

STATEMENT OF

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ON

**“THE DOCTOR’S NOT IN: COMBATTING MEDICARE PROVIDER ENROLLMENT
FRAUD”**

**BEFORE THE
UNITED STATES SENATE SPECIAL COMMITTEE ON AGING**

JULY 22, 2015

U.S. Senate Special Committee on Aging
Hearing on
“The Doctor’s Not In: Combatting Medicare Provider Enrollment Fraud”
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Chairman Collins, Ranking Member McCaskill, and members of the Committee, 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 have made important progress in strengthening our provider and supplier enrollment and screening processes, and I appreciate the opportunity to discuss CMS’ efforts to prevent ineligible providers and suppliers from entering the Medicare program.

Provider and supplier enrollment is the gateway to the Medicare program, and a cornerstone of our program-integrity strategy. Beneficiaries are at risk when fraudulent providers and suppliers perform medically-unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations and/or medical necessity. By preventing fraudulent or unqualified providers or suppliers from enrolling in the program and removing existing unqualified providers and suppliers, CMS ensures that fewer beneficiaries are exposed to risks and harm, and taxpayer dollars are spent only on services provided by legitimate providers and suppliers.

Thanks in part to the authorities provided by the Affordable Care Act, CMS has improved the provider and supplier enrollment and screening process. We are seeing real results from our efforts, and have generated over \$927 million in savings from revocations since March 2011, protecting both beneficiaries and the Medicare Trust Funds. These actions are part of a larger set of provider enrollment and screening activities which have saved the Medicare program \$2.4 billion in avoided costs.¹ These savings reflect the actions CMS has taken to deactivate billing privileges for more than 543,163 providers and suppliers that do not meet Medicare

¹ These savings estimates use the same methodology as the identified “costs avoided by revoking billing privileges” savings measure that was certified by the OIG in the 2nd and 3rd Year FPS Reports to Congress. Please see CMS’ Report to Congress: Fraud Prevention System Third Implementation Year, for more information (available at: <http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html>). While these particular estimates have not been certified by the OIG, they reflect comparable calculations applied to actions taken under authorities provided in both the Affordable Care Act and CMS’ previously existing authorities.

requirements, and to revoke the enrollment and billing privileges of an additional 34,888 providers and suppliers since 2011.²

Perhaps most importantly, increased screening efforts have allowed CMS to deny 4,949 applications in the last 12 months based on improved enrollment screening, preventing these providers or suppliers from ever submitting a claim. This is the clearest signal of how CMS is prioritizing prevention.

Strengthening and Modernizing Provider and Supplier Enrollment

CMS has made a number of significant improvements to the Medicare provider and supplier enrollment process. We have implemented improved user workflows for initial enrollment, changes of information submissions, and user revalidation. In order to reduce errors in reporting, CMS increased transparency so that providers and suppliers can see all their enrollment information that is currently on file. CMS has made the enrollment process electronic, providing modern tools such as e-signatures and the capability for providers and suppliers to upload supporting documents online. All of these changes have resulted in a marked increase in all forms of electronic applications, rising from ten percent in 2011 to over 45 percent in 2015.

To enroll in the Medicare program, a provider or supplier may submit its enrollment application online using the Provider Enrollment, Chain and Ownership System (PECOS) or by paper by sending a CMS-855 to its Medicare Administrative Contractor (MAC). PECOS is a centralized database that contains providers' and suppliers' enrollment information. CMS contracts with MACs, which are responsible for verifying provider application information before the providers are permitted to enroll into Medicare. The National Supplier Clearinghouse is responsible for verifying information for suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). If approved, enrollment information must be resubmitted and recertified every three years for DMEPOS and every five years for all other providers and suppliers.

² Deactivated providers and suppliers have their Medicare billing privileges stopped; however, their billing privileges can be restored upon the submission and approval of an updated enrollment application. Revoked providers and suppliers have their Medicare billing privileges terminated and are barred from re-entering the Medicare program for a period of one to three years, depending on the severity of the revocation.

