

STATEMENT OF

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ON

**“CMS EFFORTS TO REDUCE IMPROPER PAYMENTS IN THE MEDICARE
PROGRAM”**

**BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON ENERGY POLICY, HEALTH CARE & ENTITLEMENTS**

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U.S. House Committee on Oversight & Government Reform
Subcommittee on Energy Policy, Health Care & Entitlements
Hearing on
CMS Efforts to Reduce Improper Payments in the Medicare Program
May 20, 2014

Chairman Lankford, Ranking Member Speier, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) program integrity efforts. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. We share this Subcommittee' commitment to protecting beneficiaries and ensuring taxpayer dollars are spent on legitimate items and services, both of which are at the forefront of our program integrity mission. We have made important strides in addressing improper payments and reducing waste, abuse and fraud across our programs and I appreciate the opportunity to discuss the priorities of CMS' Center for Program Integrity.

CMS is using a multi-faceted approach to target all causes of waste, abuse, and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. We are working closely with law enforcement, states, private insurers, and providers in our efforts. CMS must strike an important balance while overseeing the Medicare program: limiting the administrative burden on legitimate providers and suppliers to preserve beneficiary access to necessary health care services while fulfilling our obligation to ensure taxpayer dollars are not lost to waste, abuse, and fraud. We have instituted many program improvements since the passage of the Affordable Care Act and other legislation, and are continuously looking for ways to refine and improve our program integrity activities.

In addition to CMS's ongoing program integrity efforts, the FY 2015 President's Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield \$13.5 billion in gross savings for Medicare and Medicaid over 10 years. Such efforts targeting waste, abuse, and fraud have already helped extend the life of the Medicare Trust Fund, and are critical to protect Medicare for years to come.

Waste, abuse, and fraud can also inflict real harm on Medicare beneficiaries. Through prevention, we can decrease beneficiaries' exposure to risks and harm while preserving Trust

Fund dollars. For example, in the case of a Chicago-area dermatologist that was indicted in October 2012 for falsely diagnosing patients with skin cancer, patients endured the risks and trauma of unnecessary surgery. Using a proactive approach, CMS stopped payments to this provider in conjunction with law enforcement making the arrest and prosecuting the case.

Prevention

Provider enrollment is the gateway to billing the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the Medicare program.

Strengthening Provider Enrollment

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 CMS put these additional requirements in place for newly enrolling and revalidating Medicare and Medicaid providers and suppliers in March 2011. This enhanced screening requires certain categories of providers and suppliers that have historically posed a higher risk of fraud to undergo greater scrutiny prior to their enrollment or revalidation in Medicare. These new screening requirements resulted in an estimated additional 50,000 site visits, and in April 2014, CMS announced that upon notification, providers designated to the high screening level will be required to submit fingerprint-based background checks to gain or maintain billing privileges for Medicare.

The Affordable Care Act also required CMS to screen all existing 1.5 million Medicare suppliers and providers under the new screening requirements. Since March 25, 2011, more than 770,000 providers and suppliers have been subject to the new screening requirements and over 260,000 provider and supplier practice locations had their billing privileges deactivated for non-response as a result of these screening efforts.¹ Since implementation of these requirements, CMS has also revoked 17,534 providers' and suppliers' ability to bill the Medicare program. These providers and suppliers were removed from the program because they had felony convictions,

¹ Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

were not operational at the address CMS had on file, or were not in compliance with CMS rules, such as licensure requirements.

Enrollment Moratoria

The Affordable Care Act also provides the Secretary the authority to temporarily pause the enrollment of new Medicare, Medicaid, or Children's Health Insurance Program (CHIP) providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In the last year, CMS has used this authority in seven metropolitan areas² to safeguard taxpayer dollars while ensuring patient access to care is not interrupted. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHAs) and ambulance companies in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground-based ambulances in and around Houston.³ In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in the metropolitan Philadelphia area.⁴ CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of home health agencies and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. In Miami alone, CMS has revoked the billing privileges of 101 HHAs in 2013, with 67 revocations occurring after the moratorium was put into place. Additionally, law enforcement made arrests in a \$48 million Miami home health

² The seven metropolitan areas where CMS has issued moratoria are: Miami, FL (Miami-Dade and Monroe Counties); Chicago, IL (Cook, DuPage, Kane, Lake, McHenry and Will Counties); Dallas, TX (Dallas, Collin, Denton, Ellis, Kaufman, Rockwall, and Tarrant counties); Houston, TX (Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller Counties); Detroit, MI (Wayne, Macomb, Monroe, Oakland, and Washtenaw Counties); Philadelphia, PA (Philadelphia, Bucks, Delaware, and Montgomery Counties in Pennsylvania and Burlington, Camden, and Gloucester Counties in New Jersey); and Fort Lauderdale, FL (Broward County)

³ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-26.html>

⁴ <http://cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-01-30-2.html>

scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies in the last 12 months, and 92 revocations occurring after the moratorium was put into place in Houston.

Improper Payments in Medicare Fee-for-Service

Medicare fee-for-service has been deemed a “high risk” program by the Government Accountability Office in part due to the sheer size and complexity of the program. CMS pays 1.5 million providers for health care for 54 million beneficiaries under the Medicare program. The Office of Management and Budget has determined that Medicare is also a “high error” program due to its annual estimated error amount. Each year, CMS estimates the improper payment rate and a projected dollar amount of improper payments for Medicare, Medicaid, and CHIP.⁵ While these improper payments represent a fraction of total CMS spending, any level of improper payment is unacceptable and we are working diligently to reduce these documentation, coding and claims processing errors.⁶

Improper payments are errors that are not necessarily fraudulent. The vast majority of Medicare FFS improper payments fall into two categories: 1) inadequate documentation to support the services billed and 2) the documentation as provided did not support that the services were medically necessary. Payments deemed “improper” under these circumstances tend to be the result of documentation and coding errors made by the provider as opposed to payments made for inappropriate claims. The most common error providers make is the failure to properly document the beneficiary’s need for the service and most improper payments are made when information in the medical record did not support the services billed.

The factors contributing to improper payments are complex and vary from year to year. For example, a contributing factor to the FY 2013 Medicare FFS error rate was the implementation of new policies regarding documentation. Although the policy change will ultimately strengthen

⁵ <http://www.hhs.gov/afi/2013-hhs-agency-financial-report.pdf>

⁶ The annual rates for all Federal programs that are deemed high-error are posted on the website www.paymentaccuracy.gov.

the integrity of the program, there is a change management aspect to implementing new policies. Since it takes time for providers and suppliers to fully implement new policies, especially those with new documentation requirements, it is not unusual to see changes in error rates following implementation of new policies.

CMS has designed its systems to detect anomalies on the face of the claims, and through these efforts, we are paying the claims correctly as they are submitted nearly 100 percent of the time. For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid in Medicare Part B and Medicaid. This program was first implemented with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians.⁷ In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program.⁸ MUE edits prevent payments for services such as hysterectomy for a man or prostate exam for a woman. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website.⁹ The use of the NCCI procedure-to-procedure edits saved the Medicare program \$530 million in FY 2013, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over \$7.5 billion since 1996 based on savings reports from claims-processing contractors.

The main challenge with improper payments is that detection relies on evaluating the medical record – to identify whether the service was medically needed - for example – which is not submitted with claims. CMS and its Medicare Administrative Contractors (MACs) develop

⁷ Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations.

⁸ MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

⁹ Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities.

medical review strategies using the improper payment data to ensure that we target the areas of highest risk and exposure. The review strategies range from issuing comparative billing reports that educate providers about their billing practices by showing the provider in comparison to his or her state and national peers, to encourage providers to conduct self-audits, to targeted medical review of specific providers. The Medicare Administrative Contractors reported that medical review resulted in \$5.6 billion in savings for FY 2013.¹⁰

Prior Authorization

One area that previously had high incidences of improper payments was the Powered Mobility Device (PMD) benefit; CMS found that over 80 percent of claims for motorized wheelchairs did not meet Medicare coverage requirements in 2011.¹¹

As result of these and other findings showing very high improper payment rates for PMDs, CMS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.¹² Since implementation, CMS observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims submitted as of September 30, 2013, monthly expenditures for the PMDs included in the demonstration decreased from \$20 million in September 2012 to \$9 million in August 2013 in the non-demonstration states and from \$12 million to \$4 million in the demonstration states.¹³

We believe the decrease in overall spending is due in part to national Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers adjusting their billing practices nationwide (not just in the demonstration states) and reflects suppliers complying with CMS policies based on their experiences with prior authorization in the demonstration states.¹⁴ The decrease in spending can also be attributed to the continuous DMEPOS supplier education

¹⁰ <http://www.hhs.gov/budget/fy2013/fy2013-other-information.pdf>

¹¹ <http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf>

¹² The seven states are: CA, IL, MI, NY, NC, FL and TX

¹³ http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf

¹⁴ http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/PMD_Demo_1yrUpdate_12182013_508Clean.pdf

and outreach mechanisms implemented by the Durable Medical Equipment Medicare Administrative Contractors (DME MACs) and CMS as well as other initiatives to prevent fraud and reduce expenditures for medically unnecessary PMDs.

Additionally, overall the industry's feedback has been positive. Several DMEPOS suppliers have suggested prior authorization helps their business by providing a more predictable cash flow and improved relationships with the ordering physician. These suppliers have expressed support for the demonstration and would like it to be expanded to other states and items.

While the private sector widely uses prior authorization to control waste, abuse, and fraud, CMS is seeking authority to expand the use of this tool. The President's FY 2015 Budget includes a proposal that builds on the success of the Prior Authorization of PMDs Demonstration by giving CMS the authority to require prior authorization for all Medicare fee-for-service items, particularly those items at the highest risk for improper payment. By allowing prior authorization on additional items, CMS can ensure in advance that the correct payment goes to the right provider for the appropriate service, and preventing potential improper payments before they are made.

Fee-for-Service Recovery Auditors

CMS uses the Recovery Auditors to perform medical review to identify and correct Medicare improper payments primarily on a post payment basis. CMS uses the vulnerabilities identified by the Recovery Auditors to implement actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the first quarter of FY 2014, the Recovery Auditors have returned over \$7.4 billion to the Medicare Trust Fund.

Recovery Audit Program Improvements

CMS is currently in the procurement process for the next round of Recovery Audit Program contracts and plans to award these contracts this year. In February 2014, CMS announced a number of changes to the Recovery Audit Program that will take effect with the new contract awards as a result of stakeholder feedback. CMS believes that improvements to the RAC

program will result in a more effective and efficient program, including improved accuracy, less provider burden, and more program transparency.

Zone Program Integrity Contractors Reviews

Zone Program Integrity Contractors (ZPICs) identify providers that have aberrant billing patterns and other behaviors that are indicative of fraud. The ZPICs use medical review on a pre- and post-pay basis to identify medically unnecessary billed services. In addition, CMS, in coordination with its ZPICs, uses a variety of administrative actions to stop payments, including payment suspension or revocation of billing privileges when there is a credible allegation of fraud.

