# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations


A Joint Initiative by Senators
Baucus, Hatch, Grassley, Carper and Wyden

April 2013

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

Of the 164 white papers submitted to the Senate Finance Committee by various health care stakeholders, 146 addressed the intent of the Senators' solicitation to identify potential solutions to combat Medicare and Medicaid fraud, waste, and abuse. (See app. I for a description of stakeholder types that submitted white papers.) Ninety five percent, or 139 of the 146 white papers, had one and often multiple recommendations, which ranged from very broad to quite specific.

## Scope and Methodology

Identifying the recommendations contained in the white papers was not a straightforward task. A small portion of the white papers were organized such that recommendations were clearly identified; in the remaining white papers, however, we had to analyze a significant portion of the papers' nearly 2,000 pages of background or contextual information to better understand and capture any recommendations. We used a qualitative data analysis software tool to help identify the white papers' policy recommendations and to help categorize them. To assess the prevalence of recommendations, we used the number of white papers as the denominator, which allowed us to group together similar but not identical recommendations.

We used two frameworks to categorize the recommendations—topic areas and cross cutting themes (See fig. 1).

> *Topic areas.* The five broad topic areas were improper payments, audit burden, enforcement, data management, and beneficiary protection.[1] Because these topics were broad, we also categorized recommendations by specific subtopics within each topic area. Table 1 describes each of the five topic areas.
>
> *Cross-cutting themes.* Several themes—coordination, simplification, education, and duplication—cut across multiple topics. For example, various papers recommended actions to improve coordination between CMS and other payers (improper payments); among auditors (audit burden); and among CMS, auditors, and enforcement officials (enforcement). Table 2 describes the four cross-cutting themes.

[1]Because of the nature of the white papers, there is overlap, to some extent, among all the different categories.

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

**Figure 1: Recommendation Topics, Subtopics, and Themes**

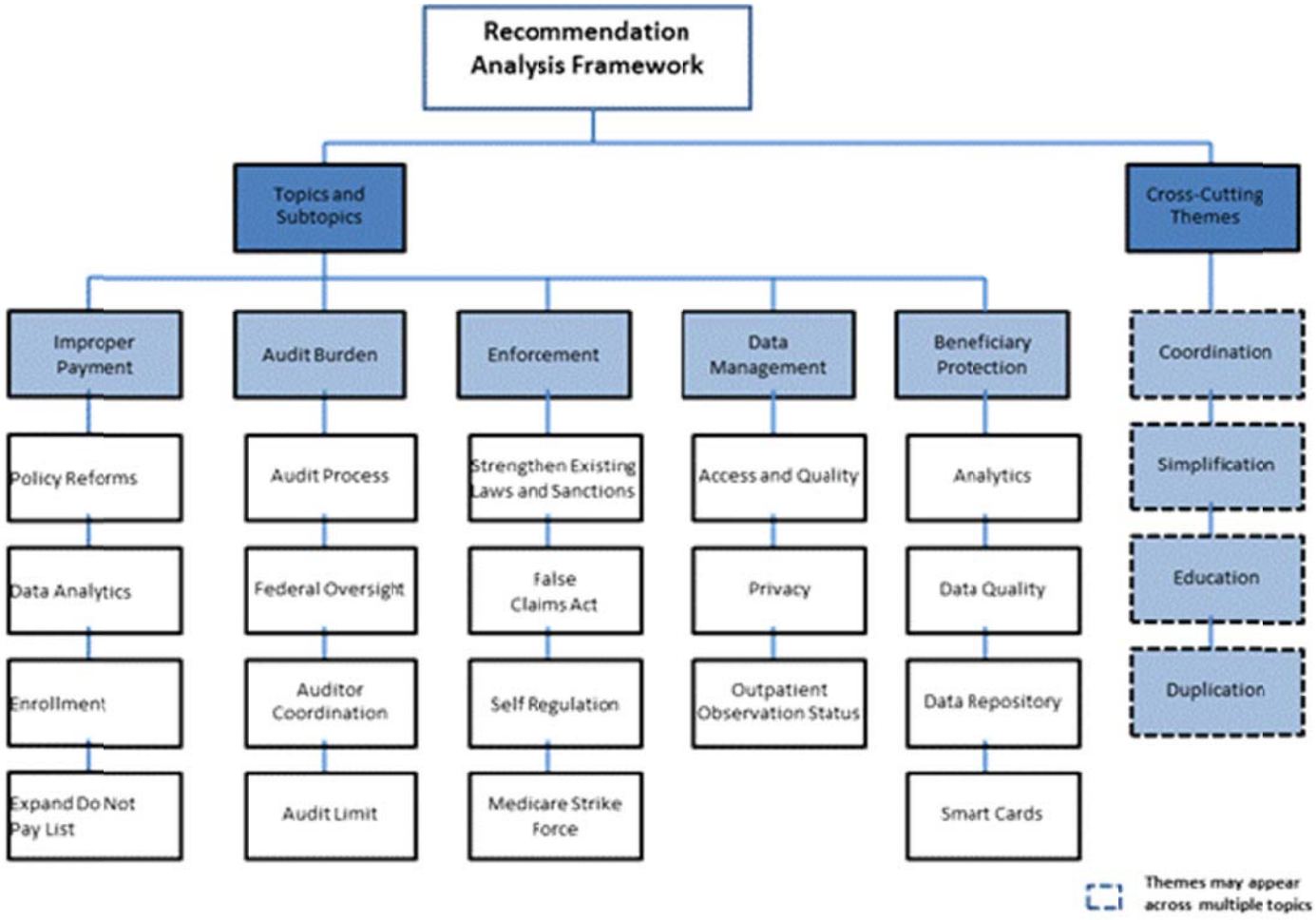


**Table 1: Description Categorization Framework: Topic Areas**

| Topic area | Description |
|---|---|
| Improper payment | A broad range of issues including provider and facility credentialing, payment processes and denials; creation of public and private partnerships to share information; and the use of predictive analytics and other technologies designed to ensure that services are rendered to the intended beneficiary by the correct provider. |
| Audit burden | Program integrity issues related to the audit process from initiation through resolution, as well as federal oversight of auditing entities such as contractors and state Medicaid programs. It does not include a discussion of how improper payments are identified (this topic was covered in the improper payments section). |
| Enforcement | Strengthening enforcement tools such as criminal sanctions and civil monetary penalties or requiring mandatory reporting and removal of negligent physicians by hospitals. |
| Data management | Data quality and systems, sharing, and protection. |
| Beneficiary protection | The quality of care provided to Medicare and Medicaid beneficiaries or beneficiaries' financial health and satisfaction with the care received. |

