcommittee's commitment to protecting taxpayer and trust fund dollars, while also protecting beneficiaries' access to care, and look forward to continuing this work.

Chairman BUCHANAN. Thank you.

And I thank both of you for your excellent testimony.

We will now proceed to a question and answer session. In keeping with my past precedent, I will hold my questions until the end.

I now recognize Mr. Schweikert.

Mr. SCHWEIKERT. Thank you, Mr. Chairman.

I want to work through, first, a couple of conceptual things, because we were actually trying to take some of the GAO report and make some charts, but it probably would have been easier just to pick up the phone and call you.

First off, in my fee-for-service compared to, we will call it the managed care option, it is, what, a two-thirds/one-third mix right now?

Mr. COSGROVE. That is correct.

Mr. SCHWEIKERT. If I look at payments in error, doesn't mean they are fraud, payments in error, I pay too much, pay too little, most of those sit in the fee-for-service side, correct?

Mr. COSGROVE. Because of the volume of dollars——

Mr. SCHWEIKERT. But even as a ratio.

Mr. COSGROVE. The improper payment rate is fairly similar across fee-for-service and Medicare Advantage.

Mr. SCHWEIKERT. And the collection side for both an overpayment and underpayment? The cleanup, recapture.

Mr. COSGROVE. On the Medicare Advantage side, let me speak to that right now, that is the intention of the RADV audits. There is a national RADV audit that is done every year to estimate the improper payment rate. But to go into the collection, I was talking about the annual RADV audits that are done. Those began with the 2007 payment year. When we did our report, I think something like $14 million had been recovered, and more was expected, based on the determination of the appeals.

Mr. SCHWEIKERT. And we are right now auditing what year?

Mr. COSGROVE. We are in 2017, which is why we think these need to be speeded up.

Mr. SCHWEIKERT. We are in 2017? So the RADV audit, if I would ask for it right now, saying where we are, you are actually doing current year?

Mr. COSGROVE. The most recent payment year that is going under the RADV audits, I believe, is 2013, unless you have——

Mr. SCHWEIKERT. Yeah. That is what I was saying—sorry, we must have had a miscommunication. So it is 2013 you are doing in 2017?

Mr. COSGROVE. Correct.

Mr. MORSE. Yes.

Mr. SCHWEIKERT. Okay. Now, if I were to come back to you and say, all right, those are our payments in error world, and sometimes there is no malicious intent, sometimes it is poorly documented, sometimes it is too much, too little. Okay. In actual fraud, can you help me understand my fraud mix on something such as, the—you called it the takedown, but what just happened. How much of this was actually in the fee-for-service side, how much was in the managed side?

Mr. MORSE. For the takedown, I mean, it would be—most of it would be in Medicare fee-for-service, however, it is—I don't think

the Justice Department or the Inspector General's Office distinguished between how those providers were being——

Mr. SCHWEIKERT. Can you speak up for me?

Mr. MORSE. I don't think the Justice Department or the Inspector General's Office was distinguishing how they were being paid. They were looking at Medicare fee-for-service. It could be Medicare Advantage plans, it also could be Medicare Part D, which is the prescription drug program, as well.

Mr. SCHWEIKERT. Is there a disproportionate portion of this that might have been in D? I am trying to understand where we actually have mechanisms that are working, why in some ways in the report GAO says, "We should do more audits," and then says, "But the audits are poorly modeled." I mean, that is actually in your report saying we need more audits, but the audits have problems.

Mr. COSGROVE. Right.

Mr. SCHWEIKERT. So I am just trying to work through what my solutions are.

Mr. MORSE. So we appreciate the GAO's recommendations. Actually, in fiscal year 2015, we released an RFI for a Part C RAC as required under statute. One of the things that we actually contemplated and proposed to the various stakeholders was changes to the methodology, in part, in response to the GAO's recommendation. So we are taking those under advisement and are working to implement everything——

Mr. SCHWEIKERT. Okay. In my last 50 seconds, if I were to ask for just what we have documented as fraud, what is my mix? How much is durable equipment? How much is in pharmaceuticals? How much is blatant miscoding, patients that were never there? If I were to look at what are our areas of fragility, what are we seeing in actual fraud?

Mr. MORSE. We look at—you know, the challenge from our perspective is we look at improper payments, whether it is fraud, waste, or abuse. The challenge——

Mr. SCHWEIKERT. The question is purely on fraud.

Mr. MORSE. But the challenge of fraud is we won't know if it is fraud until the Justice Department or the Inspector General's Office makes that determination as part of the legal requirements. So it is postpayment and end of settlement into the——

Mr. SCHWEIKERT. So we are in a world where we don't really know what fraud is until Justice actually does their work?

Mr. MORSE. Fraud requires that intent element.

Mr. SCHWEIKERT. So how do you build a model that quickly reacts to noise in the data systems you told us you are building?

Mr. MORSE. Sure. What we look at are potential sort of just suspicious payments, abhorrent billing patterns, things that would just be outside the norm that we want to flag, but for us to also identify if it is potentially fraud, we have to do sort of on-the-ground investigating, we have to collect the medical records. It is a much more time-consuming process.

Mr. SCHWEIKERT. I am way overtime, but thank you for your tolerance, Mr. Chairman.

Chairman BUCHANAN. I now recognize the Ranking Member, Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman. I want to thank the two of you for being here and for your testimony.

Mr. Morse, I want to thank you for your dedication as a career civil servant, as well as the nearly 4,000 other career employees still at the agency.

Like many people in this room, I am very concerned that the administration has not yet appointed a Director of Program Integrity. We need someone at this post to combat fraud, and the position has been vacant for 6 months.

Waste, fraud, and abuse must be taken seriously, and it is not clear that this administration has a vision of how Medicare should be moving forward in these matters.

From the oversight perspective, waste, fraud, and abuse are very different. Are they all issues of program integrity? They are not the same.

So, Mr. Morse, can you discuss the differences between waste, fraud, and abuse, and how to address them through policy?

Mr. MORSE. Sure, I would be happy to. So we as an agency look at waste, fraud, and abuse collectively, because the challenge becomes for us, we are not really trying to distinguish necessarily between the two, we are just trying to make sure that Medicare is correctly paying, regardless of whether it is fraud, waste, or abuse. So we have implemented the improper payment rate for Medicare looks at just improper payments writ large. And as I mentioned in our testimony, as Chairman Buchanan mentioned in his opening statement, most of our improper payments are actually documentation errors. About 60 percent of them are documentation errors, which really means a physician or another provider may have forgotten to sign something that was important for the order that we consider to be required. That doesn't mean that the payment was fraud, waste, or abuse; it just means that it was improper. So by our standard, it still is an improper payment, but that service could have been medically necessary. It could have been received by the beneficiary and needed. We are just doing it—we do that as part of the—our statutory obligation to monitor improper payments.

When it gets to waste and abuse, we have a number of initiatives that we have in place that really help us identify what is potentially more problematic. We have got our fraud prevention system, which as I mentioned at the outset, is an advanced data analytics system, which looks at all of Medicare's Part A and B claims before we pay them, and it tries to identify any sort of abhorrent billing patterns and looks for changes in the data, spikes in billing patterns, things that maybe should not be combined in a particular service, and those get flagged for our potential followup, potential auditing of the medical records on an onsite investigation.

We also receive numerous complaints from, whether it is the Inspector General's Office with potential leads, beneficiaries, other healthcare providers. We have got a number of measures around provider enrollment where we very carefully monitor provider behavior. We provide systems that run sort of in the background 24 hours a day, 7 days a week, that look for things like whether or not a felony conviction of a particular provider, whether they have lost their license.

So we do a number of potential background checks to look at potential waste and abuse as well.

Mr. LEWIS. How do you go about weeding out bad players? There are certain institutions or groups located in one State or maybe one county, one city, and they just pick up and move someplace else under a different name.

Mr. MORSE. That is a great question. And, actually, it is a moving target, and it is a challenge for us, because one of the things that we have learned is that as our advanced data systems get more advanced, the fraud schemes have to get more advanced as well. So one of our challenges is to stay ahead of that.

We have got field offices in several of the large cities. We, again, do a lot of data analytics work. We look at a lot of the claims data, identify potential leads. We work very closely with law enforcement, both at the State level and at the Federal level, and really, spend a lot of our time and effort trying to identify where those emerging trends might be occurring. Based on something that we may have seen in one particular area, we can take that data and try to flag it and sort of put that into our different data systems around the country and see if we end up seeing similar patterns.

Mr. LEWIS. Thank you very much, Mr. Morse. Thank you.

I yield back, Mr. Chairman.

Chairman BUCHANAN. Mrs. Walorski, you are recognized.

Mrs. WALORSKI. Thank you, Mr. Chairman.

Mr. Morse, according to this report, and many of us are talking about reports today, this is the HHS report, Office of Inspector General, on Medicare Part D, and it is on this issue of opioids that you touched on just at the end of your testimony, and I appreciate that. But what I think is interesting about this and draws a red flag for me is one of the things they talk about in here is a prescriber in my home state of Indiana wrote an average of 24 opioid prescriptions each for 108 beneficiaries in a year, costing Medicare Part D $1.1 million just to that Indiana physician. And I guess—I am not a health person professional, it draws a red flag to me.

And I guess my question is, and I know you were probably getting to this on your statement, but what processes does CMS have in place to flag and investigate these suspicious prescribing practices like this, and what do you think needs to be done to improve the system? Because I am guessing that you are going to say that here's what we do, and then you are going to say we need to do more. And so my question is, what is the "more"? And to have gone through—whatever the filters are, to have gone through one doctor in my State to be able to produce these kinds of records I think is astounding. So just from your professional opinion, where do we go on this? What else has to happen? And then what do we need to do as Congress to help you get those filters?

Mr. MORSE. Thank you. So, we have reviewed that opioid report from the Inspector General's Office also, and it is quite concerning.

We have got a number of efforts underway in Medicare, both through the service and in Medicare Part D, that try to address opioid-prescribing abuses, as well as it has obviously been a major focal point of this administration, of the Secretary of the past administration. CMS has an opioid strategy that it published in January of 2017 on this very issue in looking at sort of all the various

levers that an agency as a payer can potentially be sort of pulling to help to address the opioid epidemic.

From the program integrity side, we have a number of things we look at. We work with the Medicare program on the overutilization monitoring system. This looks at it largely from the beneficiary perspective, but looks at does the beneficiary potentially have too many prescriptions? Are there too many, potentially in this case, opioid prescriptions being prescribed in overlapping ways? And how do we kind of make sure that that is not——

Mrs. WALORSKI. Right. But obviously, the filters that you are talking about didn't catch this. And so from your perspective, if you had the magic wand and you could say, look, I am over this, I studied this, I am the professional, here's exactly what we need to do, let's at least try this, what would it be?

Because the other thing disturbing about this, is that there are a half of a million beneficiaries receiving high amounts of opioids.

Mr. MORSE. That is correct.

Mrs. WALORSKI. So the filters aren't working. Whatever was done prior to January of 2017 is not working. So we take that off the chart here, and we say that you say what is it that we are not seeing here, and what can we in Congress do to help you get there?

Mr. MORSE. We also have abusive prescribing authorities within Program Integrity at CMS——

Mrs. WALORSKI. Do you use them often?

Mr. MORSE. We have used them only a handful of times at this point, because part of it is we need to be able to establish sort of that pattern and the practice. And when we see a pattern and the practice, it often is then referred to——

Mrs. WALORSKI. How long is a pattern and a practice? So who is your doctor here that took this to the limit and over the top? He is writing an average of 24 prescriptions each for 108 people in a year, and that wasn't flagged.

Mr. MORSE. But when we do see something like that in our data, we flag it for law enforcement. So, I mean, that is how those cases begin, though. So in that case, you know, there may have been data that is from CMS in this particular case. There may have been data from CMS that we then flag for our law enforcement partners, who then begin those investigations.

So when the behavior is that egregious, if it is something that we can see in our data, it is something that we need to be able to send to the Inspector General's Office, the State law enforcement, to DOJ, and then they begin sort of the more serious criminal and civil prosecutions.

Mrs. WALORSKI. So what happens now as a result of this report? Because still, what you are describing is what is happening pre-2017. As a result of these egregious violations, what new things are going into play now?

Mr. MORSE. Well, we are actually very pleased that the CARA legislation from about a year ago was passed, and CMS is working to implement the Medicare lock-in program. So lock-in is something that has been used very effectively by both State Medicaid programs, as well as by private payers to be able to lock in a single beneficiary and a single prescriber. So essentially, it helps monitor

that overutilization, and it helps sort of prevent that abuse from happening.

Mrs. WALORSKI. Sure. I appreciate it.

