TESTIMONY OF
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IN THE
CENTERS FOR MEDICARE & MEDICAID SERVICES
ON
MEDICARE AND MEDICAID IMPROPER PAYMENTS
BEFORE THE
SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION AND INTERNATIONAL SECURITY
JULY 12, 2005

Chairman Coburn, Senator Carper, distinguished Subcommittee members, thank you for inviting me here to discuss the Centers for Medicare & Medicaid Services (CMS) initiatives to reduce improper payments in the Medicare and Medicaid programs. At CMS, we consider ourselves a leader in engaging in activities to identify, reduce and recover improper payments in Medicare and Medicaid.

Today, I would like to give you some background on the Medicare, Medicaid and SCHIP programs, and then discuss the types of payment errors we are finding and our proposed actions for reducing the occurrence of errors. Finally, I will discuss briefly some of the challenges we face complying with the Improper Payments Information Act of 2002 (IPIA). It is important to note that because my testimony focuses on our efforts to identify incorrect or erroneous payments and not on CMS fraud and abuse efforts, the improper payments I will be discussing are generally not due to bad actors but rather other types of errors.

Background on Medicare and Medicaid

Medicare is a Federal health insurance program that provides medical insurance to 42 million people. About 36 million individuals are entitled to Medicare because they are over the age of 65 and about 6 million beneficiaries who are under age 65 are entitled because of disability; those under age 65 generally begin to get Medicare when they have been receiving Social Security disability cash benefits for 24 months. Total Medicare spending for 2005 is estimated to be about $328 billion.

The majority of Medicare spending is for fee-for-service hospital and physician services. The fee-for-service component of Medicare also covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. This fee-for-service component of Medicare is administered by CMS through contracts with private companies that process claims for Medicare benefits. During 2005, CMS estimates that Medicare contractors will process well over one billion claims (1.156 billion claims) from providers, physicians, and suppliers for items and services that Medicare covers. Specifically, CMS administers the claims processing and payment systems for Medicare through contracts with Carriers, Durable Medical Equipment Regional Carriers (DMERCs), Fiscal Intermediaries (FIs), and Quality Improvement Organizations (QIOs). These entities review claims submitted by providers to ensure payment is made only for medically necessary services covered by Medicare for eligible individuals.

In addition to fee-for-service, Medicare also pays private plans. The Medicare Advantage plans, which include both coordinated care plans and private fee-for-service plans, generally provide more benefits at a lower cost to beneficiaries. Currently, about 4.8 million beneficiaries are enrolled in Medicare Advantage local plans. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) expanded the program with the establishment of a new regional contracting option for health plans, called Medicare Advantage regional plans. Local Medicare Advantage plans serve individual counties and groups of counties, whereas regional PPOs will bid to serve an entire region - which may be a state or multi-state area. Both local and regional plans must provide all original Medicare benefits.

Medicaid is a partnership between the Federal government and the states. While the Federal government provides financial matching payments to the states, each state is responsible for overseeing its Medicaid program, and each state essentially designs and runs its own program within the Federal structure. The Federal government pays the states a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that currently ranges between 50 and 77 percent. In FY 2005, total Medicaid expenditures – those that include both Federal and state contributions – are estimated to be approximately $330 billion. Roughly 57 million American will be enrolled in the Medicaid program during 2005.

In addition to Medicaid, CMS also administers the State Children's Health Insurance Program (SCHIP). Program benefits became available October 1, 1997, and will provide $40 billion in Federal matching funds over 10 years to help states expand health care coverage to the Nation's uninsured children. SCHIP is a state-administered program and each state sets its own guidelines regarding eligibility and services. Total SCHIP expenditures, including both Federal and state contributions, are estimated to be $7.6 billion with an enrollment of approximately 6.2 million beneficiaries during FY 2005.

CMS IPIA Compliance

Given the staggering size of these programs' expenditures, even small amounts of payment error can represent a significant impact to both Federal and state treasuries and taxpayers. For this reason, CMS, as part of a sound financial management strategy, has a relatively long history of using improper payment calculations as a tool to preserve the fiscal integrity of Medicare, Medicaid and SCHIP. CMS uses improper payments calculations to identify the amount of money that has been inappropriately paid, identify and study the causes of the inappropriate payments, and focus on strengthening internal controls to stop the improper payments from continuing. However, the variation in financing and administration among Medicare, Medicaid and SCHIP requires distinct approaches to applying this financial management tool.

