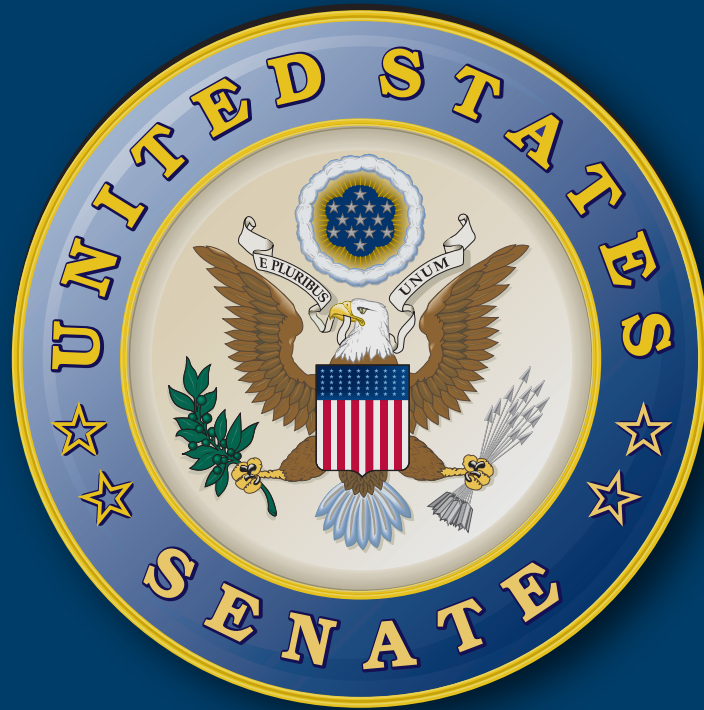


# Opportunities To Curb Waste, Fraud and Abuse in Medicare and Medicaid

An Overview of White Papers Submitted At The Request  
Of The United States Senate Finance Committee



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

January 2013

## Background

On May 2, 2012, a bi-partisan group of Senate Finance Committee Members including Chairman Baucus, Ranking Member Hatch and Senators Grassley, Carper, Wyden and Coburn (“Senators”) released a solicitation letter (See Attachment A) requesting input from health care stakeholders in three areas critical to Medicare and Medicaid reforms: program integrity, payments, and enforcement. This solicitation came after an April 2012 hearing at the Finance Committee where the Senators heard from the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services Office of the Inspector General (HHS-OIG) about their ongoing efforts to address fraud, waste and abuse in Medicare and Medicaid. While the Senators appreciated the efforts by CMS and HHS-OIG to more aggressively combat these issues, concern was raised about what else could be done and thus the idea for soliciting ideas from the health care community as a whole. Stakeholders had until June 29, 2012, to submit their ideas or “white papers” and were asked to give input as to ideas for improvement in current Medicare and Medicaid program integrity efforts, as well as additional solutions that should be considered.

## Review of White Papers

A database was created containing all 164 white papers submitted to the Senators by health care community stakeholders. We used some judgment in compiling the number of unique white papers. For example, one stakeholder submitted three documents that we counted as one white paper.

In reviewing the 164 submissions, we identified a total of 146 white papers totaling nearly 2,000 pages that addressed the intent of the Senators’ solicitation to identify new solutions to Medicare and Medicaid waste and fraud. We excluded 18 white papers from our analysis for a variety of reasons, for example:

- one of the submissions was a letter stating the intent to submit a white paper, though no white paper was actually submitted; and
- the remaining exclusions were submissions that were outside the scope of the solicitation letter, for example:
  - calling for broad reforms to reduce healthcare spending overall by revamping the malpractice system, nationalizing health care, or capping the earnings of physicians and hospitals;
  - recommending reforms to clinical research or National Institutes of Health priorities; or
  - restricting certain treatments for individuals who have not been recently employed or have severe cognitive impairments.

While all of these issues are important to the overall health care debate, the solicitation was looking specifically for improvement to program integrity and other ways of addressing waste and fraud.

