

**STATEMENT OF**

**DEBORAH TAYLOR**

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

**ON**

**IMPROPER PAYMENTS**

**BEFORE THE**

**U.S. HOUSE COMMITTEE ON  
APPROPRIATIONS, SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN SERVICES,  
EDUCATION, AND RELATED AGENCIES**

**MARCH 17, 2011**

**U.S. House Committee on Appropriations**  
**Subcommittee on Labor, Health and Human Services, Education and Related Agencies**  
**Hearing on Improper Payments**  
**March 17, 2011**

Chairman Rehberg, Ranking Member DeLauro, and Members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce improper payments in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The Administration is strongly committed to reducing the rate of improper payments and ensuring that our programs pay claims in an accurate and timely manner.

Background on Improper Payments

Like other large and complex Federal programs, Medicare, Medicaid, and CHIP are susceptible to payment, billing and coding errors—called “improper payments.” These rates are determined annually in an open and transparent process required by the Improper Payments Information Act (IPIA), as amended by the Improper Payments Elimination and Recovery Act (IPERA) of 2010. While these improper payments represent a fraction of total program spending, any level of improper payment is unacceptable and CMS is aggressively working to reduce these claims processing, coding and documentation errors.

The IPIA uses the term “improper payment” to describe these errors, however it is important to clarify what these billing anomalies are – and are not. They can result from a variety of assorted circumstances, including: 1) services with no documentation, 2) services with insufficient documentation, 3) incorrectly coded claims, or 4) services provided that were not determined “reasonable and necessary.” Further, improper payments do not always represent an unnecessary loss of Medicare, Medicaid, or CHIP funds. They are usually not fraudulent nor necessarily payments for inappropriate claims; rather, they tend to be an indication of errors made by the provider in filing a claim or inappropriately billing for a service. Most improper payments by providers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Examples of common payment errors made by Medicare providers include services that were performed in a medically unnecessary setting<sup>1</sup>, or were incorrectly coded.<sup>2</sup> Other payment errors result when providers fail to submit

---

<sup>1</sup> Medically unnecessary setting: Medicare claims fall into this category when services are provided in a more intensive (and expensive) setting than is considered reasonable and necessary by Medicare. For example, if a minor surgery is done in an inpatient hospital setting on a healthy beneficiary, instead of in an outpatient setting, the entire claim is classified as an “improper payment.”

documentation when requested, fail to submit adequate documentation to support the claim, or when Medicare pays a claim that should have been paid by a different group health plan or other liable party.

The Administration is committed to reducing waste and improper payments across the government. On November 20, 2009, President Obama issued Executive Order 13520 calling on all Federal agencies to reduce waste and improper payments across Federal programs and CMS is working hard to carry out the Order. In addition, the President has: issued a memorandum on intensifying and expanding payment recapture audits (March 10, 2010); issued a memorandum to enhance payment accuracy by creating a “Do Not Pay” List (June 18, 2010), and signed IPERA into law (July 22, 2010),

### Improper Payments in Medicare Fee-for-Service

The traditional, Medicare fee-for-service (FFS) program represents the majority of Medicare spending, with hospital and other institutional services representing the largest shares of this spending. This component of Medicare is administered by CMS through contracts with private companies that process claims for Medicare benefits.

In keeping with requirements to promptly pay claims in Medicare, our claims processing systems were built to quickly process and pay the roughly 4.8 million claims that we receive each day, totaling approximately 1.2 billion claims in fiscal year 2011. Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, CMS heavily relies on automated edits to identify inappropriate claims. Nevertheless, most claims are paid by CMS without requesting or individually reviewing the medical records associated with the services listed in the claim.