Medicare IPIA Compliance

In 1996, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare fee-for-service (FFS) program as part of the Chief Financial Officer's Audit. The OIG produced FFS error rates from FY 1996 to FY 2002. Beginning in FY 2003, CMS, working with the OIG, implemented a much more robust process – the Comprehensive Error Rate Testing (CERT) program – to assess and measure improper payments in the Medicare fee-for-service program. The CERT program not only produces a national paid claims error rate, but also very specific improper payment rates. These include:

- contractor-specific improper payment rates – measures the accuracy of our claims processors;
- provider-type specific improper payment rates – measures how well the providers who care for our beneficiaries are preparing and submitting claims to the program;
- other management related information which provide insight into payment errors by region and reason.

Thus, in 2002 when the Improper Payments Information Act (IPIA) was enacted, CMS needed to make only minor changes to our ongoing processes to come into compliance with the OMB guidance on the IPIA. And in fact, CMS has gone beyond the scope of the IPIA requirements and OMB guidelines to calculate additional improper payment rates, as discussed earlier. This enhanced scrutiny reflects the Agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments.

Calculating rates is only one step in the process. Remediation is the key part of CMS IPIA compliance activities. CMS, through its contractors, including the Carriers, DMERCs, FIs, and QIOs use the error rates to identify where problems exist and target improvement efforts. The cornerstone of these efforts is our Error Rate Reduction Plan (ERRP), which includes agency level strategies to clarify CMS policies and implement new initiatives to reduce improper payments. In the past, ERRPs have included plans to conduct special pilot studies (i.e. electronic medical record submission pilot) and specific education-related initiatives. CMS also directs Carriers, DMERCs, and FIs to develop local efforts to lower the error rate by targeting provider education and claim review efforts to those services with the highest improper payments. The type and nature of the errors we see in the program all lend themselves to different types of corrective actions to mediate them.

For example, a primary cause of Medicare payment errors in the past has been providers not submitting the medical record documentation needed to verify the appropriateness of payment in response to our requests for documentation. Often providers did not understand the CERT program or were concerned that submitting medical records to a CMS contractor would be in violation of Health Insurance Portability and Accountability Act (HIPAA) regulations. However, the HIPAA Privacy Rule permits disclosure of protected health information to carry out treatment, payment or health care operations. Thus, we expanded our education efforts to ensure that providers understand that responding to our requests does not violate HIPAA.

Another significant cause of errors has been providers not submitting the appropriate types of medical record documentation to support the types of services billed to the Medicare program. CMS implemented a number of corrective actions to reduce these types of errors, including education and more intensive efforts to locate and contact providers.

CMS also uses contractor-specific error rates to evaluate the performance of the contractors that process Medicare claims. Current contracting authority, however, limits CMS' ability to take action against contractors with high error rates. However, Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to take the necessary steps between now and 2011 to implement Medicare Contracting Reform (MCR), which will change the contracting process and the contractor incentive structure. One key outcome of this initiative will be the ability to use incentives to get our contractors to eliminate improper payments. In 2004, CMS conducted a study to evaluate whether the Agency could reduce improper payments by using award fees as incentives for contractors to lower their paid claims and provider compliance error rates. The outcome of that pilot was positive and CMS plans to use award fees as incentives in the future as part of MCR.

We believe our efforts in Medicare have been a success. Our goal is to lower the national Medicare FFS error rate, which currently stands at 10.1 percent, to 7.9 percent by November of 2005. Our long terms goals are improper payment rates of 6.9 percent in 2006, 5.4 percent in 2007, and 4.7 percent in 2008. Preliminary data indicates that CMS is on track to meet its November goal. Also, beginning in 2006, CMS will be producing error rates twice a year. This increased availability of data will help CMS and its contractors to better target efforts to reduce error rates.

The key challenge facing CMS in the coming years will be assessing IPIA compliance with the new drug benefit and expanded Medicare Advantage programs. We conducted a risk assessment of the Medicare Advantage program this year and believe the risk to be substantial and will thus be outlining a strategy for IPIA compliance for FY 2006. For the drug benefit, which begins this January, we will be conducting a risk assessment during calendar 2006 in time to lay out a strategy for IPIA compliance by FY 2007.

