STATEMENT OF

PETER BUDETTI, M.D., J.D.
DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR PROGRAM INTEGRITY,
CENTERS FOR MEDICARE & MEDICAID SERVICES

AND

LAURENCE D. WILSON
DIRECTOR
CHRONIC CARE POLICY GROUP, CENTER FOR MEDICARE
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

"OVERSIGHT AND BUSINESS PRACTICES OF DURABLE MEDICAL EQUIPMENT COMPANIES"

BEFORE THE

U. S. SENATE COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS, SUBCOMMITTEE ON FINANCIAL AND CONTRACTING OVERSIGHT

APRIL 24, 2013

U.S. Senate Committee on Homeland Security and Governmental Affairs, Subcommittee on Financial and Contracting Oversight

Oversight and Business Practices of Durable Medical Equipment Companies

April 24, 2013

Chairman McCaskill, Ranking Member Johnson, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce wasteful spending for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Thanks to an aggressive and multifaceted strategy to address DMEPOS fraud, waste, and abuse, per-capita DME spending has declined almost 10 percent from 2008 to 2011 without any loss of access of quality for Medicare beneficiaries.[1] Total DME spending has also decreased; in 2011, Medicare DME spending totaled $7.8 billion, down 6 percent from $8.3 billion in 2008.[2] CMS is pursuing a comprehensive strategy to further reduce the fraud, waste and abuse that result in improper payments by reimbursing suppliers at market rates through the DMEPOS competitive bidding program; preventing improper expenditures through the Power Mobility Device (PMD) prior authorization demonstration; screening DMEPOS suppliers to root out bad actors; and a program integrity strategy centered on prevention and partnering with law enforcement. Through these initiatives and new tools provided by the Affordable Care Act, CMS is working to ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program's DMEPOS benefit.

Background

CMS is the largest purchaser of health care in the United States, and each year the Medicare program, beneficiaries, and taxpayers spend billions of dollars for DMEPOS for millions of Medicare beneficiaries. Yet, the current Medicare DMEPOS benefit is plagued by an obsolete fee schedule methodology, grossly inflated prices, and a well-documented proliferation of fraudulent practices fueled by these inflated prices. With the exception of the nine areas in Round 1 of the program where competitive bidding is now in effect, CMS is statutorily required

[1] See "HRR Table – All Beneficiaries," available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html

[2] See "HRR Table – All Beneficiaries," available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/index.html

to pay for DMEPOS items and services using fee schedule rates for DMEPOS items in Medicare Part B. In general, the statute requires that fee schedule rates are calculated using historical supplier charge data from more than 20 years ago that are often much higher than current market prices. As a result, Medicare payment rates are often higher than the prices paid by non-Medicare customers for identical items and services. Medicare beneficiaries and taxpayers bear the cost of these inflated fee schedule rates. The Department of Health and Human Services' Office of Inspector General (OIG), the Government Accountability Office (GAO), and other independent analysts have repeatedly warned that the fee schedule prices paid by Medicare for many DMEPOS items are excessive, as much as three or four times the retail prices and amounts paid by commercial insurers or customers who purchase these items on their own. These inflated prices in turn increase the amount beneficiaries must pay out-of-pocket for these items in the form of deductibles, co-insurance, and premiums and help fuel the well-documented proliferation of DMEPOS fraud, waste, and abuse. For example, CMS noted in a 2011 report[3] that over 80 percent of claims for power mobility devices in the Medicare fee-for-service program, representing approximately $492 million, did not meet Medicare coverage requirements.

DMEPOS Competitive Bidding Program

The DMEPOS competitive bidding program is one of the most powerful tools in CMS' arsenal to reduce DMEPOS spending and provide greater value to the Medicare program, beneficiaries and taxpayers. It is projected to save the Medicare Part B Trust Fund $25.8 billion and beneficiaries $17.2 billion over ten years.[4] The program works by establishing Medicare's DMEPOS payments based on competitive market pricing, thereby reducing beneficiary out-of-pocket costs, program outlays, and suppliers' incentive to fraudulently bill Medicare for DMEPOS. This year, building on the program's initial successes, CMS will expand DMEPOS competitive bidding from nine initial sites in the Round 1 Rebid to an additional 91 metropolitan areas for Round 2. Moreover, prices for diabetic testing supplies nationwide will be set based on a national mail-order competition.