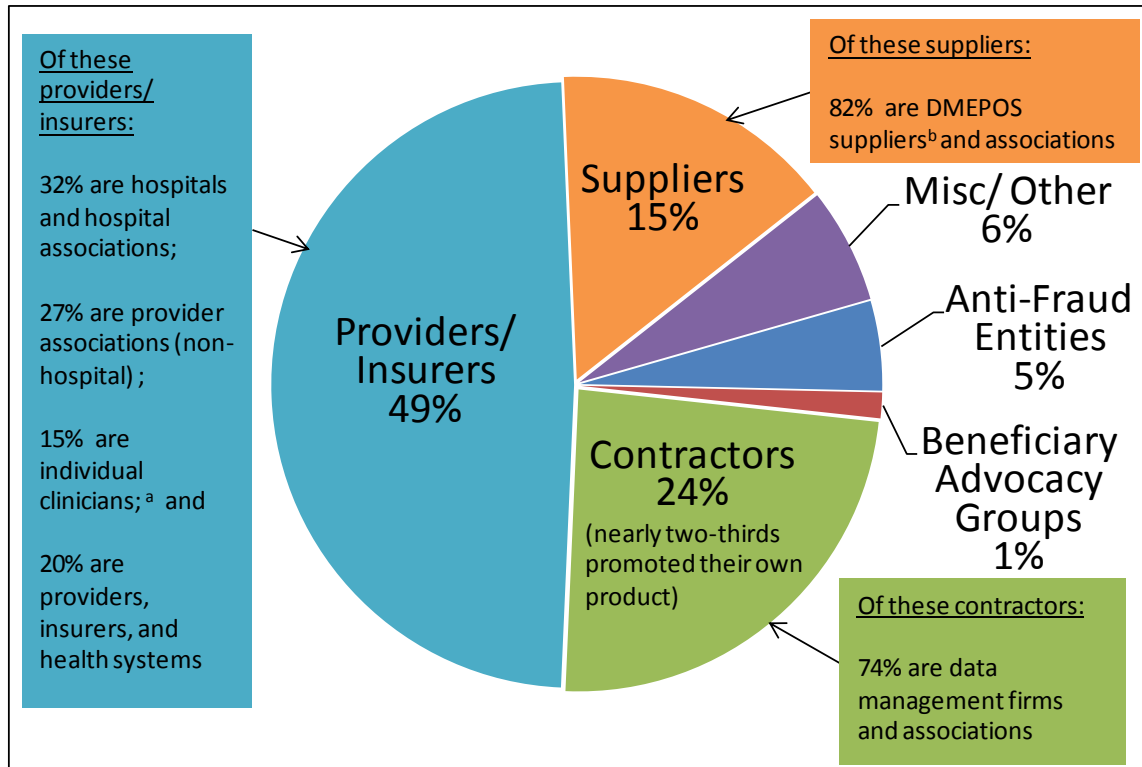
## Stakeholders

White papers were submitted by a variety of individuals, corporate stakeholders, and associations, including:

- Providers, suppliers, insurers, and health systems;
- Contractors from both the government and private sector;

- Health care trade associations including non-profit entities with an anti-fraud focus such as the National Association of State Medicaid Directors and the National Healthcare Anti-Fraud Association; and
- Others such as think tanks, medical licensing boards, and legal reform societies.

**Figure1: Percent of White Paper Submissions by Stakeholder Type and Major Stakeholder Subtypes**



<sup>a</sup> These doctors, nurses, or other clinicians did not appear to represent a particular health care entity.

<sup>b</sup> DMEPOS suppliers are companies that provide durable medical equipment, prosthetics, orthotics, and supplies.

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),<sup>1</sup> and state attorneys general offices.

## Programs Covered

Most papers discussed Medicare and Medicaid, or Medicare only. Few were specifically directed at Medicaid.