Thank you, Mr. Chairman.

Chairman BUCHANAN. Mr. Holding, you are recognized.

Mr. HOLDING. Thank you, Mr. Chairman.

I think we are getting a pretty solid impression that CMS audits are not timely, and this is unfair to both the plans and the taxpayers.

So starting with focusing on Medicare Advantage, and CMS's use of the Risk Adjustment Data Validation (RADV) audits, Mr. Morse, could you talk a little bit about how an audit process works for Medicare Advantage, and how often does CMS conduct these audits?

Mr. MORSE. Sure. I would be happy to do that. So CMS started with a pilot in 2007 where we identify the plans. So we look at 30 plans each year. The plans are then notified for the audit, and they have about 20 weeks to respond to us, would then submit medical records. And in order to do that they have got to go back to all the various providers who make up that patient's medical record and submit the documentation to the plan and then to us.

We then begin the review of the medical records, and make the determination of whether the diagnoses are there for which we paid the plans. We calculate any payment variation by removing diagnoses that were not supported by the medical record. So for example, if there is a diagnosis of a hypertension in the medical record that we have paid for the plan but not in the medical record, we will make a cost adjustment to downgrade that medical record because hypertension was not one of the factors that was mentioned in the medical record.

So the auditing process itself takes at least 18 months. We do multiple rounds of documentation review and medical record review. And it is a very sort of thoughtful and time-consuming process for us to be able to go through and make sure that we are calculating everything correctly.

Mr. HOLDING. So I have in my notes that the most recent data related to the RADV is from the 2007 plan year, and that that currently is under appeal. Is that correct?

Mr. MORSE. That is correct, yes.

Mr. HOLDING. So what takes so long to do these audits? And when you go into the audits what is your goal? I mean, are you hitting your goal as far as the timeframe is concerned? And if so, I mean, what is taking so long?

Mr. MORSE. Sure. Thank you. Let me take the first part of your question. So the length of time—in part, the 2007 audit was a pilot program, so essentially, it was a demonstration as to thinking through the methodology——

Mr. HOLDING. Does it demonstrate that it doesn't work?

Mr. MORSE. To demonstrate the methodology and make determinations as to whether or not it is a fair and accurate way to calculate overpayments.

So we did the demonstration in 2007. We then needed to be able to solicit stakeholders' feedback in subsequent years to make sure

that this payment methodology was going to be accurate and would be one that we would be able to use going forward.

We are in the process of identifying the actual overpayment amounts in 2011, 2012, and 2013. And in those years, as part of the methodology that we determined from the 2007 pilot, we also will be extrapolating against the findings, so essentially, they will be extrapolated overpayments at that point.

Mr. HOLDING. So getting to the second part of my question, what do you anticipate is a reasonable timeframe for these audits to take place? What is your goal?

Mr. MORSE. We certainly would like the audit timeframes to be in the roughly 18 months to 2 years, just given they are done manually, and they are labor intensive for us to do, because it takes clinical expertise to be able to go through the medical record, make sure everything is there, make sure that everyone is reading it accurately and that we agree on the assessment and then make the calculation——

Mr. HOLDING. Do you use any statistical software, predictive statistical analysis that can identify and kind of batch these things for you to look at manually?

Mr. MORSE. We do. We use software for both the data collection in getting the medical records in, as well as a notice to calculate the overpayments. But the actual review of the medical records themselves has to be done by someone with clinical knowledge, because you have got to look at a patient medical record and know, you know, is that diagnoses supported by the findings? And that actually takes a real person. We can't duplicate that with just software and data analytics.

So there is data analytics in the program, certainly, but that work is actually done by people.

Mr. HOLDING. All right. Thank you.

Mr. Chairman, I yield back.

Chairman BUCHANAN. Mr. Crowley, you are recognized.

Mr. CROWLEY. I thank the chairman. Thank you for yielding me the time, and thank you for holding this hearing here today.

Regardless, I think, of party line, we can all agree that fraud is a serious crime, and given human nature, as our Founding Fathers recognized as well, are prone to corruption from time to time, that as we change the system, there are always those who are looking to exploit or manipulate it for nefarious purposes.

I hope we as a committee can use today's hearing to explore what steps HHS and CMS are taking to ensure we continue the progress we have been making to combat waste, fraud, and abuse in the Medicare program.

I want to thank both of our witnesses for being here today, for the valuable information they are presenting to us as a subcommittee.

Mr. Morse, though the future of the ACA has been in the news every day, I think most people don't realize the extent to which the ACA changed the fraud-fighting landscape in the Medicare system. It gave increased funding to combat fraud, provided new tools to screen providers so they can prevent criminals from getting into the system on the front end, improved data analytics, and insti-

tuted more payment review to check for problems before our money goes out the door.

Mr. Morse, can you talk about how the Medicare program has improved as a result of these ACA provisions? And what would have been the status of the Medicare program integrity without these tools added by the ACA?

Mr. MORSE. Thank you, Mr. Crowley. So, Congressman Crowley, I would say the ACA is just one of a number of pieces of legislation, though, passed through this committee that have been actually extremely helpful to us in fighting fraud, waste, and abuse in Medicare.

And if you look at just after the ACA passage, the Small Business Jobs Act of 2010 allowed us to be able to implement the Fraud Prevention System, which is the advanced data analytics system that we use. It works somewhat similar to sort of what the credit card companies use to be able to flag potential bad actions or suspicious—essentially, suspicious behavior.

The CARA legislation that I just referred to with Congresswoman Walorski a moment ago, allows us to be able to do lock-in for Medicare, which we are currently implementing for the Part D program. So locking in a single beneficiary to a single prescriber. We have got the—MACRA has been extremely helpful for us as we are beginning to remove the Social Security number now for the beneficiary ID cards.

So we do have a number of authorities, even outside the ACA, that have actually been extremely helpful.

Mr. CROWLEY. No. And I recognize those additions, but I was just focusing specifically, because those other provisions are not under attack, so to speak, in the same way that the ACA has been, and maybe we are coming to the end of that attack, but we will see. Only time will tell.

And I would hate to see these ACA provisions and the program integrity efforts initiated by the Obama administration be reversed. So that is why I was specifically speaking about the ACA provisions as it pertains to attacking fraud and abuse within the system itself.

Our witnesses have highlighted the gains we have achieved in combatting waste, fraud, and abuse in the Medicare program, through the ACA and through executive action, as well as the other bills that you have mentioned, Mr. Morse, and HHS and CMS under President Obama in particular. Our role as Congress should be to strengthen the integrity of the Medicare program, strengthen Medicare Trust Fund, and protect taxpayers from billions of dollars of loss that had played out.

So I think it is in the interest of the taxpayer to look at the benefits of the ACA as it pertains to health benefits itself, but these other benefits that are derived in terms of fighting waste, fraud, and abuse. So I thank you all for your testimony today.

I thank the chairman for this hearing today. Thank you.

Chairman BUCHANAN. Mr. Meehan, you are recognized.

Mr. MEEHAN. Thank you, Mr. Chairman.

I want to thank the panel, not just for your presence here today, but for the important work that you do. I know it is not easy, and you have got a big responsibility, but we are also grateful for you

allowing us to get the benefit of your experience and wisdom so we can determine how things can be done better.

Some of my colleagues have recognized we are seeing not only a growth in concern about fraud, but also the opioid epidemic. Both on the front end with overprescribing, and also a growing concern about those who have entered into the treatment space, and questions about how people are being recruited. And I know you don't get into the value of the services, but there are real questions about the competency of what is being delivered and payment schemes as well.

In general, a recent report from the Permanent Subcommittee on Investigations in the Senate found that only a small percentage of potential incidents of fraud and abuse on the Part D program were brought to the attention of the medic were actually investigated. In fact, from 2015 statistics, there were 8,900 total actionable complaints, yet only about seven percent were investigated.

In light of the opioid epidemic and the real concerns that have been pointed out here, can you explain why 93 percent of the cases of potential fraud and abuse regarding prescription drugs did not seem to be acted upon?

Mr. MORSE. So when we are looking at potential fraud and abuse, we also have to look at and balance that with sort of the burden on the providers. So one of the things we need to be careful of is really describing whether or not it is just fraud and abuse in looking at the prescribers' billing patterns. Anything that is flagged for us that is potentially abusive behavior and really egregious behavior is actually referred often—if it is not referred to the law—whether it is referred to the medic or not, also goes through to law enforcement, to the private plans to take action, but we also have to balance that with sort of the latitude that we need to be able to give prescribers in their prescribing patterns as well.

So, the challenge for us is really kind of balancing that fine line of being thoughtful for allowing, you know, beneficiaries who often need a certain amount of prescriptions and certain amounts of, whether it is opioids or other pain medication, to be able to, you know, receive those, you know, receive that medication following the CDC guidelines that were published about 1½ years ago with something that potentially, you know, moves into the fraud, waste, and abuse area.

When it is something that is potentially fraudulent, we do our best to make sure that we flag that, either for action ourselves and also to be able to be action that is taken by law enforcement, Inspector General's Office——

Mr. MEEHAN. You know, you mentioned some standard there. What kind of metrics do you use? How do you calculate where a prescription may be in a volume that is appropriately related to a particular condition versus those who we know are overprescribing, particularly in the opioid area, where we believe the prescriptions are not going to a particular recipient, but are finding their ways out into an open market and leading to further abuse?

Mr. MORSE. So the volume question is one that I have to refer to my colleagues in the Medicare program who set sort of the requirements for what Medicare will pay for under certain prescription drug guidelines. So it is not really a program integrity ques-

tion for me, per se. We just then enforce what the guidelines are and what has been set through the Medicare program. And then the Part D plan sponsors who administer the prescription drug program under Part D will do the same, you know, in their programs as well.

Mr. MEEHAN. Okay. I am not sure I completely understand that. But tell me, if there is a seven percent rate right now of investigations, so to speak, does that reflect the complete utilization of the resources at your disposal or should we be doing more? Or is there a more effective way to get at a higher percentage? What is the right balance there?

Mr. MORSE. I think one of the things that we are very much looking forward to is the implementation of lock-in, which allows—as I mentioned before, it has been very effectively used by the private plans and by State Medicare——

Mr. MEEHAN. Would you speak on that in the remaining moments? Because the private plans seem to do a better job than the government at getting to the bottom of this. Why do they do a better job? What metrics are they using? And why aren't we doing that with the government programs?

Mr. MORSE. One of the things that we have seen that we have been actually working with the plans to think about is so—is they do a couple things. One is limits on, you know, potential—the volume of potential drugs, and then they use lock-in.

The lock-in program that was enacted through this committee under CARA is one of the most effective tools that we have seen and that we are working to implement now, so——

Mr. MEEHAN. Well, thank you.

Mr. Chairman, my time is up, and I yield back.

Chairman BUCHANAN. Mr. Bishop, you are recognized.

Mr. BISHOP. Thank you, Mr. Chairman, and thank you for your leadership on this issue. And thank you to the panel for being here today and sharing your time with us. It is enlightening, and we appreciate it.

Last Congress, I was on the Judiciary Committee, and we were actively involved in addressing the opioid epidemic. And I know that you have heard questions from this panel about that, and it is simply because all of us have had some real concerns in our districts and across this country at the duration of the epidemic and how quickly it is moving.

Last year, the House Judiciary Committee equipped law enforcement and first responders with ways in which to deal onsite with the overdosing that is going on. Thousands and thousands of situations where police and first responders had no way to respond, and Congress came up with a plan and a solution, and we provided the community programs resources to enhance diversion programs, lots of great solutions, but there is so much more to be done.

And in the midst of this crisis and what is going on with the news with the DOJ and the crackdown you have seen on prescription drugs, I know that you are in the heat of this battle as well and doing the best you can to address the problem.

Mr. Morse, I understand in the cases where Medicare data finds that the ratio of beneficiaries to providers is abnormally high, CMS has a process in place to set up what you call a moratorium area.

And I am wondering—Mr. Meehan raised the issue earlier—what specifically the evidence is considered to developing something like this? Can you tell us a little bit about how you do that, historically how you have applied this, and whether or not you have seen an uptick in this process of developing moratoria areas around the country?

Mr. MORSE. Sure. When we thought about doing a moratoria, the concept began from us looking at data around potential patterns of services that were being abused. So whether it is—as far as a fraud, waste, or abuse, it was services that we were looking at that we were finding some significant improper payments, and most often, home health, what is called nonemergency ambulance transportation, so someone using an ambulance service that is not going to an emergency room, so often to go to a doctor's appointment in some way. And then for something like durable medical equipment.