[3] Medicare Fee-for-Service 2011 Improper Payments Report, available at http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

[4] FY 2014 Congressional Justification, Page 38. Available at http://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2014-CJ-Final.pdf

Congress established the Medicare DMEPOS Competitive Bidding Program in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L. 108-173). The program was modeled after the successful demonstration projects in Polk County, Florida and San Antonio, Texas between 1999 and 2002, which resulted in 20 percent savings for Medicare and beneficiaries without any negative impact on access to equipment or quality of care for beneficiaries. Under the MMA, the DMEPOS Competitive Bidding Program was to be phased into Medicare so that competition under the program would initially begin in 10 metropolitan statistical areas (MSAs) in 2007. Consistent with the statutory mandate, CMS conducted the Round 1 competition in 10 areas and for 10 DMEPOS product categories, and implemented the program on July 1, 2008. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P.L. 110-275) delayed the start of the program. MIPPA terminated the Round 1 contracts that were in effect and reinstated fee schedule payment rates, required rebidding of the first round at a later date, and imposed a nationwide 9.5 percent payment reduction for all Round 1 items in 2009.

CMS implemented the Round 1 Rebid of the competitive bidding program in nine MSAs on January 1, 2011, covering nine DMEPOS product categories and awarding 1,217 DMEPOS competitive bidding program contracts to 356 suppliers. All contract suppliers were thoroughly vetted during bid evaluation to ensure that they were in good standing with Medicare and met Medicare enrollment rules, quality and financial standards, and accreditation and state licensure requirements. CMS also screened and evaluated all bids to ensure that they were bona fide and based on real supplier costs. Only qualified bidders with bona fide bids were offered contracts. The bid evaluation process ensured that there would be more than enough suppliers, including small business suppliers, to meet the needs of the beneficiaries living in the competitive bidding areas (CBAs). Approximately 51 percent of the winning suppliers from the Round 1 Rebid are small business suppliers, well exceeding the 30 percent goal established by CMS. Ninety-two percent of suppliers that were offered a contract accepted the contract terms.

CMS has closely monitored the results of the competitive bidding program since implementation to ensure that savings goals of the program have been achieved and – more importantly – to

ensure that beneficiary access to appropriate supplies and equipment has not been compromised. To ensure effective monitoring, CMS implemented a real-time claims monitoring system which analyzes the utilization of the nine product categories. CMS' claims monitoring system was designed to pay particular attention to potential changes in key secondary indicators such as hospital admissions, emergency room visits, physician visits, and admissions to skilled nursing facilities before and after the implementation of the new payment model. For the first year of the program, CMS' real-time claims monitoring and subsequent follow-up has indicated that beneficiary access to all necessary and appropriate items and supplies has been preserved in the nine CBAs.

Moreover, CMS' monitoring revealed the competitive bidding program may have curbed previous inappropriate distribution of these supplies. For example, when CMS' monitoring showed declines in the use of mail-order diabetes test strips and Continuous Positive Airway Pressure (CPAP) supplies in the CBAs, CMS initiated three rounds of outbound phone calls to users of these supplies in the nine CBAs: two rounds of calls for users of mail-order diabetes test strips and one round of calls to users of CPAP supplies. In each round, CMS staff randomly identified 100 beneficiaries who used the items before the program began but had no claims for the items in 2011. The calls revealed that in virtually every case, the beneficiary reported having more than enough supplies on hand, often multiple months' worth, which would suggest that beneficiaries had historically received excessive replacement supplies before they were medically necessary.