CMS is seeking to improve and redesign PECOS to better match CMS' and the provider and supplier community's needs, providing the capacity for changes occurring across CMS. We are also seeking to improve the data quality in the National Plan and Provider Enumeration System (NPPES), the system that assigns National Provider Identifiers (NPI) to providers and suppliers enrolled in the Medicare program. When the system was first launched, its purpose was to produce a single identifier number for providers and suppliers. Today, the needs of the industry have changed and NPPES is seen as a source for the both provider and supplier identifier and serves as a centralized reference for other purposes, such as for external, commercial claims processing. In addition, other payers leverage National Provider Identifier data to understand the potential universe of health care providers and to vet providers participating in their programs.

Risk-based screening of providers and suppliers

The Affordable Care Act required CMS to implement risk-based screening of providers and suppliers who want to participate in Medicare and Medicaid, and CMS put these additional requirements in place for newly enrolling and revalidating Medicare, Medicaid, and CHIP 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.

All Medicare providers and suppliers undergo a baseline screening, including confirmation of the provider's or supplier's Social Security Number through the Social Security Administration and license and certification through the state licensing boards; and searches in the General Services Administration's (GSA) System for Award Management for Government contracting exclusion (suspension and debarments) and the Department of Health and Human Services (HHS) Office of Inspector General's (OIG's) exclusion list for all individuals listed on the application.

Providers and suppliers in the "limited risk" category undergo this verification of licensure and verification of compliance with Federal regulations and state requirements. Providers and suppliers in the "moderate and high risk" category undergo additional screening, including unannounced site visits. CMS uses site visits to verify that a provider's or supplier's practice location meets requirements and helps prevent questionable providers and suppliers from

enrolling in the Medicare program. Since 2011, CMS contractors have completed 222,566 site visits, which have resulted in 1,279 revocations.

Additionally, individuals with a five percent or greater direct or indirect ownership interest in a designated high risk provider or supplier must undergo fingerprint-based criminal background checks. On an individual basis, a provider or supplier may be elevated to high-risk, and therefore subject to the additional screening, if it has had a payment suspension or had billing privileges revoked in the last 10 years, or if it previously had been excluded from Medicare.

Provider and Supplier Revocations and Terminations

CMS routinely revokes billing privileges from enrolled providers and suppliers based on information contained in the Social Security Administration's complete death master file and CMS' repository of information contained in OIG's exclusion list, the Medicare Exclusion Database (MED). Under section 1128 of the Social Security Act, the Secretary, through HHS OIG, must exclude individuals and entities from Federal health care programs based on felony or misdemeanor convictions related to the Medicare or Medicaid programs, or related to the abuse or neglect of patients, and has discretionary authority to exclude individuals on a number of grounds, including misdemeanor convictions related to health care fraud. Revocations are retroactive to the date of a provider's respective plea or conviction, and if the provider or supplier submitted claims after that date, CMS demands those payments be repaid.

CMS has historically relied on the MED and the GSA System for Award Management list to identify relevant felony convictions because there is not a centralized or automated means of obtaining felony convictions of Medicare providers and suppliers. CMS is currently working on a process to match enrollment data against public and private databases to receive timely felony conviction data.³

State Medicaid agencies are required to terminate the enrollment of any provider that has been terminated by Medicare or another state Medicaid program for cause. Additionally, CMS has the

³ OIG has the authority to exclude individuals and entities from Federally-funded health care programs pursuant to sections 1128 and 1156 of the Social Security Act and maintains a list of all currently-excluded individuals and entities called the List of Excluded Individuals and Entities (LEIE). If a provider or supplier is on the LEIE, CMS has the authority to deactivate or revoke their billing privileges.

discretionary authority to revoke Medicare billing privileges where a state has terminated or revoked a provider's or supplier's Medicaid billing privileges. CMS established a process for states to report and share information about Medicaid termination. States have been instructed to report all "for cause" Medicaid terminations, for which state appeal rights have been exhausted, to CMS by submitting a copy of the original termination letter sent to the provider, along with specific provider identifiers, and the reason for Medicaid termination. This prevents bad actors from jumping from program to program.

