STATEMENT OF

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ACTING DIRECTOR AND CHIEF FINANCIAL OFFICER,
OFFICE OF FINANCIAL MANAGEMENT
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

ELIMINATING WASTE AND FRAUD IN MEDICARE AND MEDICAID

BEFORE THE

SENATE HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS COMMITTEE SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, FEDERAL SERVICES, AND INTERNATIONAL SECURITY

APRIL 22, 2009

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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Chairman Carper, Senator McCain, and distinguished Subcommittee members, thank you for inviting me here to discuss the Centers for Medicare & Medicaid Services (CMS) initiatives to reduce improper payments in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Today, I would like to give you some background on our efforts to ensure payments to providers in Medicare, Medicaid, and CHIP are accurate, including an overview of the tools CMS has developed to address the problem of waste and fraud. I will describe how CMS succeeded in lowering the Medicare Fee-for-Service (FFS) error rate for Fiscal Year (FY) 2008 and our status in measuring improper payments in the Medicaid program and CHIP. I will also discuss briefly some of the challenges we face complying with the Improper Payments Information Act of 2002 (IPIA, P.L. 107-300). It is important to note that most of the improper payments I will be discussing are generally not due to willful

fraud. Rather, most of these errors are the result of documentation and processing mistakes.

Background on Medicare, Medicaid, and CHIP

Medicare is a Federal health insurance program that provides medical insurance to about 46 million people. About 38 million individuals are entitled to Medicare because they are age 65 or older, and about 8 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 entitled to Social Security disability cash benefits for 24 months. Total gross Medicare benefits for FY 2008 were $454 billion.

The majority of Medicare spending is FFS Medicare, with hospital and physician services currently representing the largest shares of this spending. The FFS 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 component of Medicare is administered by CMS through contracts with private companies that process claims for Medicare benefits.

Medicare also offers a prescription drug benefit in Part D and, as an alternative to FFS Medicare, medical coverage through privately-run plans in Part C. More than 26 million beneficiaries have Part D prescription drug coverage in 2009 through a Prescription Drug Plan (PDP) or a Medicare Advantage Prescription Drug Plan (MA-PD). Medicare

beneficiaries are filling 100 million prescriptions a month under Part D. Over 10 million people are enrolled in some type of Medicare Advantage plan.

During 2008, Medicare contractors processed almost 1.2 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 Medicare Administrative Contractors (MACs). These entities, in addition to Quality Improvement Organizations (QIOs), review claims submitted by providers to ensure payment is made only for medically necessary services covered by Medicare for eligible individuals.

Medicaid is a partnership between the Federal government and the States. While the Federal government sets broad guidelines and 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 normally ranges between 50 and 76 percent. The American Recovery and Reinvestment Act (ARRA, P.L. 111-5) temporarily increased FMAP rates by a minimum of 6.2 percent through December 31, 2010. In FY 2008, total Medicaid expenditures – those that include both Federal and State contributions – were estimated to be approximately $352 billion.

In addition to Medicaid, CMS also jointly administers CHIP with States. Federal matching funds are provided to help States expand health care coverage to uninsured children. Each State sets its own guidelines regarding eligibility and services within certain Federal parameters. On February 4, 2009, President Obama signed the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA, P.L. 111-3). CHIPRA reauthorizes CHIP through FY 2013 and provides an additional $44 billion in new funding to finance the program, effective April 1, 2009. CHIPRA also includes outreach and enrollment funds to extend coverage to an estimated 4 million more low-income uninsured children. Total enrollment for both Medicaid and CHIP for FY 2009 is estimated to be approximately 57 million.

CMS IPIA Compliance

Given the staggering size of these programs' expenditures, even small amounts of payment error can have a significant impact on both Federal and State treasuries and taxpayers. CMS uses improper payments calculations to estimate 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 CHIP requires distinct approaches to applying these financial management tools.

Medicare IPIA Compliance

In 1996, the Department of Health & Human Services (HHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare 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, developed and implemented a process capable of looking in more detail at where errors were occurring. Entitled the Comprehensive Error Rate Testing (CERT) program, it not only produces a national paid claims error rate, but also improper payment rates specific to claims-processing contractors, participating providers, and errors specific to either regions of the country or reasons for error. Thus, in 2002 when the IPIA was enacted, CMS needed to make only minor changes to our existing processes for FFS Medicare to come into compliance with the Office of Management and Budget's (OMB) guidance on the IPIA.