Fraud Prevention System (FPS)

Under the Small Business Jobs Act of 2010, CMS is required to use predictive modeling and other analytic technologies to identify and prevent waste, abuse, and fraud in our Medicare fee-for-service program. Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS designed the FPS to accommodate different analytic model types to address a variety of fraud schemes. The most important indicator of success is that the models in the FPS have led to administrative action – we have used our revocation authority to remove bad actors from the Medicare program, which is the surest way to protect Trust Fund dollars and beneficiaries, suspended potentially fraudulent payments from going out the door, and referred leads and cases to law enforcement.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS First Implementation Year Report to Congress,¹⁵ in its first year of implementation, the FPS stopped, prevented or identified an estimated \$115.4 million in improper payments. These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the suspension of payments, and changes in behavior that result from CMS actions. The FPS

¹⁵ <http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf>

achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; and CMS is expanding the ways that we are using the FPS to identify bad actors and improper payments that will enhance its success. For example, CMS initiated a pilot project with one MAC to determine whether providers flagged by the FPS are appropriate targets for medical review and education. CMS found that the early education by the MACs changed about half of the providers' billing behavior, while others required increasing levels of intervention. CMS is also working to implement edits directly into the FPS that would stop payment based on Medicare payment policy. CMS is expanding both of these efforts in the FPS.

Collaborating with law enforcement

Earlier this year, the Government announced that in Fiscal Year (FY) 2013, its waste, abuse, and fraud prevention and enforcement efforts in the Health Care Fraud and Abuse Control (HCFAC) program resulted in the record-breaking recovery of \$4.3 billion in taxpayer dollars from individuals trying to defraud Federal health care programs serving seniors and taxpayers.¹⁶ Over the last five years, the Administration's enforcement efforts have recovered \$19.2 billion, up from \$9.4 billion over the prior five-year period. Over the last three years, the average return on investment (ROI) of the HCFAC program is \$8.10 for every dollar spent, which is an increase of \$2.70 over the average ROI for the life of the HCFAC program since 1997.

As a result of these and other efforts, there has been a measurable decrease in Medicare payments for certain medical services that have also been targeted by the Medicare Strike Force.

DME Competitive Bidding

Finally, on January 1, 2011, CMS implemented Round 1 of DME competitive bidding program in nine areas, including Miami and CMS implemented Round 2 of the program in 91 additional areas on July 1, 2013. It is projected to save the Medicare program approximately \$27 billion and beneficiaries \$18 billion over ten years.¹⁷ 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

¹⁶ <http://oig.hhs.gov/publications/docs/hcfac/FY2013-hcfac.pdf>

¹⁷ FY 2015 Congressional Justification, Page 41.

DMEPOS. Moreover, CMS' monitoring revealed the competitive bidding program may have curbed previous inappropriate distribution of these supplies. Round 1 of 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 the Round 1 program is in effect. The competitive bidding program resulted in average savings of 35 percent below the fee schedule rates and saved more than \$400 million in the first two years of operation while preserving beneficiary access to quality items in the nine Round 1 Rebid areas.¹⁸ For the second round of the program, which started in July 2013, CMS is projecting savings of 45 percent below fee schedule prices for DMEPOS items, and savings for the national mail-order program are estimated at 72 percent below fee schedule prices.

Law enforcement activity combined with various measures taken by CMS, which themselves were prompted by enforcement activity, appear to have contributed to even further declines in Medicare payments for DME in Miami over time. Payments by Medicare for DME in Miami-Dade County alone hit an all-time high in the third-quarter of 2006, when payments exceeded \$73 million, those payments have decreased over time, and in the first-quarter of 2013 payments were under \$15 million.

Working Across the Health System

CMS is coordinating a variety of efforts with Federal and state partners, as well as the private sector to better share information to combat fraud. CMS issued new compliance program guidelines to assist Medicare Advantage plans and prescription drug plans design and implement a comprehensive plan to detect, correct and prevent waste, abuse, and fraud. CMS also enhanced its data analysis and improved coordination with law enforcement to get a more comprehensive view of activities in Medicare Advantage and Part D. The Part C and D program integrity contractor, the MEDIC, identified vulnerabilities and performed analysis that identified over \$105 million in improper payments. The MEDIC then sent notification to plan sponsors to delete the records associated with improper payments from FYs 2011 and 2012. To increase the impact of the proactive analysis, CMS proposed a rule that would provide CMS, the MEDIC,

¹⁸ <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-Sheets/2013-Fact-Sheets-Items/2013-10-31.html>

and other agencies the ability to request and collect information directly from pharmacy benefit managers, pharmacies, and other downstream entities of Part D plans.

In July 2012, the Secretary of HHS and the Attorney General announced a historic partnership with the private sector to fight waste, abuse, and fraud across the health care system. The ultimate goal of the Healthcare Fraud Prevention Partnership (HFPP) is to exchange facts and information to identify trends and patterns that will uncover waste, abuse, and fraud that could not otherwise be identified. The HFPP currently has 36 partner organizations from the public and private sectors, law enforcement, and other organizations combatting waste, abuse, and fraud. In 2013 and 2014, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions such as payment system edits, revocations and payment suspensions to stop payments from going out the door and improve our collective forces against waste, abuse, and fraud. Just last week, the Secretary and Attorney General announced a nationwide takedown by Medicare Fraud Strike Force operations in six cities that resulted in charges against 90 individuals, including 27 doctors, nurses and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately \$260 million in false billings.¹⁹

Moving Forward

Our health care system should offer the highest quality and most appropriate care possible to ensure the well-being of individuals and populations. CMS is committed to protecting taxpayer dollars by preventing or recovering payments for wasteful, abusive, or fraudulent services. But the importance of program integrity efforts extends beyond dollars and health care cost alone. It is fundamentally about protecting our beneficiaries – our patients – and ensuring we have the resources to provide for their care. Although we have made significant progress by implementing important policies like prior authorization to prevent improper payments before they are made and utilizing technology and data to reduce coding errors and other billing anomalies, more work remains to be done.

¹⁹ <http://www.hhs.gov/news/press/2014pres/05/20140513b.html>

Going forward, we must continue our efforts to move beyond “pay and chase” to prevent fraud before it happens, provide leadership and coordination to address these issues across the health care system, and ensure that we take administrative action as swiftly as possible to stop suspected instances of waste, abuse, and fraud. 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.

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Shantanu Agrawal is a Board-certified Emergency Medicine physician and Fellow of the American Academy of Emergency Medicine. He is currently serving as an appointee for the Obama Administration as Deputy Administrator for Program Integrity and Director of the Center for Program Integrity at the Centers for Medicare & Medicaid Services (CMS). His focus is to improve healthcare value by lowering the cost of care through the detection and prevention of waste, abuse, and fraud in the Medicare and Medicaid programs. Prior to this role, Dr. Agrawal served as Chief Medical Officer of the Center for Program Integrity, where he helped to launch new initiatives in data transparency and analytics, utilization management, assessment of novel payment models, and a major public-private partnership between CMS and private payers.

Prior to joining CMS, Dr. Agrawal was a management consultant at McKinsey & Company, serving senior management of hospitals, health systems, and biotech and pharmaceutical companies on projects to improve the quality and efficiency of healthcare delivery. Dr. Agrawal has also worked for a full-risk, capitated delivery system as the head of clinical innovation and efficiency. He has published articles in *JAMA*, *New England Journal of Medicine*, *Annals of Emergency Medicine*, among others, and has given national presentations on health care policy and the cost of care.

Dr. Agrawal completed his undergraduate education at Brown University, medical education at Cornell University Medical College, and clinical training at the Hospital of the University of Pennsylvania. He also has a Masters degree in Social and Political Sciences from Cambridge University. Dr. Agrawal has continued to work clinically both in academic and community settings and holds an academic position in Washington DC.



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Testimony of:
Brian P. Ritchie
Acting Deputy Inspector General for Evaluation and Inspections
Office of Inspector General
U.S. Department of Health and Human Services

Hearing:
“Medicare Mismanagement: Oversight of the Federal
Government Efforts to Recapture Misspent Funds”

House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

May 20, 2014
2154 Rayburn House Office Building
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Recapture Misspent Funds"
House Committee on Oversight and Government Reform
Subcommittee on Energy Policy, Health Care and Entitlements

Good morning, Chairman Lankford, Ranking Member Speier, and other distinguished Members of the Subcommittee. Thank you for the opportunity to testify about the U.S. Department of Health and Human Services (the Department) Office of Inspector General's (OIG) recommendations to prevent Medicare improper payments, increase recoveries of overpayments, ensure effective performance by contractors, and improve the Medicare appeals process that resolves disputes over improper payments. Fighting waste, fraud, and abuse in Medicare is a top goal, and improper payments cost Medicare billions of dollars each year. Reducing this amount is paramount.

In short, more action is needed from the Centers for Medicare & Medicaid Services (CMS), its contractors, and the Department to achieve this goal. CMS needs to better ensure that Medicare makes accurate and appropriate payments. When improper payments do occur, CMS needs to identify and recover them. It must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve issues about improper payments efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

Overall, the Department has implemented many of OIG's recommendations, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. In fiscal year (FY) 2013, OIG audits and investigations resulted in expected recoveries of \$5.8 billion in stolen or misspent funds across Department programs. In addition, OIG reported estimated savings of more than \$19 billion resulting from legislative and regulatory actions supported by OIG recommendations.¹ The Health Care Fraud and Abuse Control Program (a joint program of the Department, OIG, and the Department of Justice to fight waste, fraud, and abuse in Medicare and Medicaid) returned more than \$8 for every \$1 invested.²

¹ Office of Inspector General's *Semiannual Report to Congress*, Fall 2013, available online at <http://oig.hhs.gov/reports-and-publications/archives/semiannual/2013/SAR-F13-OS.pdf>.

² The \$8 to \$1 return on investment is a three-year rolling average from FY 2010-2013. For more details on this and other HCFAC accomplishments, see the FY 2013 *Health Care Fraud and Abuse Control Program Report*, available online at <http://oig.hhs.gov/reports-and-publications/hcfac/index.asp>.

Despite these successes, further actions are needed to protect Medicare and Medicaid from waste, fraud, and abuse. In March 2014, OIG issued its *Compendium of Priority Recommendations*, which highlights additional opportunities for cost savings and program and quality improvements.³ Implementing these recommendations could result in billions of additional dollars saved. My testimony today focuses on a selection of those key recommendations.

CMS Needs to Better Ensure that Medicare Makes Accurate and Appropriate Payments

Overall, improper Medicare payments cost taxpayers and beneficiaries about \$50 billion a year.⁴ Medicare fee for service, the largest program, reported an error rate of 10.1 percent (\$36 billion) in FY 2013. OIG's audits and evaluations have identified opportunities to reduce Medicare improper payments for specific program areas and services. Examples of two critical areas include payments for prescription drugs and payments to home health agencies.

Better Protect Medicare and Beneficiaries from Inappropriate Prescribing, Use, and Billing for Prescription Drugs

OIG has extensively examined CMS's monitoring and oversight of the Part D program and the effectiveness of controls to ensure appropriate payment and patient safety. Our work has found limitations in program safeguards that leave Part D vulnerable to improper payments and Medicare patients vulnerable to potentially harmful prescribing. For example, we found that Medicare inappropriately paid millions of dollars for prescriptions from unauthorized prescribers, such as massage therapists and athletic trainers.⁵

Further, thousands of retail pharmacies demonstrated extremely high billing for at least one of the eight measures of questionable billing we developed (e.g., billing for very high numbers of prescriptions per Medicare patient).⁶ For example, one pharmacy billed an average of 116 prescriptions per Medicare patient – almost 5 times the national average of 24 prescriptions per Medicare patient. Pharmacies with questionable billing could have billed for drugs that were not medically necessary or that were not provided to beneficiaries. We have also uncovered extreme prescribing patterns by hundreds of physicians (e.g., prescribing extremely high numbers of prescriptions per Medicare patient, relative to their peers).⁷ For example, over 100 general-care

³ Office of Inspector General's *Compendium of Priority Recommendations*, March 2014, available online at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

⁴ *Department of Health and Human Services FY 2013 Agency Financial Report*, available online at <http://www.hhs.gov/afr/2013-hhs-agency-financial-report.pdf>.