The DME competitive bidding program is already generating significant savings for the Federal government and the approximately 2.3 million Medicare fee-for-service beneficiaries residing in the areas where competitive bidding is in effect. According to CMS's analysis of claims from 2010 and 2011, the competitive bidding program has reduced DMEPOS spending by approximately $202.1 million—or 42 percent overall—in the nine Round 1 Rebid areas.[5] The program has significantly reduced payment amounts, with an average price reduction of 35 percent from the fee schedule. For example, if Medicare suppliers in the nine CBAs had instead

[5] Competitive Bidding Update—One Year Implementation Update, available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf

been paid the 2011 Medicare fee-schedule amounts, Medicare suppliers would have been paid $173.31 per month for stationary oxygen equipment (e.g., oxygen concentrators), of which the beneficiary would have paid 20 percent in cost-sharing. (The supplier would have received $2,079.72 over the course of the year, of which the beneficiary would have paid $415.94 in cost-sharing.) Under the competitive bidding program, the average Medicare allowed monthly payment amount for stationary oxygen equipment in the nine competitive bidding areas has been reduced by 33 percent from $173.31 to $116.16. Further, a beneficiary's cost-sharing responsibility for stationary oxygen equipment rental for a year has been reduced by an average of $137 in the nine areas.

Building on the success of the Round 1 Rebid, CMS announced in August 2011 the expansion of the competitive bidding program, as required by MIPPA and the Affordable Care Act,[6] to 91 additional areas for Round 2. In addition to the items included in the Round 1 Rebid, CMS expanded the list of items bid by combining standard manual wheelchairs, standard power wheelchairs, and scooters to form a new expanded standard mobility device product category; expanded bidding for support surfaces throughout all Round 2 areas; and added negative pressure wound therapy pumps and related supplies and accessories as an additional product category. CMS also conducted a national mail-order competition for diabetic testing supplies at the same time as Round 2. The national mail-order competition includes all 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

On January 30, 2013, CMS announced the new payment rates for the eight product categories included in Round 2 of the DMEPOS competitive bidding program—prices that are, on average, 45 percent less than Medicare's current fee schedule amounts, and 72 percent less for mail-order diabetic supplies. As with Round 1 of the program, competitive bidding will yield significant savings for Medicare, beneficiaries, and taxpayers. For example, Medicare suppliers are currently paid based on fee schedule amounts that average $77.90 per month for mail-order diabetic testing supplies (100 lancets and test strips), of which the beneficiary pays 20 percent

[6] MIPPA required competition for Round 2 of the program to be conducted in 2011 in 70 additional MSAs. The Affordable Care Act (P.L. 111-148 and P.L. 111-152) subsequently expanded the number of Round 2 MSAs from 70 to 91 and mandates that all areas of the country be subject either to DMEPOS competitive bidding or payment rate adjustments to the fee schedule using competitively bid rates by 2016.

(approximately $15.58 per month on average). Under the competitive bidding program, the average Medicare allowed monthly payment amount for these supplies will be reduced from $77.90 to a national rate of $22.47.

CMS announced 13,126 Round 2 DMEPOS competitive bidding contracts to 799 suppliers, as well as contracts to 18 mail-order diabetic testing suppliers, on April 9, 2013. As in Round 1, supplier participation is robust. Ninety-two percent of suppliers offered contracts at the competitive bidding prices accepted them, and 63 percent of contract suppliers participating in Round 2 are small businesses. As the DMEPOS competitive bidding program expands, it will contribute to significantly lower costs for taxpayers and beneficiaries.

Prior Authorization for PMD Demonstration

CMS is also moving aggressively to address concerns about fraud related to power mobility devices (PMDs). PMDs are a group of DMEPOS such as power wheelchairs and power operated vehicles (scooters). On September 1, 2012, CMS implemented a prior authorization demonstration for all PMD orders written on or after that date in seven states with high incidences of fraud and error prone providers.[7] The demonstration requires prior authorization, or pre-approval, for PMDs for Medicare beneficiaries who reside in these states (California, Illinois, Michigan, New York, North Carolina, Florida and Texas), helping ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines.