In November 2008, HHS reported a Medicare FFS paid claims error rate of 3.6 percent. This exceeded our 2008 goal of 3.8 percent, and was a decrease from the 3.9 percent reported in 2007, and lower than the 4.4 percent rate reported in 2006. The FFS error rate has declined significantly from the 10.1 percent reported in 2004 to the 3.6 percent reported in 2008.

CMS reported for the first time an error rate for improper payments in the Medicare Advantage (MA) program, and is also on track to develop a composite payment error methodology for the Part D program. The MA error rate for calendar year (CY) 2006 was 10.6 percent. The MA error rate represents the combined impact of two sources of error:

- The MA payment system error estimate captured calculation errors and other system issues in CMS' data systems that affected Part C prospective payments to plans.
- The risk adjustment error estimate captured errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS.

CMS uses diagnosis data to calculate a risk score for each beneficiary, which is a key element of CMS' monthly Part C premium payment to a health plan for that beneficiary. To validate risk scores, CMS conducts medical record reviews on a national sample of beneficiaries to determine the extent to which plan-reported diagnoses are supported by medical record documentation. The FY 2008 reported risk adjustment error estimate was based on corrected risk scores for the sampled beneficiaries, due to diagnoses not supported by medical record documentation. The sample estimate was extrapolated to the program level.

This is the first year CMS measured an MA composite error rate under the IPIA. Improper payments due to payment system errors are routinely resolved and payment adjustments are made.

In response to an OIG audit in which the adequacy of CERT medical review of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims was questioned, as well as to strengthen our confidence in the CERT review findings and assure the accuracy of the reported error rate, CMS began an effort to independently perform blind, random reviews of its CERT review contractors' payment determinations

starting with the FY 2008 measurement.[1] We expect the results of those reviews to be completed later this summer.

Medicaid and CHIP IPIA Compliance

Since CMS last appeared before the Subcommittee, the Agency has successfully implemented the Medicaid and CHIP payment error rate measurement (PERM) program to calculate and report a national error rate for Medicaid and CHIP.

FY 2007 represented the first year of "full" implementation of the PERM program, expanded from FY 2006 to include reviews of Medicaid managed care and eligibility, as well as CHIP FFS, managed care, and eligibility. This expansion made Medicaid and CHIP fully compliant with the IPIA by 2008. The FY 2007 Medicaid error rate estimate was 10.5 percent. Likewise, for CHIP, the FY 2007 error rate estimate was 14.7 percent. However, these rates would be lower if undetermined eligibility cases were not factored in. A case is cited as undetermined in the eligibility reviews when, after due diligence on the part of the PERM reviewer, a definitive determination of eligibility or ineligibility can not be made. When considering these error rates, it is important to remember that under the PERM program, each State is measured against its own policies and standards. The error rate therefore reflects: 1) how well a State complied with its own program requirements, and 2) any payments that may have been paid incorrectly but were not necessarily fraudulent.

In addition, CMS initiated the State corrective action process, whereby States analyze root error causes that contribute to improper payments and develop corrective action

[1] OIG Report A-01-07-00508

plans to address error causes which should ultimately reduce improper payments over time.

CMS has increased State outreach in an effort to further educate States on the PERM program. We have developed PERM 101 documents which provide an introduction to the PERM program and are available to assist States in educating stakeholders. For FY 2009, CMS also issued early guidance to States on the error rate measurement process and allowed States to submit test data in preparation for the regular PERM cycle.

Also, in response to States' expressed desire to provide input beyond the rulemaking process, CMS is working to improve communications with the States. For example, we have expanded the PERM Technical Advisory Group (TAG) capacity by establishing an Error Rate Reduction Subcommittee, an Eligibility TAG, and a Difference Resolution Committee. The TAGs have provided States the opportunity to offer and discuss suggestions and recommendations for reducing State cost and burden. We have also established monthly calls with all States participating in a PERM cycle where States have the opportunity to communicate any questions or concerns directly to CMS.

CHIPRA provides for a 90 percent Federal match for CHIP spending related to PERM administration and excludes such spending from the 10 percent administrative cap. It also requires the Secretary to publish a new rule addressing CHIP PERM requirements by August 4, 2009. CMS is currently developing a notice of proposed rulemaking that will include CHIPRA requirements and clarify existing guidance. The rule on PERM must illustrate clearly defined criteria for errors for both States and providers; clearly defined

processes for appealing error determinations; and clearly defined responsibilities and deadlines for States in implementing any corrective action plans.