⁵ *Medicare Inappropriately Paid for Drugs Ordered by Individuals Without Prescribing Authority*, OEI-02-09-00608, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00608.asp>.

⁶ *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00600.asp>.

⁷ *Prescribers With Questionable Patterns In Medicare Part D*, OEI-02-09-00603, June 2013, available at <http://oig.hhs.gov/oei/reports/oei-02-09-00603.asp>.

physicians prescribed at a rate of more than 70 prescriptions per Medicare patient. Nationally, general-care physicians average 13 prescriptions per Medicare patient. While questionable billing is not necessarily improper or fraudulent, it may be an indication of such and warrants further scrutiny.

These vulnerabilities are even more concerning in light of the increasing number of OIG investigations into prescription drug fraud. For example, a physician in Kansas and his wife ran a pill mill and wrote thousands of medically unnecessary prescriptions for narcotics. The physician was directly linked to the deaths of four patients, and he billed the drugs to Federal health care programs and private insurers for over \$4 million dollars. Both the physician and his wife were sentenced to more than 30 years in prison.⁸ The serious and growing problem of prescription drug abuse lends a greater urgency to efforts to address fraud and improve monitoring and oversight of Part D.⁹

Key OIG recommendations to CMS related to the issues described above include:

- require Part D plans to verify that prescribers have the authority to prescribe,
- instruct the Medicare program integrity contractor to expand its analysis of prescribers, and
- provide Part D plans with additional guidance on monitoring prescribing patterns.

CMS issued a proposed rule that would require all prescribers of Part D drugs to be enrolled in the Medicare fee-for-service program (or officially opt out).¹⁰ If implemented, this requirement could help CMS, Part D plans, and the Medicare program integrity contractor enhance their monitoring and better prevent and detect Part D improper payments and potential fraud.

CMS Should Better Prevent, Identify, and Recover Improper Payments to Home Health Agencies

For decades, OIG has raised concerns about improper Medicare payments to and fraud committed by home health agencies. CMS has taken steps to protect against improper Medicare billing for home health services, but these actions have not fully addressed the problem.

For example, CMS implemented a requirement of the Affordable Care Act that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. However, OIG found that almost one-third of home health services claims in 2011 and 2012 did not meet these requirements, resulting in \$2 billion in

⁸ U.S. Department of Justice Press Release, Jury: Haysville Doctor and Wife Guilty in Deadly Prescription Drug Overdoses, June 24, 2010, available online at <http://www.justice.gov/usao/ks/PressReleases/2010/jun/June24a.html>.

⁹ See *Spotlight on Drug Diversion*, available at <http://oig.hhs.gov/newsroom/spotlight/2013/diversion.asp>.

¹⁰ Federal Register, Volume 79, Number 7, pages 1982-1987, published January 10, 2014, available online at <http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf>.

improper payments.¹¹ Furthermore, CMS has struggled to collect all of the overpayments to home health agencies that it has identified and has not implemented a requirement promulgated in 1998 that home health agencies obtain surety bonds, which could aid in recouping some of these funds.¹²

In addition, OIG found that in 2010, one-quarter of home health agencies met the threshold of at least one of six questionable billing measures that we created (e.g., billing for unusually high numbers of visits per patient or average payment amounts per patient, relative to other home health agencies).¹³ For example, 13 home health agencies billed for more than 300 visits per Medicare patient in 2010. In comparison, the median number of visits per Medicare patient across all Medicare home health agencies was only 32. Further, OIG investigations have uncovered significant home health fraud, including a case in Texas involving more than \$300 million in alleged fraudulent Medicare billing.¹⁴

Key OIG recommendations to CMS related to improper payments for home health services include:

- create a standardized form to ensure better compliance with the face-to-face encounter documentation requirements,
- implement the surety bond requirement for home health agencies, and
- increase monitoring of Medicare claims for home health services.

CMS Should Maximize Recovery of Improper Payments and Better Address Payment Vulnerabilities to Prevent Improper Payments

The ultimate goal is preventing improper payments entirely. However, the reality is that Medicare pays billions of dollars improperly each year. CMS must maximize the recovery of overpayments identified by its contractors and others. It is also paramount to prevent the recurrence of improper payments by identifying why they occurred and improving program safeguards accordingly.

¹¹ *Limited Compliance with Medicare's Home Health Face to Face Documentation Requirements*, OEI-01-12-00390, April 2014, available online at <http://oig.hhs.gov/oei/reports/oei-01-12-00390.asp>.

¹² *Surety Bonds Remain an Unused Tool to Protect Medicare from Home Health Overpayments*, OEI-03-12-00070, September 2012, available online at <http://oig.hhs.gov/oei/reports/oei-03-12-00070.asp>.

¹³ *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012, available online at <http://oig.hhs.gov/oei/reports/oei-04-11-00240.asp>.

¹⁴ U.S. Department of Justice Press Release, *Dallas Doctor Arrested for Alleged Role in Nearly \$375 Million Health Care Fraud Scheme*, February 28, 2012, available online at <http://www.justice.gov/opa/pr/2012/February/12-crm-260.html>.

Maximize Recovery of Overpayments

CMS's challenges in recovering overpayments are not limited to home health agencies. OIG examined overpayments in "currently not collectible" status – a classification that CMS uses for overpayments in which the provider has not made a repayment for at least six months.¹⁵ In FY 2010, CMS reported that \$543 million in overpayments had been newly designated as "currently not collectible." However, CMS had limited information to track most of these overpayments in its accounting system. For those it did track, virtually all went uncollected. According to contractors, inaccurate provider contact information delays or prevents some overpayment-demand letters from reaching providers. Expanding the types of provider identifiers used to offset overpayment could improve debt recovery efforts, particularly for providers with multiple Medicare national provider identifiers.

These challenges echo earlier OIG findings that the vast majority of overpayments identified by CMS's program integrity contractors went uncollected. Further, CMS did not adequately track information on these overpayments and their collection status.¹⁶

CMS contracts with Recovery Auditors (RACs) to identify Medicare improper payments for recovery (in cases of Medicare overpayments) or return (in cases of Medicare underpayments). OIG reviewed the RAC program for the Medicare fee-for-service program in 2010 and 2011.¹⁷

RACs audits identified improper payments totaling \$1.3 billion in FYs 2010 and 2011. These audits resulted in about \$768 million recovered from providers and about \$135 million in payments returned to providers.

Better Address Vulnerabilities to Prevent Improper Payments

In addition to recovering overpayments, CMS uses RAC audits to identify vulnerabilities and develop corrective action plans to prevent future improper payments. Vulnerabilities have included, for example, billing for services or supplies on behalf of deceased beneficiaries. By June 2012, CMS reported that it had taken corrective actions to address most of the vulnerabilities it had identified from the 2010 and 2011 RAC audits. These corrective actions were not considered closed, however, because CMS had not yet evaluated their effectiveness, a key step in its process. Thus, it is not clear to what extent these corrective actions have prevented improper payments from recurring.

¹⁵ *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670, June 2013, available online at <http://oig.hhs.gov/oei/reports/oei-03-11-00670.pdf>.

¹⁶ *Collection Status of Medicare Overpayments Identified by Program Safeguard Contractors*, OEI-03-08-00030, May 2010, available online at <http://oig.hhs.gov/oei/reports/oei-03-08-00030.pdf>.

¹⁷ *Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, September 2013, available online at <http://oig.hhs.gov/oei/reports/oei-04-11-00680.pdf>.

CMS has missed opportunities to address improper payment vulnerabilities identified by its program integrity contractors. In 2011, OIG found that CMS had resolved or taken significant action on only about a quarter of the vulnerabilities that its program integrity contractors had reported in 2009.¹⁸

Key OIG recommendations to CMS to maximize recovery of improper payments and address payment vulnerabilities include:

- improve tracking and monitor the status of overpayment collections,
- expand the types of provider identifiers used to recover overpayments,
- address program vulnerabilities identified by contractors in a timely manner, and
- evaluate the effectiveness of corrective actions.

CMS Needs to Ensure Effective Performance by Its Contractors

CMS relies on contractors to operate vital functions of the Medicare program, including paying claims, running program integrity activities, identifying overpayments, and recouping overpayments. CMS contracts with Medicare Administrative Contractors (MACs) to process claims and implement payment safeguards; program integrity contractors, including the Medicare Drug Integrity Contractor (MEDIC), Zone Program Integrity Contractors (ZPICs), and Program Safeguard Contractors (PSCs), to protect Medicare from fraud and abuse; and RACs to identify and collect overpayments. OIG reviews of these contractors over the past decade have consistently identified problems, including failure to use data to assess contractor performance and inadequate response when contractors do not meet performance standards.¹⁹

Use Data More Effectively to Oversee Contractor Performance and Include Key Metrics in Performance Evaluations

Program integrity contractors are required to periodically report to CMS data describing their activities. However, OIG found that the data used by CMS to oversee ZPICs were not accurate or uniform, preventing a conclusive assessment of contractor activities. Further, OIG found significant differences in fraud detection efforts across ZPICs (and in earlier work, across PSCs) that could not be explained by differences in budget or oversight responsibility. Yet, CMS had not assessed the wide variation across contractors' activity data, and CMS contractor

¹⁸ *Addressing Vulnerabilities Reported by Medicare Benefit Integrity Contractors*, OEI-03-10-00500, December 2011, available online at <http://oig.hhs.gov/oei/reports/oei-03-10-00500.asp>.

¹⁹ Findings and recommendations from a series of OIG evaluations of contractor oversight and performance are summarized and referenced in OIG's *Compendium of Priority Recommendations*, March 2014, available online at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.

performance evaluations provide few quantitative details about the contractors' achievements in detecting and deterring fraud and abuse.²⁰

Additionally, CMS's performance evaluations for RACs lacked metrics related to key contract requirements, such as identification of improper payments. In response to our report, CMS noted that it has revised its RAC evaluations to incorporate metrics on identification of improper payments and accuracy rates and is considering additional performance measures. We encourage CMS to continue to increase its use of performance metrics and data to oversee contractor performance.²¹

Evaluate Contractor Performance in a Timely Manner and Respond More Effectively When Performance Requirements Go Unmet

OIG found that CMS conducts extensive activities to review MACs' performance. However, the reviews are not always conducted in time to inform future contract award decisions. Further, CMS did not ensure that its MACs resolved or developed action plans to address unmet quality assurance standards.²²

Key OIG recommendations to CMS related to contractor performance include:

- improve and more effectively use data to assess contractor performance, including to analyze performance across contractors and assess the causes of variation;
- strengthen performance evaluations and include key metrics to assess how well contractors are performing core functions; and
- conduct performance evaluations in a timely manner and address unmet performance standards more effectively.

The Medicare Appeals System Needs Fundamental Changes

Medicare appeals decisions affect providers, beneficiaries, and the program as a whole. It is imperative that the appeals system be efficient, effective, and fair.

²⁰ *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*, OEI-03-09-00520, November 2011, available online at <http://oig.hhs.gov/oei/reports/oei-03-09-00520.asp>.

²¹ *Medicare Recovery Audit Contractors and CMS's Actions To Address Improper Payments, Referrals of Potential Fraud, and Performance*, OEI-04-11-00680, August 2013, available online at <http://oig.hhs.gov/oei/reports/oei-04-11-00680.asp>.

²² *Medicare Administrative Contractors' Performance*, OEI-03-11-00740, January 2014, available online at <http://oig.hhs.gov/oei/reports/oei-03-11-00740.asp>.