CMS uses the Comprehensive Error Rate Testing (CERT) process to sample and review Medicare FFS claims to project an improper payment rate. At the recommendation of the Department of Health and Human Services (HHS) Office of the Inspector General, CMS applied a stricter and improved methodology for calculating the Medicare FFS error rate in FY 2009. As a result of this change, the FY 2009 and FY 2010 overall error rates were higher than in FY 2008; 12.4 percent and 10.5 percent in FY 2009 and FY 2010 respectively. The Administration announced last year that CMS will cut the

---

<sup>2</sup> Incorrect coding: Claims are placed into this category when providers submit medical documentation that support a lower or higher code than the code submitted. (CMS Improper Medicare Fee-For-Service Payments Report, [https://www.cms.gov/CERT/10\\_CERT\\_Reports\\_and\\_Data.asp#TopOfPage](https://www.cms.gov/CERT/10_CERT_Reports_and_Data.asp#TopOfPage)).

Medicare FFS improper payment rate in half by 2012, from 12.4 percent to 6.2 percent. CMS is making progress in meeting this goal, with a 1.9 percent point reduction in the error rate between FY 2009 and FY 2010.

In addition to measuring the Medicare FFS error rate, the CERT program guides CMS in developing corrective actions to reduce improper payments in the future. CMS continues to analyze the improper payment data garnered from the CERT program and also uses the results to provide feedback to Medicare contractors to inform and enhance their medical review efforts, focus on high risk areas, and improve overall operations.

To help reduce medical necessity errors, which occur when documentation submitted by a provider does not sufficiently establish the beneficiary's medical need for an item or service, CMS has developed Comparative Billing Reports, which compare a provider's billing pattern for various procedures or services to their peers on a State and national level. Also, Medicare's automated systems can detect and reject payment for medical services that are physically impossible, such as a hysterectomy billed for a male beneficiary. Additionally, CMS has developed "medically unlikely" payment systems edits, which catch services when the quantity billed exceeds acceptable clinical limits.

*Recovery Audit Program in Medicare FFS:*

The Recovery Audit program is another tool in CMS' efforts to detect and reduce improper payments. The Recovery Audit program began as a 6-State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.<sup>3</sup> Congress expanded the Recovery Audit program in the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national Recovery Audit program in Medicare FFS by January 1, 2010. Recovery Auditors work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis. The permanent Medicare FFS Recovery Audit program, as of March 1, 2011, corrected a total of \$261.5 million in improper payments, including \$43.6 million in underpayments corrected and \$217.9 million in overpayments collected.

More importantly, the Recovery Auditors help CMS identify areas where policy changes, systems changes, and provider education and outreach can help prevent future improper payments. CMS

---

<sup>3</sup> CMS began this demonstration in Florida, California, and New York in 2005, and later expanded to Massachusetts, South Carolina, and Arizona.

employs a robust system to identify patterns in the vulnerabilities identified by Recovery Auditors and to undertake appropriate corrective actions. During the demonstration, Recovery Auditors identified a number of improper payments in claims related to inpatient rehabilitation facilities (IRF). CMS recognized that the Agency's policy was outdated and published a regulation (CMS 1538-F) to update the policy and also conducted extensive provider education to ensure that providers bill IRF claims correctly. In the national program, Recovery Auditors have identified several areas where edits can be helpful in preventing improper payments. CMS is implementing edits to stop the payment of claims after a beneficiary's date of death, stop the payment of durable medical equipment while the beneficiary is receiving care in an inpatient setting, and to stop the payment for individual services that should have been bundled into another payment. In addition, the claim processing contractors have been able to implement local system edits to stop improper payments relating to durable medical equipment bundling (wheelchair and accessories and knee prosthetics) and drugs paid exceeding recommended dosages.

Some vulnerabilities cannot be fixed with automated edits and may require ongoing medical review and other more resource intensive activities. As such, the President's FY 2012 Budget Request includes a legislative proposal that would allow CMS to retain a dedicated portion of the funds recovered by Recovery Auditors to implement additional corrective actions to prevent future improper payments, such as targeted prepayment review and provider education. Funding these activities to prevent future improper payments is estimated to generate net savings of \$230 million over 10 years.