One of the things that we have found is, you know, by placing a moratoria or a cap on the number of providers in that area, it helps us to limit sort of what the universe is of the providers who are supplying those particular services. In order to make those determinations, we look at the number of beneficiaries to the number of providers, both in that area and then in surrounding areas, and then also in other parts of the country, because not every area is going to have—so if we put a home health moratoria in Illinois, for example, some parts of Illinois are more rural than others, so we also look at specific ZIP Code by ZIP Code, what does it look like, making sure that we have enough beneficiaries or enough providers to serve those beneficiaries, as compared to sort of any other parts of the country that might be relevant in terms of the size.

In some of those States where we have, you know, put the moratoria in place, the number of—again, just for home health as an example—the number of home health providers dramatically will exceed what we have found to be helpful and when we think it has been an indicator of potential fraud and abuse.

Mr. BISHOP. Can you talk about the history of imposing these moratoria across the country? Has there been an uptick in your decision to do that over previous years?

Mr. MORSE. No. Actually, in recent years, the home health moratoria has held fairly steady. We have increased them. The home health moratoria has been increased from a county-based system to a State-based system, so they are statewide in five States. In part because we were finding that home health organizations were setting themselves up just right outside sort of the jurisdiction that we were putting the moratoria in and then, essentially, just eluding the idea of the moratoria. So we put them in statewide where we thought that the number of providers would still be sufficient for those beneficiaries. But otherwise, they have largely held steady the last couple of years.

We found them to be an effective method of at least capping that number of suppliers and providers in that area, because often the concern otherwise is if there is a huge uptick in the number of providers and suppliers in any one particular area, and there is sort of a limited or finite number of beneficiaries needing the services, does that potentially contribute to some fraud or abusive behavior?

Mr. BISHOP. Thank you for your efforts. We appreciate it.

Mr. Chairman, I yield back.

Chairman BUCHANAN. Mr. Curbelo.

Mr. CURBELO. Mr. Chairman, thank you very much for this hearing, and I thank the Ranking Member as well.

This issue is of critical importance to my community in south Florida. Most people know south Florida is one of the most beautiful parts of this country, a lot of hard working entrepreneurial people. But we have another distinction, which isn't as attractive or as desirable. And I will just read the first line from a Miami Herald article published recently. "With Federal agents leading Medicare fraud busts nationwide and in the nation's Medicare fraud capital of Miami, last week, a drug-dealing Miami doctor pleaded guilty to conspiracy to commit healthcare fraud, $4.8 million."

Now, people in my community are sick and tired of having this reputation, and people in my community ask me, how come a Visa and American Express and MasterCard can prevent fraud, yet we are always reading about the Medicare fraud that is being chased in the newspaper?

And I want to know today, from both of our witnesses, if there is any more authority that Congress can give CMS to remedy this situation.

By the way, Mr. Chairman, I would like to submit for the record this Miami Herald article and the corresponding DOJ press release.

Mr. SCHWEIKERT [presiding]. Without objection.

[Member Submission for the Record follows:]

JUSTICE NEWS

Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Thursday, March 23, 2017

Miami-Based Physician Charged for Role in Pain Pill Diversion and Medicare Fraud Scheme

A physician licensed in Puerto Rico, who was practicing medicine in Miami, was charged in a 16-count indictment unsealed today for his alleged participation in a multi-faceted $20 million health care fraud scheme involving the submission of false and fraudulent claims to Medicare and Medicaid and the illegal distribution of oxycodone and other controlled substances.

Acting Assistant Attorney General Kenneth A. Blanco of the Justice Department's Criminal Division, Acting U.S. Attorney Benjamin G. Greenberg of the Southern District of Florida, Special Agent in Charge George L. Piro of the FBI's Miami Field Office, Special Agent in Charge Shimon R. Richmond of the U.S. Department of Health and Human Services Office of Inspector General's (HHS-OIG) Miami Regional Office and Special Agent in Charge Brian Swain of the United States Secret Service's (USSS) Miami Field Office made the announcement.

Roberto A. Fernandez, M.D., 51, of Miami, was charged with one count of conspiracy to commit health care fraud and wire fraud, 11 counts of health care fraud, one count of conspiracy to defraud the United States and pay and receive health care bribes and kickbacks, one count of conspiracy to distribute controlled substances and two counts of distribution of controlled substances. Fernandez was arrested on March 22, 2017, and made his initial appearance today before U.S. Magistrate Judge Andrea M. Simonton of the Southern District of Florida.

According to the indictment, from approximately December 2009 to March 2017, Fernandez owned and operated Florida-based Latin Foundation for Health Inc. and purported to practice medicine as an "area of critical need" doctor at Latin Foundation for Health and other facilities in Miami-Dade County.

The indictment alleges that from approximately January 2011 through February 2017, Fernandez referred Medicare beneficiaries and Medicaid recipients who were purportedly under his care to Calan Pharmacy & Discount Service LLC, a Medicare Part D provider, and several Miami-area home health agencies in exchange for illegal bribes and kickbacks from his co-conspirators. The indictment further alleges that Fernandez submitted false and fraudulent claims through Medicare Part B for services, office visits and procedures that he never provided, such as therapeutic injections and removal of lesions from patients' faces, and provided prescriptions for home health services and medications regardless of whether they were medically necessary.

The indictment further alleges that Fernandez illegally dispensed controlled substances, including but not limited to the Schedule II controlled substances Oxycodone and Hydrocodone and the Schedule IV controlled substance Alprazolam, to his co-conspirators.

According to the indictment, Fernandez and his co-conspirators caused Medicare to pay at least approximately $4.4 million based on false and fraudulent claims that they caused to be submitted. The indictment also alleges that Medicare, through Part D, paid a total of approximately $20 million as a result of claims submitted listing Fernandez as the prescribing physician.

An indictment is merely an allegation and the defendant is presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

The FBI, HHS-OIG and USSS investigated the case, which was brought as part of the Medicare Fraud Strike Force, supervised by the Criminal Division's Fraud Section and the U.S. Attorney's Office for the Southern District of Florida. Former Fraud Section Trial Attorney and current Assistant U.S. Attorney Lisa H. Miller of the Southern District of Florida and Fraud Section Trial Attorney Adam G. Yoffie are prosecuting the case.

Since its inception in March 2007, the Medicare Fraud Strike Force, now operating in nine cities across the country, has charged nearly 3,000 defendants who have collectively billed the Medicare program for more than $11 billion. In addition, the HHS Centers for Medicare & Medicaid Services, working in conjunction with the HHS-OIG, are taking steps to increase accountability and decrease the presence of fraudulent providers.

Topic(s):
Healthcare Fraud
Prescription Drugs

Component(s):
Criminal Division
Criminal - Criminal Fraud Section
USAO - Florida, Southern

Press Release Number:
17-306

Updated March 24, 2017



MIAMI-DADE COUNTY JULY 17, 2017 10:40 AM

Opioid-pushing Miami doctor pleads guilty to $4.8 million Medicare fraud

BY DAVID J. NEAL
dneal@miamiherald.com

With federal agents leading Medicare fraud busts nationwide and in the nation's Medicare fraud capital of Miami last week, a drug-dealing Miami doctor pleaded guilty to conspiracy to commit healthcare fraud.

The case of Miami's Roberto Fernandez, similar to Miramar doctor Joaquin Mendez's Friday guilty plea to the same charges in a different case, demonstrates if greed fuels these schemes, doctors can be the engine. Fernandez admitted in court documents that just his role in the schemes cost Medicare $4.8 million. His guilty plea could cost him a maximum of 10 years in prison.

Working from 2011 to earlier this year with pharmacy owners Niurka Fernandez (doing 10 years on fraud charges) and Arturo Oms (eight years), Fernandez wrote prescriptions and made referrals of Medicare beneficiaries for Medicare kickbacks.

ADVERTISING

All three billed Medicare for drugs that weren't necessary and sometimes not given to the patients in whose names they were billed to Medicare. And he used name brand drugs for the unnecessary prescriptions, allowing for more fraudulent billing from Fernandez and Oms. Like Mendez, he contributed his signature to care and prescription plans that allowed for fraud in home health care.

Fernandez admitted to billing Medicare for services not rendered. But, perhaps most damagingly, Fernandez admitted to being part of the state's opioid crisis by prescribing controlled substances oxycodone, hydrocodone and alprazolam to patients and patient recruiters for $100 to $200 per prescription.

"Too many trusted medical professionals like doctors, nurses, and pharmacists have chosen to violate their oaths and put greed ahead of their patients," Attorney General Jeff Sessions said in a statement after Thursday's monsoon of healthcare fraud arrests. "Amazingly, some have made their practices into multimillion dollar criminal enterprises. They seem oblivious to the disastrous consequences of their greed. Their actions not only enrich themselves often at the expense of taxpayers but also feed addictions and cause addictions to start. The consequences are real: emergency rooms, jail cells, futures lost, and graveyards."

In announcing the 412 arrests Thursday, the Department of Justice said, "The charges also involve the individuals contributing to the opioid epidemic, with a particular focus on medical professionals involved in the unlawful distribution of opioids and other prescription narcotics."

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Mr. CURBELO. And we are very pleased, we are very pleased that there was this massive Medicare fraud bust all over the country recently, but that is an indication of a far greater problem, and this is what we are catching. We can only imagine what we are not catching.

So I want to know, Mr. Morse, is there anything else that this institution can do to empower you to focus more on prevention so that we can hopefully stop reading all these articles about chasing fraud and putting people in jail?

Mr. MORSE. Thank you for that question. Actually, this institution has done a fantastic job of doing that already. The Ways and Means Committee has increased HCFAC funding for Medicare in recent years. You have given us the authority—actually, as you talk about the ability of credit cards to find fraud, we use actually a similar system from the Small Business Jobs Act of 2010, which allows us to do very advanced data analytics and identify potential patterns of fraud and abuse there. We have found that to be extremely effective. That program alone has saved over $1 billion in the last 2 years in terms of preventative dollars before they go out the door.

One of the challenges that you speak to, though, is the complexity of actually detecting and preventing fraud, because a lot of it takes on-the-ground investigations. It takes looking through a medical record from a provider, making sure that that medical record actually meets what the beneficiary actually received in terms of the services or needed in terms of services. And that often is—it is labor intensive. It is potentially burdensome on the provider. So we do very cautiously balance that burden, you know, with our investigative work.

But we actually have been very appreciative with everything the committee has done. Even most recently, in MACRA removing Social Security number from the beneficiary ID card in Medicare is going to help us along for identity theft. We have a number of authorities that we found to be extremely helpful, and we, you know, continue to do better and continue to make progress going forward, but——

Mr. CURBELO. So, Mr. Morse, you don't think there is anything we can do on the front end as these potential providers, candidates to become Medicare providers are applying? Because I hear from legitimate healthcare providers all the time: The easiest thing to do is to set up a Medicare fraud scheme because you automatically get approved.

Now, you have told me here today that it is a burdensome process to get approved as a Medicare provider? How do I reconcile that with what I am hearing from healthcare providers back home?

Mr. MORSE. We have got a number of provider screening requirements that are already in place. So we screen for whether or not a provider is potentially, you know, a felon or they have any sort of felony conviction. We make sure that they are properly licensed in their jurisdiction. And then we also do, even if they are enrolled, we do continuous monitoring in the background. We have data systems that actually do that electronically without actually any burden on the provider, the provider doesn't know this is going

on, and we are able to kind of look and make sure that that provider is maintaining their compliance with our program standards.

But, you know, we will then take action if we find that there is any potential abuse of billing or any issues that arise from that provider's behavior.

Mr. CURBELO. Thank you, Mr. Morse.

And, Mr. Chairman, I want to thank you again. Whatever it takes, I think this Committee, this Congress needs to empower these agencies to remedy this situation for taxpayers, for Medicare beneficiaries. It is very demoralizing to read on a weekly basis in Miami these articles about people running these schemes that have cost the taxpayers billions and billions of dollars, and by the way, threaten the solvency of Medicare, Social Security, and many other of our entitlement programs.

I thank our witnesses. We need to do much better. Thank you, Mr. Chairman, for this opportunity.

Chairman BUCHANAN. [Presiding.] Thank you.

I want to thank our witnesses. A couple of questions. When we talk about a number of $60 billion, is that a ballpark? Could it be $80 billion, $90 billion? Do we really know what that number is? I mean, is that just an estimate?

Mr. MORSE. Thank you. Actually, so building on the conversation that we had with you a couple of weeks ago, it really is an estimate, because we are required under statute to estimate improper payments, and there is the IPERA legislation that gives guidance in terms of the things that we need to be able to measure for improper payments. So especially on the fee-for-service side, a lot of that improper payment error rate of that 60 billion, roughly 43 of it is Medicare fee-for-service. Of that 43 billion about 60 percent of that is documentation errors. So for us to look at that——

Chairman BUCHANAN. What about the other 40 percent, what happens there?