States sampled under PERM in FY 2007 or FY 2008 under former rules have the option to elect any payment error in whole or in part for the States on the basis of that data for those fiscal years as its base PERM year or elect to have FY 2010 or FY 2011 as it base year under the new rule created by this provision. States also have the option to apply PERM data for meeting MEQC requirements and vice versa, with certain conditions.

To help ensure IPIA compliance, CMS expects to:

- Continue efforts to achieve greater program efficiency;
- Reduce improper payments in Medicaid and CHIP through State corrective actions;
- Have States initiate recovery of erroneously paid Federal funds in these programs as identified through the PERM program; and
- Report national Medicaid and CHIP program error rates for each fiscal year measured.

CMS will continue to identify areas in improper payment measurement that can be improved upon to make the PERM program more efficient, to reduce cost and burden, and to help ensure accurate program error rates. Through experience, lessons learned, and State partnership, CMS is committed to advancing the efficiency and accuracy of the PERM program as it evolves.

Health Care Fraud and Abuse Control (HCFAC) Funding

CMS' actions to safeguard Federal funds are not just limited to the error rate programs described in this testimony. Program integrity and fiscal oversight is an integral part of CMS' 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 recent years. These changes include the creation of new divisions within CMS to focus on identifying problem areas through trend analysis of claims data.

Title II of the Health Insurance Portability and Accountability Act (HIPAA) established the HCFAC program to detect, prevent, and combat health care fraud and abuse. HCFAC is comprised of three separate funding streams, with the majority of funding supporting the Medicare Integrity Program (MIP). $720 million in annual MIP funding supports medical claims review, benefit integrity, provider and health maintenance organization (HMO) audits, Medicare secondary payer oversight, and provider education and training.

HCFAC funding supports four key CMS program integrity strategies: prevention, early detection, coordination, and enforcement. Each of these strategies is designed to ensure that CMS can address improper payment issues as quickly and efficiently as possible, and allows the Agency to coordinate with our colleagues at OMB, OIG, and the U.S. Department of Justice (DOJ) to maximize our return on investment.

In recent years, the President's budget requests have sought additional funding for HCFAC activities. The Omnibus Appropriations Act of 2009 (P.L. 111-8) allocated $198 million in new discretionary funding to the Agency in FY 2009. This funding will enable CMS to expand our existing efforts against fraud and abuse in the Medicare, Medicaid, and CHIP programs. This appropriation will supplement existing HCFAC programs, such as our regional HCFAC satellite offices, and strengthen combined HHS/DOJ investigatory efforts into Medicare Advantage, the Part D drug benefit, Medicaid (through the Medicaid Integrity Program), and CHIP. The President's Budget Overview has also made increased HCFAC funding a strong priority by again requesting a discretionary allocation adjustment of $311 million in FY 2010. A five-year investment in a discretionary allocation adjustment for HCFAC is estimated to yield $2.7 billion in program savings between FY 2010 and 2014.

Medicaid Integrity Program

Section 6034 of the Deficit Reduction Act of 2005 (DRA) established the Medicaid Integrity Program in section 1936 of the Social Security Act (P.L. 109-171). The Act directs the Secretary to establish a 5-year comprehensive plan to combat fraud, waste, and abuse in the Medicaid program, beginning in FY 2006. The first Comprehensive Medicaid Integrity Plan (CMIP) covering FYs 2006 to 2010 was released in July 2006; the second, covering FYs 2007-2011, was released in October 2007; the third, covering FY 2008-2012, was released in June 2008. CMS' Medicaid Integrity Group (MIG) is responsible for implementing the Medicaid Integrity Program.

The Medicaid Integrity Program offers a unique opportunity to prevent, identify, and recover inappropriate Medicaid payments. It also supports the efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although each state works to ensure the integrity of its respective Medicaid program, the Medicaid Integrity Program provides CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter providers who would exploit the program.

The DRA states that CMS must enter into contracts to perform four key activities: 1) review provider actions; 2) audit claims; 3) identify overpayments; and 4) educate providers, managed care entities, beneficiaries, and others on payment integrity and healthcare quality. To date, CMS has awarded umbrella contracts to several contractors to perform the functions outlined above. These contractors are known as the Medicaid Integrity Contractors (MICs). Currently, there are MICs performing review and audit functions in 24 States and the District of Columbia. We plan to have MICs working in all fifty States by the end of FY 2009.