This approach to protect the Medicare Trust Funds is drawn from the private sector. Prior authorization is currently being used by private insurance for many services and items including PMDs, as well as in other health care programs such as TRICARE and in certain State Medicaid programs. However, unlike some other prior authorization programs, CMS' PMD demonstration

[7] These seven states accounted for 43% of the roughly $606 million spent annually on PMDs. See *Prior Authorization of Power Mobility Devices (PMD) Demonstration Executive Summary*, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/PMD_PowerpointExecutiveSummary_v3.pdf

program does not automatically deny payment for a PMD if it did not go through prior authorization.[8]

With prior authorization, suppliers and beneficiaries will know before an item is delivered to a beneficiary whether Medicare will pay for the PMD. This helps ensure that Medicare pays only for PMDs that meet the longstanding coverage requirements, thereby limiting fraud, waste and abuse. Further, suppliers and beneficiaries will know before the item is delivered if they will have to pay for the item. Currently, in many cases, if an item is not covered, Medicare beneficiaries have to pay for the entire cost of the item because the PMD is delivered to the beneficiary and then Medicare denies the payment because the coverage criteria has not been met.

Prior authorization is another important tool that will help CMS to reduce fraud and improper payments for PMDs, while continuing to ensure that beneficiaries have access to needed durable medical equipment.

Provider, Supplier, and Claims Screening

While programs like DMEPOS competitive bidding and the PMD prior authorization demonstration are working to bring the rates Medicare pays for DMEPOS in line with market rates and ensure PMD billing is medically necessary, CMS is also using program integrity tools to screen providers, suppliers, and DMEPOS claims.

New Tools in the Affordable Care Act

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in the Medicare and Medicaid programs and the Children's Health Insurance Program (CHIP), and CMS put these additional requirements in place for newly enrolling and revalidating Medicare providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically

[8] If a supplier submits a PMD claim without first seeking prior authorization, the claim will undergo prepayment review. As part of the review process, the DME MAC sends letters to the supplier requesting all documents to support the claim. Once the supplier has submitted all the necessary documentation, the DME MAC conducts a review of the documentation within 60 days. This is the standard time frame for prepayment review. If the DME MAC determines payment is appropriate, the payment is processed.

posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation of billing privileges in Medicare, Medicaid, and/or CHIP. Using our new authority, CMS has designated newly enrolling DMEPOS suppliers to the high level of screening prior to enrollment, meaning all new DMEPOS suppliers will receive an announced or unannounced site visit, and will be subject to a fingerprint-based criminal history record checks prior to enrollment once CMS procures an FBI-approved contractor.[9] Current DMEPOS suppliers are designated to the moderate level of screening, and receive an announced or unannounced site visit before the revalidation of their billing privileges. Categories of providers and suppliers in all screening levels are subject to database checks that verify licensure and that a provider or supplier meets all applicable Federal regulations and State requirements.

The Affordable Care Act also required CMS to screen all of the existing 1.5 million Medicare suppliers and providers under these new screening requirements. CMS embarked on an ambitious project to revalidate the enrollment information of all existing providers and suppliers, and these efforts will ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Since March 2011, CMS approved for enrollment nearly 458,435 Medicare providers and suppliers, including 30,105 DMEPOS suppliers, under these enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 159,449 enrollments, including 24,880 DMEPOS enrollments, and revoked 14,009 enrollments, including 1,753 DMEPOS enrollments.[10]

Additionally, the number of DMEPOS suppliers enrolled in Medicare has declined approximately 14 percent over the past six years with no loss of access to DMEPOS for Medicare beneficiaries. The most significant factor in this reduction is the requirement that DMEPOS suppliers become accredited and possess a surety bond of at least $50,000—that is, a bond issued by an entity (the surety) guaranteeing that a DMEPOS supplier will fulfill their financial obligations to Medicare. The surety bond requirement, included in the Balanced

[9] CMS expects to release a contract request to provide the fingerprinting and background checks in spring 2013 with an anticipated award date in late 2013.