In recent years, the system has experienced an unprecedented surge of appeals.²³ According to the Office of Medicare Hearings and Appeals (OMHA), from FY 2012 to 2013, the number of appeals reaching the Administrative Law Judges (ALJ, the third level of appeals) doubled.²⁴ OMHA estimates that its backlog will reach a million claims by the end of this fiscal year. A concerted effort by all key players—including CMS, OMHA, and Congress—is needed to address this issue and to maintain the integrity of the appeals system.

Before the recent surge, OIG completed work that focused on the ALJ level of appeals.²⁵ Although the work covered FY 2010, many of the findings and recommendations are relevant to understanding and addressing the current challenges.

A small percentage of providers account for a large number of appeals

Medicare providers make up the vast majority – 85 percent – of appellants. Moreover, only 2 percent of providers accounted for nearly one-third of all ALJ appeals. Specifically, 96 providers filed at least 50 appeals each with 1 provider filing over 1,000 appeals. ALJ staff has raised concerns that some providers appeal every payment denial and may have incentives to appeal because the cost is minimal and a favorable decision for the appellant is likely.

For more than half of appeals, ALJs decided fully in favor of appellants

In 2010, ALJs reversed prior-level decisions and decided fully in favor of appellants for 56 percent of appeals. In comparison, Qualified Independent Contractors (QICs) – the second level of appeals – decided fully in favor of appellants for only 20 percent of appeals. Appellants were most likely to receive favorable ALJ decisions for Part A hospital appeals (72 percent) and least likely for Parts C and D appeals (18 percent and 19 percent, respectively).

Differences between ALJ and prior-level decisions were due to different interpretations of Medicare policies and other factors

Several factors led to ALJs reaching different decisions than those in the prior level of appeals. We found that ALJs tended to interpret Medicare policies less strictly than did QICs. QICs also tend to be more specialized in Medicare program areas than ALJs and have clinicians on staff; ALJs tend to rely on evidence and testimony from the treating physicians. Both QIC and ALJ staff noted that lack of clarity in some Medicare policies is also a factor in the differing decisions.

²³ OIG found that Medicare redeterminations – the first level in the Medicare appeals process – increased by 33 percent from 2008 to 2012. Increases in appeals by Part A providers related to RAC audits was one driver of the increase. See *The First Level of the Medicare Appeals Process, 2008-2012: Volume, Outcomes, and Timeliness*, OEI-01-12-00150, October 2013, available online at <http://oig.hhs.gov/oei/reports/oei-01-12-00150.asp>.

²⁴ Department of Health and Human Services, *Justification of Estimates for Appropriations Committees, Fiscal Year 2015*, available online at <http://www.hhs.gov/budget/fy2015/fy-2015-hhs-congressional-budget-justification.pdf>.

²⁵ *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals*, OEI-02-10-00340, November 2012, available online at <https://oig.hhs.gov/oei/reports/oei-02-10-00340.asp>.

Further, ALJs vary amongst themselves in decision-making. The fully favorable rate for appellants ranged from 18 to 85 percent among the 66 ALJs.

CMS participation affects the outcome of appeals

CMS participated in 10 percent of ALJ appeals in FY 2010. For those in which CMS participated, the ALJs were less likely to decide fully in favor of the appellant.

Current practices regarding appeals documents are highly inefficient

Both CMS and ALJ staff identified problems with case files. They reported that a case file at the ALJ level often differed in content, organization, and format compared to the same appeal's case file at the QIC level, creating inefficiencies in the appeals system. Because the QICs' case files are almost entirely electronic and ALJs primarily accept only paper case files, the QICs must convert the files to paper format before sending to the ALJs. Most staff noted that this process is resource intensive and prone to error.

Key recommendations to OMHA and CMS related to improving the appeals process include:

- identify and clarify Medicare policies that are being interpreted differently and develop and coordinate training on those policies;
- standardize case files and make them electronic;
- continue to increase CMS participation in ALJ appeals; and
- implement a quality assurance process to review ALJ decisions.

OIG Will Continue Working to Prevent and Recover Medicare Improper Payments

Reducing Medicare improper payments and ensuring effective program administration requires a concerted effort by a number of key players, including the Department, CMS, CMS contractors, providers, Congress, and OIG.

More action is needed to ensure that payments are made accurately. Any improper payments that do occur must be identified and recovered, and solutions must be identified and implemented to prevent recurrence. As CMS relies on contractors for most of these crucial functions, oversight of and accountability for contractor performance is paramount. Finally, the Medicare appeals system to resolve issues about improper payments must operate efficiently, effectively, and fairly.

While CMS has taken some important steps to identify and recover improper payments and implement safeguards to prevent them, our work demonstrates that further improvements are

needed. A comprehensive list of OIG's priority recommendations can be found in our *Compendium of Priority Recommendations* on our Web site.²⁶

OIG will continue to audit and evaluate Medicare payments and vulnerabilities and recommend solutions to reduce the billions of dollars wasted each year. We are challenged in meeting this mission by declining resources for Medicare and Medicaid oversight at a time when these programs and our responsibilities are growing. By the end of this fiscal year, we expect to reduce our Medicare and Medicaid oversight by about 20 percent. Yet the Department estimated that Medicare and Medicaid outlays would grow by about 20 percent from 2012 to 2014. Full funding of our 2015 budget request would enable us to provide more robust oversight and advance solutions to protect the Medicare and Medicaid programs, beneficiaries, and taxpayers.

We are committed to strong oversight of Medicare to reduce waste, fraud and abuse as comprehensively and effectively as possible with the tools and resources we have available. At stake are billions of dollars, the solvency of the program, and the health and well-being of beneficiaries.

Thank you for your interest and support and for the opportunity to discuss some of our work related to Medicare oversight. I am happy to answer any questions you may have.

²⁶ Available at <http://oig.hhs.gov/reports-and-publications/compendium/index.asp>.



Testimony

Before the Subcommittee on Energy
Policy, Health Care and Entitlements,
Committee on Oversight and Government
Reform, House of Representatives

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MEDICARE

Further Action Could Improve Improper Payment Prevention and Recoupment Efforts

Statement of Kathleen M. King
Director, Health Care

GAO Highlights

Highlights of GAO-14-619T, a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Due to its size, complexity, and susceptibility to mismanagement and improper payments, GAO has designated Medicare as a high-risk program. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about \$604 billion, and reported an estimated \$50 billion in improper payments—payments that either were made in an incorrect amount or should not have been made at all. Most of these improper payments were made through the Medicare FFS program, which pays providers based on claims and uses contractors to pay the claims and ensure program integrity.

This statement focuses on the progress made and steps still to be taken by CMS to improve improper payment prevention and recoupment efforts in the Medicare FFS program. This statement is based on relevant GAO products and recommendations issued from 2007 through 2014 using a variety of methodologies. GAO also updated information by examining public documents and, in April 2014, GAO received updated information from CMS on its actions related to laws and regulations discussed in this statement.

View GAO-14-619T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

May 20, 2014

MEDICARE

Further Action Could Improve Improper Payment Prevention and Recoupment Efforts

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has made progress improving improper payment prevention and recoupment efforts in the Medicare fee-for-service (FFS) program, but further actions are needed.

Provider enrollment. CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) that address past weaknesses identified by GAO and others. The agency has also put in place other measures intended to strengthen existing procedures, but could do more to improve provider enrollment screening and ultimately reduce improper payments. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses, meet certain Medicare standards, and are at legitimate locations. CMS also recently contracted for fingerprint-based criminal history checks of providers and suppliers it has identified as high-risk. However, CMS has not implemented other screening actions authorized by PPACA that could further strengthen provider enrollment.

Prepayment controls. In response to GAO's prior recommendations, CMS has taken steps to improve the development of certain prepayment edits—prepayment controls used to deny Medicare claims that should not be paid; however, important actions that could further prevent improper payments have not yet been implemented. For example, CMS has implemented an automated edit to identify services billed in medically unlikely amounts, but has not implemented a GAO recommendation to examine certain edits to determine whether they should be revised to reflect more restrictive payment limits. GAO has found that wider use of prepayment edits could help prevent improper payments and generate savings for Medicare.

Postpayment claims reviews. Postpayment claims reviews help CMS identify and recoup improper payments. Medicare uses a variety of contractors to conduct such reviews, which generally involve reviewing a provider's documentation to ensure that the service was billed properly and was covered, reasonable, and necessary. GAO has found that differing requirements for the various contractors may reduce the efficiency and effectiveness of such reviews. To improve these reviews, GAO has previously recommended CMS examine ways to make the contractor requirements more consistent. CMS reported that it has begun to address these recommendations. Although the percentage of Medicare claims that undergo postpayment review remains very small, GAO has found that the overall number of postpayment claims reviews has been increasing in recent years. HHS has reported that the increase in claims reviews is one factor causing backlogs in the Medicare appeals process.

GAO has ongoing work focused on how CMS could continue its efforts to reduce improper Medicare payments. For instance, GAO is examining the extent to which CMS's provider enrollment system can help prevent and detect the continued enrollment of ineligible providers in Medicare. GAO also has work underway to examine whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining further action Medicare could take to improve its improper payment prevention and recoupment efforts.¹ In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about \$604 billion, and reported some of the largest estimates of improper payments among federal programs—payments that either were made in an incorrect amount or should not have been made at all.² Due to its size, complexity, and susceptibility to mismanagement and improper payments, we have designated Medicare as a high-risk program since 1990.³

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has estimated that improper payments in the Medicare program were almost \$50 billion in fiscal year 2013.⁴ CMS separately calculates error rates and performance targets for the Medicare fee-for-service (FFS) program, Medicare Advantage, and the Medicare Prescription Drug Benefit.⁵ Medicare FFS accounted for more than 70 percent of Medicare's estimated improper payments in 2013. The Medicare FFS estimated improper payments were about \$36 billion or about 10.1 percent of total FFS payments. This is about \$6.5 billion

¹Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

²An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

³GAO, *High-Risk Series: An Update*, GAO-13-283 (Washington, D.C.: February 2013)

⁴A list of abbreviations used in this statement is provided in appendix I.

⁵Medicare consists of four parts. Parts A and B are known as Medicare FFS. Part A covers hospital and other inpatient stays and Part B covers hospital outpatient, physician, and other services. Part C, also known as Medicare Advantage, is the private plan alternative to Medicare FFS under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit.

higher than in 2012 and did not meet the fiscal year 2013 target error rate of 8.3 percent that the agency set for itself to reduce improper payments.⁶ Improper payments may be a result of fraud, waste, or abuse, but it is important to distinguish that the \$50 billion in estimated improper payments reported by CMS in fiscal year 2013 is not an estimate of fraud in Medicare.⁷ Reported improper payment estimates include many types of payments that should not have been made or were made in an incorrect amount such as overpayments, underpayments, and payments that were not adequately documented.

According to HHS, the primary cause of improper payments in Medicare FFS was administrative and documentation errors in large part due to insufficient documentation, meaning the medical records submitted by the provider or supplier were inadequate to support payment for the services billed.⁸ HHS has reported that physicians and suppliers substantially contributed to insufficient documentation errors. HHS also cited the provision of services that were found not to be medically necessary and incorrect diagnosis coding as causes for FFS improper payments. Medical necessity errors occur, for example, when a claim is paid for a service that should have been provided in a less intensive setting. This error type has accounted for the majority of Part A inpatient hospital improper payments. For Medicare Advantage, HHS reported that the majority of the improper payment estimate resulted from insufficient documentation to support the diagnoses submitted by private health plans for payment. HHS cited administrative and documentation errors as the cause for all improper payments in the prescription drug benefit. Despite

⁶See Department of Health and Human Services, *Fiscal Year 2012 Agency Financial Report* (Washington D.C.: Nov 15, 2012).