In addition to implementing key program integrity functions such as reviewing Medicaid providers and identifying inappropriate payments, the DRA requires CMS to provide effective support and assistance to States to combat provider fraud and abuse. CMS provides this support in the form of State program integrity reviews, training opportunities, resource support for special projects, and ongoing technical assistance. Specifically, the MIG created the Medicaid Integrity Institute (MII), a national Medicaid program integrity training partnership with DOJ's national training center in Columbia,

SC. The MII provides State employees a comprehensive program of course work encompassing all aspects of Medicaid program integrity. In FY 2008, the MII, provided training to 417 staff from almost every State and estimate at least 750 State staff to attend in FY 2009.

CMS recognizes the valuable role of the provider community as an ally in identifying potentially fraudulent practices in their respective industries as well as serving as a source of intelligence regarding specific conduct. We have done extensive outreach to the provider community through presentations and speeches at conferences and other national forums, interviews for trade publications, and through the CMS Open Door Forums.

CMS also understands the value of education in preventing fraud, waste, and abuse because many overpayments are the result of billing mistakes rather than intentional fraud. The Education MICs will work closely with all of Medicaid's partners and stakeholders and provide education to providers on various program integrity issues.

Regional Fraud, Waste and Abuse Efforts

Experts agree that the most effective way to eliminate fraud is to stop it before it ever starts. One way this can be done is by exercising more due diligence on providers and suppliers before issuing them the Medicare numbers that enable them to bill Medicare. Over the last two years, CMS has begun focusing resources on front-end controls with the end goal of reducing or eliminating common schemes by sham providers by

thoroughly vetting all providers before allowing them to obtain a Medicare enrollment number.

Where we see unusual, high volume, or high-dollar claims, we will still examine the claims, but we may also visit the provider or supplier, interview beneficiaries, and, in the case of home health, we may visit the ordering physician. We look at the entire chain to ensure that high volume prescribers are prescribing only what is medically necessary, to ensure that suppliers or other providers are in fact providing what was prescribed, and to ensure that the beneficiary has a true medical need and is not, willingly or otherwise, a part of a criminal enterprise.

Home medical equipment—DMEPOS—is an industry that is historically at high risk for fraud. In South Florida and Los Angeles, where Medicare billing is disproportionately high, the number of DMEPOS suppliers increased nearly 20 percent between 2005 and 2007.

One important tool to help fight DMEPOS fraud is competitive bidding for DMEPOS suppliers, authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173). Under current law, CMS is required to begin this program in 2009. CMS will be issuing further guidance on its timelines and bidding requirements for the competitive bidding program. In finalizing these guidelines, CMS will continue to seek input from all affected stakeholders to ensure program

implementation consistent with the legislative requirements and ensuring that CMS' processes for collecting and evaluating bids are fair and transparent.

Until DME competitive bidding is fully operational, CMS is pursuing a "stop-gap program" to focus on Medicare fraud in seven high-risk areas across the country where CMS is increasing our oversight of the highest paid DMEPOS suppliers and the highest billed DMEPOS equipment and supplies. The "stop-gap program" increases pre-payment reviews of medical equipment suppliers and will also single out the highest-billed claims—continuous positive airway pressure (CPAP) devices, oxygen equipment, glucose monitors and test strips, and power wheelchairs—which are the most lucrative items for suppliers and thus, at the greatest risk of fraud. The plan toughens background checks on new suppliers and increases scrutiny on the highest ordering physicians and the highest utilizing beneficiaries.

The "stop-gap plan" goes beyond the current durable medical equipment Provider Enrollment Demonstrations in Los Angeles and Miami, which have already revoked more than 1,150 billing numbers and raised the tally of suppliers expelled from Medicare by 50 percent. The plan also targets the highest utilizing beneficiaries who are potentially receiving kickbacks, and focuses on the equipment and supplies most likely to be abused.

In January 2009, CMS issued a new rule to require most non-physician suppliers of durable medical equipment to obtain a $50,000 surety bond, in order to deter illegitimate

suppliers from enrolling in Medicare. Effective October 1, 2009, most DME suppliers participating in the Medicare program will be required to have both a surety bond and accreditation from a deemed accrediting organization. The combination of the surety bond and accreditation requirements is an important step to ensure that CMS is only doing business with legitimate partners and will allow CMS to expel fraudulent suppliers from the program and keep them out.

