

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

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Chairman Carper, Senator Coburn, distinguished Subcommittee members, thank you for inviting me here to discuss the Centers for Medicare & Medicaid Services (CMS) initiatives to reduce improper payments in Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP). At CMS, we continue to be a government-wide leader in engaging in activities that identify, reduce and recover improper payments in our programs.

Today, I would like to give you some background on Medicare, Medicaid and SCHIP and then discuss the types of payment errors we are finding and our proposed actions for reducing the occurrence of errors. I will also provide you with information about how CMS succeeded in lowering the Medicare Fee for Service (FFS) error rate for Fiscal Year (FY) 2006 and our status in measuring improper payments in the Medicaid program and SCHIP. I will discuss briefly some of the challenges we face complying with the Improper Payments Information Act of 2002 (IPIA). It is important to note that because my testimony focuses on our efforts to identify

incorrect or erroneous payments and not on CMS fraud and abuse efforts, the improper payments I will be discussing are generally not due to bad actors but rather other types of errors.

Background on Medicare, Medicaid and SCHIP

Medicare is a Federal health insurance program that provides medical insurance to 44 million people. About 37 million individuals are entitled to Medicare because they are age 65 or older, and about 7 million beneficiaries who are under age 65 are entitled because of disability. Those under age 65 generally begin to get Medicare when they have been entitled to Social Security disability cash benefits for 24 months. Total gross Medicare benefits for 2007 are estimated to be nearly \$426 billion.

The majority of Medicare spending is FFS Medicare, with hospital and physician services currently representing the largest shares of this spending. The FFS component of Medicare also covers a wide range of other items and services, including home health care, ambulance services, medical equipment, and preventive services. This FFS component of Medicare is administered by CMS through contracts with private companies that process claims for Medicare benefits. During 2007, CMS estimates that Medicare contractors will process well over one billion claims (1.2 billion) from providers, physicians, and suppliers for items and services that Medicare covers. Specifically, CMS administers the claims processing and payment systems for Medicare through contracts with Carriers, Fiscal Intermediaries (FIs), and Durable Medical Equipment Medicare Administrative Contractors (DME MACs).¹ These entities in addition to Quality

¹ CMS currently is in the process of implementing Medicare Contracting Reform, which will consolidate existing contracts and contractor functions. Once fully implemented, all contractors will be referred to as Medicare Administrative Contractors (MACs).

Improvement Organizations (QIOs) review claims submitted by providers to ensure payment is made only for medically necessary services covered by Medicare for eligible individuals.

Medicaid is a partnership between the Federal government and the states. While the Federal government sets broad guidelines and provides financial matching payments to the states, each state is responsible for overseeing its Medicaid program, and each state essentially designs and runs its own program within the Federal structure. The Federal government pays the States a portion of their costs through a statutorily determined matching rate called the Federal Medical Assistance Percentage, or FMAP, that currently ranges between 50 and 76 percent. In FY 2007, total Medicaid expenditures – those that include both Federal and State contributions – are estimated to be approximately \$336 billion.

In addition to Medicaid, CMS also administers SCHIP. Program benefits became available October 1, 1997, with \$40 billion in Federal matching funds available over the succeeding 10 years to help States expand health care coverage to uninsured children. SCHIP is a state-administered program and each State sets its own guidelines regarding eligibility and services. Total SCHIP expenditures, including both Federal and State contributions, are estimated to be \$8.2 billion for FY 2007. Total enrollment for both Medicaid and SCHIP for FY 2007 is estimated to be approximately 53.4 million.

CMS IPIA Compliance

Given the staggering size of these programs' expenditures, even small amounts of payment error can represent a significant impact to both Federal and State treasuries and taxpayers. For this

reason, CMS, as part of a sound financial management strategy, has a relatively long history of using improper payment calculations as a tool to preserve the fiscal integrity of Medicare, Medicaid and SCHIP. CMS uses improper payments calculations to identify the amount of money that has been inappropriately paid, identify and study the causes of the inappropriate payments, and focus on strengthening internal controls to stop the improper payments from continuing. However, the variation in financing and administration among Medicare, Medicaid and SCHIP requires distinct approaches to applying these financial management tools.

Medicare IPIA Compliance

In 1996, the Department of Health and Human Services' (DHHS) Office of Inspector General (OIG) began estimating improper payments in the Medicare FFS program as part of the Chief Financial Officer's Audit. The OIG produced FFS error rates from FY 1996 to FY 2002.