**Table 2: Description of Categorization Framework: Cross-Cutting Themes**

| Cross-cutting theme | Description |
|---|---|
| Coordination | Improve coordination of activities among payers, state and federal governments, providers, and audit entities, including the sharing of data and best practices. |
| Simplification | Improve efficiency by simplifying and streamlining payment and audit policies associated with program integrity. |
| Education | Better educate providers, suppliers, beneficiaries, and the anti-fraud workforce, including law enforcement. |
| Duplication | Reduce duplication in auditor activities, documentation requirements, and other areas. |

The frequency of a recommendation did not necessarily equate to its specificity or significance. For example, recommendations to simplify program coverage and payment policies were among those raised the most frequently, but few, if any, stakeholders specified how these policies should be simplified. Additionally, some papers recommended measures that may already be underway. For example, many papers recommended the use of predictive analytics by CMS to screen improper Medicare and Medicaid payments before they are made. CMS has been using predictive analytics as part of its Fraud Prevention System since July 2011 to identify improper Medicare claims before they are paid.[2] In addition, the agency is providing guidance and training to state Medicaid program integrity staff on their use of predictive analytics to identify improper Medicaid payments. Finally, in developing this overview of the

[2]See GAO, *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).

recommendations, we identified recommendations that urged Congress to modify specific laws or to pass specific bills. (See app. II.)

## Recommendation Overview

The following recommendations overview summarizes recommendations by key topic or cross-cutting theme based on the prevalence of the recommendation. Within each key topic, subtopics and cross-cutting themes are discussed according to the frequency that stakeholders raised them.

### Recommendations by Program Type

Most of the white papers addressed both Medicare and Medicaid and therefore many of the policy recommendations applied to both programs. Although there were a considerable number of recommendations specifically applicable to Medicare, few focused solely on Medicaid program integrity. (See table 2.)

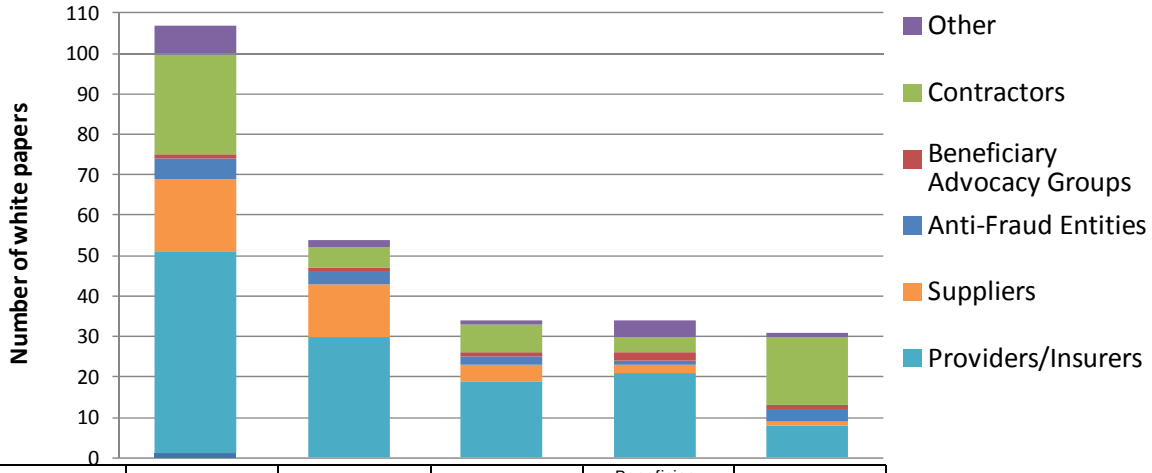
**Table 3: Recommendations by Program Type**

| Program type | Number of papers with applicable recommendations | Percentage of papers with applicable recommendations |
|---|---|---|
| Medicare and Medicaid | 103 | 74% |
| Medicare | 74 | 53% |
| Medicaid | 18 | 13% |

### Most Frequent Topics and Themes

The majority of papers contained recommendations related to improper payment and audit burden. Stakeholders who submitted white papers varied in the topics that were most important to them. For example, providers and contractors (71 percent) submitted most of the papers containing recommendations related to improper payments, while providers and suppliers (80 percent) were responsible for those containing recommendations related to audit burden. Contractors (55 percent) submitted most of the papers containing recommendations related to data management.

**Figure 2: Frequency of Recommendations by Topic Areas and Contributing Stakeholders**




| Topics | Improper Payment | Audit Burden | Enforcement | Beneficiary Protection | Data Management |
|---|---|---|---|---|---|
| Number of papers with recommendations addressing topic | 106 | 54 | 34 | 34 | 31 |
| Percent of papers with recommendations addressing topic | 76% | 39% | 24% | 24% | 22% |

The three most prevalent cross-cutting themes were related to coordination, simplification, and education, with little variation in the number of papers containing recommendations in each of these three areas. (See table 4.) Generally, most of the papers that contained recommendations related to the cross-cutting themes were submitted by providers, who also submitted most of the white papers.

**Table 4: Frequency of Recommendations by Cross-Cutting Themes**

| | Coordination | Simplification | Education | Duplication |
|---|---|---|---|---|
| Number of papers containing recommendations related to theme | 45 | 42 | 42 | 16 |
| Percent of papers containing recommendations related to theme | 32% | 30% | 30% | 12% |

## Recommendations by Topic and Cross-Cutting Theme

### Improper Payment

| |
|---|
| Improper payments encompassed a broad range of issues including provider and facility credentialing, payment processes and denials; creation of public and private partnerships to share information; and the use of predictive analytics and other technologies designed to ensure that services are rendered to the intended beneficiary by the correct provider. |

Seventy six percent of the white papers contained recommendations intended to improve the processes for preventing, detecting, and deterring improper payments. Among the 106 improper payment papers several subtypes emerged from the recommendations; foremost were those calling for (1) policy reforms, followed by recommendations regarding (2) data analytics, (3) enrollment processes, and (4) coordination and educational efforts. Fewer recommendations involved simplification, expanding the do-not-pay list, and duplication. (See app. III, table 1.)