**Table 1: Programs covered**

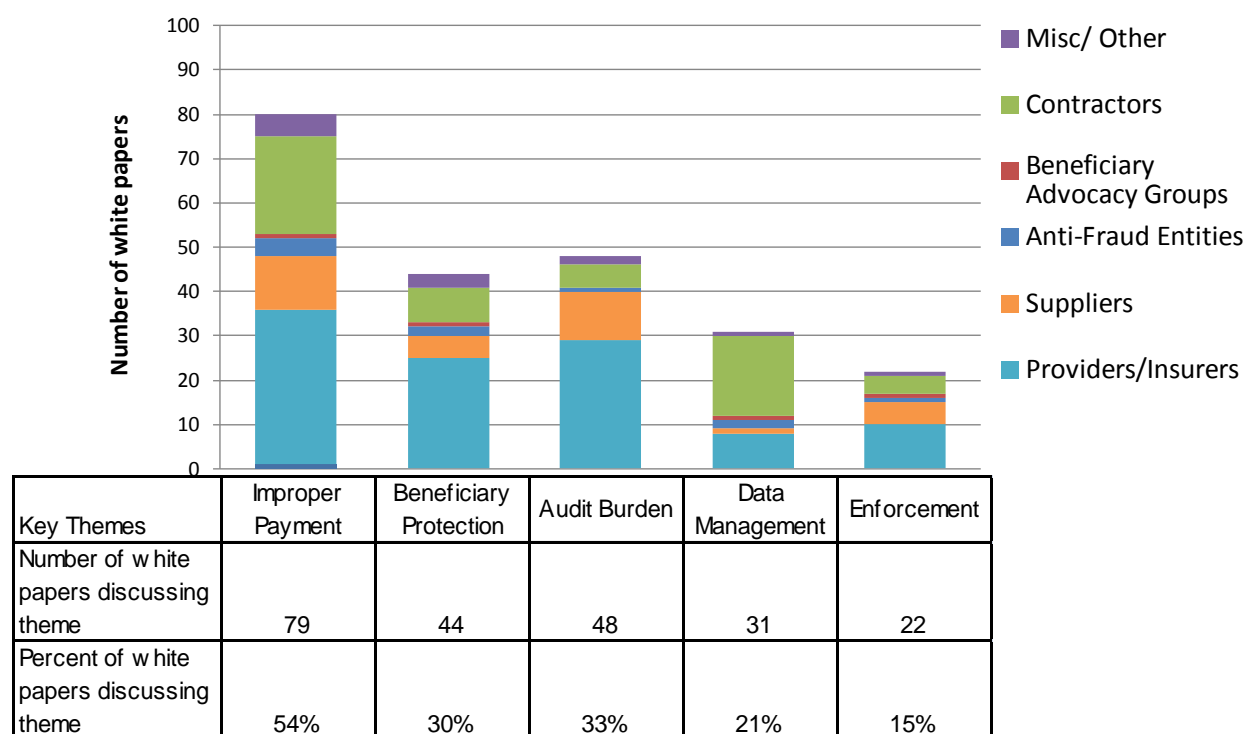
Program Type	# of papers	% of papers
Medicare and Medicaid	92	63%
Medicare	48	33%
Medicaid	6	4%
<b>Total</b>	<b>146</b>	<b>100%</b>

<sup>1</sup>One white paper was submitted by an individual who is employed by a MFCU.

## Key Themes

The May 2012 solicitation letter requested input from stakeholders in three areas: program integrity reforms, payment reforms, and enforcement reforms. We observed that most stakeholders did not differentiate between program integrity and payment reforms. Based on our review of the 146 white papers, we identified the following five broad themes: improper payments, beneficiary protection, audit burden, data management, and enforcement. These themes were addressed, with some variation, across different types of stakeholders. For example, most of the papers discussing audit burden were submitted by providers and suppliers (83 percent), while most of the papers discussing data management were submitted by contractors (58 percent).

**Figure 2: Frequency of Key Themes Inclusion in White Papers**

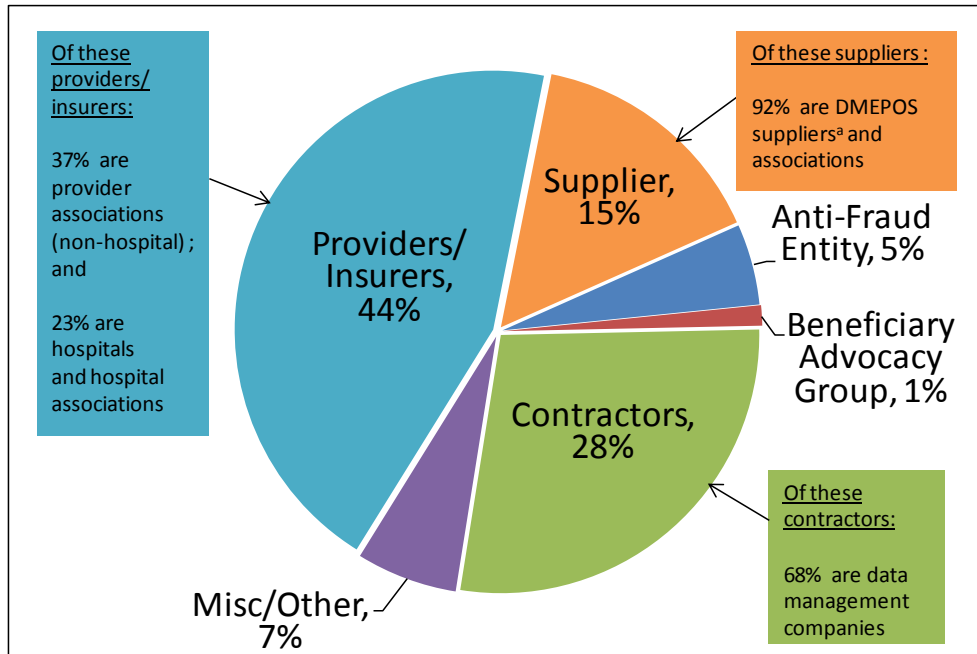


**Improper Payment:** This theme encompassed program integrity issues such as credentialing; payment or denial of payment; prevention of improper payments; creation of public and private partnerships to share information; use of predictive analytics; identification and validation of providers and beneficiaries at the time services are rendered. Common topics included:

- the use of data analytics to identify potential improper payments prior to payment (to avoid pay and chase);
- concern about the sufficiency of efforts to identify and reimburse providers for *underpayments*;
- requiring prior authorization for high-cost items, for which there is a significant level of potential fraud, such as power wheelchairs;

- linking payments to best practices/results;
- clarifying payment policies to prevent improper payment errors that may be mistaken for fraud; and
- legislative or policy reforms that would:
  - allow payments to be withheld when fraud is suspected;
  - allow reimbursement at the outpatient service level if inpatient status is denied or for certain types of complex cases (i.e. multi-factorial dental cases);
  - clarify the guidance on or abolish outpatient observation status;
  - require the lowest cost drug to be used; and
  - create a ‘non-compliance threshold’ that withholds payment to consistently non-compliant providers.

**Figure 3: Percent of White Papers Discussing Improper Payments by Stakeholder Type and Major Stakeholder Subtype**



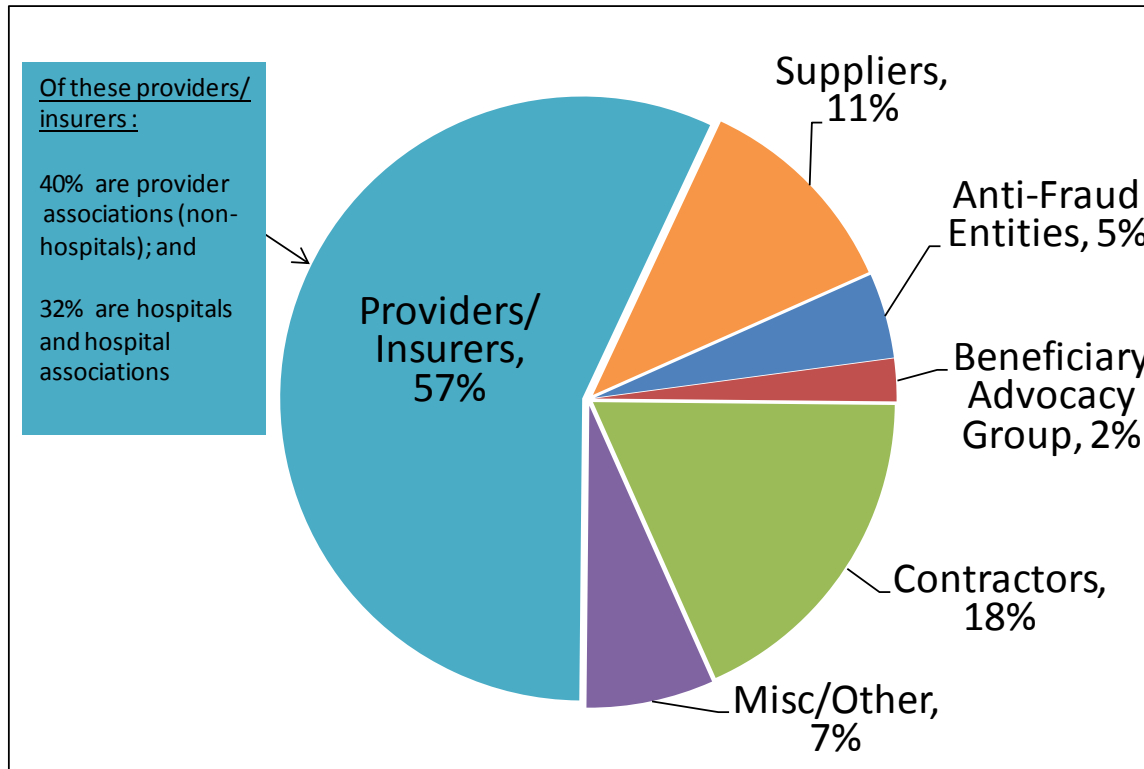
<sup>a</sup> DMEPOS suppliers are companies that provide durable medical equipment, prosthetics, orthotics, and supplies.

**Beneficiary Protection:** This theme encompassed program integrity issues that affect (1) the quality of care delivered to Medicare or Medicaid beneficiaries or patients in general or (2) beneficiary/patient financial health or satisfaction with care. Common topics included:

- the use of “outpatient observation status” by hospitals to avoid recovery audit contractor’s (RAC) scrutiny of claims,
- concern that over-broad application of the Stark law exception for physician in-office ancillary services compromises patient care by incentivizing overutilization; and

- provider and patient frustration with payer documentation requirements, which may lead them to forfeit certain courses of treatment or care.