⁷Fraud consists of intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

⁸Department of Health and Human Services, *Fiscal Year 2013 Agency Financial Report* (Washington D.C.: Dec 16, 2013). Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate improper payment estimates. The CERT program categorized five types of errors—no documentation, insufficient documentation, medical necessity, incorrect coding, and other errors (such as duplicate payments). In this statement, the term provider includes entities such as hospitals or physicians, and supplier means an entity that supplies Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs.

CMS efforts to address these causes, reducing Medicare improper payments continues to be a challenge.

Today, my testimony will focus on the progress made and steps still needed by CMS to reduce improper payments in the Medicare FFS program. I will focus on CMS's progress with respect to three key strategies we have identified in prior work that can help prevent improper payments and recoup overpayments:

- Strengthening provider enrollment standards and procedures to help reduce the risk of enrolling entities intent on defrauding the program;
- Improving prepayment controls, to ensure that claims are paid correctly the first time; and
- Improving postpayment claims review and recovery of improper payments to reduce the likelihood of improper payments and recoup overpayments.

My statement today is based primarily on previous GAO reports related to Medicare program integrity efforts issued between January 2007 and April 2014. A list of related GAO products is included at the end of this statement.⁹ We supplemented prior work with additional information on Medicare improper payments reported by HHS in its fiscal year 2013 agency financial report and with other publicly available information from HHS's website on Medicare appeals, and we received updated information from CMS in April 2014 on its actions related to relevant laws, regulations, and recommendations that had not yet been implemented discussed in this statement. Our work for this statement and the products on which it was based was conducted 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.

⁹The products listed at the end of this statement contain detailed information on the various methodologies used in our work.

CMS Has Improved Key Strategies for Preventing and Recouping Improper Payment, but More Can Be Done

CMS has made progress strengthening provider enrollment procedures and prepayment controls in the Medicare program to help ensure that payments are made correctly the first time, but the agency could further improve upon its efforts by implementing additional enrollment procedures and prepayment strategies. Likewise, additional improvements to CMS's postpayment claims review activities could improve their efficiency and effectiveness.

CMS Has Implemented Certain Enrollment Procedures to Better Screen Providers, but Has Not Completed Others

CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) and put in place other measures intended to strengthen existing procedures.¹⁰ The changes to provider screening procedures are intended to address past weaknesses identified by GAO and the HHS's Office of Inspector General (OIG) that allowed entities intent on committing fraud to enroll in Medicare. Blocking the enrollment of such providers helps to prevent Medicare from making improper payments. Specifically, CMS added screenings of categories of provider enrollment applications by risk level and contracted with new national enrollment screening and site visit contractors.

- *Screening Provider Enrollment Applications by Risk Level:* CMS and the OIG issued a final rule in February 2011 to implement many of the new screening procedures required by PPACA.¹¹ CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous screening. Based in part on our work and that of the OIG, CMS designated newly enrolling home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as high risk, and designated other providers as lower risk.

¹⁰Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

¹¹*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine whether a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare, such as having current licenses or accreditation and valid Social Security numbers. High- and moderate-risk providers are also subject to unannounced site visits.

Further, PPACA authorizes CMS to require fingerprint-based criminal background checks of providers and suppliers depending on the risks presented. In March 2014, CMS awarded a contract to a Federal Bureau of Investigation-approved contractor that will enable the agency to access criminal history information to help conduct those checks of high-risk providers and suppliers. CMS has indicated that the agency will continue to review the criteria for its screening levels and will publish changes if the agency decides to update the assignment of screening levels for categories of Medicare providers. Doing so could become important because the Department of Justice and HHS reported multiple convictions, judgments, settlements, or exclusions against types of providers not currently at the high-risk level, including community mental health centers and ambulance providers.¹²

- *National Enrollment Screening and Site Visit Contractors:* CMS contracted with two new contractors at the end of 2011 to assume centralized responsibility for two functions that had been the responsibility of multiple contractors. One of the new contractors is conducting automated screenings to check that existing and newly enrolling providers and suppliers have valid licensure, accreditation, and a National Provider Identifier, and are not on the OIG list of providers and suppliers excluded from participating in federal health care programs. The second contractor conducts site visits of providers to determine whether sites are legitimate and the providers meet certain Medicare standards. A CMS official reported that, since the implementation of the PPACA screening requirements, the agency

¹²Department of Health and Human Services and the Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (Washington, D.C.: February 2014).

had revoked over 17,000 suspect providers' privileges to bill the Medicare program.¹³

Although CMS has taken actions to strengthen the provider enrollment process, we and the OIG have found that CMS has not taken other actions authorized by PPACA and that could improve screening and ultimately reduce improper payments.¹⁴ They include issuing a rule to require surety bonds for certain providers and suppliers as well as a rule on provider and supplier disclosure requirements.

- **Surety Bonds:** PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers.¹⁵ Surety bonds may serve as a source for recoupment of erroneous payments. DMEPOS suppliers are currently required to post a surety bond at the time of enrollment.¹⁶ CMS told us in April 2014 that the agency collected about \$1.6 million in DMEPOS supplier overpayments between February 2012 and March 2013. However, also in April 2014, CMS reported that it had not scheduled for publication a proposed rule to impose a surety bond requirement as authorized by PPACA for other types of at-risk providers and suppliers—such as home health agencies and independent diagnostic testing facilities.
- **Providers and Suppliers Disclosure:** CMS has not yet scheduled the publication of a proposed rule for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care

¹³S. Agrawal, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, *Preventing Medicare Fraud: How Can We Best Protect Seniors and Taxpayers?*, testimony before the Senate Special Aging Committee, March 26, 2014.

¹⁴GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, GAO-12-351 (Washington, D.C.: Apr. 10, 2012).

¹⁵A surety bond guarantees that if a provider or supplier does not fulfill its obligation to Medicare, CMS can recover its losses via the surety bond.

¹⁶42 U.S.C. § 1395m(a)(16)(B). A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, the surety bond is paid to Medicare. *Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*, 74 Fed. Reg. 166 (Jan. 2, 2009).

program.¹⁷ As we reported in April 2012, agency officials indicated that developing the additional disclosure requirements has been complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.¹⁸

We are currently examining the ability of CMS's provider enrollment system to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Specifically, we are assessing the process used to enroll and verify the eligibility of Medicare providers in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) and the extent to which CMS's controls are designed to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in PECOS.¹⁹

CMS Has Improved Prepayment Controls, but More Could Be Done to Prevent Improper Payments

CMS has enhanced its efforts to reduce improper payments by improving prepayment controls, particularly prepayment edits to deny claims that should not be paid. CMS has stated that one of its key goals is to pay claims properly the first time—that is, to ensure that payments go to legitimate providers in the right amount for reasonable and necessary services covered by the program for eligible beneficiaries. To do so, among other things, CMS uses prepayment controls such as prepayment edits—instructions that CMS's contractors, including Medicare Administrative Contractors (MAC), program into claims processing systems that compare claim information to Medicare requirements in

¹⁷At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose, in a form and manner and at such time as determined by the Secretary, any current or previous affiliation with another provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or State Children's Health Insurance Program; or has had its billing privileges denied or revoked. Pub. L. No. 111-148, § 6401(a), 124 Stat. 119, 750 (2010).

¹⁸GAO-12-351.

¹⁹PECOS is CMS's centralized database for Medicare enrollment information. To bill Medicare, providers and suppliers must first enroll in PECOS and as part of the enrollment process CMS contractors validate certain provider information.

order to approve or deny claims or to flag them for additional review.²⁰ For example, some prepayment edits are related to service coverage and payment, while others are implemented to verify that the claim is properly filled out, that providers are enrolled in Medicare, or that patients are eligible Medicare beneficiaries.²¹ Most of the edits implemented by CMS and its contractors are automated and applied to all claims; if a claim does not meet the criteria of the edits, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff to determine whether it should be paid.

We previously evaluated CMS's implementation of prepayment edits and found that while use of prepayment edits saved Medicare at least \$1.76 billion in fiscal year 2010, the savings could have been greater had prepayment edits been used more widely.²² For example, based on our analysis of a limited number of national policies and local coverage determinations in 2012,²³ we identified \$14.7 million and \$100 million in payments, respectively, that were inconsistent with policies and determinations and were therefore improper. Such inconsistencies could have been identified using automated edits.

As we recommended, CMS has taken steps to improve the development of certain prepayment edits that are implemented nationwide. For example, the agency has centralized the development and

²⁰Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine whether claims should be paid. MACs process and pay FFS claims. In addition to MACs, CMS has other types of contractors to help identify and recover improper payments, address fraud and abuse, or develop specific types of edits.

²¹For more information on the scope of prepayment coverage, payment and coding edits, see GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102 (Washington, D.C.: Nov. 13, 2012).

²²GAO-13-102.

²³CMS typically develops national coverage determination policies for services that have the potential to affect a large number of beneficiaries and that have the greatest effect on the Medicare program. Development of national coverage determinations is a lengthy process, which requires review of clinical evidence and allows for public comment. In addition, each MAC has the authority to develop local coverage determinations (LCDs) that delineate the circumstances under which services are considered reasonable and necessary and are therefore covered in the geographic area where that MAC processes claims.

implementation of automated edits based on a type of national policy called national coverage determinations.²⁴ In addition, CMS has modified its processes for identifying provider billing of services that are medically unlikely, in order to prevent circumvention of automated edits designed to identify an unusually large quantity of services provided to the same patient.²⁵ However, as of April 2014, CMS had not fully implemented several of the recommendations we made in 2013 that we believe would promote greater use of prepayment edits and better ensure proper payment.²⁶ For example, the agency did not include, in its written guidance to agency staff on procedures for ensuring consideration of automated edits, time frames for making decisions on whether an edit would be developed nor did it include requirements for assessing the effects of corrective actions taken. In addition, although CMS has taken initial steps to improve the data it collects about local prepayment edits implemented by its contractors, it had not yet determined a final process for how it would obtain and disseminate information about these edits across contractors.²⁷ Nor does CMS require contractors to share information with each other about the underlying policies and savings related to their most effective edits, as the agency currently lacks a database to collect such information. Having information about the most effective local edits would enable contractors to determine the most appropriate approach for implementing Medicare payment policy effectively, which could help reduce improper payments.

To help prevent improper payments, CMS also implemented a specific type of national edit, called a Medical Unlikely Edit (MUE), which limits the amount of a service that is paid when billed by a provider for a beneficiary on the same day. The limits for certain services that have been fraudulently or abusively billed are unpublished to deter providers from billing up to the maximum allowable limit. In 2013, we reported that CMS may be missing opportunities to prevent improper payments because it

²⁴GAO, *Medicare Fraud: Progress Made, but More Action Is Needed to Address Medicare Fraud, Waste and Abuse*, GAO-14-560T (Washington, D.C.: Apr. 30, 2014).

²⁵CMS refers to these automated edits as Medically Unlikely Edits (MUE).

²⁶See GAO-13-102 for our recommendations related to our evaluation of CMS's implementation of prepayment edits.

²⁷MACs may create prepayment edits to implement their LCDs. CMS has responsibility for providing information and oversight to MACs with respect to their use of prepayment edits to promote effective stewardship of Medicare funds.

has not systematically evaluated MUE limits to determine whether national edits should be revised to reflect more restrictive local limits.²⁸ In addition, we found that CMS and its contractors did not have a system in place for examining claims to determine the extent to which providers may be exceeding unpublished MUE limits and whether payments for such services were proper. As a result, we recommended that CMS examine contractor edits to determine whether any national unpublished MUE limits should be revised, consider reviewing claims to identify providers that exceed the unpublished MUE limits, and determine whether the provider's billing was proper. HHS agreed with these recommendations, but as of April 2014, CMS had not implemented them.