Mr. MORSE. The other 40 percent is potentially more suspect behavior, and it is more challenging for us to make those determinations, in part, for the——

Chairman BUCHANAN. It is an overpayment, but it might not beput in the category of fraud.

Mr. MORSE. That is the challenge, yes, is making those determinations over—at that time, as to what constitutes the overpayment. Is it potential abuse or fraud or is it simply just an overpayment and something that Medicare otherwise should have paid, even if the documentation didn't line up at the time?

Chairman BUCHANAN. So Medicare pays out a lot in terms of overpayments. What do they get back? Do we have any sense of that number?

Mr. MORSE. We have prevented—well, we look at the improper payment rate as just an estimate. So the improper payment rate is just a random sample of a number of claims.

We, from the program integrity side, at CPI, have a number of initiatives, many of which have been through authorizations from legislation from this committee, look at our potential return on investment.

In 2015, we determined that we prevented or identified about $17 billion in improper payments to Medicare alone. That is mostly—almost all Medicare fee-for-service.

Chairman BUCHANAN. Someone mentioned earlier, one of the Members, about auditing and going back four or five years. What is the likelihood of collecting anything when you go back that far?

Mr. MORSE. But it is our duty to go back that far regardless. I mean, the challenge is, you know, making sure that the trust funds are—we are able to recover the dollars, to the extent that we can, that have gone out the door, if we do——

Chairman BUCHANAN. What was the $60 billion number three years ago or four years ago? Has that number climbed? Has it stayed the same percentage? The programs increased. Is it that you use just a standard 10 percent? Is that what it historically has been or did it used to be seven or eigth and it has gone to 10 percent?

Mr. MORSE. Medicare—the fee-for-service improper payment rate in Medicare has actually come down in recent years as we instituted a number of provisions. So 2 years ago, it was just over 12 percent. This past year, it was 11 percent. So we are working to, obviously, get it as low as we can be because, clearly, it is too high, even from our perspective.

Chairman BUCHANAN. One of the thoughts I have is that there is a saying, if you can't measure it, you can't manage it. And we need to make sure we have good, accurate information in terms of trend lines and where all this is going.

Because, obviously, 10 percent of a huge program, 700 billion, someone mentioned 650, that is $70 billion a year in overpayments of fraud. That is outrageous. That is why it caught so much of my attention in these big programs, Social Security and Medicare.

It doesn't take a big percentage to get to a gigantic number, and that is why I think we need to use whatever resources we can to take the trend line and move it in the other direction.

What could we do as a Committee or in terms of policies to help get that number moving in the other direction? Because I am concerned. I mean, take a number, 60 billion, let's say we are still out of pocket 20, 30 billion, net, net, net. That is still way too much money that could be used for other things.

Mr. MORSE. We actually—I mean, so we appreciate everything this committee has already done. You know, even in the time that I have been at CMS—the couple years that I have been at CMS, Ways and Means Committee has increased our HCFAC funding, the Healthcare Fraud and Abuse Control account funding, which is a funding source and authorization for a lot of Medicare's program integrity dollars.

MACRA legislation has been extremely helpful for us. The Small Business Jobs Act has been helpful for us, the CARA legislation. So we actually feel as though the committee has been extremely supportive of program integrity work.

Chairman BUCHANAN. One thing I would just keep in mind because it is such a big number is we need to have a mindset of continuous improvement. It doesn't matter what the number is until it gets to zero, which it probably never will, obviously. We need to be moving in that direction.

Mr. Cosgrove, what are your thoughts on what we could be doing better or differently? What could we do as a Committee to help you guys be more successful in getting that number down, that percentage down?

Mr. COSGROVE. I think that CMS has made a lot of improvements. We have made several recommendations to CMS that they need to do a better job in cases of setting objectives and monitoring performance, so that for the activities that are underway currently, they know how well they are working and how they can be improved.

One recommendation that we put into our high-risk report was intended to help move past pay and chase by doing more prepayment reviews before the money actually goes out to the provider. Currently, the prepayment reviews are done mostly by the MACs, by the Medicare administrative contractors.

There was a demonstration where the recovery audit contractors, who typically do postpayment reviews and collect fees on a contingency basis, did some prepayment reviews. We recommended that CMS seek legislative authority to allow the RACs to do prepayment reviews.

We think that prepayment reviews are more effective and efficient than trying to collect the money later on, and that this would add additional resources to the battle against improper payments. So I think that is one area to consider, allowing the RACs to do prepayment reviews.

Chairman BUCHANAN. Well, I think that is something we should look into. I think anybody knows, in business, once the money goes out, it is tough, especially if you are going four or five years later to get it back. So if you can prevent it from going out—if it is something that is a legitimate service or equipment that has been provided, it is different—but it is not.

Okay. Well, let me just close with, I would like 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 follow:]

GAO U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

August 22, 2017

The Honorable Brian Higgins
House of Representatives

Dear Congressman Higgins,

This letter responds to your request that we address a question submitted for the record related to the July 19, 2017 hearing entitled *Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program*. GAO's response to this question is enclosed.

If you have any questions about this response or need additional information, please contact James Cosgrove at cosgrovej@gao.gov or call (202) 512-7114.

Sincerely yours,



James Cosgrove

Question for the Record to the Witnesses

The Honorable Brian Higgins

As you know, on May 15, 2017, *The New York Times* detailed a story of a whistleblower exposing a Medicare Advantage plan's alleged fraud. This report joins other whistleblowers with similar accounts of the practices of similar organizations and multiple lawsuits filed by the Department of Justice alleging fraud by insurers. The cases demonstrated the dire need for a robust Recovery Audit Contractor program to recoup Medicare Advantage overpayments. I am aware that a Request for Proposals was released in December 2015, more than 18 months ago. However, as of today's date, this increased auditing has yet to begin.

What do you think needs to be done to fully implement Section 1893(h) of the Patient Protection and Affordable Care Act of 2010, which provides CMS with general authority to enter into contracts with Recovery Audit Contractors to identify and reconcile overpayments in Medicare Advantage (Part C)?

During my testimony I noted several factors that hinder CMS's efforts to recover Medicare Advantage (MA) improper payments, including the agency's lack of specific plans or a timetable for incorporating Recovery Audit Contractors (RACs) into the MA program to identify improper payments and help with their recovery. In April 2016, we recommended that CMS develop specific plans for incorporating a RAC into the risk adjustment data validation (RADV) program.[1] In July 2016, CMS described to us its initial steps to meet this goal. In July 2017, CMS officials told us that the agency is evaluating its strategy for the MA RAC with CMS leadership. We continue to believe that CMS should develop specific plans for incorporating a RAC into the RADV program to help the agency address the resource requirements of conducting contract-level audits.

[1]GAO, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments*, GAO-16-76 (Washington, D.C.: April 8, 2016).

Jonathan Morse's Hearing on
"Medicare Advantage"
W&M O&I
July 19, 2017

Questions from Chairman Vern Buchanan

1. **Can you describe what efforts CMS has taken to quantify the amount of Medicare dollars lost because of fraud? How does CMS distinguish fraud related losses from other payment errors such as those stemming from missing documentation?**

Answer: Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare.[1] CMS takes seriously our responsibility to make sure our programs pay the right amount, to the right party, for the right beneficiary, in accordance with the law and agency policies. It is important to remember that while all payments made as a result of fraud are considered improper payments, improper payments typically do not involve fraud. Rather, for CMS' programs, improper payments are most often payments for which there is no or insufficient supporting documentation to determine whether the service of item was medically necessary, and there is no information or indication suggesting that the provider knowingly failed to create or maintain such documentation. Fraud itself is a legal term, and cases of alleged fraud are investigated and prosecuted through civil and/or criminal law enforcement processes. CMS works closely with our colleagues in law enforcement and refers cases of suspected fraud to them for further investigation and additional actions if necessary.

During Fiscal Year (FY) 2016, the Federal Government won or negotiated over $2.5 billion in health care fraud judgments and settlements[2], and it attained additional administrative impositions in health care fraud cases and proceedings. As a result of these efforts, as well as those of preceding years, in FY 2016 over $3.3 billion was returned to the Federal Government or paid to private persons. Of this $3.3 billion, the Medicare Trust Funds received transfers of approximately $1.7 billion during this period.[3]

As part of these efforts, CMS uses the Comprehensive Error Rate Testing (CERT) program to review a stratified random sample of Medicare fee-for-service (FFS) claims to estimate an improper payment rate. The CERT methodology is based on results from both data processing and medical record reviews for a national random sample of claims and primarily identifies payments that did not meet Medicare coverage, coding, and billing rules. The Medicare FFS improper payment rate decreased from 12.1 percent in 2015 to 11.0 percent, or $41.08 billion, in 2016. The decrease from the prior year's reported error estimate was primarily driven by a reduction in improper payments for inpatient hospital claims.

CMS achieved significant savings through activities aimed at preventing improper payments before they go out the door.[4][5] The Fraud Prevention System (FPS) resulted in $604.7 million in fraudulent

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[1] https://www.hhs.gov/sites/default/files/fy-2016-hhs-agency-financial-report.pdf
[2] The amount reported as won or negotiated only reflects the federal recoveries and therefore does not reflect state Medicaid monies recovered as part of any global federal-state settlements.
[3] https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf
[4] https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf
[5] https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf

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

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

2. Are there any additional authorities or other actions from Congress that can assist CMS in combatting Medicare fraud?

Answer: CMS appreciates the additional authorities and tools that Congress has provided in recent legislation, including the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and 21st Century Cures Act. The President's Budget strengthens the integrity and sustainability of Medicare and Medicaid by investing $751 million in discretionary Health Care Fraud and Abuse Control (HCFAC) funding, which is $26 million above the FY 2017 Omnibus.

This enhanced funding would allow CMS and their law enforcement partners to continue the shift away from a "pay-and-chase" model toward identifying and preventing fraud and abuse before it happens. CMS will use additional resources to target program integrity activities toward high risk providers and reduce burden on compliant providers.

3. In your testimony, you wrote that RADV audits in Medicare Part C "recover overpayments identified by RADV; encourage accurate coding; increase the incentive for MA organizations to submit valid and accurate diagnosis codes." I understand that CMS does not share with plans information on how CMS approaches diagnosis codes in their audits to ensure their validity and accuracy, is this true?
   1. **Why doesn't CMS make this information public?**
   2. **What other actions does CMS take to ensure that plans have adequate guidance on complying with CMS coding requirements?**

Answer: CMS hosts training sessions for MA organizations and provides instructional materials for the audits, such as checklists and submission instructions, which explain how CMS approaches diagnosis codes to ensure their validity and accuracy (e.g., coded according to official coding guidelines and following risk adjustment methodology). CMS established the payment error calculation methodology for the RADV audits through a public notice and comment process. In February 2012, CMS provided information about the RADV audits in a payment error calculation methodology paper titled, "Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits."[6]

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[6] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/RADV-Resources.html

CMS has also issued guidance regarding a requirement that MA organizations report and return overpayments that they identify, including those overpayments resulting from submission of improper risk adjustment data. The regulation codifying these requirements was finalized in May 2014 for Contract Year 2015, and specifies that a MA organization has identified an overpayment when the organization has determined, or should have determined through the exercise of reasonable diligence, that it has received an overpayment. Subregulatory guidance has also been issued to MA organizations with further policy and operational guidance.

4. Recently, GAO raised concerns about CMS's progress in validating encounter data.
Since then, what steps has CMS taken to validate encounter data accuracy and reliability?
   1. When does CMS anticipate the validation process to be completed?
   2. How will the transition to more complete encounter data impact CMS efforts to audit plans?

Answer: Risk adjustment data validation (RADV) audits of Medicare Advantage organizations (MAOs) are designed to ensure the accuracy and integrity of risk adjustment data and Medicare Part C program risk adjusted payments in order to protect the Medicare Trust Funds. RADV audits verify whether the diagnosis codes submitted for payment by MAOs are supported by medical record documentation. Historically, CMS has used MA diagnoses submitted into CMS' Risk Adjustment Processing System (RAPS). In recent years, CMS began collecting encounter data from MA organizations. In 2015, CMS used encounter data as an additional source of diagnoses for enrollee risk scores. In 2016, CMS began using diagnoses from encounter data to calculate risk scores, by blending encounter data-based risk scores with RAPS-based risk scores. In 2017, CMS continued using a blend, incorporating a higher percentage of encounter data-based risk scores. In the 2018 Advance Notice, we proposed to continue using the 2017 blend of 75% RAPS and 25% encounter data for payment. CMS also solicited comments on whether and how to apply a uniform industry-wide adjustment to the encounter data-based portion of the blended risk score under the Part C and End-Stage Renal Disease (ESRD) models for payment to MAOs in 2018.

