

# New Approaches to Program Integrity: A Conversation with Shantanu Agrawal, M.D., Director, Center for Program Integrity, Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services

*Fraud, waste, and abuse of federal healthcare programs serving seniors and taxpayers affect every American by draining critical resources from our healthcare system. Along with hampering our healthcare system, these illegal activities undermine the nation's economy.*

*In 2014, the U.S. was projected to spend \$3.1 trillion on healthcare, generating billions of claims from healthcare service and product providers every year. Medicare alone accounts for \$635 billion in annual spending. In fiscal year 2013, the fraud, waste, and abuse prevention and enforcement efforts pursued by the U.S. government resulted in a record-breaking recovery of \$4.3 billion in taxpayer dollars. The Centers for Medicare and Medicaid Services (CMS), and its comprehensive program integrity strategy, implements innovative data technologies and draws on expertise from across the country to continue to make improvements in protecting the integrity of our healthcare programs and safeguarding taxpayer resources. Dr. Shantanu Agrawal, director, Center for Program Integrity, joined me on The Business of Government Hour to discuss topics including strategic priorities of the Center, how it is moving beyond the “pay and chase” approach and exploring new ways to engage the private sector to combat fraud, waste, and abuse. The following is an edited excerpt of our discussion, complemented with additional research. – Michael J. Keegan*

## On the Mission of CMS's Center for Program Integrity

Let's start by providing some context on the mission of the Centers for Medicare and Medicaid Services (CMS), which is an agency inside the U.S. Department of Health and Human Services. CMS is the agency that administers the Medicare and Medicaid programs. Between these programs, CMS covers about 100 million beneficiaries or patients. Medicare is generally, with some exceptions, healthcare for the elderly. Medicaid is generally healthcare for the socioeconomically disadvantaged. The Medicaid programs are run directly by the states. There are 56 different Medicaid programs that among them account for about 4.4 million claims per day.



On the Medicare side, we also see about that many, roughly 4.5 million claims per day and pay about a billion dollars per day.

Between these programs, CMS accounts for about 40 percent of the national healthcare expenditure, including both the public and private sectors. This makes it the largest [healthcare] payer certainly in the United States, probably the world. I'd say the most significant evolution within CMS has to do with the many initiatives required under the Affordable Care Act (ACA) to move us from a volume-driven healthcare system to one that prioritizes value.

The Center for Program Integrity (CPI) was created just before the passage of the Affordable Care Act, but I think what was really important is that the ACA gave the Center expanded

authority. Our mission focuses on the entire spectrum of fraud, waste, and abuse in Medicare and Medicaid. I think of it very simply as: paying for the right services for our beneficiaries and ensuring the safety of these beneficiaries in both programs. We are slotted for about 500 FTEs at the Center, after some recent internal alignment changes, so it is fairly sizable. I think what's really important is that we have a presence not only at headquarters, which is just south of Baltimore, but that we have offices throughout the country, with staff located in Philadelphia, Dallas, New York, Chicago and LA. That kind of national presence is important for a number of our activities and really allows us to have more on-the-ground intelligence of what's actually going on.

### On Challenges

It is interesting. There's quite a bit of discourse in society today about delivering value in healthcare: making sure what a payer is paying for—public or private payers—delivers value to patients. As a physician, I understand there's agreement or consensus that a significant portion of healthcare expenditures don't deliver the value to patients that we expect. Various experts peg about 30 percent to 40 percent of healthcare costs as wasteful—such things as unnecessary testing, duplication of services, lack of coordination, or lack of integration of care.