Medicaid and SCHIP IPIA Compliance

CMS, along with the states, has a strong interest in strengthening financial oversight and ensuring payment accuracy in the Medicaid and SCHIP programs. The states provide a crucial first line of defense in safeguarding Medicaid and SCHIP program dollars. At the Federal level, CMS's primary role is to exercise proper oversight and review of state financial practices and to provide guidance and support for states' program integrity efforts. Prior to 2000, three states --

Illinois, Texas, and Kansas -- on their own initiative had attempted to estimate improper payment rates for their programs.

However, no model had been developed to estimate payment errors at the national level. Thus, in fiscal year (FY) 2000, CMS adopted a Government Performance and Results Act (GPRA) goal to explore the feasibility of developing a methodology to estimate improper payments for the Medicaid programs. To meet this goal, CMS initiated the payment accuracy measurement (PAM) demonstration project. This commitment has evolved into a five-year project to test various methods and strategies for measuring improper payments at the state level. By the end of FY 2005, 38 states will have participated in the program. Our lessons learned from this activity are driving our IPIA compliance strategy going forward.

IPIA compliance strategy for Medicaid and SCHIP rests on a proposed policy of joint state-Federal cooperation to achieve the intended outcome of the statute. In August of 2004, CMS published a proposed rule that would require states to measure improper payments in their Medicaid and SCHIP programs. According to the proposed regulation, the states would report their error rates to CMS, and CMS would calculate an IPIA compliant national error rate.

CMS has received extensive comments to this draft regulation from states and consumer advocacy groups. In addition, the lessons learned from our state pilots have highlighted some significant differences with Medicare that will cause us to have a longer timeline for IPIA compliance. In particular, because Medicaid and SCHIP are needs-based programs, a robust eligibility component must be factored into improper payment rate calculation. Also, the significant percentage of Medicaid and SCHIP beneficiaries who receive care in a managed care setting, rather than through fee-for-service providers, requires a particularly careful assessment of these payments.. Finally, many comments on the rule express concern that IPIA is a Federal, not state, responsibility and the cost and administrative burden that each state would incur by measuring the error rate each year would be high.

Based on these assessments of the pilots and comments on the rule, we plan to publish an Interim Final Rule rule later this summer that will lay out CMS’s strategy for full-IPIA compliance in Medicaid and SCHIP, including managed care, eligibility and fee-for-service components, in time for reporting in the FY 2008 Performance and Accountability Report.

Fraud, Waste and Abuse

As I previously mentioned, CMS's actions to safeguard Federal funds are not just limited to the error rate programs described in this testimony. Program and fiscal integrity oversight is an integral part of CMS's financial management strategy and a high priority is placed on detecting and preventing improper or fraudulent payments. To that end, CMS has made significant changes to its program integrity activities in the past year. These changes include the creation of new divisions within CMS to focus on data analysis to identify problem areas through trend analysis of claims data and to oversee potential fraud areas in the Discount Drug Card and Prescription Drug programs.

Several specific actions have been taken by CMS to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. In particular, a new satellite office in Los Angeles, California has been created, to work in conjunction with an existing satellite office in Miami, Florida, and has been instrumental in helping curtail fraudulent spending in high risk areas. Nine Medicare-Medicaid (Medi-Medi) match projects that CMS has in place in key states also help identify aberrant spending through their matching of Medicare and Medicaid claims data. For the first time, Medicare claims and Medicaid claims are being jointly data mined to identify fraud and abuse. Data mining health care claims for fraudulent activity has been commonplace for several years now. However, by blending both programs claims, patterns emerge that may not have been as evident when viewed separately. In many cases, a small number of crooked providers are exploiting both programs. The knowledge gleaned from our Medi-Medi activities helps both programs identify vulnerabilities and plug those gaps. This project will help reduce overall payment errors.

When instances of fraud or abuse are detected through any of these oversight mechanisms, CMS refers those cases to law enforcement. CMS has actively partnered with its law enforcement partners at the Department of Justice and Office of Inspector General to aggressively pursue enforcement actions against those providers and suppliers that are found to be deliberately defrauding the Federal health care programs.

Conclusion

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicare and Medicaid programs. As evidenced by the testimony today, the

Agency has taken significant actions to both meet and exceed the IPIA standards in Medicare, and CMS is taking a number of proactive steps to become IPIA compliant in Medicaid. Going forward, the Agency is developing a comprehensive strategy that will strengthen Federal oversight of State financial practices. We have made a great deal of progress and we look forward to continuing to work cooperatively with you. CMS and the Administration fully support this Subcommittee's efforts to improve the fiscal health of the Medicare and Medicaid programs. I look forward to answering any questions you might have.