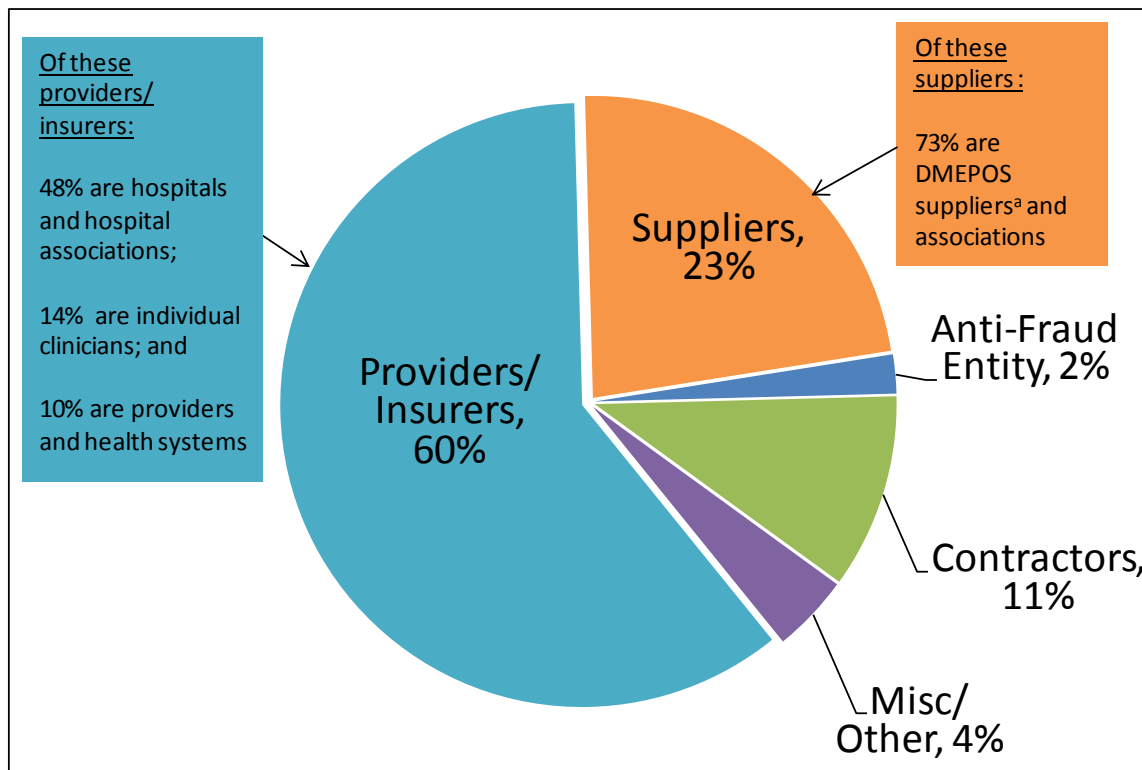
**Figure 4: Percent of White Papers Discussing Beneficiary Protection by Stakeholder Type and Major Stakeholder Subtype**



**Audit Burden:** This theme encompassed program integrity issues related to the audit process from initiation through resolution, including contractor oversight. Audit burden does not include a discussion of how improper payments are identified (we included this topic earlier in the section on improper payments). Common topics included concerns about:

- the number of audit entities involved (some papers cited duplication among auditing entities or policies, while others called for streamlining the number of entities);
- the volume and complexity of payment rules and regulations;
- whether payment rules are applied consistently and whether audit entities are inappropriately overturning “medical necessity” decisions;
- audit entities’ interactions with providers during the audit process;
- difficulty communicating with audit entities during the audit process;
- burden and cost of documentation requirements; and
- financial burden of payment suspensions and the impact on businesses.