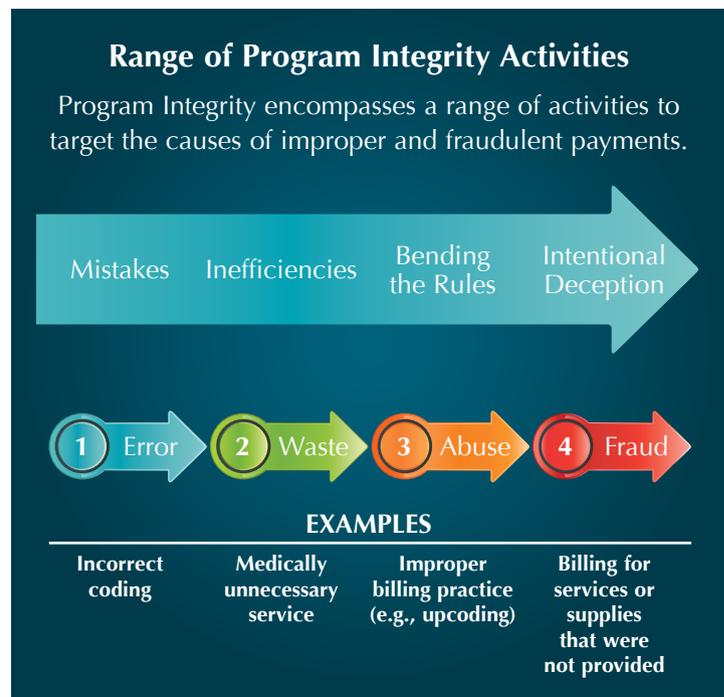
It is important to place our work in the broader context of waste in the healthcare system, which is connected to things like misaligned incentives, in the way that we pay for care. These can actually lead to abusive practices. We also have to acknowledge that a criminal element targets the healthcare systems to plunder resources that should be going to life-saving services and patient care. Leakage in the system, public or private, occurs at different levels. Our challenge involves having to address the full spectrum of activities related to fraud, waste, and abuse. Each area requires different and distinct strategies to combat them.

The waste related to misaligned incentives, or the supposed "fraud" from poor documentation, won't be mitigated by the same strategies in which we go after the actual bad actors ... that criminal element I mentioned earlier. We have a variety of ways of addressing these concerns. We can do it through payment and coverage policy. We can do it through payments innovation, education and outreach, and then direct activities that control utilization.

Challenges abound, given the sheer size and complexity of the programs administered by CMS, but here are a few:



- **Ensure Coordination:** Our first challenge is ensuring successful coordination of our efforts across the department and with other federal agencies. I've seen among CMS leadership a real willingness to do that and build on that coordination, which has aided my efforts.
- **Identify Real Vulnerabilities:** The second challenge has its roots in the volume and size, the sheer magnitude of the programs. We need to make sure we're not overwhelmed by this reality. We need to understand how to



prioritize the various issues we encounter. It is a challenge to make sure that we are going after issues that represent real vulnerabilities, which, if successfully addressed, can lead to real savings. That savings can then be used to provide legitimate healthcare services for our beneficiaries.

- **Balance Means with Ends:** Finally, I think we need to make sure we address program vulnerabilities with the right tools at our disposal. It is a matter of balancing ends and means. We need to secure the integrity of our programs. We need to do this without overly burdening the very legitimate physicians and providers that we have in our system that are seeing our patients and providing necessary healthcare services. I think it's a very difficult balance to achieve.

### On Key Strategic Priorities

Meeting these challenges head-on involves pursuing key strategic priorities. I'd like to highlight some key priorities:

- **Provider Enrollment Screening Standards:** We've integrated literally hundreds of databases to give us access to right-time information, so we can check provider eligibility both at the time of enrollment and

post-enrollment to ensure providers are maintaining their eligibility. We receive about 10,000 enrollment applications per month—not a trivial task. This year, we are also focusing on enrolling providers, who may want to simply prescribe medication under Medicare and not bill other kinds of services.

- **Program Integrity Education, Training, and Collaboration:** There are several initiatives we are pursuing around education and training. The Medicaid Integrity Institute (MII) provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to the states in a structured learning environment. The MII's effective training is tailored to meet the ongoing needs of state Medicaid program integrity employees, with the goal of raising national program integrity performance standards and professionalism. We're also providing similar services directed at the private sector through our public-private partnership.

On the other side, we'll continue to expand our outreach and education with providers to make sure they're aware of our policies and collaborate on remedying issues we all care about. Again, the vast majority of providers are doing the right thing. They're taking care of patients and we need to preserve that relationship, but we also need to weed out those bad actors while we collaborate with those whose intentions are good, but for whatever reason seem to be missing the mark when it comes to documentation.

We are also looking to conduct similar activities with private payers—many of the same issues and vulnerabilities that we experience are also experienced by the private sector. We're working more closely now with the private sector to try to close those vulnerabilities across the entire healthcare system.