In addition to traditional provider-enrollment activities, CMS' sophisticated predictive analytics technology, the Fraud Prevention System (FPS), identifies investigative leads to further protect the Medicare program from inappropriate billing practices and provide oversight on provider-enrollment actions. In its first three years of implementation, CMS has identified approximately \$242 million in cost-avoidance savings from revoking provider billing privileges as a result of FPS leads.⁴

Revalidation of existing Medicare providers and suppliers

CMS must also revalidate all existing Medicare providers and suppliers under new requirements established by the Affordable Care Act. All Medicare providers and suppliers already enrolled prior to the new screening requirements becoming effective were sent revalidation notices by March 23, 2015. CMS has requested the revalidation of all 1.6 million existing Medicare providers to ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Thus far, the revalidation initiative has mailed 1,652,895 revalidation notices and resulted in 888,060 approvals. These revalidation efforts alone resulted in the deactivation of over 307,388 provider and supplier practice locations as well as the revocation of 17,655 providers' and suppliers' billing privileges.

Further Improvements to Strengthen Medicare Program Integrity

CMS is proud of the results we have seen from provider and supplier enrollment and screening efforts, which have removed hundreds of thousands of questionable providers and supplies from the Medicare program, saving taxpayers billions of dollars. As you know, GAO reviewed the

⁴ Report to Congress: Fraud Prevention System Third Implementation Year. Available at: <http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html>

implementation of four enrollment screening procedures that CMS uses to prevent and detect ineligible or potentially fraudulent providers and suppliers from enrolling in the Medicare program. In the report entitled “Medicare Program: Additional Actions Needed to Improve Eligibility Verification of Providers and Suppliers,” GAO concluded that, as part of an overall effort to enhance program integrity and reduce fraud risk, effective enrollment and screening procedures are essential to ensure that ineligible or potentially fraudulent providers and suppliers do not enroll in the program and that CMS has taken steps to develop and implement such procedures.⁵ GAO analysis identified areas for improvement in our PECOS system, including verification of provider practice locations and physician licensure statuses. We appreciate GAO’s work in this area and are working to address its recommendations, as discussed further below.

CMS has made significant progress in reducing the number of questionable providers and suppliers enrolling in Medicare. GAO noted in the report that only 2.3 percent of provider and supplier practice locations are potentially ineligible for Medicare participation as providers and suppliers. This small percentage of provider or supplier locations that could not be confirmed as eligible or ineligible by GAO could result from data-entry issues. For example, information (such as a missing suite number) may be missing, while the address itself could be an eligible practice location.

CMS routinely advises the provider and supplier community of the importance of maintaining accurate, up-to-date provider enrollment practice location information. CMS also has initiated several actions to improve Medicare enrollment screening and to reduce provider burden. In March 2014, CMS updated its guidance on verification of practice locations to remove redundant practices, such as the use of 411.com and USPS.com, to verify practice locations because the provider and supplier address verification system in PECOS performed the same checks. If the MAC is unable to validate the practice location using the software incorporated in PECOS, they are permitted to request clarifying information (*i.e.*, letterhead showing the appropriate address, phone/power bill, or other documentation containing the provider/supplier’s legal business name and address) from the provider or supplier or request an unannounced site visit. To strengthen

⁵ GAO Report GAO-15-448. “Medicare Program: Additional Actions Needed to Improve Eligibility of Verification of Providers and Suppliers”

the enrollment screening process, CMS will enhance the address verification software to better detect potentially ineligible addresses. CMS is working towards configuring the provider and supplier address verification system in PECOS to flag Commercial Mail Receiving Agencies, vacancies, invalid addresses, and other potentially questionable practice locations. We expect this enhancement to be complete by early next year. Removing the redundant requirements allowed CMS to reduce provider and supplier burden and eliminate duplication of effort without reducing the effectiveness of our program integrity efforts.