[10] "Deactivate" means that the provider or supplier's billing privileges were stopped, but can be restored upon the submission of updated information. Revoke means that the provider or supplier's billing privileges are terminated and cannot be reinstated.

Budget Act of 1997 (P.L. 105-33) and in a Final Rule promulgated by CMS on January 2, 2009, required new DMEPOS suppliers to obtain a surety bond by May 4, 2009 and enrolled suppliers by October 2, 2009. Based upon these new requirements, 10,533 DMEPOS suppliers were revoked between October 2009 and December 2009.[11] In addition to those revoked, approximately 1,500 more suppliers voluntarily terminated their enrollment between September 2009 and December 2009, likely to avoid facing revocation actions until they could procure a surety bond or obtain accreditation. Evidence indicates that despite these reductions in DMEPOS supplier enrollment, beneficiaries continue to have access to the DMEPOS they need.

The National Supplier Clearinghouse

CMS uses a variety of contractors to administer and oversee the Medicare fee-for-service program. Each of these contractors has different roles and responsibilities. Some contractors assist CMS in screening providers and suppliers; others combat fraud and identify improper payments. CMS has one dedicated contractor, the National Supplier Clearinghouse (NSC), to receive, review, and process applications from organizations and individuals seeking to become DMEPOS suppliers in the Medicare program. NSC's process involves implementing safeguards to ensure only legitimate suppliers enter and remain in the Medicare program, and includes announced and unannounced site visits to prospective suppliers to determine that they meet required supplier standards; checking that the supplier has all applicable licenses; checking that the supplier and its principals are not excluded from participating in Federal programs by virtue of being on General Service Administration (GSA) or OIG excluded lists; and checking that the supplier meets accreditation and surety bond requirements.

Stopping fraud and abuse also includes monitoring DMEPOS suppliers. The NSC assigns fraud level indicators to assist in its expanded reviews of suppliers, which include increased unannounced on-site reviews, license expiration checks, and phone calls to suppliers. The NSC also coordinates and assists in fraud-fighting efforts with CMS, law enforcement, and other contractors on an ongoing basis.

[11] Due to the large number of last minute filings, 2,803 of those revocations were subsequently overturned as suppliers were able to demonstrate compliance with both requirements.

Durable Medical Equipment Medicare Administrative Contractors

In addition to having a contractor dedicated to screening only DMEPOS suppliers in the Medicare program, CMS also contracts with entities dedicated to screening and analyzing DMEPOS claims. The Durable Medical Equipment Medicare Administrative Contractors (DME-MACs) process claims and handle the first level of providers' claims appeals. They implement all Medicare payment system changes, and conduct training and outreach regularly to suppliers to educate them on proper claims coding and new Medicare payment policies. While DME-MACs focus on claims processing, they also play important roles in CMS' anti-fraud efforts. For instance, DME-MACs put automated edits in place to identify and address claim coding errors, mutually exclusive claims, or medically unlikely claims. They regularly analyze claims data received to identify suppliers with patterns of errors or unusually high volumes of particular claims types, and to develop additional prepayment edits. They also coordinate the timing and implementation of these edits with other contractors. When DME-MACs identify potential fraud, they send leads to antifraud contractors to investigate further.

A New Approach to Program Integrity

Beyond CMS' programs to pay DMEPOS suppliers market rates and screen providers and suppliers, CMS is using other new approaches to prevent DMEPOS fraud. CMS' approach involves pre-payment claims screening, targeted use of contractors for essential program integrity functions, and partnership with law enforcement to investigate fraud.

Zone Program Integrity Contractors (ZPICs)

Zone Program Integrity Contractors (ZPICs) help CMS perform a variety of program integrity functions at a regional level.[12] They are dedicated exclusively to the prevention, detection, and recovery of potential fraud, waste, or abuse, and coordinate with their contractor partners to implement administrative actions, including claim edits, payment suspensions, and revocations. ZPICs also refer overpayments for collection.