Postpayment Claims Reviews Have Increased in Recent Years, but More Could Be Done to Increase Consistency across Contractors

Medicare uses four types of contractors to conduct postpayment claims reviews to identify and recoup overpayments.²⁹ The contractors all use the same Medicare coverage and payment guidelines.

- MACs, in addition to conducting prepayment claims reviews, conduct postpayment claims reviews to help ensure accurate payment and specifically to identify payment errors. This includes identifying ways to address future payment errors—for example, through automated controls that can be added on a prepayment basis and by educating providers with a history of a sustained or high level of billing errors to ensure that they comply with Medicare billing requirements.
- Zone Program Integrity Contractors (ZPIC), the CMS contractors responsible for detecting and investigating fraud, perform postpayment claims reviews as a part of their investigations.³⁰

²⁸GAO, *Medicare Program Integrity: Few Payments in 2011 Exceed Limits Under One Type of Prepayment Control, but Reassessing Limits Could Be Helpful*, GAO-13-430 (Washington, D.C.: May 9, 2013).

²⁹In this statement, we discuss the four types of primary contractors that perform claims reviews. In addition to these four, in 2012 CMS established the Supplemental Medicare Review Contractor type to perform national claims reviews of Medicare Part A, Part B, and durable medical equipment providers and suppliers. This type of contractor conducts large-volume medical reviews nationwide for specific services, such as Inpatient Psychiatric Facility Interrupted Stays, Epidural Injections, and Place-of-Service coding. We are not discussing this type of contractor because it was too new to examine during our most recent work on Medicare postpayment contractors.

³⁰Program safeguard contractors conducted activities to investigate fraud prior to the establishment of ZPICs, and are still doing so in one of seven geographic zones.

Therefore, ZPIC reviews generally focus on providers whose billing patterns are unusual or aberrant in relation to those of similar providers in order to identify potential fraud.

- The Comprehensive Error Rate Testing (CERT) contractor estimates the Medicare FFS improper payment rate by using the results of postpayment claims reviews conducted on a sample of claims processed by the MACs. CERT reviews may also help identify program vulnerabilities by measuring the payment accuracy of each MAC, and the Medicare FFS improper payment rate by type of claim and service.
- Recovery audit contractors (RAC) conduct postpayment claims reviews to identify improper payments. Use of RACs was designed to be in addition to MACs' existing claims review processes, since the number of postpayment reviews conducted by MACs and other contractors was small relative to the number of claims paid and the amount of improper payments. Whereas RACs are paid on a contingency fee basis based on the amount of improper payments they recoup, the other three contractors are paid under the terms of their contract using appropriated funds.³¹ In February 2014, CMS announced a "pause" in the RAC program as the agency makes changes to the program and starts a new procurement process for the next round of recovery audit contracts. CMS said it anticipates awarding all five of these new Medicare FFS recovery audit contracts by the end of summer 2014.³²

All four types of contractors conduct complex reviews of claims. Complex reviews involve manual examinations of each claim and any related documentation requested and received from the provider, including paper files, to determine whether the service was billed properly, and was covered, reasonable, and necessary. Licensed clinical professionals, such as licensed practical nurses, and certified coders typically perform

³¹Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years. Typically, contractors that perform recovery audits are paid a contingency fee based on a percentage of the overpayments collected. In Medicare, the RACs are paid a contingency fee based on both the percentage of overpayments collected and underpayments identified.

³²PPACA required the expansion of Medicare RACs to Parts C and D. See Pub. L. No. 111-148, § 6411(b) 124 Stat. 119, 775 (2010) (codified at 42 U.S.C. § 1395ddd(h)). CMS has implemented a RAC for Part D, and CMS said it plans to award a contract for a Part C RAC by the end of 2014.

the reviews. Contractors have physician medical directors on staff who provide guidance about making payment determinations on the basis of medical records and other documentation and who may discuss such determinations with providers.

In addition to conducting complex reviews, RACs also conduct automated and semiautomated postpayment claims reviews. Automated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Automated postpayment reviews analyze paid claims and identify those that can be determined to be improper without examining any additional documentation, such as when a durable medical equipment supplier bills for items that should have been included as part of a bundled payment for a skilled nursing facility stay.³³ Semiautomated reviews use computer programming logic to check for possible improper payments, but allow providers to send in information to rebut the claim denial before it is implemented. If providers send in information, RAC staff review it before making a final determination.

Our prior work has found that the overall number of postpayment claims reviews has been increasing in recent years, but remains a very small percentage of total Medicare claims submitted.³⁴ In 2012, the most recent year for which we have data, the four types of Medicare postpayment review contractors conducted about 2.3 million claims reviews, which is a 55 percent increase from 2011. RACs conducted about 2.1 million, or 90 percent, of these reviews in 2012. All four types of contractors listed except the CERT contractor increased the number of claims they reviewed in 2012, as shown in table 1.

³³If the durable medical equipment claim is submitted prior to the bundled skilled nursing facility claim, the durable medical equipment claim may not appear to be improper when made.

³⁴GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*. GAO-13-522 (Washington, D.C.: July 23, 2013).

Table 1: Volume of Contractors' Postpayment Claims Reviews, by Type of Contractor 2011-2012

Type of contractor	Type of review	2011	2012	Percent change
Medicare Administrative Contractors (MAC) ^a	Complex ^b	10,518	84,070	699%
Zone Program Integrity Contractors (ZPIC) ^c	Complex	92,655	107,621	16
Comprehensive Error Rate Testing (CERT) contractor	Complex	47,877	41,396	-14
Recovery Audit Contractors (RAC) ^d	Automated ^e	723,484	985,946	36
	Complex ^f	634,613	1,121,509	77
	Total	1,358,097	2,107,455	55
Total		1,509,147	2,340,542	55%

Source: GAO analysis of CMS data.

^aReviews completed by MACs do not include the reviews performed by the three legacy contractors that were continuing to provide claims administration services as of June 2013.

^bComplex reviews are manual examinations of claims documentation including paper files, to determine whether the service was billed properly and was covered, reasonable, and necessary. They typically are performed by licensed clinical professionals or certified coders.

^cReviews completed by ZPICs include those performed by the program safeguard contractors (PSC) and reflect PSCs' reviews of potentially abusive physical therapy claims in one geographic area.

^dRAC data are reported for fiscal years 2011 and 2012, rather than calendar year.

^eAutomated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Only the RACs conducted automated postpayment reviews.

^fRAC complex reviews are based on the number of additional documentation requests received and also include semiautomated reviews.

While the number of postpayment reviews has increased significantly, the percentage of Medicare claims reviewed after payment remains small. The 2.3 million reviews performed by these four types of contractors accounted for less than 1 percent of the more than 1 billion FFS claims paid annually. About 1.4 million of the reviews were complex reviews which required the submission of documentation for review.

As a systematic matter, the increase in postpayment claims reviews is one factor causing backlogs and delays at the third level of the Medicare appeals process. Medicare providers and suppliers can appeal prepayment and postpayment claims determinations through the Medicare appeals process, which offers four levels of administrative review followed by judicial review. The first two levels of appeals for FFS claims are managed by two CMS contractors—the MAC that processed the original claim and a Qualified Independent Contractor, in that order.³⁵

³⁵There are five Qualified Independent Contractors that serve different areas of the country and focus on specific parts of the Medicare FFS program.

The third level of appeal is to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA), a separate staff division within HHS. A Part A or Part B appeal filed with OMHA should generally be decided within 90 days of the appeal being filed.³⁶ However, due to a backlog of cases, OMHA currently reports that the average time for appeals to be decided in fiscal year 2014 is 346 days.³⁷ The number of appeals filed at the ALJ level increased from 59,601 in fiscal year 2011 to 384,651 in fiscal year 2013, according to OMHA. OMHA's website currently says that new appeals will take about 28 months before they are put on an ALJ's hearing docket. OMHA has reported that part of the reason for the backlog in Medicare appeals is the increase in postpayment contractor activities. We have been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and what HHS is doing to address it.

We have made recommendations to CMS in the past to improve the postpayment claims review process, and we continue to do work in this area. In October 2012, we reported on CMS's Fraud Prevention System (FPS), which uses predictive analytics to analyze Medicare FFS claims.³⁸ FPS is intended to detect aberrant billing practices as quickly as possible so they can be investigated to determine whether the payments are proper. At the time, we recommended that CMS integrate FPS with Medicare's payment-processing system to allow for the prevention of payments until suspect claims could be investigated by ZPICs. Although CMS reported in April 2014 that it had integrated the systems, the system still does not have the ability to suspend payment until suspect claims can be investigated. CMS has begun to implement prepayment edits in FPS that automatically deny claims based on attributes of the FPS edit which reviews the claim against historical claims across all lines of business.³⁹

³⁶OMHA also adjudicates other Medicare appeals, including those related to Part D prescription drug coverage. However, Part A and Part B appeals make up the vast majority of appeals made to OMHA.

³⁷OMHA prioritizes beneficiary appeals and expedited appeals of Part D drug denials.

³⁸GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

³⁹CMS told us that it implemented the first FPS edit in January 2014 and that two additional FPS edits are planned for implementation in June 2014 and two more in September 2014.

In July 2013, we reported that the differences in CMS's postpayment claims review requirements for the four types of contractors may reduce the efficiency and effectiveness of claims reviews by complicating providers' compliance with the requirements.⁴⁰ For instance, while RACs have to obtain approval from CMS for the billing issues they choose to review on a widespread basis and notify providers and suppliers of those issues on their websites, the other contractors do not. In addition, the minimum number of days that CMS requires a contractor to give a provider to submit additional documentation for a complex review before the claim can be found improper for lack of documentation varies among the contractors from 30 days for ZPICs to 75 days for the CERT contractor. Staffing requirements and quality assurance requirements also vary among the four types of contractors. We recommended that CMS examine all postpayment review requirements for contractors to determine whether they could be made more consistent without negative effects on program integrity. We also recommended that CMS reduce differences in those requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. In commenting on that report, CMS agreed with our recommendations and stated that the agency was beginning to review its requirements for postpayment claims reviews. We are following up on this work with a study reviewing, among other things, whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

In conclusion, given the amount of estimated improper payments in the Medicare program, the imperative for CMS to use all available authorities to prevent and recoup improper payments is clear. Although CMS has taken important steps to strengthen key strategies for identifying and preventing improper payments, the agency must continue to improve upon these efforts. Identifying the nature, extent, and underlying causes of improper payments and developing adequate corrective action processes to address vulnerabilities are essential prerequisites to reducing them. As CMS continues its implementation of PPACA, additional evaluation and oversight will help determine whether implementation of relevant provisions has been effective in reducing improper payments. We are continuing to conduct a body of work that assesses CMS's efforts to refine and improve its ability to prevent, identify, and recoup improper payments. Notably, we are currently

⁴⁰GAO-13-522.

assessing the extent to which CMS's information system can help prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Additionally, we are examining CMS's oversight of some of the contractors that conduct postpayment reviews of claims including whether CMS has a strategy for coordinating these contractors' claims review activities. Separately, we have also been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and how it is being addressed. Through this work, we hope to develop further recommendations for CMS to help the agency continue to refine its efforts to reduce improper Medicare payments.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

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Appendix I: Abbreviations

ALJ	Administrative Law Judge
CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
FFS	fee-for-service
FPS	Fraud Prevention System
HHS	Department of Health and Human Services
LCD	local coverage determination
MAC	Medicare Administrative Contractor
MUE	Medically Unlikely Edit
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
PECOS	Provider Enrollment, Chain, and Ownership System
PPACA	Patient Protection and Affordable Care Act
PSC	program safeguard contractor
RAC	recovery audit contractor
ZPIC	Zone Program Integrity Contractor

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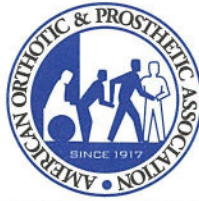
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Kathleen M. King is a Director of the Health Care Team at the U.S. Government Accountability Office, where she is responsible for leading various studies of the health care system, specializing in Medicare management and prescription drug coverage. She has more than 25 years' experience in health policy and administration. She was previously Vice President of Health Policy at the National Academy of Social Insurance, Vice President of the Washington Business Group on Health and, before that, she was the Executive Associate Administrator at the Health Care Financing Administration, now known as the Centers for Medicare & Medicaid Services. She has also been a professional staff member at the Senate Committee on Finance, a health policy specialist at the Congressional Research Service, a budget analyst at the Indiana State Budget Agency, and a research associate for the Ohio Legislative Services Commission. Ms. King received her M.A. in Government and Politics from the University of Maryland.