CMS recently took the opportunity to consolidate the myriad anti-fraud contractors we utilize for integrity efforts for DMEPOS suppliers under one umbrella. The new contractors, Zone Program Integrity Contractors (ZPICs), serve the same jurisdictions as the MACs. CMS continues to fight waste, fraud, and abuse by those who are determined to steal from the Medicare trust funds and the Agency relies upon the ZPICs to assist us in developing innovative ideas and methods to stop this fraudulent flow of money and protect the trust funds. The ZPICs have a broad portfolio, ranging from conducting investigations and providing support to law enforcement, to conducting data analysis against all Medicare FFS payment types. Five ZPICs will concentrate on fraud "hot spots" in FL, IL, TX, NY and CA where we know the program has the greatest vulnerabilities. By better focusing our program safeguard activities and consolidating contractors to allow them to look across multiple claims types, CMS will be able to more efficiently and accurately detect and prevent fraud before it occurs.

While the majority of CMS' focus has been on the numerous aspects of Medicare FFS fraud, the past two years have also included an increased focus on oversight of the Medicare Part D prescription drug program and the Part C managed care program. CMS currently utilizes special contractors called the Medicare Part D Integrity Contractors

(MEDICs) to oversee marketing, enrollment and eligibility issues that are potentially fraudulent. During 2007, the MEDIC contracts were expanded to include oversight of the Part C managed care program. The MEDICs have worked closely with the Medicare Advantage Organizations (MAOs) and the Part D Plan Sponsors to cull complaint information received through the MEDIC fraud hotlines, information obtained by the MAOs or Part D Sponsors, and complaints received through the complaints tracking system in CMS' regional offices. These complaints are then vetted to determine which have elements that would potentially be considered fraud. Those are then referred over to the OIG for further investigation, and the MEDICs provide support to OIG and DOJ as the investigations develop into civil or criminal matters. CMS also has internal oversight mechanisms for the Part D Sponsors and MAOs to ensure they are complying with CMS' contract requirements and all applicable regulations. Entities which are found to be non-compliant are subject to corrective action plans, sanctions, or civil money penalties.

Recovery Audit Contractors

Section 306 of the MMA gave CMS authority to pilot new tools designed to detect improper payments. This MMA provision directed the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, which would collect Medicare overpayments and return any underpayments. The over- and underpayments were identified through a careful review of individual Medicare claims to determine if the claims were medically necessary, correctly coded, and conformed to Medicare payment policy. This initial demonstration project ran from 2005 to 2008 in California, New York, Florida, Massachusetts, South

Carolina, and Arizona. The demonstration proved to be successful, recovering $992.7 million in gross overpayments, as well as $37.8 million in underpayments that were paid out to providers.

The demonstration results showed the effectiveness of a recovery auditing program. The Tax Relief and Health Care Act of 2006 (P.L. 109-432) mandated the use of recovery audit contractors in all States by 2010. The national RAC program began work on February 6, 2009. CMS' implementation plan is to phase-in the recovery audit contractors nationally. This incremental approach will allow CMS to work closely with the national and State health care associations to ensure that health care providers have up to date information regarding the nationwide expansion process.

CMS learned many key things during the RAC demonstration phase. As important as the recovery of past improper payments is, CMS sees the RAC program more importantly as a tool in reducing and eliminating future improper payments. To that end, CMS responded to feedback from providers on the demonstration project and made some important modifications prior to implementing the national program. These changes include: mandatory medical director and coding experts included to oversee each RAC claims review; a mandatory independent validation of the RACs; a 3-year maximum look-back period going back to October 1, 2007; quality assurance reviews; and a mandatory payback of any contingency fee by the RAC if the claim is overturned on appeal. With these important improvements, CMS seeks to ensure accuracy, maximize

transparency, and minimize provider burden as the RAC program goes national. Further information on the status of the RAC program can be found at: www.cms.hhs.gov/RAC.

Conclusion

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicare, Medicaid, and CHIP programs. As evidenced by the testimony today, the Agency has taken action to meet IPIA standards in Medicare and is taking a number of proactive steps to become IPIA-compliant in Medicaid and CHIP. The Agency has developed a strategy that will strengthen Federal oversight of State financial practices. We have made progress, but there remains work to do to root out waste, fraud and abuse in the Medicare, Medicaid, and CHIP programs. Congress appropriated additional funds to HCFAC for FY 2009, and the Administration has again requested a discretionary allocation adjustment in the President's FY 2010 Budget Overview. We will use any funds appropriated by Congress to build upon our work to date, to more rapidly respond to emerging program integrity vulnerabilities and to identify and recoup improper payments. CMS looks forward to continuing to work cooperatively with the Congress. CMS and the Administration fully support this Subcommittee's efforts as a steward of taxpayer dollars to improve the fiscal integrity of the Medicare, Medicaid, and CHIP programs.

I look forward to answering any questions you might have.