#### Improper Payments in Medicare Parts C and D

The Medicare Advantage managed care benefit (Part C) and the prescription drug benefit (Part D) differ significantly from Medicare FFS and, as a result, require different approaches to measure and address improper payments. Unlike Medicare FFS, CMS prospectively pays Medicare Part C and Part D plans a monthly capitated payment. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, Part D payments are also reconciled against expected costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The Part C error rate reported for FY 2010 (based on payment year 2008) is 14.1 percent, a reduction from the FY 2009 rate of 15.4 percent. Most of the Part C payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by Medicare Advantage (MA) plans to CMS for

payment purposes. Specifically, the risk adjustment error reflects the extent to which diagnoses that plans report to CMS are supported by medical record documentation.

To reduce the level of Part C improper payments due to risk adjustment error, the President's FY 2012 budget includes a proposal to require CMS to conduct contract-level Risk Adjustment Data Validation (RADV) audits, and to extrapolate the sample results for each MA contract to all enrollees in that contract for a given year. That is, the payment error for a contract's sampled beneficiaries, which is based on diagnoses not supported by medical record documentation during the RADV process, would be extrapolated from the sample to all contract enrollees. Enactment of this proposal would result in increased collections of improper payments made to MA plans, and is estimated to save \$6.16 billion over 10 years.

CMS has made strides in developing a Medicare Part D composite error estimate based on a series of payment error sources, and plans to report a Part D composite error rate beginning in FY 2011. For FY 2010 reporting, a total of four component error estimates were reported. The four components were: 1) a Part D payment system error of 0.1 percent, 2) a low-income subsidy payment error of 0.1 percent, 3) payment error related to Medicaid status for dual eligible Part D enrollees of 1.8 percent, and 4) payment error related to prescription drug event data validation of 12.7 percent. The majority of the prescription drug event data error rate was due to missing prescription documentation from pharmacies. To reduce this error rate, CMS has provided Part D sponsors with additional guidance and addressed the timing of documentation submissions to assist them in improving collection of prescription documentation from pharmacies

*Recovery Audit Program in Medicare Parts C and D:*

The Affordable Care Act expanded the Recovery Audit program to Medicare Parts C and D and the Medicaid program, and CMS is drawing from the lessons learned from the Medicare FFS Recovery Audit program as we implement this new statutory authority. In January 2011, CMS awarded a contract to identify incorrect payments and recoup overpayments in Medicare Part D. Additionally, we are seeking public comment through a solicitation issued on December 27, 2010 in the Federal Register on innovative strategies for review of additional Medicare Parts C and D data, including the effectiveness of sponsors' anti-fraud plans.

## Improper Payments in Medicaid and CHIP

While CMS administers the Medicaid Program and CHIP, these two programs are essentially more than 50 individualized programs around the country, in which CMS works with each State and Territory to administer a program that meets the particular health care needs and level of benefits established by that jurisdiction, within Federal guidelines. The measurement of nationwide improper payments is therefore correspondingly difficult, and efforts to reduce improper payments in Medicaid and CHIP require cooperation from both the Federal government and individual States.

In 2005, CMS developed the Payment Error Rate Measurement (PERM) program to review improper payments in three components of Medicaid and CHIP: Fee-for-Service (FFS) claims, managed care claims, and eligibility cases. The PERM program uses a rolling 17-State three-year rotation for measuring improper payments, so that CMS measures each State once every three years. In addition, starting in FY 2010 with Medicaid, a three-year weighted average national rate is also produced. As required by the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, CMS published a final regulation in August 2010 (CMS -6150-F) that to help ensure error measurements are as meaningful and accurate as possible, while avoiding unnecessary burdens on States and providers.<sup>4</sup>

The FY 2010 Medicaid three-year weighted average national error rate (which includes data reported in 2008 through 2010) is 9.4 percent. Though causes of improper payments vary from State to State, PERM helps CMS identify trends and common errors across States. The vast majority of Medicaid errors are due to insufficient documentation to support the services provided and cases reviewed for eligibility that were either not eligible or their eligibility status could not be determined.