**Figure 5: Percent of White Papers Discussing Audit Burden by Stakeholder Type and Major Stakeholder Subtype**



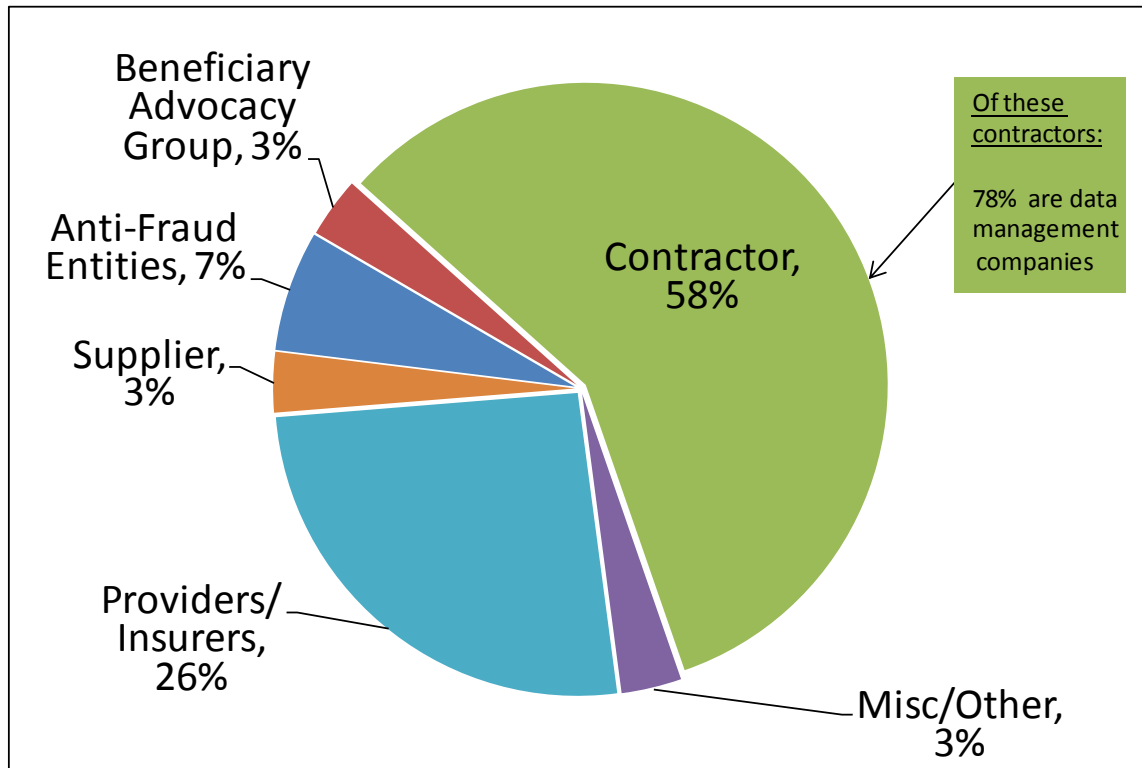
<sup>a</sup> DMEPOS suppliers are companies that provide durable medical equipment, prosthetics, orthotics, and supplies.

**Data Management:** This theme encompassed program integrity issues related to data quality and systems, data sharing, and data protection. Common topics included:

- Improving data quality and systems so that they:
  - match identifying information and medical information to the correct person;
  - verify patient identity, including the use of biometrics and smart cards;
  - validate each transaction in real time confirming that services are rendered, and preventing drug diversion and doctor shopping; and
  - allow for pre-payment verifications.
- Improving data sharing to:
  - allow access and sharing of information across state and federal programs;
  - remove the legal barriers to facilitate and strengthen the ability for data sharing to occur between Medicare, Medicaid, and the private sector; and
  - allow the use of state board data to identify physicians who are committing fraud.
- Protecting sensitive data by limiting access to the Social Security Administration's death file and protecting identifying information by:

- removing Social Security numbers from Medicare cards;
- safeguarding national identifiers for insurance companies; and
- creating unique/alternate identifiers for providers and beneficiaries.