CMS is committed to open data and transparency to empower patients and doctors to make decisions about their care and to support innovative approaches to improve quality, accessibility, and affordability in the healthcare system. In the 2018 Call Letter[7], CMS defined six measures that we expect to use to assess plans' performance. In the Call Letter, we established performance thresholds for two of the measures and announced that we will establish thresholds for the remaining measures. The Call Letter also noted that we will identify contracts failing to meet the performance thresholds for follow up communication, technical assistance, and tracking, and will conduct monitoring and compliance activity, including but not limited to notices of non-compliance, warning letters, and corrective action plans as needed to improve performance.

CMS has taken several steps to provide specific recommendations to MA organizations to help improve the quality of data including: monthly user group calls; one-on-one calls; on-site visits; report cards (which provide MAOs with information on frequency, volume, and accuracy of their submissions by service type, compared to MA regional and national benchmarks and the FFS national benchmark); providing technical assistance to MA organizations; and researching plan-specific issues.

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[7] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-04-03.html

Questions from Rep. George Holding

During the hearing, I asked about the contract-level RADV audit process and why it takes so long to conduct. I have a few follow up questions on CMS's use of a Fee-For-Service Adjuster in the RADV process.

1. **Describe the purpose of the FFS adjuster and how CMS uses it in the contract-level RADV audit process?**

Answer: CMS described a Fee-For-Service Adjuster in a methodology notice published on February 24, 2012.[8]

2. **Has the adjuster played a role in the delay in concluding 2011-2013 contract-level RADV audits? If so, how?**

Answer: The payment year 2011, 2012, and 2013 audits are in various stages of the RADV audit process. During RADV audits, MA organizations submit medical records to validate the diagnosis information they submitted for payment. These records are reviewed for CMS by medical record coders, referred to as the medical record review phase. Based on the diagnoses found during medical record review, CMS recalculates the payment the plan should have received and compares it to the payment the plan actually received. This process is referred to as the payment error calculation phase. Following payment error calculation, audit reports are generated and released to MA organizations. The RADV audits for payment year 2011 have completed the payment error calculation phase. For payment year 2012, the audit is in the payment error calculation phase. The audit for payment year 2013 is in the medical record review phase.

3. **How was the adjuster determined? Does the agency intend to publish information on the methodology behind its development? If not, why?**

Answer: CMS described a Fee-For-Service Adjuster in a methodology notice published on February 24, 2012.[9]

Questions from Rep. Brian Higgins

As you know, on May 15, 2017, *The New York Times* detailed a story of a whistleblower exposing a Medicare Advantage plan's alleged fraud. This report joins other whistleblowers with similar accounts of the practices of similar organizations and multiple lawsuits filed by the Department of Justice alleging fraud by insurers. The cases demonstrate the dire need for a robust Recovery Audit Contractor program to recoup Medicare Advantage overpayments. I am aware that a Request for Proposals was released in December 2015, more than 18 months ago. However, as of today's date, this increased auditing has yet to begin.

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[8] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf

[9] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Other-Content-Types/RADV-Docs/RADV-Methodology.pdf

1. What do you think needs to be done to fully implement Section 1893(h) of the Patient Protection and Affordable Care Act of 2010, which provides CMS with general authority to enter into contracts with Recovery Audit Contractors to identify and reconcile overpayments in Medicare Advantage (Part C)?

Answer: CMS is strongly committed to program integrity in the MA program and takes seriously our responsibility to protect taxpayer dollars by identifying and correcting improper payments. CMS uses several tools to address the Part C improper payment rate: contract-level Risk Adjustment Data Validation (RADV) audits, requirements that MA organizations report and return overpayments, and program and financial audits.

CMS is always interested in additional input on how we can improve our programs. CMS is required to implement Recovery Audit Contractor (RAC) Programs in Medicare under Section 1893(h) of the Social Security Act. In 2014, CMS issued a Request for Proposal for a Part C RAC; however, no proposals were received. In December 2015, CMS issued a Request for Information seeking industry input on expanding the RAC Program to include the identification and correction of overpayments and underpayments associated with diagnosis data submitted to CMS by Medicare Advantage Organizations for Part C payment, as well as input on the level of contractor interest and capability to conduct this type of work. The Administration is currently evaluating its Part C RAC strategy. We are working to revise the Part C RAC Program design to create a more robust business model for potential contractors that fits into CMS's larger Part C program integrity efforts.

[Public Submissions for the Record follows:]

Alliance of Specialty Medicine

Statement for the Record
Before the House Ways and Means Committee
Subcommittee on Oversight
"Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program"

Wednesday, July 19, 2017

Chairman Buchanan, Ranking Member Lewis, and members of the Subcommittee, the Alliance of Specialty Medicine (the Alliance) would like to thank the House Ways and Means Oversight Subcommittee for the opportunity to provide input on efforts by the Centers for Medicare and Medicaid Services (CMS) to identify and combat waste, fraud, and abuse in the Medicare program. The Alliance is a coalition of medical specialty societies representing more than 100,000 physicians and surgeons from specialty and subspecialty societies dedicated to the development of sound federal health care policy that fosters patient access to the highest quality specialty care. As patient and physician advocates, the Alliance welcomes the opportunity to provide input in the formulation of health and Medicare policy.

While we recognize the importance of improving program integrity for Medicare to protect taxpayer dollars, the Alliance is increasingly concerned with CMS' approach to program integrity, which places numerous, burdensome requirements on physician practices. These initiatives are duplicative, disruptive to physician practices, and often lead to penalties based on technicalities or inconsistent application of program requirements. CMS also provides little transparency with respect to the scope, authority, and operations of initiatives they undertake, thereby creating additional uncertainty for the physician community and limiting accountability for CMS and its contractors.

To address these concerns, the Alliance urges Congress to:

- Streamline Medicare program integrity efforts to minimize burden and duplication;
- Increase transparency in Medicare medical review and audit initiatives;
- Enforce transparency in the development of local coverage and payment policies;
- Implement safeguards to ensure that Medicare denials and overpayment recoupments are proper; and
- Promote improvement through education and corrective action plans (CAPs) rather than penalties.

Additional details on these recommendations are provided below.

Streamline Program Integrity Efforts to Minimize Burden and Duplication

CMS and its contractors conduct multiple types of pre-payment review, post-payment review, and medical record auditing to determine the accuracy of Medicare payments to physicians and other providers. These may include reviews by Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Unified Program Integrity Contractors (UPICs), and

Supplemental Medical Review Contractors (SMRCs), to name a few. Further, CMS also undertakes medical reviews as part of its Comprehensive Error Rate Testing (CERT) program. As a whole, these reviews are often duplicative, burdensome, and disruptive to physician practices, requiring time and resources of clinicians and administrative staff and preventing physicians from focusing on delivering high-quality care to the patients they serve.

To address this burden and duplication, the Alliance recommends that Congress require CMS to streamline its efforts related to medical reviews and auditing. For example, CMS should conduct a comprehensive review of its program integrity initiatives to assess their effectiveness, identify areas of duplication as well as opportunities for collaboration or consolidation across program integrity contractors, and discontinue efforts that are not focused on those claims and providers with the highest risk for improper payment. For initiatives that remain, CMS should adopt a streamlined approach to conducting reviews that all contractors should be required to follow. As part of this effort, CMS should ensure that contractors' efforts are coordinated such that the same records are not requested and the same claims are not reviewed multiple times, and that record requests are consolidated across contractors such that physicians are not barraged with record requests throughout the year.

Improve Transparency in Medicare Medical Review and Audit Initiatives

In addition to the duplication and burden they present, CMS' numerous medical review and audit initiatives lack transparency that is needed to hold CMS and its contractors accountable. As such, the Alliance has identified several recommendations for improving transparency for these initiatives.

First, CMS should be required to establish a new web portal for consolidating information on CMS' program integrity efforts, including information on contractors and their performance. The portal should include clear information on the function and scope of authority used to engage with each of the various Medicare program integrity contractors. CMS should also include information on each contractor, including its sampling and extrapolation methodologies. For each contractor, CMS should also annually publish key data related to its performance on audits, including the number of denials and appeals, net denials (defined as total denials minus denials overturned on appeal), and overall appeal rates.

Additionally, to ensure that they are targeting their efforts appropriately, Medicare auditors should be required to submit potential audits for review and approval by the Secretary. The Secretary should specify through a notice-and-comment process the criteria upon which proposed audits are assessed, and approved audits should be posted on the program integrity web portal.

Enforce Transparency in the Development of Local Coverage and Payment Policies

Too often, improper payments are identified on the basis of inconsistent or unclear Medicare coverage and payment policies. Additionally, contractors regularly do not follow proper notice and comment processes when developing or updating local coverage determinations. To address these challenges, the Alliance urges Congress to enforce transparency in the development of local coverage and payment policies by requiring contractors to adhere to CMS' established

requirements for soliciting comments and recommendations and for obtaining input from representatives of relevant specialty societies, as part of the contractor's notice and comment period for new or revised local coverage determinations (LCDs). Local contractors must also be required to provide a formal notice-and-comment process for any and *all changes* they intend to implement that would revise coverage and payment policies. Contractors who fail to meet these standards should be subject to successive penalties, up to and including termination.

Implement Safeguards to Ensure that Medicare Denials and Overpayment Recoupments are Proper

CMS' current program integrity contracts do not include sufficient safeguards to ensure that contractors make appropriate determinations with respect to denial of claims or services or identification of overpayments. For example, the individuals responsible for making denial determinations may not have the right expertise or training to assess the medical necessity of a given clinical scenario. Additionally, contractors often have limited accountability for making proper determinations that are upheld upon appeal, which encourages them to pursue overpayments even when evidence for improper payment is limited.

To mitigate physician burden and hassle associated with improper denials and overpayment determinations, the Alliance recommends that CMS be required to implement safeguards to ensure that Medicare denials and overpayment recoupments are proper. Specifically, CMS should mandate physician review for Medicare denials by requiring a physician practicing in the same specialty or sub-specialty and with clinical expertise or knowledge of the service in question to validate whether a medical necessity denial is warranted. Additionally, for those contractors whose determinations are overturned on appeal, Congress should require that they face financial penalties that, at a minimum, cover providers' administrative costs in pursuing the appeal, as an incentive to ensure contractor determinations are correct from the start.

Promote Improvement through Education and Corrective Action Plans Rather than Penalties

In recognition of the fact that improper payments are largely due to unintended coding and billing errors of providers acting in good faith, rather than bad actors committing fraud, the Alliance recommends that Congress should institute an approach for addressing improper payments in the Medicare program that prioritizes education and information-sharing, rather than harsh financial penalties. For example, CMS should be required to publicly report on common coding and billing errors and omissions, including providing detailed break-outs by error or omission type, physician specialty, contractor, and region, among others. CMS should also be required to provide enhanced educational offerings to physician practices on how to avoid common coding and billing mistakes.

Congress should also replace financial penalties with corrective action plans (CAPs) that provide clear steps for physician practices to reduce their improper payment rates. To support improvement under the CAPs, CMS should also be required to institute a program that would provide technical assistance to physician practices while they work to address internal deficiencies that may have led to a high volume of coding and billing errors and inappropriate payments.

Conclusion

Addressing fraud, waste, and abuse in the Medicare program must be a priority for CMS, and the Alliance recognizes the importance of targeted, high-value initiatives that address those providers or claims at the highest risk of fraud or improper payment. However, CMS must balance its program integrity objectives against the burden and disruption they create. The recommendations detailed above outline specific and actionable steps that can be taken to reduce the negative impacts of CMS' program integrity initiatives on physician practices to allow physicians to focus their attention and resources on providing the high-quality care Medicare beneficiaries need.

Thank you again for taking our written comments into consideration. The Alliance of Specialty Medicine looks forward to working with the Subcommittee on improving CMS' program integrity efforts.



July 19, 2017

Testimony of the American Medical Rehabilitation Providers Association (AMRPA)

To the Ways and Means Committee Oversight Subcommittee Hearing on "Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program"

The American Medical Rehabilitation Providers Association (AMRPA) thanks Chairman Buchanan, Ranking Member Lewis, and Members of the Oversight Subcommittee for holding this hearing to examine efforts to combat waste, fraud, and abuse in the Medicare program. AMRPA is the national trade association representing more than 500 freestanding inpatient rehabilitation hospitals and units of general hospitals (IRFs), outpatient rehabilitation service providers, and other medical rehabilitation providers working with more than 600,000 patients each year to maximize their health, functional skills, independence, and participation in society.