(1) Policy Reform

Eighty three percent of the 106 improper payment papers included recommendations to modify current improper payment policies. Recommendations in this broad subtype varied widely and included the following:

- *Provide Incentives:* Provide incentives to encourage investments in fraud-prevention activities. For example, several provider and insurer stakeholders recommended revising the medical loss ratio formula to include fraud prevention expenses;[3]

[3]The 2010 Patient Protection and Affordable Care Act (PPACA) requires certain health insurers to provide rebates to their customers for each year that the insurers do not meet a set financial target called a medical loss ratio (MLR), which measures the share of a health care premium dollar spent on medical benefits, as opposed to company expenses such as overhead, administrative costs, or profits. Recognizing the importance of fraud reduction expenses and the disincentive if these expenses were treated solely as non-claims and non-quality improving expenses, the final rule implementing PPACA 's MLR requirements allows payments recovered through fraud reduction efforts as adjustments to incurred claims, thus giving issuers of health coverage the opportunity to recoup monies invested to deter fraud. The Department of Health and Human Services noted that allowing an unlimited adjustment for all fraud prevention activities would undermine the purpose of requiring issuers of health coverage to meet the MLR standard in the Affordable Care Act and stated that it believed that issuers would continue to invest in fraud reduction, including fraud prevention, regardless of the medical loss ratio treatment and encouraged issuers to do so.

- *Focus on Prevention:* Proactively prevent fraud and abuse by implementing programs that focus efforts on high-risk providers and high-cost services. For example, recommendations in this category included policy reforms that would reduce or prevent prescription drug abuse, drug diversion, and doctor shopping by restricting high-risk beneficiaries to specific providers and tracking prescriptions in real time; and
- *Improve Payment Policies and Guidance:* Stakeholders made a variety of recommendations to improve payment policies and guidance, including linking payment to best practices, bundling payments, and simplifying the process for returning overpayments. Additionally, stakeholders recommended centralizing and simplifying compliance program and payment documentation guidance. Specific examples include:
    - reducing the volume and complexity of Medicare rules to reduce the portion of improper payments due to technical errors and honest mistakes;
    - making Medicare rules easily available from a central location instead of from the various manuals and agency websites;
    - simplifying the Medicare benefit design; and
    - allowing hospitals to resubmit denied inpatient claims as outpatient claims.[4]

(2) Data Analytics

Thirty-seven percent of improper payment papers included recommendations to use data analytics to enable targeted, informed fraud identification and prevention such as:

- *Predictive Modeling and Data Mining:* Leveraging analytical tools to prevent improper payments, including the use of data mining programs to identify complex patterns and relationships among individuals intent on committing fraud; and predictive modeling to identify high-risk providers and services, as well as potentially fraudulent billing practices such as "code creep" (i.e. upcoding and unbundling) that increase provider and facility reimbursements;

[4]On March 18, 2013, CMS issued a proposed rule, under which hospitals will be permitted to resubmit denied inpatient claims for some of the services provided as outpatient claims under Medicare Part B, provided they resubmit within one year from the date of service. Additionally, the recently reintroduced Medicare Audit Improvement Act, H.R.1250 (formerly H.R. 6575), would permit hospitals to resubmit denied inpatient claims as outpatient claims beyond CMS's one-year period.

- *Pre-Payment Analysis and Real-Time Fraud Prevention:* Applying data analytics at the point a claim is being processed and ensuring that services were provided to the correct beneficiary by the correct provider and facility; and
- *Leveraging Resources and Increasing Financial Support:* Maximizing existing resources, such as allowing state Medicaid programs to take advantage of Medicare's robust data analytics and expertise; leveraging available funds by taking advantage of CMS's ability to purchase analytical tools and software for Medicaid program integrity at a lower cost than individual states could negotiate; applying financial recoveries from fraud and abuse cases to future fraud and abuse efforts; and increasing federal funding for anti-fraud systems and predictive modeling technologies.

(3) Enrollment Process

Thirty two percent of improper payment papers included recommendations to change the process for enrolling providers, suppliers, or beneficiaries as a way to prevent improper payments and strengthen program integrity. Examples of such recommendations included the following:

- *Ensuring Competency of Enrolled Providers:* Several recommendations focused on ensuring the competency of enrolled providers to safeguard public funds as well as beneficiaries. Stakeholders recommended various methods for accomplishing this goal, including implementing criminal background checks and fingerprinting requirements, and requiring credentialing and other evaluations such as identity analytics to screen providers, including physicians, facility owners, financial investors, and executive-level managers;[5]
- *Strengthening Admission Standards:* Introducing a variety of admission standards to prevent fraud and abuse from occurring. For example, increasing new provider application fees for certain service areas such as home health; offering probationary initial enrollment in Medicare or Medicaid; and increasing oversight of new providers by conducting surveys early on; and

[5]Depending on a provider's risk level, PPACA authorizes CMS to require fingerprint-based criminal history checks; CMS has not yet implemented this authority.

- *Temporarily Limit New Providers:* Limiting the number of new provider numbers issued in areas and for services at risk of excessive growth, for example placing a moratorium on the number of new home health agencies allowed in certain regions.[6]

(4) Coordination and Education

Improper payment coordination and education recommendations were each included in 23 percent of improper payment papers. These recommendations included improving the coordination among stakeholders, as well as focusing on educational efforts to reduce improper payments resulting from errors in billing.