**American Orthotic &
Prosthetic Association**

**Statement of the American Orthotic and Prosthetic Association on
Combating Fraud, Waste, and Abuse in the Medicare Program, Oversight and
Government Reform Committee, May 20, 2014**

The American Orthotic and Prosthetic Association (AOPA) is pleased to provide this statement concerning Medicare fraud and the delivery of care to Medicare beneficiaries who have suffered a loss of a limb or impaired use of a limb or the spine. AOPA, founded in 1917, is the largest orthotic and prosthetic trade association with a national membership that draws from all segments of the field of artificial limbs and customized bracing for the benefit of patients who have experienced limb loss or limb impairment resulting from a chronic disease or health condition. Members include patient care facilities, manufacturers and distributors of prostheses, orthoses, and related products, plus educational and research institutions.

Annual Medicare spending for custom orthotics and all prosthetics is less than one percent of all Medicare spending. However, Medicare fraud has an outsized impact on the beneficiaries whose limb loss or impairment results in the need for orthotics or prosthetics. Patients treated by AOPA's members already are confronted with the trauma of limb loss or impairment, loss of mobility, diminished independence, and sometimes financial hardship. When seen by a fraudulent supplier, the patient also oftentimes experiences a financial loss after paying for a device that is inappropriate or never delivered. Additionally, a patient in this situation has to find another supplier and make another copayment, and he or she may lose important time in the rehabilitation process. Dobson-DaVanzo's research concluded that nearly one-third of the \$3.62 billion CMS paid between 2007-2011 for orthotic and prosthetic services for Medicare beneficiaries went to unlicensed providers, as well as those who fail to meet the accreditation requirement legislated by Congress in 2000. Additional research by Dobson-DaVanzo tracking Medicare data has demonstrated the overall cost-effectiveness of O&P care. For example, the analytic work indicated that over the first eighteen months patients who receive spinal orthoses had total Medicare episode payments that were 0.3% lower than those who did not receive orthotic bracing for the comparable back ailment. These are important trends for saving Medicare dollars.

AOPA and its members believe the best way to fight fraud in the orthotics and prosthetics sector is to prevent fraud in the first place. We also believe that it is possible – and preferable – to combat fraud without punishing an entire healthcare sector because of the actions of a handful of bad actors. Regrettably, it seems that the Centers for Medicare and Medicaid Services (CMS) has opted for the latter approach, despite Congress having given the agency adequate authority to drive fraudulent suppliers from the Medicare program.

The Fraud-Fighting Tools CMS Has Not Used

Section 427 of the Beneficiary Improvement and Protection Act (BIPA) of 2000 requires CMS to ensure that Medicare payments for custom fabricated orthotics and all prosthetics are furnished by "qualified practitioners" and "qualified suppliers." The orthotics and prosthetics profession supported this effort and consistently has pushed to have this requirement implemented. Currently, 14 states have enacted orthotics and prosthetics licensure statutes. In 2005, CMS issued Transmittal 656 to Medicare payment contractors specifying that contractors must have claims processing edits in place to make sure that in those states where prosthetics or orthotics must be provided by a licensed or certified orthotist or prosthetist, payments are made only to practitioners and suppliers that meet relevant state orthotics and prosthetics licensure laws. However, CMS has not taken concrete steps to enforce this requirement. For example, in 2009, a "60 Minutes" expose demonstrated that CMS was paying unlicensed providers for orthotic and prosthetic services. The amount of Medicare funds inappropriately paid by CMS was in the tens of millions. The fraud discussed in that report involved Florida, a state with orthotics and prosthetics licensure requirements.

Since Congress passed BIPA, AOPA and its members have met with CMS administrators and staff regarding implementation of the law, and in 2007, we were told that proposed regulations would be issued by the end of that year. We are still waiting. On June 25, 2013, AOPA shared with CMS the results of two studies that demonstrate that CMS had been paying unlicensed suppliers.

- In one study, the health economics and policy consulting firm Dobson-DaVanzo examined Medicare claims data from 2007-2011 and did not find significant changes in the distribution of payments to medical supply facilities with uncertified orthotics and prosthetics professionals on their staffs. We note that orthotist and prosthetist licensing requirements in most states track very closely with the typical certification requirements of training and education so that a person who is not certified will almost never meet eligibility for licensure. It is possible to be certified and not licensed, but it is virtually impossible to be licensed and not certified.
- In the other study, conducted in 2013, orthotics and prosthetics suppliers who were receiving Medicare payments were contacted in three licensure states and asked if they had a licensed orthotics and prosthetics professional on staff. This study revealed that 65 out of 78 surveyed suppliers by their own admission did not have a licensed professional on staff.

In a letter to AOPA dated August 2, 2013, CMS Administrator Marilyn Tavenner denied that CMS has been paying unlicensed orthotics and prosthetics suppliers. In the letter, Administrator Tavenner states that systematic claims edits have been in place since 2005 to deny claims submitted by unlicensed suppliers in nine states with orthotics and prosthetics licensure requirements (AL, FL, IL, NJ, OH, OK, RI, TX, and WA) and that the agency is implementing claims edits for the remaining five states with licensure requirements (AR, GA, KY, MS and TN). (This was reported in a Medicare Learning Network Matters article on the same day.) This amounts to an admission by the agency that it has been paying unlicensed suppliers in at least five licensure states (and CMS has omitted any reference to Pennsylvania and Iowa, both of which have enacted O&P licensure as well). Also, the effectiveness of the claims edits in the other nine states is questionable, in light of the fraud that has been documented in two of these states (FL and TX) since 2005 when these edits reportedly were implemented.

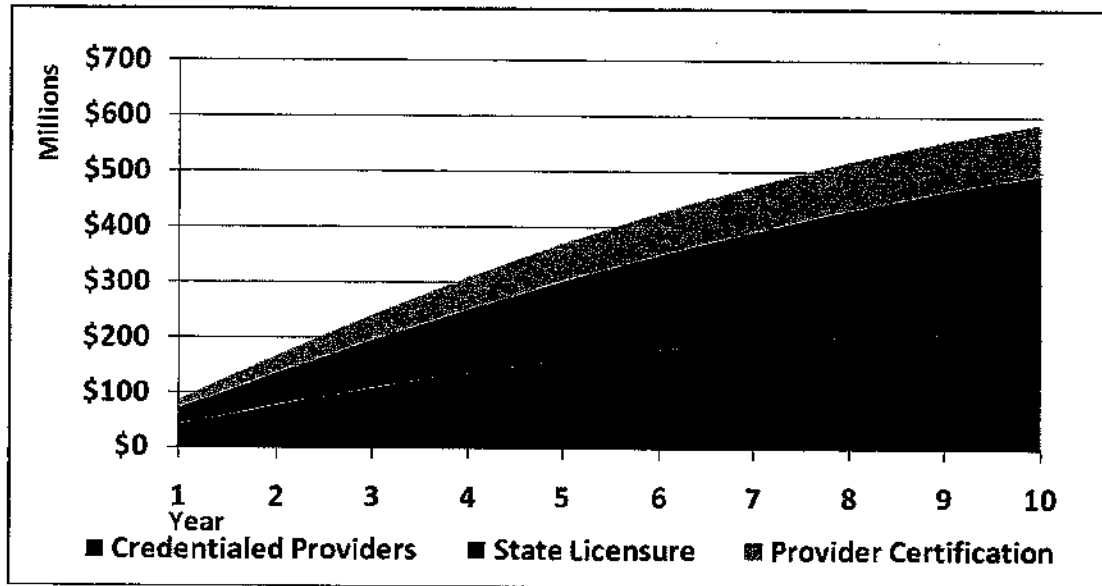
It is difficult to understand how the relative proportion of Medicare payments to non-certified orthotics and prosthetics suppliers is unchanged if unlicensed providers no longer are receiving payments in states where certification is required. We have seen evidence of only a small reduction in the proportion of payments to non-certified orthotics and prosthetics personnel since 2009. This also is supported by the results of the independent survey of orthotics and prosthetics suppliers, which showed that unlicensed, non-certified suppliers continue to provide and be paid for orthotics and prosthetics furnished to Medicare beneficiaries, even in states where licensure is required.

H. R. 3112, the Medicare Orthotics and Prosthetics Improvement Act, has been introduced in Congress and would build upon the fraud-fighting provisions included in BIPA. It would help reduce fraud, protect patients, and save Medicare funds by keeping out fraudulent providers in the first place. As the Dobson-DaVanzo report notes: "If CMS was to actively enforce that unlicensed providers cannot receive payment for providing orthotics and prosthetics services to Medicare beneficiaries within a licensure state, Medicare savings could be realized. Under such enforcement of limiting payments to providers with proven licensure and standards of training and experience, payments to unqualified providers would be eliminated. As the '60 Minutes' special suggested, allowing non-certified personnel to provide these services, especially in states with licensure, could lead to fraud and abuse in orthotics and prosthetics services, as well as expose patients who received these services to inappropriate or substandard care. Therefore, shifting payments to only certified providers could result in better care for beneficiaries and lower Medicare payments." An estimate of how much could be saved by implementation of these provisions is provided in the following excerpt from a 2009 report prepared by Morrison Informatics.

Table 1 – First Year Medicare Savings Estimated Range Following H.R. 2479 (now H.R. 3112)

Provisions, with Amendment		
Provision	Medicare Savings Range	Proportion of Savings
Credentialed Providers	\$40 - \$101	47%
State Licensure	\$28 - \$71	33%
Provider Certification	\$18 - \$44	20%
Total	\$86 - \$216	100%

Figure 1 – Minimum Cumulative 10-Year Medicare Savings Projection Following H.R. 2479 (now H.R. 3112) Provisions, with Amendment



Concerns about CMS’s failure to implement BIPA Section 427 were brought to the agency’s attention most recently in a letter from the Chair of the House Ways and Means Committee and the Chair of the Health Subcommittee. CMS’s response, dated March 6, 2014, stated that CMS is developing a notice of proposed rulemaking and anticipates that it will be published in 2014. AOPA is skeptical, since we have been told by Ms. Tavenner and other CMS administrators in the past that proposed regulations were forthcoming. In its response, CMS also said that “when a state has enacted a new licensure law, CMS implements an edit that immediately limits payment to only those suppliers that have a specialty of orthotics and prosthetics on their enrollment applications. Then the [National Supplier Clearinghouse] determines whether all orthotic and prosthetic suppliers in the affected state have the required licenses or certifications.” However, the National Supplier Clearinghouse generally scrutinizes a potential orthotics and prosthetics supplier only when the supplier seeks a new Medicare provider number and on a regular three year re-enrollment cycle thereafter. AOPA is not aware of actions taken by National Supplier Clearinghouse to monitor orthotics and prosthetics suppliers for licensure after granting a Medicare number.