[12] Six of the seven ZPICs have been awarded.

The ZPICs' main responsibilities are to:

- Investigate leads generated by the new Fraud Prevention System (FPS) and a variety of other sources;
- Perform data analysis to identify cases of suspected fraud, waste, and abuse;
- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars;
- Make referrals to law enforcement for potential prosecution;
- Provide support for ongoing investigations;
- Provide feedback and support to CMS to improve the FPS; and
- Identify improper payments to be recovered.

The Fraud Prevention System

On June 30, 2011, CMS launched the Fraud Prevention System (FPS). Created under the Small Business Jobs Act of 2010, the FPS analyzes all Medicare fee-for-service claims, including DMEPOS claims, using risk-based algorithms developed by CMS and the private sector, prior to payment, allowing CMS to take prompt action where appropriate. CMS uses the FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. For example, ZPIC investigators formerly had to check multiple systems to determine whether a beneficiary ever visited the doctor who billed Medicare for services and supplies. The FPS has consolidated the dispersed pieces of potentially-related claims data – beneficiary visits with a doctor or orders for DMEPOS billed under Part B, and hospital and other provider services billed under Part A – enabling CMS and the ZPICs to automatically see the full picture.

Importantly, the FPS is a resource management tool; the system automatically sets priorities for the ZPICs workload to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts in priority order, allowing program integrity analysts to quickly investigate the most egregious, suspect, or aberrant activity. CMS and the ZPICs use the FPS information to identify, stop, and prevent improper payments utilizing a variety of administrative tools and actions, including pre-payment

review, claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement.

Early results from the FPS show significant promise and CMS expects results to increase as the system matures over time. As reported in our Report to Congress,[13] in its first year of implementation, the FPS:

- Prevented or identified an estimated $115.4 million in improper payments;
- Achieved a positive return on investment, saving an estimated $3 for every $1 spent in the first year;
- Generated leads for 536 new fraud investigations;
- Provided new information for 511 existing investigations; and
- Triggered 617 provider interviews and 1,642 beneficiary interviews regarding suspect claims or provider activity.

The ZPICs' workload also incorporates lessons learned from the DME Stop Gap project, which was developed in response to the escalation in DMEPOS fraud and the delay in implementation of DMEPOS competitive bidding mandated by MIPPA. This two-year project was initiated in FY 2009 to enhance detection and prevention activities in connection with fraud, waste and abuse in DMEPOS in seven States (California, Florida, Illinois, Michigan, North Carolina, New York and Texas). The project was intended to address fraud involving high risk suppliers, ordering physicians, DMEPOS items, and beneficiaries in each area. Under this project, CMS and its contractors first identified and then interviewed or conducted site visits to the highest paid and highest risk DMEPOS suppliers, ordering physicians, and utilizing beneficiaries, allowing CMS to identify and scrutinize the highest billed and highest risk DMEPOS equipment and supplies. Based on the findings, appropriate administrative actions were initiated. The second year of the project concluded on September 30, 2011 and the results to date include onsite interviews and reviews of 5,371 high risk providers, suppliers, and beneficiaries; implementation of 15,470 claims processing edits to prevent improper payment (with associated $36.4 million in denied claims); $69 million in requested overpayments; 1,240 new investigations opened; and

[13] Report to Congress: Fraud Prevention System First Implementation Year 2012 http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

479 suppliers revoked or deactivated. As a result of the success of this project, all lessons learned have been incorporated into the ZPIC core functions related to combating fraud, waste and abuse in DMEPOS suppliers.