- *Opportunities for Coordination:* Maximizing opportunities for coordination to improve, prevent, detect, and deter fraud through activities such as sharing data between federal agencies including CMS and Department of Justice (DOJ), federal contractors, Medicare and Medicaid, health plans, and other stakeholders. For example,
    - improving coordination between the states and CMS to share state Medicaid program integrity best practices; and
    - establishing a Medicaid program integrity liaison with each state's Medicaid program to share information about improper payment trends and improve collaboration.
- *Education:* Recommendations in this category typically involved reducing improper payments by educating providers and Medicaid program integrity and enforcement staff. For example,
    - offering a physician education series about documentation requirements;
    - centralizing all CMS rules and guidance in one location;
    - issuing CMS guidance for providers on certain dates, such as the 15th day of each month or once a quarter, so that providers can more easily keep track of documentation requirements;
    - creating a CMS billing resource center so that providers could contact CMS directly to discuss questions about billing and documentation requirements;

[6]PPACA authorizes CMS to implement moratoriums on the enrollment of new Medicare or Medicaid providers and suppliers, including categories such as new home health agencies. On February 2, 2011, CMS issued a final rule implementing this measure, but has not yet used this authority.

- having CMS review industry-developed education materials to ensure their accuracy and to promote their use among referring physicians; and
- requiring CMS to provide examples of appropriate chart notes and other required documentation to assist physicians in properly documenting services; and
- expanding the Medicaid Integrity Institute.[7]

(5) Simplification, Expanding the Do-Not- Pay List, and Preventing Duplication

Among improper payment white papers, less prevalent recommendations were related to simplifying processes (20 percent); expanding the do-not-pay list (6 percent); and preventing duplication (4 percent). Specific recommendations included:

- simplifying payment policies and processes through the development of standardized documentation requirements;
- expanding the Do-Not-Pay list to include providers with retired or revoked Drug Enforcement Agency (DEA) registrations and pharmacies suspected of fraud; directing CMS to share names of suspended providers so that health plans can also suspend payments;[8] and
- eliminating duplication of effort for program integrity activities involving the same providers, beneficiaries, or other stakeholders.

[7]The Medicaid Integrity Group, within CMS, established the Medicaid Integrity Institute to provide a national Medicaid training program for state program integrity officials. At no cost to states, the institute offers substantive training and support in a structured learning environment. In time, the institute intends to create a credentialing process to elevate the professional qualifications of state Medicaid program integrity staff.

[8]Providers who prescribe or dispense controlled substances are required to register with the DEA. Registered providers that violate the law or regulations may have their DEA registration revoked.

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

## Audit Burden

Audit burden includes program integrity issues related to the audit process from initiation through resolution, as well as federal oversight of auditing entities such as state Medicaid programs and audit contractors. It does not include a discussion of how improper payments are identified (this topic was covered in the improper payments section).

Thirty-nine percent of the white papers contained recommendations related to audit burden. Among the 54 audit burden papers, the most prevalent subtopic recommendations called for changes to the (1) audit process, and (2) federal oversight of state Medicaid programs and Medicare and Medicaid audit contractors, followed by recommendations for (3) simplification, and (4) improving coordination among the various auditing entities. Other common recommendations, raised by 25-35 percent of the 54 papers that discussed audit burden included limiting the scope or duration of audits; better educating providers, suppliers, and auditors about payment policies; and reducing duplication among various auditors and audits. (See app. III, table 2.)

(1) Audit Process

Seventy-four percent of the audit burden papers called for changes to the audit process, such as reforming and clarifying processes and policies, updating documentation requirements, applying CMS policies consistently; and standardizing audit documentation requirements. Specific recommendations in this category included:

- increasing CMS involvement in the audit process (e.g. more direct communication between providers and CMS during the audit process);
- better aligning the durable medical equipment competitive bidding process and Zone Program Integrity Contractors' (ZPIC) audit processes so that a supplier who is awarded a contract and experiences an increase in billing volume is not penalized for having an aberrant billing pattern;
- providing objective criteria for providers and suppliers to be removed from a prepayment audit because, at present, ZPICs appear to have the authority to keep suppliers under prepayment review indefinitely for unknown reasons;
- implementing procedures to promote due process by requiring contractors to: (1) provide notice of an investigation; (2) provide all exculpatory evidence regarding the

investigation to the audited entity; and (3) allow the audited entity to respond to the complaints upon which investigations are initiated prior to any affirmative action taken to limit the contractual right to Medicare payment;[9]

- requiring audit contractors to communicate electronically with providers rather than using the postal service;
- paying interest to providers and suppliers when their denials are overturned upon appeal;[10]
- giving states and Medicaid recovery audit contractors flexibility in considering the use of non-state-based Medical Directors or deploying part-time, state-based Medical Directors to make efficient use of expensive resources; and
- improving the Payment Error Rate Measurement (PERM) program to differentiate between fraud and clerical error.[11]

(2) Federal Oversight of States and Contractors

Sixty-seven percent of papers that discussed audit burden included recommendations related to federal oversight of state Medicaid program integrity activities and Medicare and Medicaid audit contractors.

- One prominent Medicaid anti-fraud entity and one federal Medicaid audit contractor recommended improving federal oversight of state program integrity activities. For example, recommendations included:
    - developing methods for better assessing the effectiveness of federal and state program integrity activities;
    - eliminating duplication among the various tools CMS uses to assess state program integrity activities; and
    - increasing state incentives to prevent improper payments;

[9]In general, Medicare contractors audit providers and are not permitted to conduct covert investigations, which are the purview of law enforcement entities. However, ZPICs are authorized to perform unannounced site visits.

[10]H.R.6575 would require recovery audit contractors whose denials are overturned through the appeals process to pay a fee to prevailing providers.

[11]The PERM is a measure of improper payments, including payments on fraudulent claims.

- Providers and suppliers generally recommended that CMS exercise greater oversight of Medicare and Medicaid audit contractors, including
    - enforcing contractor statement-of-work and other requirements, and limiting audit contractors' capacity to interpret, change, and create policies;
    - requiring additional training on claims review and medical necessity criteria for audit contractors;
    - modifying the incentives for recovery audit contractors, who are currently paid a percentage of improper payments recouped;
    - penalizing audit contractors for overturned or incorrect audit findings; and
    - requiring audit contractors to update audit policies and practices to reflect administrative law judge (ALJ) rulings and findings on similar audits.[12]
- Contractors made several recommendations related to reimbursement
    - One recovery audit contractor recommended increasing the incentive for recovery audit contractors to increase their efficacy in identifying and recovering improper payments.
    - Conversely, a Medicaid integrity contractor recommended that such contractors be reimbursed a fixed fee instead of a contingent fee.