AMRPA supports the Committee's efforts to ensure that the Centers for Medicare and Medicaid Services (CMS) preserve the integrity of the Medicare program by paying accurate and appropriate amounts to providers. The proper management of Medicare funds and payment of claims is central to ensuring rehabilitation providers' ability to serve seniors and persons with disabilities. We look forward to working with the Committee on policies that reduce payment errors, preserve program resources, and promote access to medically necessary, quality rehabilitative care.

As Chairman Buchanan noted in his opening statement, the overall Medicare payment error rate yields little information about the program's integrity. Many payment errors are attributable to faulty or incomplete documentation and therefore it is difficult to determine whether they represent a loss to the Medicare trust fund or, in his words, simply "typographical errors." AMRPA agrees with the Chairman that different types of payment errors require different solutions. To that end, our testimony summarizes the reasons which may underlie IRF payment errors and offers solutions to reduce error rates and alleviate provider burdens that threaten beneficiaries' access to care.

IRF Payment Error Rates Result from a "Perfect Storm" of Overly Burdensome Documentation Requirements and Overzealous Contractors

Jonathan Morse, Acting Director of CMS' Center for Program Integrity, testified that improper payments most often occur where there is insufficient documentation to determine whether an item or service was medically necessary. Although Director Morse acknowledged that an "improper payment" is not necessarily – or typically – fraudulent, he stated that improper payments for IRF and home health claims were "the largest contributors to the 2016 Medicare

FFS improper payment rate." However, Director Morse did not discuss the data underlying this statement or seek to explain to the Committee why increasing numbers of IRFs are finding it difficult to meet CMS' extensive documentation requirements.

A review of the *HHS FY2016 Agency Financial Report* is instructive. From FY 2015 to FY 2016, the improper payment rate for freestanding IRFs increased from 55.7 to 73.2 percent, while the rate for hospital-based units grew from 34.4 to 53 percent. In FY 2016, 99.7 percent of improper payments to freestanding IRFs resulted from missing or insufficient medical necessity documentation, versus 87.2 percent in FY 2015. For IRF units, improper payments based on lack of medical necessity documentation increased from 51.6 to 83.7 percent.

According to HHS' findings, the overall IRF improper payment rates increased 37 percent from 2015 to 2016 and improper payments to IRF units based on medical necessity has apparently increased by a dramatic 62 percent in a single year. However, it defies logic that such significant changes could be due to providers, which are unrelated and geographically diverse due to the CERT sampling process, engaging in the same new pattern of behavior. As noted in the HHS report, the CERT program ensures a statistically valid random sample; therefore, the improper payment rate calculated from that sample reflects all Medicare FFS payments over the report period.

Because the CERT sample includes different, random groups of providers from year to year, we think HHS' findings are more reflective of changes in the CERT review criteria or processes rather than actual shifting provider behavior. Contractor behavior may also contribute to increases in rates of "improper payments" as their coverage criteria and corresponding documentation requirements changes over time as well, even where there is no underlying change in the regulations or CMS' subregulatory guidance, such as the Medicare Benefit Policy Manual (MBPM).

Thus, the more rational – and factually based – explanation is that rising IRF improper payment rates and claim denials have been driven by providers' inability to satisfy increasingly burdensome documentation requirements, coupled with contractor audit procedures that are designed to penalize providers for even the most minor documentation errors. In many instances contractors apply overly subjective interpretations of vague policies governing IRF services, including where no regulation exists. The intensive therapy requirement (also known as the "Three-Hour Rule") in the regulations is a prime example. CMS has repeatedly stated that the "preponderance" of therapy and rehabilitation services received by IRF patients must be delivered in a "one-on-one" modality, *i.e.*, a single therapist working with the patient. For example, contractors will often deny IRF claims for failure to satisfy the Three-Hour Rule when in excess of 80 percent of a patient's therapy is individualized.

Current IRF medical necessity requirements are heavily document-laden and lend themselves to easy, accounting-style audits based on technical noncompliance. As a result, legitimate, medically necessary rehabilitative care is not recognized and is instead categorized as

an "improper payment." The problem is exacerbated by the fact that many contractors responsible for reviewing IRF claims are paid on a contingency fee basis – the higher the denial rate, the higher their fees. Additionally, beyond returning the contingency fee itself, there are no financial penalties for contractors incorrectly denying payment. Together, these factors converge to create a "perfect storm" in which IRFs are found to have improper payment rates of up to 73 percent.

While AMRPA shares the Committee's goal of combatting waste, fraud, and abuse in the Medicare program, the vast majority of claim denials our members experience are related to technical violations of subregulatory coverage policies. For example, one of our members recently experienced claim denials for each of the following reasons during a contractor payment review:

- Pre-admission physician examination did not indicate the prior level of function – even though the prior level of function is documented elsewhere in the medical record;
- The Individualized Plan of Care (IPOC) was not completed within four days;
- No physician signature on pre-admission review or the signature is outside the 48-hour window or was done with an electronic medical record (EMR) that somehow does not meet CMS' requirements; and
- The interdisciplinary team conference was missing documentation from one team member (*e.g.*, case manager, therapist, etc. such as a signature on the team note).

In addition, contractors often go beyond the policies outlined in CMS coverage manuals to impose even stricter requirements on IRFs. For example, despite contrary assurances from CMS, contractors have misconstrued 42 C.F.R. § 412.622 to impose an absolute requirement that each document identified in regulation be completed exactly as specified, including rigid timelines for each, and thus denied coverage when the patient's medical record clearly demonstrates medical necessity. In so doing, they far exceed the scope of their authority. These overly restrictive interpretations of coverage policies result in claim denials for medically necessary and appropriate rehabilitative care, harming both patients and IRF providers.

Moreover, the preadmission documentation requirements in CMS coverage manuals have themselves been found to exceed the scope of agency regulations. In *Cumberland County Hospital System v. Price,* a U.S. District Court recently held that the preadmission requirements for IRFs set forth in the MBPM are far more detailed and impose significantly greater documentation burdens on providers than those set forth in the corresponding CMS regulations. The court noted that

> The list of criteria in the MBPM does not merely clarify or interpret the requirements in the regulation, but creates a new standard by specifying particular items of information not provided

> for in the regulation. Significantly, these criteria are not simply precatory. . . . Rather, the MBPM states that they are mandatory. It provides that the preadmission screening documentation "must indicate" certain matters and "must also include" the remaining matters specified. MBPM ch. 1 § 110.1.1.

In the face of these increasingly detailed and more restrictively interpreted requirements, it is no surprise that the improper payment rate for IRFs is increasing.

Further, the current Medicare appeals process offers little hope of any timely resolution of disputes over disallowed "improper" claims. The average processing time for appeals at the Office of Medicare Hearings and Appeals (OMHA) is now 1,057 days (over three years!), despite statutory requirements that redetermination appeals be completed within 60 days and administrative law judge (ALJ) and Medicare Appeals Council (MAC) decisions be rendered within 90 days. Many of AMRPA's members have been waiting three to four years even for a hearing before an ALJ, without access to the funds in controversy. However, once they reach this level of appeal, IRFs are successful in getting the substantial majority of denials overturned. A data collection effort by the IRF stakeholders, representing 22 percent of the industry, found a statistic of Overturn Rate In Favor of Providers (in Dollars) of 86.8 percent, and an Overturn Rate in Favor of Providers (in Number of Cases) of 80.2 percent.

This combination of overzealous contractors and a hopelessly backlogged appeals system has resulted in an oversight system that diminishes patient access, rather than maximizing it. As IRFs have payments withheld at higher rates due to technical denials, they must put funds in reserve to offset the withholdings until an appeal can be processed years later. Further, they must dedicate resources to complying with documentation requests and filing appeals with their contractors. This puts a strain on IRF funds that would otherwise be used to provide intensive rehabilitation services to Medicare beneficiaries. This trend is untenable and underscores the need for legislative action to address the issue of unduly burdensome audits and the resulting explosion in the number of Medicare appeals.

Proposals to Reduce IRF Payment Error Rates and Alleviate Provider Burdens That Threaten Access to Medically Necessary Rehabilitative Care

Reining in the most arbitrary documentation requirements on which auditors rely to deny claims would, over time, substantially reduce the strain that Medicare claims appeals are placing on our administrative law system, judicial system, and taxpayers. These types of reforms, such as limiting technical denials, would not result in Medicare paying for medically unnecessary care. Contractors should be prohibited from using isolated documentation or minor technical irregularities as the principal basis for denying payment for medically necessary services. This proposed change would prevent claims from being denied for perfunctory reasons such as failing to check a box on a form or documenting the post-admission one or a few hours late, unless they are systematic or can otherwise be shown to impact patient care.

To prevent contractors from engaging in abusive auditing practices, AMRPA urges Congress to amend section 1893(h) of the Social Security Act to eliminate the contingency fee structure for Recovery Audit Contractors (RACs). As noted above, this structure incentivizes inappropriate contractor behavior, such as opportunistic audits focused on minor technical flaws that deny payment for medically necessary care without regard to the actual appropriateness of the care provided or any evidence of improper intent or fraud.

In addition, Medicare contractors should be barred from conducting payment reviews based solely on statistical analyses when a provider demonstrates why its caseload is at variance with the applicable regional or national analyses. In recent years, Medicare contractors have increasingly audited cases citing statistical analysis as their rationale. For example, the contractor's letter may state that documents are requested because the provider exceeds the regional average for the particular types of cases audited, such a stroke. In reality, the multitude of factors that influence individualized post-acute care placement decisions are not conducive to an oversimplified and overgeneralized audit-by-number approach. Such statistical analyses merely demonstrate variation from a mean, not improper practices. Audits on this basis alone are therefore harassing, unwarranted, and add to the overall burden of a flawed recovery audit program.

Finally, to address the issue of excessive appeal wait times, AMRPA recommends that Congress enact legislation, such as the Audit & Appeal Fairness, Integrity, and Reforms in Medicare (AFIRM) Act, that would:

- provide additional resources for OMHA and the Departmental Appeals Board to increase the volume of adjudications and decrease processing times;
- penalize inaccurate contractors by reducing their ability to request additional documentation from providers;
- provide a one-year exemption from post-payment review of claims to providers that achieve a low rate of claims denials over a two-year period;
- establish a method to exempt compliant providers from audits; and
- reestablish the use of clinical inference and judgment by requiring claims reviews to be conducted or approved by physicians.

In addition, Congress should consider including in such legislation provisions that penalize contractors with high rates of denials overturned on appeal by subjecting them to reductions in their fees where there is a repeated pattern of overturned claims denials.

While these recommendations are not exhaustive, not only would these reforms help to address Medicare's broken claim review and audit system, and the years-long appellate backlog that has resulted, but they are in line with broader initiatives of this Committee to cut through red

tape, simplify regulations, and ultimately help make delivering health care to Medicare beneficiaries more efficient, clinically driven, and patient-centric.

* * *

In closing, AMRPA thanks and commends the Committee for its efforts to eliminate fraud, waste, and abuse in the Medicare program. We appreciate the opportunity to provide testimony for the hearing record and stand ready to work with the Committee on policies that reduce payment errors, preserve program resources, and promote access to medically necessary, quality rehabilitative care.

COUNCIL FOR MEDICARE INTEGRITY

July 25, 2017

Committee on Ways and Means
Oversight Subcommittee

To Whom It May Concern:

On behalf of the Council for Medicare Integrity, which works to ensure the future solvency of the Medicare Trust Fund for the 55 million Americans who rely on the program every day, we thank you for the opportunity to submit our statement for the record in response to the July 19th hearing entitled Efforts to Combat Waste, Fraud and Abuse in the Medicare Program.

As you are aware, Medicare loses more money to improper payments than any other program government-wide. The Recovery Audit Contractor (RAC) Program is a vital tool in the fight against such rampant misbilling.

A Medicare improper payment is made when a provider misbills a claim – billing to the wrong code, duplicating the submission of claims, failing to provide the needed documentation or even providing services that are not medically necessary. Over the past four years, **more than $166 billion has been lost from the Medicare program due to these types of preventable billing mistakes**.

Year	Medicare FFS CERT Billing Error Rate	Medicare Improper Payments By Year
FY2013	10.1%	$36 billion
FY2014	12.7%	$46 billion
FY2015	12.1%	$43 billion
FY2016	11.0%	$41 billion

Medicare Trustees have recently reported that at current spending levels the Part A Trust Fund faces insolvency in just 12 short years (2029). After that, Medicare will have to reduce coverage to 88 percent of what is covered today, relying solely on dwindling payroll deductions to fund the program. These coverage cuts will greatly impact the financial security of all current and future American seniors.