**Figure 6: Percent of White Papers Discussing Data Management by Stakeholder Type and Major Stakeholder Subtype**



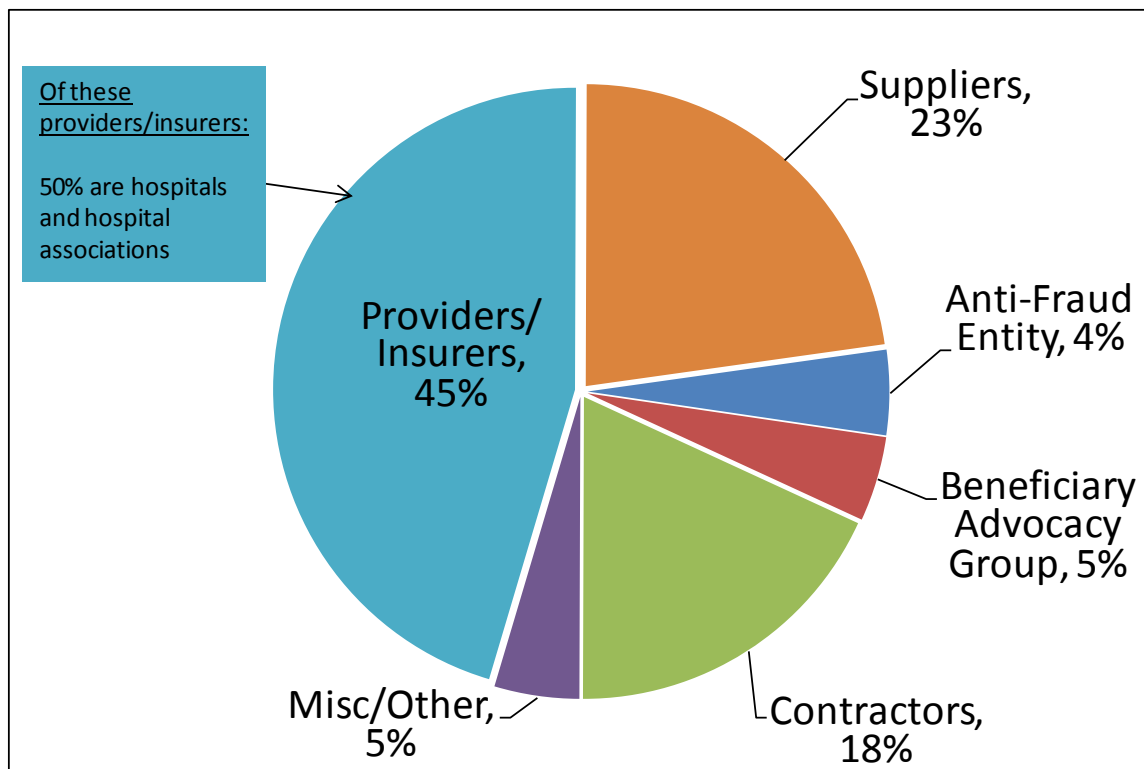
**Enforcement:** This theme encompassed program integrity issues related to enforcement tools, such as: strengthening criminal sanctions and civil monetary penalties or requiring mandatory reporting and removal of negligent physicians by hospitals. Enforcement does not include the number or depth of audits, oversight of contractors, or calls to create penalties for contractors (we included these topics earlier in the section on audit burden). Common topics included:

- Partnerships and data sharing with law enforcement entities, specifically:
  - partnerships between the Centers for Medicare & Medicaid Services (CMS) and the Federal Trade Commission to monitor advertising activity to ensure it is not misleading; between federal, state, and local entities that prevent fraud, waste, and abuse (such as state attorneys general offices and CMS);
  - increased and real-time access to Medicare claims data by law enforcement; and
  - providing evidence packages to enforcement personnel that contain the information needed to prosecute.



- Praise for the Health Care Fraud Prevention and Enforcement Action Teams (HEAT);
- Concerns about the penalties levied against hospitals for excessive readmissions and the potential for pushing back treatment dates even when that is not in the patient’s best interest;
- Increasing penalties and enforcement for perpetrators of fraud, but not for those who make “honest mistakes;”
- Support for specific legislation that addresses enforcement which encompasses several of the ideas listed above; and
- Increasing enforcement of existing laws, such as the Stark law.

**Figure 7: Percent of White Papers Discussing Enforcement by Stakeholder Type and Major Stakeholder Subtype**



## White Paper Recommendations

Ninety four percent of the white papers included recommendations, and 6 percent did not. Some of the recommendations were very broad (e.g. “streamline Medicare and Medicaid policies”) while others were very specific (e.g. “exclude physical therapy from the Stark Law’s in-office ancillary services exception”). Illustrative examples of the recommendations include:

- Increasing Federal funding of state Medicaid anti-fraud activities;
- Eliminating duplication and redundancy in Federal and state Medicare/Medicaid anti-fraud programs (both specific programs and generally);
- Changing certain Medicare payment policies that, through disparate pricing issues, lead to fraud, waste, and abuse;
- Ensuring that provider enrollment policies are consistent and utilized effectively;
- Requiring the Center for Medicare & Medicaid Services (CMS) to use existing statutory authorities (e.g., moratorium, mandatory compliance programs) that they have yet to utilize;
- Clarifying the circumstances in which use of care and the setting for care is appropriate such as when it is appropriate to use inpatient care versus outpatient;
- Making numerous process changes to how the various CMS audit contractors operate to ensure they are doing so efficiently and effectively;
- Balancing the incentives for Medicare contractors to identify overpayments with penalties for contractors whose findings are overturned on appeal through the CMS administrative process; and
- Creating an advisory panel to provide clinical input as a component of contractor oversight.