(3) Audit Simplification

Fifty percent contained recommendations to simplify audit policies, and practices, and among these, thirty-seven percent contained recommendations to reduce the number of auditors to decrease duplicative audits. For example, specific recommendations in this category included:

- simplifying documentation requirements through the implementation of standardized forms for documenting medical necessity, updated as necessary to reflect current clinical standards;
- reducing the number of different types of CMS audit contractors and reducing the number of duplicative audits; and
- reducing the overlap between different auditing entities.

[12]The OIG recently found that improvements were needed in the ALJ appeals process, that differences between ALJ and lower appeal level decisions were due to different interpretations of Medicare policy and requirements at the ALJ level, and that the rate of making decisions favorable to providers varied by ALJ. See HHS-OIG, *Improvements Are Needed at the Administrative Law Judge Level of Medicare Appeals,* OEI-02-10-00340 (November 2012).

(4) Audit Coordination

Forty-three percent of papers that focused on audit burden included recommendations that all the different entities involved in health care, including payers, payment contractors, auditors, and providers share data and improve communication. Specifically, many papers recommended requiring Medicare payment and audit contractors to coordinate with one another to prevent inconsistent application of policies and reduce duplicative documentation requests and the resulting burden on providers and suppliers.

(5) Audit Limit and Education

Less prevalent recommendations, included in 33-35 percent of the audit burden papers, included recommendations to limit the scope or duration of audits and to better educate providers, suppliers, and auditors about payment policies. Specific recommendations that fell into this subtopic and cross-cutting theme included:

- subjecting providers who had demonstrated higher levels of compliance to reduced audit activity;
- targeting audit and review activity to suspected fraud or patterns of billing errors instead of occasional technical documentation errors; and
- educating auditors on the clinical standards of care that physicians practice and differences from coding guidelines and CMS payment policy requirements.

## Enforcement

Enforcement includes strengthening tools such as criminal sanctions and civil monetary penalties or requiring mandatory reporting and removal of negligent physicians by hospitals.

Twenty-four percent of the white papers we reviewed made recommendations related to enforcement tools. In these 34 papers, the two dominant recommendations were to (1) improve coordination among enforcement officials and others, and (2) strengthen laws that allow CMS and other entities to sanction non-compliant providers, suppliers, and beneficiaries. (See app. III, table 3.)

(1) Improving Coordination Among Enforcement Officials

Forty-one percent of the 34 enforcement white papers contained recommendations to improve coordination among enforcement officials and others. These recommendations focused on collaboration between states and CMS and (a) law enforcement and investigative agencies, such as state Attorneys General, Federal Bureau of Investigation (FBI), and/or the Health and Human Services Office of Inspector General (OIG); and (b) public and private health insurance providers. Many recommendations were broadly stated (i.e. "We recommend that the Committee explore ways to encourage partnerships between the federal government, state, and local entities."). However, specific recommendations included:

- strengthening public-private partnerships by fully implementing and funding the 1997 DOJ directives, which called for increased cooperation and information sharing between private and public entities;[13]
- encouraging states to upgrade their monitoring programs to allow for better interactions within and among states;

[13]For example, one paper suggested that using existing authority under the Health Insurance Portability and Accountability Act (HIPAA) and DOJ's Criminal Resource Manual to strengthen local or regional taskforces would enable private insurers, law enforcement, and the attorneys general to meet regularly and work cohesively to address specific issues. The DOJ written policies and directives concerning criminal investigations are, for the most part, set out in the U.S. Attorneys' Manual, which is supplemented by a Criminal Resource Manual. The Criminal Resource Manual, among other things, provides attorneys with more specific guidance and examples for prosecuting violations. The guidance and examples provided are usually based on prior experience or previously prosecuted cases.

- enabling prosecutors to include amounts lost by commercial plans in enforcement agencies' prosecutions, which is likely to allow federal and state prosecutors to seek and obtain even larger penalties against those who commit fraud by exposing the scope of the crime;
- establishing a central repository of fraud and abuse cases;[14] and
- increasing the frequency and distribution of anti-fraud alerts regarding specific, new, or evolving fraud schemes and potential fraud threats.

(2) Strengthening Existing Laws and Sanctions

Thirty-five percent of the 34 enforcement white papers contained recommendations to strengthen existing laws and increase existing fines and penalties. Providers and insurers most often made recommendations to strengthen enforcement efforts—such as strengthening the Stark law and Anti-Kickback statute and increasing fines and penalties. Anti-fraud organizations suggested increasing anti-fraud funding, prosecuting more cases, and increasing coordination between the federal government and states. Specifically, recommendations included:

- strengthening the Anti-Kickback statute, by:
    - defining remuneration more broadly to include providing anything of value,
    - requiring the writing of financial relationships in contracts and keeping records of hours and financial transactions,
    - requiring annual certification of anti-kickback requirements with fines for false certification,
- strengthening the Stark law by
    - issuing regulations and guidance that clarify issues surrounding physician-owned implant distributors, and
    - extending self-referral sanctions to the referring physician.
- encouraging enforcement authorities to pursue more cases and not only the 'big fish;'
- requiring CMS to use existing statutory authorities (e.g. moratorium, mandatory compliance programs) that it has yet to utilize; [15]

[14]CMS, HHS-OIG, and DOJ work together to investigate and prosecute alleged fraud in Medicare, Medicaid, and CHIP. Additionally, these agencies coordinate with state Medicaid Fraud Control Units (MFCU), which are primarily responsible for investigating and prosecuting fraud within their state Medicaid programs. Although fraud cases may be handled jointly by these agencies, they are entered into each agency's unique database, which may not capture the same data elements. For example HHS-OIG captures provider type, whereas DOJ's Civil Division does not collect data by provider type.