It's more important than ever that Medicare improper payments are reduced and the recovered dollars channeled back into the Trust Funds to prolong the life of the program.

Since the RAC Program began in 2009, recovery auditors have returned more than $10 billion in improper Medicare FFS payments to the Trust Funds and more than $800 million in underpayments to providers, all while reviewing fewer than 2 percent of all program claims. This work has extended the life of the Medicare program by two full years. Independent third-party validators, hired by CMS, have shown that recovery auditors consistently have an average accuracy rate of 96 percent.

Recently, the Centers for Medicare and Medicaid Services (CMS) chose to scale back the RAC Program – greatly reducing the amount of improper payments that can be identified, leaving billions in taxpayer dollars unrecovered. Currently, a Medicare provider can bill erroneously 91 percent of the time and yet only have 5 out of every 100 claims reviewed for accuracy.

Increase the Volume and Type of Claims Reviewed

Private health insurance payers generally have all claims reviewed for billing accuracy by an outside contractor both before and after they are paid. With Medicare however, CMS determines a set of billing issue areas/scenarios can be reviewed for accuracy and then sets the additional document request (ADR) limit, which determines the percentage of those claims that can be reviewed.

The contrast between Medicare auditing practices and the auditing conducted by private payers is startling. Despite the dire need to safeguard Medicare dollars, CMS currently allows RACs to **review fewer than 20 Medicare claim types** (down from 800 claim types previously) and now only allows auditors to review a mere 0.5 percent **of Medicare provider claims after they have been paid**. Considered a basic cost of doing business, the same providers billing Medicare comply, without issue, with the more extensive claim review requirements of private health insurance companies.

Given the state of Medicare solvency and the loss of more than $40 billion each year to improper payments, the number and type of claims that are reviewed for billing accuracy must be increased to recover more improper payments.

Similar to the state Medicaid waiver discussions, the audit scenario review process should also be revisited to create efficiencies and expedited processes to allow previously approved audit issue areas to be reapproved for review.

Add Prepayment Reviews

Like private payers, CMS can also leverage prepayment audits to catch billing mistakes before claims are paid. In 2012, a Recovery Audit Contractor Prepayment Review Demonstration Project was implemented in eleven states to audit a limited number of certain error-prone claim types before they were paid. The short demonstration was greatly successful, saving Medicare $192 million. Despite this success, the demonstration was paused in 2014 and never restarted.

For the past two years, the Government Accountability Office (GAO) has consistently urged CMS **to ask for the legislative authority to add a permanent Medicare prepayment review program to prevent improper payments from leaving the program erroneously**. The GAO has said that *"CMS may be missing an opportunity to better protect Medicare funds and agency resources."* Despite this, CMS has thus far declined to implement prepayment reviews.

As James Cosgrove, director, healthcare for the GAO, testified during the Ways and Means hearing, it would be beneficial for Congress to step forward to help further reduce improper payments by providing CMS with the authorization to implement a permanent RAC prepayment review program to allow claims to be reviewed for accuracy before they are paid – ensuring that our tax dollars are spent more efficiently.

Expanded Recovery Auditing Efforts Can Protect Medicare Solvency

Recovery auditing is a tool that's proven very successful for Medicare. Recovery audits are also budget neutral.

Recovery auditors are active partners with the federal government working hard to determine where Medicare billing problems exist and helping CMS drive discussions regarding which billing areas need to be a focus of concern and which do not.

RACs ensure that when billing errors are made, providers are educated to help reduce the likelihood those errors will be repeated. RAC reviews can also help prevent patients from being billed for unnecessary services and ensure that patients receive the right care in the right setting. Recovery audits have absolutely no direct impact on the Medicare providers working hard to deliver much needed healthcare services to beneficiaries. **RAC audits serve purely as an important financial safeguard for the Medicare program by ensuring payment accuracy.**

We thank you again for your consideration and ongoing efforts to improve oversight of this vital healthcare program. Our goal is to ensure that Medicare has a strong financial future for the millions of Americans who rely on the program.

Sincerely,

Kristin Walter

Kristin Walter
The Council for Medicare Integrity
www.medicareintegrity.org

About the Council for Medicare Integrity
The Council for Medicare Integrity is a 501(c)(6) non-profit organization. The Council's mission is to educate policymakers and other stakeholders regarding the importance of healthcare integrity programs that help Medicare identify and correct improper payments.

James Cosgrove's printed testimony at a recent subcommittee hearing ("Hearing on Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program") claims:

"CMS estimates that improper payments in MA totaled about $16.2 billion in fiscal year 2016, nearly 10 percent of CMS's payments to MAOs that year."

That statement is followed by a footnote. The footnote reads:

"See Department of Health and Human Services, FY 2016 Agency Financial Report (Washington, D.C.: Nov. 2016). In fiscal year 2016, CMS estimated that the net overpayments in MA (overpayments minus underpayments) were about $7 billion, or 4 percent."

It is clear that by making it a footnote, the GAO clearly did not want you to see the facts.

And if you read the report further you find that 70% of the 4% is associated with risk scoring and 30% is associated with typical government SNAFUs.

Since no one (specifically not the GAO) has found anything significantly wrong with risk scoring after 20 years of claiming risk adjustment is a problem (clearly not all risk adjustment is calculated incorrectly or is fraud), it is likely that incorrect risk adjustment calculating and reporting is about or less than 1% of public Part C health plan program spend. That's 1% too much in my opinion but to have the GAO beating on my non-profit Medicare health plan sponsored by a charity all the time while never saying a thing about the real problems in Original for-profit Democratic Party Medicare, where the net improper payment rate is 10% -- $40 billion -- and there are stories every day about massive fraud, is a perfect example of why we real people want the swamp drained.

Dennis Byron
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Dennis MA 02638
508-385-2517
(No fax)

I represent myself, a person on a public Part C health plan which Mr. or Ms. Cosgrove of GAO attacks constantly (while never analyzing fee for service Medicare)



Charles N. Kahn III
President and CEO

August 2, 2017

Representative Vern Buchanan
Chairman, Ways & Means Subcommittee on Oversight
2104 Rayburn House Office Building
Washington, D.C. 20515

RE: Clarifying Testimony Regarding Improper Payments in IRFs

Dear Chairman Buchanan:

The Federation of American Hospitals (FAH) is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Our members include teaching and non-teaching, inpatient, rehabilitation, long-term acute care, psychiatric, and cancer hospitals in urban and rural America, and provide a wide range of acute, post-acute and ambulatory services. The FAH appreciates the opportunity to submit this letter for the record in connection with the House Ways and Means Oversight Subcommittee's July 19 hearing, "Efforts to Combat Waste, Fraud, and Abuse in the Medicare Program."

The FAH believes it is important to clarify and provide additional context to the written testimony of Jonathan Morse, the Acting Director of the Center for Program Integrity within the Centers for Medicare & Medicaid Services (CMS). Specifically, the testimony stating that "improper payments for home health and Inpatient Rehabilitation Facility (IRF) claims were the largest contributors to the 2016 Medicare FFS improper payment rate," may be misunderstood. Mr. Morse correctly cautioned the Subcommittee against assuming that improper payments necessarily indicate bad actors, and further stated that improper payments "typically do not involve fraud" but instead involve technical coverage issues or medical necessity. However, the potential for a misunderstanding of his testimony warrants additional clarification.

IRF Medicare claims are uniquely susceptible to being swept up in Medicare's overall improper payment rate due to technicalities, varying Medicare contractor regulatory interpretations, and a significant backlog of appeals before the Office of Medicare Hearings and Appeals (OMHA). Unfortunately, however, the improper payment rate often inaccurately

characterizes our IRF members as treating patients who may not need their services, rather than entities treating complex Medicare beneficiaries under complex coverage and payment requirements. The following examples illustrate that the IRF improper payment error rate is arguably overstated.

IRFs Claims Must Adhere to a Myriad of Technicalities: IRFs must meet an unusually large number of both operational and patient admission requirements. IRF claims therefore are flagged and reviewed for technicalities that have nothing to do with a patient's actual need for, and ability to benefit from, IRF treatment. For example, timing of physician signatures (by as little as one hour or less), ambiguous board certification requirements arbitrarily imposed by contractors but not actually required by Medicare, or a patient's medication list deemed not "unique" to an IRF are minor technicalities that can result in a claim being wrapped up into an improper payment estimate without any relation to the necessity of the services provided.

Medicare Contractors Apply Unsupported Regulatory Interpretations: Medicare contractors (MACs, RACs, ZPICs, etc.) are charged with reviewing Medicare claims for erroneous payments, but they often justify their payment denials with interpretations of policies that have no basis or support in applicable laws or regulations. The IRF-specific "3-hour Rule" is a good example. This Rule stipulates that all IRF patients must receive and be reasonably expected to tolerate and benefit from at least 3 hours of intensive rehabilitation therapy. There are three "modes" of intensive therapy in an IRF: individual therapy (one-on-one with a therapist), concurrent therapy (two or more patients who are each receiving different therapy activities or interventions from a single therapist), or group therapy (where two or more patients are all performing the same therapy with a single therapist). CMS has only stated that the "preponderance" of intensive therapy must be in the form of individual therapy, but has not specified details beyond that standard. Nevertheless, Medicare contractors are applying their own definitions of "preponderance," causing significant confusion within IRFs about how long patients can receive therapy in each mode. Regardless of the patient's qualification for and benefit from IRF treatment, claims are being denied when the time allocation of a patient's therapy modes does not meet a contractor's interpretation of "preponderance."

Successful Appeals Are Not Reflected in IRF Improper Payment Rate: The improper payment rate does not adequately account for reversals of claims denials on appeal to OMHA. IRFs achieve better than a 70 percent overturn rate of such denials when they appeal such denials to Administrative Law Judges (ALJs). Yet the severe backlog of appeals awaiting an ALJ hearing at OMHA substantially distorts IRFs' claim denial rates. It currently takes years for an appeal to be heard at OMHA, thus preventing CMS from capturing its outcome in the improper payment estimate, even when the appeal is successful. Some of our IRF members have claim denials awaiting adjudication for services provided to Medicare beneficiaries dating back to 2008. Our IRF members strongly desire to have an opportunity to settle the thousands of IRF claim denials sitting in OMHA awaiting adjudication. If these successful appeals were accounted for in the improper payment estimate, the IRF improper payment rate would be much lower than published.

We understand the importance of examining improper payments in Medicare and the need to take steps to avoid such payments, and appreciate the Subcommittee's efforts in this area. However, discussion of the Medicare improper payment rate as related to IRFs must have appropriate context, with the recognition that many key factors contribute to a mischaracterization of the IRF improper payment rate, as discussed above. The reality is that IRF patients overwhelmingly receive medically necessary care, and a significant amount of IRF denials are based on technicalities, complex and misinterpreted Medicare policies, and a Medicare appeals backlog that prevents an accurate representation of improper payments.

We appreciate the opportunity to provide our views on these important matters, and look forward to working with the Oversight Subcommittee as it continues its efforts to ensure appropriate payments in Medicare.

Sincerely,



Partnership for Quality Home Healthcare

THERE'S NO PLACE LIKE HOME

The Honorable Vern Buchanan
Chair
Subcommittee on Oversight
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

The Honorable John Lewis
Ranking Member
Subcommittee on Oversight
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

August 2, 2017

Dear Chairman Buchanan and Ranking Member Lewis:

The Partnership for Quality Home Healthcare (PQHH) is pleased to submit these supplemental comments to your July 19 hearing entitled "Efforts to Combat Waste, Fraud and Abuse in the Medicare Program." The PQHH is a leading-edge organization of Medicare home health services providers, representing about 20 percent of the industry overall, and we take program integrity seriously.

We have a strong record of collaboration with both your committee and with CMS in bringing forth proposals to reduce or eliminate waste, fraud and abuse in the system. For instance, we have offered proposals that would simplify Medicare home health eligibility determinations, thereby making them less prone to error and/or categorization as "improper payments."

We have called for reduced subjectivity in the review of home health agency claims, possibly through the use of streamlined forms or a "check box" solution that cuts down on contractor confusion and the inappropriate labeling of *bona fide* home health claims as improper. In short, we believe a good way to reduce improper payments further in home health is to reduce subjectivity and improve standardization in the eligibility determination process, a policy option that would cut back on the number of payments deemed improper and reduce the backlog of Administrative Law Judge appeals.

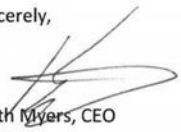
We note that the written testimony of Jonathan Morse, Acting Director of the Center for Program Integrity, Centers for Medicare Services, Mr. Morse asserted that improper payments for home health claims, along with claims for Inpatient Rehabilitation Facility services, were among the largest contributors to the 2016 fee-for-service improper payment rate of 11.0 percent.