While the PERM process identifies and classifies types of errors, States are critical partners in CMS's efforts to reduce Medicaid improper payments. States are required to submit Corrective Action Plans (CAPs) 90 days after they are notified by CMS of their error rates. While CAPs vary from State to State, the results of the recent 2010 reporting period suggest that many States intend to target provider education to improve the responsiveness of submission of requested documentation and reduce errors in State eligibility processes and procedures.

---

<sup>4</sup> CHIPRA prohibits CMS from calculating or publishing any national or State-specific error rates for CHIP until six months after the new final rule for PERM is in effect. As a result, CMS recently resumed CHIP measurement and will report CHIP improper payments in 2012.

Recent improvements to the PERM program and the corrective actions process should lead to more effective State CAPs and decreases in States' improper payments. CMS plays an important role by overseeing CAPs, as well as collecting and disseminating best practices to allow States to learn from others' successful efforts to reduce improper payments. CMS has developed and shared a model CAP example to guide State efforts and also conducts quarterly "best practice" calls, during which State leadership share their corrective action success stories with other States. States have successfully implemented a number of corrective actions that have reduced insufficient documentation and eligibility errors. Some States have conducted education and outreach sessions prior to the start of the PERM measurement to educate providers on documentation requirements and the consequences of non-compliance and are targeting specific provider types that in the past have been difficult to reach or non-compliant.

#### *Recovery Audit Program in Medicaid:*

To implement the expansion of the Recovery Audit program to Medicaid included in the Affordable Care Act, CMS issued a State Medicaid Director letter in October 2010 that offered initial guidance on the implementation of the Medicaid Recovery Audit requirements and also published a Notice of Proposed Rulemaking on November 10, 2010. To date, CMS has provided significant technical assistance to States through all-State calls and webinars and has begun the coordination with States that have Recovery Audit contracts in place, as required by the statute. Further, on February 17, 2011, CMS launched a Medicaid Recovery Audit Contractor At-A-Glance web page on the CMS website.<sup>5</sup> The page provides basic information to the public and interested stakeholders about each State's Recovery Audit program.

#### Lessons Learned from the Private Sector

CMS is also examining the techniques used by insurance companies and other private sector entities to better inform our efforts to combat improper payments. Though our Federal programs differ from private insurance in some significant ways, CMS is eager to learn from successful private sector efforts to reduce errors and improper payments. In addition to harnessing improved data analysis and predictive modeling to fight fraud, CMS is using these approaches to identify areas to target with additional medical review. As part of this effort, CMS will evaluate the accuracy of commercial products and whether these products are feasible to implement and could reduce improper payments.

---

<sup>5</sup> <https://www.cms.gov/medicaidracs/home.aspx>

CMS is also examining other tools, such as prior authorization for certain services. Private sector insurers and other Government healthcare programs use this tool successfully to ensure upfront approval for certain high cost, non-emergency services. In addition, CMS is pursuing ways to link claims data and provider data within and across our various healthcare programs. The ability to identify trends sooner and link data is an important improvement to preventing improper payments. Additionally, CMS is exploring way to leverage existing compliance programs within the provider community to inform and educate providers about payment vulnerabilities. Getting providers actively involved in the identification and prevention process will keep improper payments from occurring in the first place.

### Conclusion

CMS' number one goal is to ensure our Medicare, Medicaid, and CHIP beneficiaries receive the right services, at the right time, in appropriate levels of care and at the right price. While CMS has made progress in reducing improper payments, we acknowledge that more work remains. Reducing waste and errors in our programs will allow us to target taxpayer funds to provide health care services for our beneficiaries.

I am confident that the systems controls and ongoing corrective actions that CMS is undertaking across our programs will result in continued reductions in improper payments. I look forward to working with the Subcommittee to ensure that CMS has the necessary administrative resources and tools to continue our efforts to carry out this important work.