- requiring the Secretary of HHS and the HHS OIG to promulgate rules requiring that home health agencies establish and maintain an active compliance and ethics program;
- creating a private, industry-sponsored enforcement entity that would be authorized to investigate instances of non-compliance with HHS operational standards and impose monetary and operational sanctions;
- ensuring that cases of fraud and abuse are pursued by civil fraud authorities while cases centered on medical necessity or ambiguous payment policies are only pursued as potential overpayments;[16] and
- ensuring that hospice organizations are surveyed every 3 years.

(3) Enforcement Simplification, False Claims Act, Self-Regulation, and the Medicare Strike Force

Less frequently cited recommendations (those made in about 10 to 20 percent of papers) related to the simplification of enforcement efforts, the False Claims Act, self regulation, and the Medicare Strike Force. Providers and contractors recommended simplifying enforcement efforts. Providers were the only group to recommend implementing mechanisms for self-regulation and make recommendations related to the False Claims Act. Recommendations included:

- simplifying enforcement activities by gathering and sharing comprehensive evidence efficiently among the various investigative and enforcement entities and by prioritizing funding for enforcement to more efficiently direct resources;
- ensuring that the False Claims Act is only used in cases of fraud;
- implementing mechanisms for self-regulation, such as creating a government-registered, self-regulatory organization that would ensure voluntary compliance with federal health care laws and regulations; and
- improving or further utilizing the Medicare Strike Force teams.

[15]For example, one paper recommended that CMS implement intermediate sanctions, such as those provided for in the Omnibus Budget Reconciliation Act of 1987, which required CMS to establish a range of sanctions for nursing homes that were less severe than termination, including civil monetary penalties.

[16]A pattern of inappropriate medical necessity decisions may be indicative of fraud.

## Beneficiary Protection

Beneficiary protection encompassed topics related to the quality of care provided to Medicare and Medicaid beneficiaries or beneficiaries' costs and satisfaction with the care received.

Twenty four percent of the white papers made recommendations related to beneficiary protection. In these 34 papers, the two dominant recommendations were to improve (1) access to quality healthcare, and (2) privacy. Less frequently cited recommendations (those made in 12 percent or less of papers) were related to outpatient observation status, coordination to improve care, and beneficiary education.[17] Providers and insurers most often made recommendations to improve access to and quality of health care—such as reducing over- or under-utilization of services. Three papers from providers/insurers and a beneficiary protection group made recommendations related to the outpatient observation status—namely to allow the treating physician, not auditors or enforcement officials, to determine the most appropriate care setting. Both providers/insurers and contractors made recommendations related to improving beneficiaries' privacy—primarily by protecting beneficiaries' social security numbers. (See app. III, table 4.)

(1) Accessing Quality Healthcare

Sixty two percent of beneficiary protection white papers included recommendations to improve access to quality healthcare. They generally focused on payment policy implications on the utilization of certain medical services, and efforts to ensure beneficiaries have information about the quality of healthcare services. Examples included:

[17]Patients in observation status receive observation services, which include hospital outpatient services, such as lab tests or x-rays, provided in the Emergency Department or another area of the hospital to help doctors decide if the patient needs to be admitted as an inpatient or can be discharged. Some papers noted that the use of "outpatient observation status" by hospitals to avoid recovery audit contractor's (RAC) scrutiny of claims rendered the patient (1) liable for the claim and (2) ineligible for Medicare coverage of subsequent post-hospital skilled nursing home care because the patient did not fulfill Medicare's three day prior inpatient hospital stay requirement. On March 14, 2013, two bills—H.R. 1179 and S. 569—were introduced that would allow outpatient observation status hospitals stays of 3 days to be deemed inpatient and thus fulfill the prerequisite for Medicare skilled nursing facility coverage.

- over- or under-utilization of certain medical services:
    - reducing medically unnecessary surgeries—such as some cases of pacemaker, prostate, and angioplasty surgeries;
    - reducing screenings—such as duplicative imaging studies or tests ordered as defensive measures against potential malpractice claims;
    - reducing inappropriate use of prescription medications—such as the overuse of painkillers; and
    - preventing certain providers (such as hospice providers) from excluding patients who are considered more expensive to treat.
- Beneficiary education about the quality of healthcare services:
    - creating a hospice compare website;[18]
    - preventing predatory marketing practices, such as deceptive advertising on benefits and marketing strategies that may misinform or provide incomplete information to the consumer about all available options; and
    - improving beneficiary notice requirements and ensuring that beneficiaries are fully informed about the potential benefits and implications of new incentives under various payment programs to discourage providers from providing a lesser level of care to increase their profits.

(2) Privacy/Education

Twenty one percent of beneficiary protection white papers included recommendations related to privacy, focusing on the display of beneficiaries' social security numbers on medical identification cards (i.e., Medicare card). Twelve percent of recommendations in those white papers related to education focused on informing beneficiaries and the public about fraud. Recommendations to address these issues included:

- creating a new identification card such as the "Medicare Common Access Card" or a combined driver's license and identification card;

[18]CMS has created websites that provide information comparing providers of Medicare services such as hospitals, nursing homes, and physicians.

- creating a database of all compromised beneficiary identification numbers and routinely comparing this list against newly enrolled members to ensure that claims made under compromised numbers are reviewed before payment is made;
- informing beneficiaries about how much money is spent on fraud; and
- initiating a public awareness effort aimed at better educating the public, especially Medicare beneficiaries, about the nature of fraud and the fiscal implications of fraud and abuse on federal health care programs.

**Data Management**

| Data management encompassed issues related to data quality and systems; sharing; and protection. |
|---|

Twenty two percent of the white papers contained recommendations related to data management. Among these 31 papers, the most prevalent recommendations called for (1) using innovative data analytics, (2) sharing data and analyses among payers, (3) improving data quality or uniformity, and (4) implementing a repository for both Medicare and Medicaid data. Less frequently raised recommendations included calls for streamlining and simplifying the collection of data, using data to educate providers and suppliers (in addition to identifying improper payments), and adopting smart cards to verify beneficiary and provider information. The majority of papers discussing data management were submitted by contractors, many of whom were promoting their own product or services. (See app. III, table 5.)