The PQHH believes that that figure is artificially high, in part because home health agency claims are frequently mislabeled "improper" when in fact, they are the outgrowth of documentation errors that could be avoided if more streamlined and less subjective standards were applied to the eligibility determination process, which involves multiple writings from the physician that the beneficiary (1) is confined to the home; (2) in need of intermittent skilled care; and (3) had a face-to-face encounter with a physician before or immediately after the start of the home health episode.
While the PQHH does not contest these eligibility criteria for the home health benefit, we remain critical of the subjective nature in which they are applied by Medicare contractors, which in some instances will deem the same or similar claims "clean" and in others determine it is insufficient or improper.

The PQHH believes that a standardized system of forms, check boxes or attestations the physician can sign can help remove subjectivity at the contractor level, lower physician burden, and reduce the improper payment rate for home health services substantially, simply because such streamlined systems lower chances that documentation errors by physicians will result in "improper payments" to home health agencies.

We urge the committee and CMS to take our views into consideration as both continue their work to reduce waste, fraud and abuse in the Medicare program, and we welcome the opportunity to discuss our policy ideas for reducing improper payments in the Medicare home health program in greater detail at the committee's convenience.

Sincerely,



Keith Myers, CEO
LHC Group
Chairman, Partnership for Quality Home Healthcare
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Statement of the

SECURE ID COALITION

Before the

U.S. House of Representatives
Committee on Ways & Means
Oversight Committee

For the Hearing

Efforts to Combat Waste, Fraud and Abuse
in the Medicare Program

On

July 19, 2017

Comments of the Secure ID Coalition

The Secure ID Coalition is pleased to submit for the record to U.S. House of Representatives Committee on Ways & Means, Oversight Subcommittee hearing titled *Efforts to Combat Waste, Fraud and Abuse in the Medicare Program* the following statement.

Concerns about fraud, waste and abuse have plagued Medicare for over twenty years. According to the Centers for Medicare and Medicaid Services (CMS), the federal government spent over $569 billion on Medicare in 2015.[1] CMS reports the 'improper payments' rate – also known as waste, fraud and abuse – has risen to 10.5% of Medicare's cost, to over $59.7 billion per year. While some headway with the Fraud Prevention System (FPS) has been made in identifying and preventing fraud and false claims in FY15, it only accounts for $604.7 million – or 1.013% of the total amount of improper payments.[2] With total Medicare spending projected to increase by 5.6% per year over the next nine years, the FPS success is unfortunately reduced to nothing more than a rounding error in light of the bigger picture. More needs to be done.

Part of the problem is that the FPS data analytics helps Medicare contractors see trends in payment disparities, but much of the data is limited to claims for payment that have already been submitted, and even then, not in real-time. Critically, there are no safeguards in place to ensure that the claims are legitimate or that the claimants are really who they say they are, *before* the claims are submitted for payment. This kind of oversight is akin to a bank verifying the identities of those withdrawing funds days after the funds have been disbursed and the customer has left the parking lot.

The Secure ID Coalition proposes using a smart card to verify Medicare beneficiaries and providers at the point-of-care, before services have been provided. Based on the same chip technology used by the financial services industry to protect credit and debit cards, a smart Medicare card would be able to authenticate beneficiaries and providers in real-time at the front-end of a transaction, affirming the rightful beneficiary was present for a legitimate treatment or service. Such a verification would properly inform the CMS billing process, as the verification would be matched to the ultimate bill submitted by providers, creating an authenticated chain of trust.

Most government run healthcare programs around the world use a similar smart card based system to verify beneficiaries and providers in order to ensure that only actual services and treatments are paid.

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[1] Department of Health and Human Services Centers for Medicare & Medicaid Services, Improper Payments Information Act Report for FY2015. https://www.hhs.gov/afr/fy-2015-hhs-agency-financial-report/other-information-2.html. Accessed July 17, 2017.

[2] Department of Health and Human Services Centers for Medicare & Medicaid Services, Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year 2015. https://www.cms.gov/About-CMS/Components/CPI/Downloads/2015-final-rtc-06232017.pdf. Accessed July 17, 2017.

Smart Card Healthcare Deployment Data

State in Europe	Number of users	Number of users	Key Driver	e-Health eco system				Data base	Start roll out	Next gen (expected)	Main benefit			
	Patients	Health Professionals		PC	HPC	CR	PKI				Efficiency	Fraud	Privacy	Multi-appli-cation
Austria	6,000,000		Federal Chancellery	•		•	•	decentral	2006	2011	•	•	•	•
Bulgaria	t.b.d.	t.b.d.	MoH	t.b.d				t.b.d.	2017		t.b.d.			
France	60,000,000	250,000	MoH	•	•	•	•	decentral	1998	2007	•	•		
Germany	70,000,000		MoH	•	[1]	•	•	mixed	2011	2016	•	•	•	
Hungary	t.b.d.	t.b.d.	MoH	t.b.d.				t.b.d.	2017		t.b.d.			
Italy	55,000,000	250,000	MoI	•	•	•	•	mixed	2006	2010	•	•	•	•
Portugal	8,000,000		MoI	•		•	•	mixed	2007		•	•	•	•
Poland	35,000,000		National Insurance Organization	•		•		central	1996	2018	•	•		
Romania	21,000,000	100,000	National Insurance Organization	•	•	•	•	decentral	2013	2018	•	•		
Slovakia	5,000,000		MoH	•		•	•	decentral	2014		•	•		
Slovenia	2,000,000		MoH	•		•	•	mixed	2000	2010	•	•	•	
Spain		220,000	MoH		•		•	central	2005		•	•	•	
Switzerland	7,500,000		MoH	•		•	•	mixed	2010		•	•		
Turkey	(70,000,000)		MoH	•		•	•	mixed	2016		•	•		•
UK		200,000	MoH		•		•	central	2004		•	•	•	

t.b.d.= to be defined; MoH = Ministry of Health; MoI = Ministry of Interior; PC = Patient Card; HPC = Health Professional Card; CR = Card Reader; PKI = Public Key Infrastructure

While the use of back-end analytics is important in helping mitigate fraud, incorporating *preventative* fraud blocking mechanisms can help CMS further combat the problem of fraudulent and improper payments. In January 2016, the GAO reported that a modernized Medicare smart card could assist with fraud prevention and provide overall program savings. Based only on successfully prosecuted Medicare fraud cases, the GAO found that a smart Medicare card could have prevented almost a quarter of the fraudulent or improper payments. Since only a small percentage of fraud cases are put forward for prosecution, the actual amount of savings would be closer to sixty-percent, based on the cost savings of other national healthcare systems implementing smart beneficiary credentials.

A Medicare smart card would also help to strike at the heart of the opioid-related crime and public health crisis now facing our nation. The U.S. Department of Justice recently charged more than 400 people across the nation for healthcare fraud that cost the federal government over $1.3 billion in false Medicare and Medicaid billings, specifically by charging CMS for drugs that were never purchased – a problem that could have been prevented by authenticating the transaction and its participants prior to the transaction using a smart benefits card.

The Secure ID Coalition supports continued steps to better authenticate Medicare beneficiaries and providers are who they claim to be, as well as verifying that the services provided (and billed to CMS) have actually been received. Such a verification is another tool that CMS can use to incorporate better data into the Medicare program making it easier to limit fraud within the system. The implementation of a smart Medicare card not only benefits the taxpayer, but also the beneficiary's identity and privacy by encrypting the electronic transaction data.

Medicare faces many challenges, and in its current state, an uncertain future. Congress has the ability to prevent a significant portion of its funds from being stolen, using an inexpensive and well-trusted tool used world-wide by the healthcare and financial services industries to prevent fraud: the smart card. The Secure ID Coalition stands ready to assist the Subcommittee, and answer any questions it may have.

About the Secure ID Coalition

A non-profit founded in 2005, the Secure ID Coalition (SIDC) works with industry experts, public policy officials, and Federal and state agency personnel to promote identity policy solutions that enable both security and privacy protections. Because of our commitment to citizen privacy rights and protections we advocate for technology solutions that enable individuals to make decisions about the use of their own personal information. Members of the Secure ID Coalition subscribe to principles that include the increased deployment of secure identity solutions, as well as advise on and advocate for strong consumer privacy protections and enhanced security to reduce waste, fraud, theft and abuse. Our mission is to promote the understanding and appropriate use of technology to achieve enhanced security for ID management systems while maintaining user privacy.

To learn more about the Secure ID Coalition, please visit us at www.SecureIDCoalition.org.

SECURE COALITION ID
Protecting Identity with Technology

Strengthening National Economic Security by Securing Citizen Identity

Fulfilling the Trump Administration Agenda Through Strong Identity Authentication

Putting an End to Medicare & Medicaid Fraud.
According to a GAO report in October 2015, the cost to American taxpayers for Medicare and Medicaid improper payments due in part to waste, fraud, and abuse increased to $78 billion in 2014, despite increased efforts to identify fraud on the back end. And it's only getting worse.

The problem – and its solution – lies within the Medicare card itself.
The current Medicare card is an insecure paper document with the beneficiary's Social Security number printed on the front. Under the current system, Medicare payment transactions are sent to HHS Center for Medicare and Medicaid Services (CMS) without any verification or assurance that beneficiaries received care. The weak Medicare card and associated payment policy, known as 'pay-and-chase' for the way Medicare deals with fraud, is the primary reason that taxpayers continue to lose tens of billions of dollars each year. According to a 2016 GAO report, twenty-two percent of prosecuted fraud could have been impacted using a secure smart Medicare card.

A Medicare smart card will be a game-changer. Beneficiaries would receive a secure smart card with their protected identification information encrypted in the chip's embedded micro-processor. The chip ensures that the card can't be tampered with or forged, that the device used to read it is legitimate and the person claiming the benefits is the one to whom the card was issued. This means only approved Medicare providers and suppliers with authorized card readers, like those used for financial services, would be able to access seniors' patient information and bill for Medicare service.

Furthermore, by combining the smart card with a PIN code, CMS would have complete confidence in the legitimacy of the transactions, and any lost or stolen cards would be remotely deactivated in real time. Moreover, the Social Security number of the beneficiary is stored on the chip and is never accessible to an unauthorized party, preventing the risk of identity theft. When access to this information is required, it is only possible upon successful authentication of the parties and takes place in form of a cryptogram, similarly to the way a payment transaction is processed using a chip-based credit card.

Good news for doctors as well as taxpayers.
Several reports have shown smart cards' ability to reduce administrative burdens on providers, allowing them to access health data more quickly and securely while also reducing health record redundancies and errors. Because a Medicare smart card would authorize transactions on the front-end, it would likely decrease the amount of time it will take for CMS to process transactions, meaning doctors can be paid faster and would also reduce the need for recovery auditors. Such a system, incorporating a secure electronic card, would complement the current back-end analytic verification system with real-time front end data.

Strengthening Medicaid.
States would similarly benefit from a transition to a smart Medicaid card that would enable positive identification and assurance that they are truly serving their citizens. Whether the Federal government continues with picking up a fixed percentage of states' Medicaid costs (about 57%) or it moves to a Medicaid block grant to slash federal funding, the provision of Federal funds can be predicated upon the implementation of a smart Medicaid ID to reduce the waste, fraud and abuse endemic in those programs.

An Ally in the Fight Against Opioid Abuse. Additionally, a secure digital Medicare credential could also be used to aid in the reduction of opioid abuse, by including drug prescription authorization in the credential to identify legitimate transactions. This will also allow authorities to identify doctors and pharmacists who are writing and fulfilling excessive scrips.

The SIDC's recommendations are form-factor agnostic – how the credential will be issued is a policy decision for the issuing agency, based on factors such as business needs, threats and vulnerabilities, security risk assessment, ease-of-use for their constituency, and ease-of-issuance for the organization.

HEALTHCARE REFORM

MEDICARE WASTE, FRAUD & ABUSE

FIRST in a seven-part series

The foundation of a nation's economic growth is confidence – not only in its institutions, but in those who use them. The Secure ID Coalition highly recommends the use of multiple factors of authentication in every application that needs a positive citizen identification to access rights, benefits, or entitlements. Government needs to change the paradigm of how identity is approached, from self-asserted identity (user-name/password) to strong authentication by hardware-backed automatic processing of transactions. This paper is one of a seven-part series, highlighting key national programs that would benefit from better identity assurance with strong authentication.

To download the full white paper, *Strengthening National Economic Security by Securing Citizen Identity*, please visit us at www.SecureIDCoalition.org