As noted in the GAO report, CMS provides monthly data to the MACs, which process provider-enrollment applications in a document called the License Continuous Monitoring Report. This provides consistency in terms of State Medical Board licensure data, as MACs may need to review data from States across the country. In our response to the GAO, CMS noted that while we concur with the recommendation on the reporting of licensure data, CMS does not currently have the authority to require providers and suppliers to report licenses for states in which they are not enrolled. However, CMS will take steps to make certain that all applicants' licensure information is evaluated as part of the screening process by MACs and the License Continuous Monitoring report as appropriate. CMS will also regularly review other databases for disciplinary actions against enrolled providers and suppliers.

Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the Attorney General announced a ground-breaking partnership with the private sector to fight fraud, waste, and abuse 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 fraud, waste, and abuse that could not otherwise be identified. The HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop improper payments from going out the door.

As one part of our initiative, CMS partnered with eight major private plans to share facts and information to locate possible fraudulent store fronts. Currently, over 4,300 questionable store

front locations have been identified and, as a result, participating partners are now conducting investigations to further verify if the identified locations are enrolled in their systems and are valid and operational.

Empowering Beneficiaries: A Key Tool in Preventing Fraud

Beneficiary involvement is a key component of all of CMS' anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caregivers are some of our most valuable partners in stopping fraudulent activity. Information from beneficiaries and other parties helps us to quickly identify potentially fraudulent practices, stop payment to providers and suppliers for inappropriate services or items, and prevent further abuses in the Medicare program. We also want to recognize this Committee for the creation of The United States Special Committee on Aging Fraud Hotline and commend its efforts in educating seniors and others about the dangers of fraud.

CMS is making it easier for seniors to help us fight fraud, waste, and abuse. In June 2013, CMS began sending redesigned Medicare Summary Notices (MSNs),⁶ the explanation of benefits for people with Medicare fee-for-service, to make it easier for beneficiaries to spot fraud or errors. The new MSNs include clearer language, as well as descriptions and definitions. The MSNs have a dedicated section that tells beneficiaries how to spot potential fraud, waste, and abuse and encourages beneficiaries to report suspected fraud, waste, and abuse to 1-800-MEDICARE. CMS has an incentive reward program that offers a reward of 10 percent of the amount recovered, up to \$1,000, to Medicare beneficiaries and other individuals whose tips about suspected fraud lead to the successful recovery of funds.

CMS also partnered with the Administration for Community Living (ACL) to lend support to the Senior Medicare Patrol (SMP) program, a volunteer-based national program that educates Medicare beneficiaries, their families, and caregivers on how to prevent, detect, and report Medicare fraud, waste, and abuse. During 2013, SMP program grantees' staff and 5,406 volunteers reached over 1.5 million people.⁷ In that same time, SMP projects held 10,545 community outreach education events reaching more than 1,048,000 people, and were

⁶ <http://blog.medicare.gov/2013/06/06/redesigned-with-you-in-mind-your-medicare-summary-notice/>

⁷ <https://oig.hhs.gov/oei/reports/oei-02-14-00140.pdf>.

responsible for over 181,143 media airings to increase beneficiary awareness about issues related to Medicare fraud. In addition, over 501,400 beneficiaries were educated through 14,924 group educational sessions conducted by SMP programs in local communities. Volunteers are essential to the success of this program, contributing 105,235 hours and conducting over 148,000 one-on-one counseling sessions to educate beneficiaries about how to prevent and detect Medicare fraud within local communities.

The SMP program also works to resolve beneficiary complaints of potential fraud in partnership with State and national fraud control and consumer protection entities, including MACs, State Medicaid fraud control units, State attorneys general, CMS, HHS OIG, and the Federal Trade Commission.

Moving Forward

CMS is committed to strengthening provider and supplier enrollment and screening processes to make sure that Medicare beneficiaries receive items and services from appropriate providers and suppliers and taxpayer dollars are protected. This effort is fundamentally about protecting our beneficiaries and ensuring we have the resources to provide for their care. Although we have made significant progress in improving our provider screening and enrollment, more work remains to be done. We are committed to working with GAO as we continue to strengthen program integrity. We look forward to working with this Committee and the Congress on these efforts.