(1) Data Analytics

Although approximately 61 percent of the data management papers called for the use of innovative analytics, most of these recommendations were generally quite broad and called for use of proprietary tools and methods. Papers included more specific recommendations such as

- requiring Medicare and Medicaid to match beneficiaries' vital records to their social security files and state claims data to prevent payments on behalf of deceased individuals;

- matching Medicare and Medicaid claims data against the "Do Not Pay" list to prevent payments to incarcerated felons;[19] and
- using national and state health care statistics to identify fraud hotspots.

(2) Coordination

Thirty-five percent of papers that focused on data management included recommendations for improved coordination among payers and anti-fraud entities to make efficient use of resources. For example, papers called for

- increased claims data sharing among public and private payers to better identify fraudulent trends or schemes;
- more data sharing with providers to increase transparency and educate providers about common billing or documentation errors; and
- increased coordination between CMS and state Medicaid programs in collecting and analyzing Medicare and Medicaid data.

(3) Data Quality

Thirty-two percent of the data management papers recommended improving data quality. The few papers that offered specific suggestions on improving data quality called for:

- having federal, state, and contractual subject matter experts test Medicare and Medicaid data repositories;
- expanding CMS's Medicaid Statistical Information System (MSIS) to capture additional data elements;[20] and
- facilitating electronic transmission of medical records and claims data to improve database timeliness and accuracy.

[19]The Do Not Pay list consists of a list of databases, maintained by various federal agencies, containing information about a recipient's eligibility for federal benefits payments or federal awards, such as grants or contracts. A June 2010 Presidential Memorandum requires agencies to check the Do Not Pay list before making payments. CMS has indicated that its Medicare contractors are in compliance with this memorandum when paying claims.

[20]CMS has a pilot program to develop an expanded data set for MSIS. The project, known as T-MSIS plans to add 1,000 additional variables to the data set.

(4) Data Repository

Thirty-two percent of the papers that discussed data management called for the creation of repositories for certain types of data. Specifically, these recommendations urged

- expansion of and increased funding for the Integrated Data Repository;[21]
- creation of a national claims database for all payers (although one insurer's paper recommended a decentralized approach);
- creation of a central repository of fraud and abuse cases, including both federal and state cases; and
- creation of a centralized database for provider screening tools.

[21]See GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use,* GAO-11-475 (Washington, D.C.: June 30, 2011).

**Appendix I: Stakeholders**

A variety of individuals, corporate stakeholders, and associations submitted white papers (see fig. 1), including:

- Providers, insurers, and health systems—such as, numerous clinicians, the Therapy Management Corporation, United Health Group, and Molina Health Care;
- Contractors—such as, 3M Health Information Systems, KeyPoint Government Solutions, and Medical Auditing Solutions;
- Suppliers—such as, The Scooter Store, Ability Medical Supply, Inc., and McKesson Corporation;
- Organizations engaged in anti-fraud activities—such as, National Association of Medicaid Directors and the New York City Human Resources Administration;
- Beneficiary advocacy groups—such as, the National Patient Advocates Foundation and the Center for Medicare Advocacy; and
- Others—such as, a public policy research think tank, medical licensing boards, and legal reform societies.

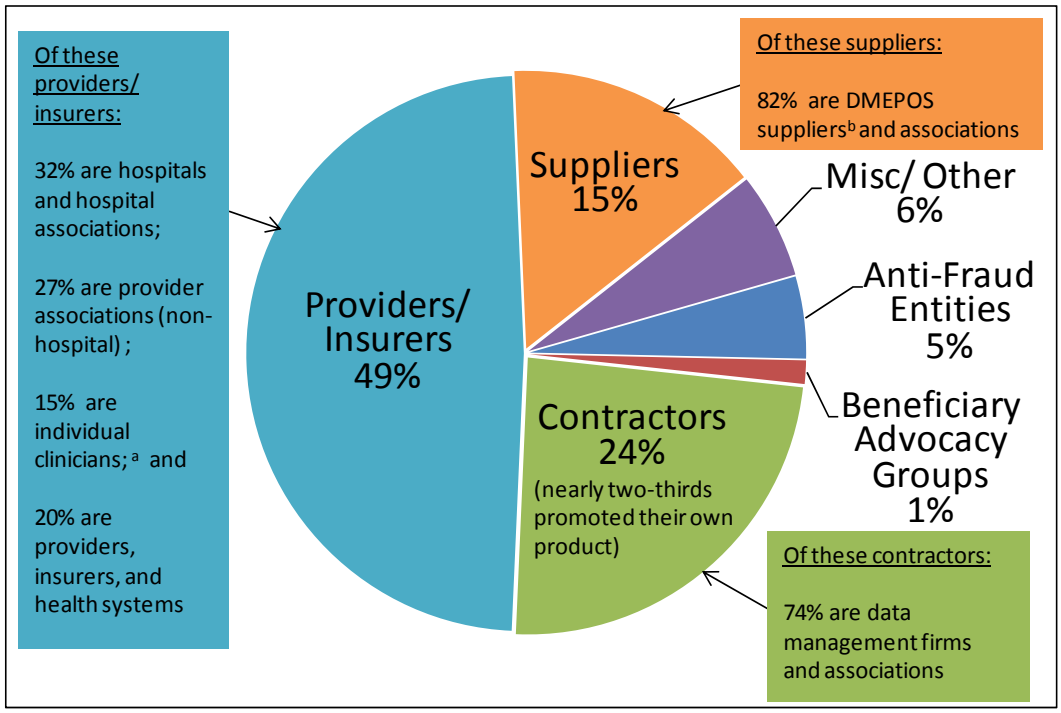
Federal and state entities responsible for identifying overpayments generally did not submit white papers—for example, individual state Medicaid program integrity offices, Medicaid Fraud Control Units (MFCU),[22] and state attorneys general offices.

[22]One white paper was submitted by an individual who is employed by a MFCU.

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

**Figure 1: Percent of White Paper Submissions by Stakeholder Type and Major Stakeholder Subtypes**




[a] These doctors, nurses, or other clinicians did not appear to represent a particular health care entity.