Beginning in FY 2003, CMS, working with the OIG, implemented a much more robust process – the Comprehensive Error Rate Testing (CERT) program – to assess and measure improper payments in the Medicare FFS program. The CERT program not only produces a national paid claims error rate, but also very specific improper payment rates. These include:

- Contractor-specific improper payment rates – which measure the accuracy of our claims processors;
- Provider-type specific improper payment rates – which measure how well the providers who care for our beneficiaries are preparing and submitting claims to the program; and
- Other management related information - which provides insight into payment errors by region and reason.

Thus, in 2002 when the IPIA was enacted, CMS needed to make only minor changes to our ongoing processes for FFS Medicare to come into compliance with the Office of Management and Budget (OMB) guidance on the IPIA. In fact, CMS has calculated additional improper payment rates for FFS Medicare, as discussed earlier. This enhanced scrutiny reflects the Agency's increased commitment to use more detailed data and analysis to eliminate improper payments.

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

For example, a primary cause of Medicare payment errors in the past has been providers not submitting the medical record documentation needed to verify the appropriateness of payment in response to our requests for documentation. Many providers were concerned that submitting medical records to a CMS contractor would be in violation of the Health Insurance Portability

and Accountability Act (HIPAA) regulations. However, the HIPAA Privacy Rule permits disclosure of protected health information to carry out treatment, payment or health care operations. Thus, we expanded our education efforts to ensure that providers understand that responding to our requests does not violate HIPAA.

Another significant cause of errors has been providers not submitting the appropriate types of medical record documentation to support the types of services billed to the Medicare program. CMS implemented a number of corrective actions to reduce these types of errors, including education and more intensive efforts to locate and contact providers. These corrective actions have resulted in an 83 percent decrease in documentation errors since 2004.

CMS also uses contractor-specific error rates to evaluate the performance of the contractors that process Medicare claims. While our previous contracting authority limited CMS's ability to take action against contractors with high error rates, implementation of Medicare Contracting Reform (MCR) enacted by the MMA is changing the contracting process and the contractor incentive structure. One key outcome of this initiative is the ability to use incentives to get our contractors to eliminate improper payments. In 2004, CMS conducted a study to evaluate whether the Agency could reduce improper payments by using award fees as incentives for contractors to lower their paid claims and provider compliance error rates. The outcome of that pilot was positive and CMS plans to use award fees as incentives in the future to reduce improper payments as part of MCR.

We believe our efforts in Medicare have been a success. In November 2006, HHS reported a Medicare FFS paid claims error rate of 4.4 percent for FY 2006, a significant decrease from the 5.2 percent reported in 2005, and significantly lower than the 10.1 percent rate reported in FY

2004. We have far exceeded our expectations, having reduced the error rate beyond the 2006 goal of 5.1 percent. With continued monitoring and error reducing efforts we aim to achieve our future targets of 4.3 percent in 2007, 4.2 percent in 2008, and 4.1 percent in 2009.

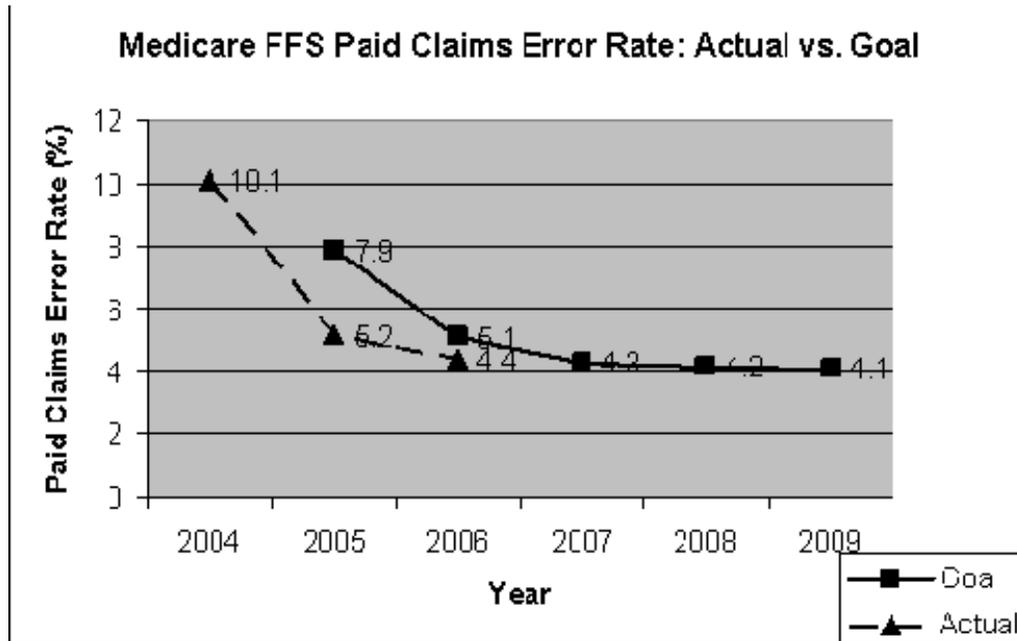


Figure 1:

Medicaid and SCHIP IPIA Compliance

Since I last appeared before the Subcommittee, CMS has made a great deal of progress in its efforts to successfully implement the Medicaid and SCHIP payment error rate measurement (PERM) program quickly and effectively, and we are on track to finalize the establishment of the PERM program. To that end CMS fully expects to implement the State corrective action process, whereby States will analyze root error causes that contribute to improper payments and develop corrective actions to address error causes which should ultimately reduce improper payments over time.

In response to States' expressed desire to provide input beyond the rulemaking process, CMS is working to improve communications with the States. We are establishing a PERM Technical Advisory Group that will consist of CMS and State representatives and will have monthly conference calls to discuss high level policy decisions and other conceptual ways to reduce State cost and burden. CMS believes that these steps will provide States the opportunity to have more direct involvement with CMS to offer suggestions and recommendations for reducing State cost and burden.

To help ensure compliance, CMS expects to:

- Continue efforts to achieve greater program efficiency;
- Reduce improper payments in Medicaid and SCHIP through States' corrective actions;
- Have States initiate recovery of erroneously paid Federal funds in these programs as identified through the PERM program; and
- Report a national program error rate in the PAR for each fiscal year measured. However, due to unexpected challenges facing the FY 2006 measurement (e.g., inaccurate State data), CMS will report a preliminary Medicaid component error rate in the FY 2007 PAR.

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

PERM was implemented to measure the FY 2006 Medicaid FFS error rate for the FY 2007 PAR. For FY 2007, we expect to measure improper payments in the FFS, managed care and eligibility components of Medicaid and SCHIP to be reported in the FY 2008 PAR. Therefore, we expect Medicaid and SCHIP to be fully compliant with IPIA by 2008. CMS has and will continue to work closely with OMB to ensure that the PERM program meets the requirements of the IPIA and subsequent OMB guidance.

Fraud, Waste and Abuse

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

CMS has taken several specific actions to ensure that Federal dollars are being properly spent and fraudulent billings are stopped when they are detected. Our Los Angeles (LA), California and Miami, Florida satellite offices continue to be successful in helping to curtail fraudulent spending in those high risk areas. We are also planning to open a satellite office in New York in Spring 2007. Through the combined efforts of the CMS LA satellite office, the Program Safeguard Contractors (PSC) and the claims processing contractors operating in California, CMS has collectively identified over \$2.1 billion in improper payments in Calendar Years 2005 thru

2006. This includes the denial of claims based upon fraud indicators and the collection of overpayments for claims reviewed after payment has occurred which have been identified as potentially fraudulent or highly suspect.

The goal of the satellite offices is to work collaboratively with our partners to test creative and innovative approaches to detect, investigate and prosecute fraud against the Medicare Trust Fund. A recent example of this is the Los Angeles tax project. The LA office is conducting a unique pilot program with the District Attorney (DA) of LA County to try and more effectively deal with the crisis of health care fraud through the prosecution of health care providers (both non-filers and low-filers) for state income tax evasion. Relying on an elaborate communications network, the LA project provides partners with a new tool for dealing with health care providers suspected of committing insurance fraud within California and it is expected to be successful in other states in which there is a state income tax.

The LA Project works. As of February, 2007, five cases have been filed under the LA project, and three convictions have resulted in prison sentences. The direct result to the Medicare program is that “bad” providers are identified and prosecuted, and providers are convicted of felony charges. Felony convictions may be used by the Medicare and Medicaid programs to revoke the billing privileges of the Medicare provider. Subsequently, the provider may be removed from the program. In addition, when restitution is ordered and collected from the provider, Medicare will receive remuneration.

Because of the success of the project in LA county, the DA of LA County and CMS are partnering to expand the program both to other areas of California and nationally. Specifically, CMS is currently working with the California Franchise Tax Board and the State of California to implement the project statewide. In addition, we are in beginning discussions with the state of New York tax authorities and prosecutors. Preliminary discussions concerning Federal expansion have begun with representatives from the Internal Revenue Service.