Recovery Audit Contractors (RACs)

The Recovery Audit Contractors are tasked with identifying a wide range of improper payments – including, but not limited to fraud – and making recommendations to CMS about how to reduce improper payments in the Medicare program. In the fee-for-service Medicare program, RACs have identified several vulnerabilities where CMS has implemented corrective actions to prevent future improper payments. For example, CMS' contractors have implemented edits to stop the payment of claims provided after a beneficiary's date of death, stop the payment of durable medical equipment claims while the beneficiary is receiving care in an inpatient setting, and stop the payment for individual services that should have been bundled into another payment. In the past, RAC reviews in Medicare have focused on incorrect coding, erroneous billing practices, and billing for the wrong setting of care. Unlike other Medicare program integrity contractors, RACs' reviews are more likely to identify overpayments from providers who are still enrolled and billing in Medicare. If RACs identify or uncover potential fraud, they are required to report it directly to CMS, and to refrain from reviewing claims that are subject to an ongoing fraud investigation. In FY 2012, Medicare fee-for-service RACs collected nearly $2.3 billion in overpayments.

Partnership with Law Enforcement

CMS is also collaborating in an unprecedented way with the private sector, law enforcement, and our State partners to develop best practices in our fight against health care fraud. At the Command Center, for example, advanced technologies and a collaborative environment allow multi-disciplinary teams of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. Since its official establishment on July 31, 2012, CMS has led 61 missions that included over 450 unique participants from CMS and our partners, including the OIG and the Federal Bureau of Investigations (FBI) in the new Command Center. These collaborative activities enable CMS to take administrative actions, such as revocations of

Medicare billing privileges and payment suspensions, more quickly and efficiently. CMS is also working with other Federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud prevention.

In addition, joint investigations by the Department of Justice (DOJ), CMS, and OIG have yielded significant recoveries for the Medicare fee-for-service program. Since its creation in May 2009, Health Care Fraud Prevention & Enforcement Action Team (HEAT), has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud data intelligence sharing workgroup. In recent years, numerous DMEPOS suppliers have been charged and convicted of defrauding the Medicare program and many have had their Medicare billing privileges revoked as a result of OIG investigations. Examples include the 20 DMEPOS company owners and marketers, most of them in the Los Angeles area, who were charged in 2009 with allegedly billing Medicare for more than $26 million in fraudulent claims for power wheelchairs, orthotics, and hospital beds.[14] More recently, a Louisiana man was sentenced to 180 months in prison for participating in a health care fraud scheme that defrauded Medicare of more than $21 million by billing for power wheelchairs, leg and arm braces, and other durable medical equipment that was never provided to beneficiaries and/or were not medically unnecessary.[15]

CMS' collaborative approach to fraud-fighting is paying off. In fiscal year (FY) 2012, fraud detection and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of $4.2 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers. Over the last three years, the average return on investment of the HCFAC program is $7.90 for every dollar spent. Since 1997, HCFAC activities have returned more than $23 billion to the Medicare Trust Funds.

[14] http://oig.hhs.gov/oei/reports/oei-04-09-00260.asp
[15] http://www.justice.gov/opa/pr/2012/August/12-crm-1032.html

Conclusion

Effective administration of the Medicare DMEPOS benefit is an essential part of CMS' mission to ensure the health care security of millions of Medicare beneficiaries. While the DMEPOS benefit has long been a source of waste and fraud, aggressive approaches that that bring Medicare payments for DMEPOS in line with market rates, that safeguard against erroneous DMEPOS billing, and that prevent inappropriate suppliers from enrolling are making DMEPOS less attractive to fraudsters and lowering Medicare's DMEPOS expenditures. The 42 percent reduction in DMEPOS expenditures over the competitive bidding program's first year is a testament to the success that can be achieved when CMS and Congress partner together to safeguard the Medicare Trust Funds. CMS is committed to addressing concerns about improper payments and fraud related to the Medicare DMEPOS benefit, and ensuring that our contractors quickly identify and correct improper payments and potential fraud. That is why, in addition to competitive bidding, CMS is transforming its approach to program integrity, focusing on preventing fraud before it happens. I look forward to working with this Subcommittee and the Congress to continue CMS' progress in modernizing the way Medicare pays for and monitors the DMEPOS benefit.