## **Next Steps**

The Senators appreciated the robust response to the solicitation. The large quantity and high quality of the white papers has resulted in it taking longer than anticipated to complete the review. In the original solicitation, the first step of this process was clear: “Our staff will review submissions and compile a summary document highlighting key proposals....we hope to identify innovative solutions that will provide taxpayers with a better return on the investments being made to combat the overpayments in these federal health care programs.” This document includes a number of illustrative examples from the solicitation which will be considered, along with the other recommendations, as this process continues.

For the next step, the Senators’ staff will work with key Committees of jurisdiction, GAO and the HHS-OIG, and interested stakeholders to develop a more detailed and refined list of administrative recommendations and potential legislative actions. The Senators appreciate the interest of all those who have contributed to this process thus far and welcome the continued involvement of key stakeholders as we move forward.

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# United States Senate

COMMITTEE ON FINANCE

WASHINGTON, DC 20510-6200

RUSSELL SULLIVAN, STAFF DIRECTOR  
CHRIS CAMPBELL, REPUBLICAN STAFF DIRECTOR

May 2, 2012

To Members of the Health Care Community:

According to the Government Accountability Office (GAO), few programs are as much at risk for fraud, waste and abuse as the Medicare and Medicaid programs. Estimates of the amount of fraud and misspending in these programs vary widely, from \$20 billion to as much as \$100 billion. Just this week, testimony before the Senate Finance Committee underscored the seriousness of this problem, as witnesses testified that while much has been accomplished in the fight against fraud and abuse, much more needs to be done. As Senators and members of the Finance Committee, we have a duty to ensure that taxpayer funds are being spent wisely.

Combating fraud in Medicare and Medicaid has long been a challenge for the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services Inspector General (HHS OIG) and the Department of Justice (DOJ). To date, numerous efforts have been made to reduce fraud, yielding a mixed record of successes and failures. We believe federal efforts would be strengthened by input from members across the health care community – providers, payers, health plans, contractors, non-profit entities, consumers, data analytics entities, governmental partners, and patients. Drawing on the collective wisdom and accumulated insights of thousands of professionals and individual experiences could offer a fresh perspective and potentially identify solutions that may have been overlooked or underutilized.

Today we are announcing an effort to solicit ideas from all interested stakeholders in the health care community, regarding solutions and suggestions for how to better prevent and combat the multi-billion dollar problem of waste, fraud and abuse in the Medicare and Medicaid programs. We invite you to submit white papers offering your best ideas, built on years of experience and insight. We want to know what areas you see for improvement in current program integrity efforts, as well as additional solutions that we should consider. Working together, we hope to identify innovative solutions that will provide taxpayers with a better return on the investments being made to combat the overpayments in these federal health care programs.

Below are the general categories in which we seek input, though some recommendations may include multiple categories:

- Program Integrity Reforms to Protect Beneficiaries and Prevent Fraud and Abuse
- Payment Integrity Reforms to Ensure Accuracy, Efficiency and Value
- Fraud and Abuse Enforcement Reforms to Ensure Tougher Penalties Against Those Who Commit Fraud

Entities interested in submitting white papers should email a PDF or Microsoft Word document to [ProgramIntegrityWhitePapers@finance.senate.gov](mailto:ProgramIntegrityWhitePapers@finance.senate.gov) by June 29, 2012. Submissions should include summary information about the entity or individual submitting a white paper, as well as

phone and email contact information. White papers should be as succinct and concrete as possible. When possible, please include cost-benefit or potential savings information. Our staff will review submissions and compile a summary document highlighting key proposals later this year.

We appreciate your submission of thoughtful and constructive solutions, as we work to conduct targeted oversight to improve federal efforts to reduce fraud and abuse in Medicare and Medicaid. Together, we believe we can improve program integrity and be better stewards of taxpayer dollars.

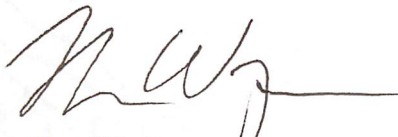
Sincerely,



Max Baucus  
Chairman



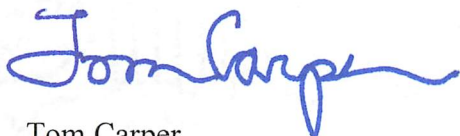
Orrin G. Hatch  
Ranking Member



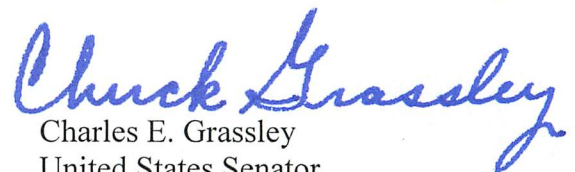
Ron Wyden  
United States Senator



Tom Coburn  
United States Senator



Tom Carper  
United States Senator



Charles E. Grassley  
United States Senator