In 2004, CMS's Miami Satellite Office launched a joint initiative with the Department of Justice (DOJ), the OIG, the Federal Bureau of Investigation, the Florida Medicare Carrier and the Florida Part A & B Medicare PSC, and the State of Florida (Department of Health, Agency for Health Care Administration, Medicaid Fraud Control Unit, and Office of Drug Control) to address widespread Infusion Fraud in South Florida. Under the typical scam, for-profit clinics and doctors are recruiting and paying kickbacks to HIV/AIDS patients to receive unnecessary or non-rendered infusion services billed at medically unbelievable frequencies and dosages. Some incorporate identity theft into the scam as well, billing for infusions and injections to bogus patients, using stolen beneficiary Medicare numbers and physician Provider Identification Numbers along with forged signatures on reassignment of benefits forms. Combinations of corrective actions like prepayment edits (beneficiary-specific, provider-specific, provider-type, dollar thresholds and medically unbelievable dosages), payment suspensions, joint federal/state site visits, provider enrollment onsite and activity checks, enrollment revocations and deactivations, data analysis and complaint investigations and prosecutions and plea agreements have resulted in savings to the Medicare Trust Fund in excess of \$1.8 Billion.

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

CMS is making improvements to its data analysis efforts. To achieve this we are collecting vulnerability data from many of our partners, including Medicare contractors, and using a variety of data analysis tools to review Medicare claims data. Much of our work will focus on addressing vulnerabilities early in their lifecycle and those that have high, estimated dollar impact to the Medicare program. Our program integrity efforts will focus on the top 10 vulnerabilities identified through our data analysis and developing corrective actions to address these identified vulnerabilities. This enhanced focus on data will enable our program integrity efforts to be more proactive rather than reactive, thus enabling us to focus more activities on actually preventing fraud rather than simply mitigating it.

Recovery Audit Contractors

Section 306 of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) gave CMS additional authority to pilot a new contracting authority designed to detect improper payments. This MMA provision directs the Secretary to demonstrate the use of Recovery Audit Contractors (RACs) in identifying Medicare underpayments and overpayments, and collecting Medicare overpayments. The demonstration is being conducted in California, Florida and New York and has been a great success. In March, 2005 CMS awarded contracts to 5 different companies with extensive experience performing recovery auditing services in private

industry and/or Medicaid. To date these five contractors have identified over \$400 million in potential overpayments, and have so far collected \$144 million. The overpayments were identified through a careful review of individual Medicare claims to determine if the claims were medically necessary, correctly coded and conformed to Medicare payment policy.

It is clear from the demonstration results thus far how effective recovery auditing can be. Based on this effectiveness, the Tax Relief and Health Care Act of 2006 mandated the use of recovery audit contractors in all states by 2010. We have developed an expansion plan which will allow us to begin using recovery audit contractors in all states in FY 2008. CMS' implementation plan will have recovery audit contractors reviewing targeted Part A and B claim types in FY 2008 and all Part A and B claim types by 2010. This incremental approach will allow CMS to work closely with the national and state health care associations to assure that health care providers have up to date information regarding the expansion process.

We have learned a great deal during the demonstration and as important as the recovery of improper payments is, CMS sees the RAC program as an important tool in reducing and eliminating future improper payments. In order to do this, CMS is analyzing all RAC findings internally and externally through an independent evaluation contractor to determine what actions CMS, Medicare providers and claims processors can take to improve payment accuracy and eliminate improper payments. These actions will include the installation of new or improved edits in the claim payment systems, industry wide and/or provider-specific education and clarifications to coverage and payment policies.

As mentioned previously, we have an aggressive timetable in place to expand the program and meet the mandated target of 2010. Based on the results of the demonstration, we expect the expansion will be successful and that recovery auditing will become an important tool in our efforts to eliminate improper Medicare payments.

Conclusion

CMS is strongly committed to protecting taxpayer dollars and ensuring the sound financial management of the Medicare, Medicaid, and SCHIP programs. As evidenced by the testimony today, the Agency has taken significant actions to meet IPIA standards in Medicare and is taking a number of proactive steps to become IPIA compliant in Medicaid and SCHIP. The Agency has developed a comprehensive strategy that will strengthen Federal oversight of State financial practices. We have made a great deal of progress, and we look forward to continuing to work cooperatively with you. CMS and the Administration fully support this Subcommittee's efforts to improve the fiscal health of the Medicare, Medicaid, and SCHIP programs. I look forward to answering any questions you might have.