In summary, CMS currently has several tools at its disposal to bolster its efforts to fight fraud in the orthotics and prosthetics field, yet it has failed to avail itself of its full arsenal. It has not issued any regulations to implement Section 427 of BIPA, and edits to prevent payment to unlicensed orthotics and prosthetics suppliers have not been implemented fully. These shortcomings were highlighted by the HHS Office of Inspector General in its October, 2012 report entitled, “CMS Has Not Promulgated Regulations to Establish Payment Requirements for Prosthetics and Custom-Fabricated Orthotics,” but still no rules have been promulgated.

RAC Audits and the ALJ Appeals Backlog

Instead of using tools to keep bad actors from participating in the orthotics and prosthetics sector, CMS has ramped up the Recovery Audit Contractor (RAC) program, which has had the effect of punishing legitimate providers.

While CMS makes payments to unlicensed and unaccredited providers, contravening Congress's intention, legitimate suppliers have been subject to RAC and prepayment audits conducted by contractors who appear to play by their own set of rules. It also appears that RAC audits penalize suppliers for paperwork or documentation errors as often, or more often, than it catches those perpetrating fraud. This sometimes results in legitimate providers, especially those who are small businesses, suffering cash flow problems or going out of business. AOPA estimates that roughly 100 orthotics and prosthetics suppliers have gone out of business, at least in part due to these audit/recoupment related cash flow problems. The impact of these closings extends beyond economics and business—it directly and negatively affects individuals with limb loss, as they have been deprived of long-standing, clinically-beneficial relationships with their health care providers. We note that AOPA has sued the U.S. Department of Health and Human Services (HHS) over RAC audits and how they are being applied to orthotics and prosthetics suppliers.

We feel that certain actions by CMS have compromised the due process rights of orthotics and prosthetics suppliers. For example, CMS issued a "Dear Physician" letter on its website in August, 2011 that had the effect of establishing new policy for payment for artificial limbs, and it applied the new policy retroactively in RAC and prepayment audits as to claims for dates of service as much as two years before the policy was issued in the letter.

There has been an explosion in the number of RAC audit claims under Medicare Part B for artificial limbs that are appealed to the Administrative Law Judge (ALJ) level. Congress and CMS have provided some modest relief for Medicare Part A providers, but none of this relief has been extended to Part B claims for artificial limbs. While we appreciate the difficult task facing the Office of Medicare Hearings and Appeals (OMHA), timely redress of improperly denied payments is critical. Many suppliers, particularly in the orthotics and prosthetics field, are small businesses that do not have the luxury of waiting months for payment of services legitimately furnished. In fact, just last year, 35 Members of Congress wrote to HHS Secretary Kathleen Sebelius that well-intentioned efforts to reduce fraud and abuse in Medicare may be harming access for vulnerable Medicare beneficiaries and placing undue burdens on legitimate orthotic and prosthetic providers. In a context of increasingly aggressive CMS audits, OMHA's decision to suspend ALJ review of provider and supplier claims is devastating to suppliers who deliver Medicare services to over 40 million beneficiaries.

Congress showed that it understood the importance of timely processing of Medicare appeals when it included in BIPA a requirement that an ALJ issue a decision about a case within 90 days of the date when the appeal request was filed. However, by OMHA's own admission, the current wait time for a hearing before an ALJ has increased to 16 months. In some areas that wait is as long as 26 months, which is unacceptable.

At the February 12, 2014 OMHA public hearing on this issue, Judge Griswold gave an explanation of OMHA's position, but offered few if any short-term remedies that would restore the right of a timely ALJ

hearing to providers. With ALJs siding fully with appellants in over half of all decisions, ALJ hearings realistically amount to a provider's primary means of challenging costly and often prejudicial CMS auditor decisions. As OMHA is leaving Medicare providers without an avenue of redress against auditors' payment denials, we believe it is only fair that CMS suspend these audits until an appropriate, timely, and statutorily required system providing due process to providers is restored.

H.R. 3112 Is A Strong Positive Step in Fighting Fraud; Surety Bonds Are Not An Answer to Fraud—They Punish All Legitimate Medicare Providers, Without Posing Any Significant Impediment to Unscrupulous Actors Who Perpetrate Medicare Fraud

Effectively fighting Medicare fraud requires implementing truly effective measures aimed at stopping unscrupulous actors and saving Medicare dollars, as in H. R. 3112, the Medicare Orthotics and Prosthetics improvement Act of 2014, while avoiding pointless or misdirected steps like RAC and Pre-payment audits about paperwork "gotchas" which have little or no relationship to preventing actual fraud. One such misdirected effort has been CMS imposition of surety bond requirements on all providers. These bonds add substantial costs to all legitimate providers, including substantial new financial burdens on small business prosthetic and orthotic facilities, but do nothing to distinguish legitimate from fraudulent providers—a fraudulent provider who pays the surety "toll" to support its enterprise of bilking Medicare then continues to receive Medicare payments unabated. It is a small, insignificant barrier to Medicare scammers, while being another financial setback for honest providers, levied on them for the privilege of serving Medicare beneficiaries.

Legislative Efforts Relating to Limiting the In-Office Ancillary Care Exception to Stark Self-Referral Rules

AOPA has noted that W&M Ranking Minority Member, Rep. McDermott has introduced a bill aimed at eliminating the exception from the Stark self-referral provisions for in-office ancillary services. AOPA supports this new legislation in principle. The O&P Alliance in recent months has communicated concerns to OIG about how, in the context of physician-owned distributorships (PODs), the in-office ancillary services rule sometimes operates and results, at least as it relates to O&P, in increases of number and value of services, which the patient does not need, costing Medicare taxpayer dollars, but no substantive action was taken. This provision has also prompted state legislative issues in states like Texas where it has been used by special interests to try to expand the prospects for payments to unqualified or under-qualified providers.

Prior Authorization is Not An Answer for Massive Non-Fraud RAC and Prepayment Audits That Have Hit Part B Medicare Claims for Artificial Limbs

The topic of prior authorization in terms of Medicare is a complex one. The BIG hitch is that in Medicare Prior Authorization, and at least most commercial plans, is NOT a promise of payment, and therefore AOPA and the vast majority of its patient care facility members oppose it as any kind of 'solution' to audits.

CMS has unfortunately seen cookie cutter solutions for RAC audits. Therefore, two years ago CMS said--if a demo project in prior authorization was acceptable for power wheelchairs (PME) in DME, let's solve the O&P RACs the same way. A major problem is that, in reality, the PME demo project resulted in longer delays for patients. CMS insists the numbers are shorter, but reliable reports estimate that it takes between 70-100 days from the date the physician orders a power wheelchair until the prior authorization goes through and the power wheelchair reaches the beneficiary. That kind of delay simply doesn't work for the care of amputees--who, even in the delays of the RAC environment, get their replacement limbs much faster. And again, prior authorization may have worked for a few limited cases in the private sector (if and only if it is a absolute guarantee of payment--otherwise, it creates its own cash flow problems), where it is an irreversible promise of payment--that is not true in Medicare.

Concepts That Will Work in Restoring Sanity to RAC and Pre-Payment Audits of Claims for Part B Artificial Limbs for Medicare Amputees

While the prior authorization route is not a solution, we wish to highlight particularly the proposal from the Orthotic & Prosthetic Alliance, which has developed a working draft for a RAC bill, detailed below. These are steps that definitely would assist in greatly reducing the devastation RAC and prepayment audits by CMS contractors has caused Part B claims for artificial limbs for Medicare amputees. A quick summary of key elements includes:

- A. Establish the prosthetist/orthotist's notes as a legitimate component of the patient medical record, comparable to a therapist
- B. Establish the prosthetist/orthotist as a recognized Medicare provider of care, distinguished from treatment as a DME supplier
- C. Skip the QIC audit stage in review, since it takes time and virtually never results in a favorable decision for the O&P provider
- D. Advance the audit more expeditiously to the ALJ for final action
- E. Mandate that CMS compile data on audits separate from DME needed to track both the very high rate of appeals on O&P RACs and high overturn rate on appeal (CMS has consistently refused to track such data).
- F. Establish financial penalties for RACs if an established % of overturns occur
- G. Address the need for more ALJs to mitigate current backlog, either by direction to OMHA (Office of Medicare Hearings and Appeals) which is the arm of HHS, as opposed to CMS, which is responsible for funding for ALJs, or a statutory change to allow CMS to fund ALJ appeals for RAC determinations.

Unlike Part A, There Has Been No Pause or Any Relief Whatsoever from CMS as to Part B RACs.

Chairman Brady's observation in announcing these hearings noted that, "The Ways and Means Committee fought hard to ensure that patients are getting the care they need, and that Medicare is properly paying hospitals for the care they provide. While we were able to provide some relief last March, it was only a temporary fix. We must work on a permanent solution. We don't want providers unnecessarily looking over their shoulder for auditors. We want hospitals to be accurately reimbursed so that they can focus all of their time on providing the right type of care for patients."

AOPA applauds the search for a longer terms solution for hospitals as those solutions in part will help address or inspire solutions for the similar audit problems facing orthotic and prosthetic providers. An additional longer term solution for orthotics and prosthetics through the enactment of H.R. 3112 would simply require CMS to implement BIPA Section 427 requirement to only make payments to "qualified providers," as those professionals certified by the two main certification organizations, or their equivalent, in the field of O&P or properly licensed in those states requiring licensure.

Another long term solution provided by H.R. 3112 is that payment will be linked to the qualification of the providers and the complexity of the device the patient needs, patient quality of care will be improved. Additionally taxpayer dollars will be saved through a reduction in poor outcomes and repeated charges for follow up O&P care that would not be necessary if a qualified provider served the patient in the first place.

Many suppliers affected by RAC audits are small businesses like our members. They do not have the financial wherewithal to sustain their business when RAC audits or other questionable tactics to fight fraud and abuse continue unabated. It would be our hope that these hearings focus on the needs of our nation's hospitals under Part A become the clarion call for expanding solutions to relieve the threatening disasters that will befall small business providers under Part B if early and significant relief is not forthcoming.

As we indicated in our statement for the April 30 Ways & Means Health Subcommittee hearing, **many, including members of Congress, see the Part A relief for hospitals in terms of the "pause" for about a year relating to RACs under the two midnight rule, and think there has been similar relief under Part B for O&P RACs--the truth is that there has been no pause or any relief whatsoever from CMS as to Part B RACs.**

Conclusion

In conclusion, AOPA wants to continue to work with Congress and CMS to ensure that those who prey on Medicare beneficiaries do not find the orthotics and prosthetics sector an easy place to establish and operate a fraud scheme. We offer our support for developing more effective means to fight Medicare fraud that does not punish legitimate suppliers who are playing by the rules. We believe that the fairest and most effective system is one that prevents fraud before it starts, and we hope that Congress will direct CMS to develop a system taking the pathways outlined in both Section 427 of BIPA 2000 and H.R. 3112 to deter fraud, promote program integrity, and protect the due process rights of legitimate orthotics and prosthetics suppliers.

AOPA appreciates the efforts of the Chairman and others on the Committee for working with us to find ways to better regulate our profession. We hope to continue to work with you to improve the quality of care we deliver to patients who need orthotics and prosthetics and to protect the integrity of the Medicare program.