[b] DMEPOS suppliers are companies that provide durable medical equipment, prosthetics, orthotics, and supplies.

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

## Appendix II: Recommendations Related to Legislation

A total of 11 white papers recommended modifications to specified existing laws or bills.

| Statute/Bill referenced | Recommendation description | Number of white papers |
|---|---|---|
| Statute | | |
| The Controlled Substances Act<br><br>(21 U.S.C. § 801 et seq.) | Amend to prohibit mailing of controlled substances or limit mail orders of controlled substances to 30-day supplies. | 1 |
| Stark Law<br><br>(42 U.S.C. § 1395nn) | Eliminate the in-office ancillary services exception for certain services. | 1 |
| | Amend to include physician-owned distributors as entities performing designated health services. | 1 |
| Deficit Reduction Act of 2005<br><br>(42 U.S.C. § 1396u-6) | Extend the Rogers Amendment to all out-of-network healthcare services, including post-stabilization care services so that payments for these services are not more than fee-for-service rates for such services. | 1 |
| Small Business Jobs Act of 2010<br><br>(42 U.S.C. § 1320a-7m) | Amend language to require CMS to issue full and open competition requests for proposals to vendors seeking to provide services to and deploy models for CMS if they have at least 5 years of state Medicaid fraud detection experience and at least 1 year operating prepayment predictive model. | 1 |
| Bill | | |
| Improving Access to Medicare Coverage Act<br><br>(S. 818/H.R. 1543) | Amend Medicare (Title XVIII of the Social Security Act) to make an individual receiving outpatient observation services in a hospital be considered an inpatient with respect to satisfying the 3-day inpatient hospital requirement so that beneficiaries qualify for Medicare coverage of any post-hospital extended care services in a skilled nursing facility. | 1 |
| The Medicare and Medicaid Fighting Fraud and Abuse to Save Taxpayers' Dollars Act<br><br>(S. 1251/H.R. 3999) | Urged passage of bill to improve program integrity. | 2 |
| The Medicare Common Access Card Act<br><br>(S. 1551/H.R. 2925) | Urged passage of bill to upgrade the Medicare card to a secure smart card to verify beneficiary and provider eligibility. | 2 |
| The Medicare Orthotics and Prosthetics Improvement Act<br><br>(S.2125/H.R. 1958) | Urged passage of bill to (1) eliminate, or dramatically curtail fraud and abuse in orthotics and prosthetics; and (2) improve the quality of care for Medicare patients—amputees and persons with significant chronic limb impairment. | 2 |

| | | |
|---|---|---|
| The Medicare Pharmacy Transparency and Fair Auditing Act<br><br>(H.R. 4215) | Urged passage of bill to focus pharmacy audits on identifying overpayments and fraud rather than on administrative errors that inappropriately generate a lucrative revenue stream for the pharmacy benefits manager. Approximately 23 states have enacted legislation that addresses these issues, but the recommendation notes a uniform federal solution is needed. | 1 |

# Senate Finance Program Integrity White Papers: Summary and Overview of Recommendations

April 2013

## Appendix III: Frequency of Recommendations by Topic, Subtopic, and Cross-cutting Theme

### Table 1: Frequency of Improper Payment-related Recommendations

| Topic | Subtopic/cross-cutting theme | Number of papers | Percent of improper payment papers |
|---|---|---|---|
| ***Improper Payment*** | ***Total unique papers containing improper payment recommendations*** | ***106*** | |
| | Policy Reforms | 88 | 83% |
| | Data Analytics | 39 | 37% |
| | Enrollment | 34 | 32% |
| | Coordination | 24 | 23% |
| | Education | 24 | 23% |
| | Simplification | 21 | 20% |
| | Expand Do Not Pay List | 6 | 6% |
| | Duplication | 4 | 4% |

### Table 2: Frequency of Audit Burden-related Recommendations

| Topic | Subtopic/cross-cutting theme | Number of papers | Percent of audit burden papers |
|---|---|---|---|
| ***Audit Burden*** | ***Total unique papers containing audit burden recommendations*** | ***54*** | |
| | Audit Process | 40 | 74% |
| | Federal Oversight | 36 | 67% |
| | Simplification | 27 | 50% |
| | Coordination | 23 | 43% |
| | Education | 19 | 35% |
| | Audit limit | 18 | 33% |
| | Duplication | 15 | 28% |

**Table 3: Type and Frequency of Enforcement-related Recommendations**

| Topic | Subtopic/cross-cutting theme | Number of Papers | Percent of enforcement papers |
|---|---|---|---|
| **Enforcement** | ***Total unique papers containing enforcement recommendations*** | ***34*** | |
| | Coordination | 14 | 41% |
| | Strengthen Enforcement | 12 | 35% |
| | False Claims Act | 7 | 21% |
| | Simplification | 7 | 21% |
| | Self Regulation | 5 | 15% |
| | Medicare Strike Force | 3 | 9% |
| | Education | 1 | 3% |
| | Duplication | 0 | 0% |

**Table 4: Type and Frequency of Beneficiary Protection-related Recommendations**

| Topic | Subtopic/cross-cutting theme | Number of papers | Percent of beneficiary protection papers |
|---|---|---|---|
| **Beneficiary Protection** | ***Total unique papers containing enforcement recommendations*** | ***34*** | |
| | Access and Quality | 21 | 62% |
| | Privacy | 7 | 21% |
| | Outpatient Observation Status | 4 | 12% |
| | Education | 4 | 12% |
| | Coordination | 3 | 9% |
| | Simplification | 2 | 6% |
| | Duplication | 1 | 3% |

**Table 5: Type and Frequency of Data Management-related Recommendations**

| Topic | Subtopic/cross-cutting theme | Number of papers | Percent of data management papers |
|---|---|---|---|
| ***Data Management*** | ***Total unique papers containing data management recommendations*** | ***31*** | |
| | Analytics | 19 | 61% |
| | Coordination | 11 | 35% |
| | Data Quality | 10 | 32% |
| | Data Repository | 10 | 32% |
| | Simplification | 6 | 19% |
| | Education | 3 | 10% |
| | Smart Cards | 2 | 6% |