- **Advanced Predictive Analytics:** Data is essential to what we do. We have implemented a state-of-the-art predictive analytics technology—the Fraud Prevention System (FPS). Since June 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service (FFS) claims prior to payment. For the first time in the history of the program, CMS is systematically applying advanced analytics against Medicare FFS claims on a streaming, nationwide basis as part of its comprehensive program integrity strategy. CMS made significant progress using the FPS to identify bad actors and take administrative action to protect program integrity.



In this June 18, 2015, photo, Shantanu Agrawal, deputy administrator for program integrity and director of the center for program integrity at the Centers for Medicare & Medicaid Services, speaks during a news conference at the Justice Department in Washington. Attorney General Loretta Lynch listens at left. Medicare says its computerized fraud prevention system identified \$454 million in problematic payments and generated a financial return for the taxpayer of \$10 for every dollar spent last year. (AP Photo/Pablo Martinez Monsivais)

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— Shantanu Agrawal, M.D.



With FPS, we work every day to try to realize savings, but it’s not only more identified savings; we’ve also taken some significant actions as a result of the system. Over 900 providers have faced some kind of administrative action, either starting a new investigation or audit or supplementing something that already existed.

- **Timely and Efficient Action:** A priority of mine is to focus on timely and efficient action. We have to focus on the right vulnerabilities and issues. We have to use the right tools at our disposal to address these issues and focus on meeting outcomes. I don’t like the notion of interminable audits or endless investigation. It’s burdensome on providers. Let’s take the most appropriate actions that address the weakness of vulnerabilities, for it is our job to ensure the integrity of these programs.

### On the Benefits of the Fraud Prevention System

I referenced the FPS earlier and wanted to elaborate. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS’s Zone Program Integrity Contractors (ZPICs). The ZPICs then identify administrative actions that can be implemented swiftly, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS is also an important management tool, as it prioritizes leads for ZPICs in their designated region, making our program integrity strategy more data-driven.

In its second year of operation, CMS’s FPS identified or prevented more than \$210 million in improper Medicare fee-for-service payments, double the previous year. It also resulted in CMS taking action against 938 providers and suppliers. The FPS is a key element of the joint anti-fraud strategy between the Department of Justice (DOJ) and HHS that has led to a record \$19.2 billion in recoveries between 2009 and 2013, up from \$9.4 billion over the prior five-year period.

### On Collaboration with the Private Sector

CMS is engaging with the private sector in new ways to better share information to combat fraud. For example, the Healthcare Fraud Prevention Partnership (HFPP) has successfully shared information and built confidence and trust among partners since its inception in July 2012. The number of state partners has grown, with the state program integrity or oversight offices of Illinois, Massachusetts, Texas, Vermont, and California joining along with private payers. We are continuing to grow strategically by adding new partners and identifying additional overlapping fraud schemes. The HFPP has completed studies—Misused Codes and Fraud Schemes, Non-Operational Providers (or “false store fronts”), Revoked and Terminated Providers, and Top-Billing and High Risk Pharmacies—that have enabled partners, including CMS, to take substantive actions to stop payments from going out the door. The HFPP is now in the process of launching three new studies based on successful



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identification of continuing challenges faced by current and new members.

The President's FY 2016 budget proposal included additional support for the HFPP collaboration. The proposal would give CMS the authority to accept gifts made to the trust funds for particular activities funded through the Health Care Fraud and Abuse Control Account, including the HFPP. Currently, the account can only receive gifts that are made for an unspecified purpose. This proposal would allow gifts to be made to support the HFPP directly, and allow both public and private partners to support the anti-fraud program.

### On Shifting Away From “Pay and Chase”

In combating fraud, waste, and abuse, we've prioritized moving away from a “pay and chase” model to a prevention model. The “pay and chase” model is fraud driven and again, there is fraud in the system, which we take seriously, as it is criminal activity. That said, we must also focus on prevention, making sure we reduce waste in the healthcare system while also driving patient value. Shedding nearly 50,000 providers who didn't belong in the system because they failed to meet our requirements is a good example of a prevention strategy at work. We no longer need to pay providers who have no business collecting payments, and therefore, won't have to chase down improper payments from these ineligible providers.

### On the Future

The shift from the current fee-for-service system to one that really prioritizes quality outcomes and value is absolutely the right shift. It's right for many reasons beyond just program integrity. It's right for American healthcare, for patients, and ultimately right for providers.

This shift would de-emphasize focusing on specific procedures and the sheer volume of services that are provided. It would emphasize less on performing more procedures and

ask the question that frankly, patients care about a lot more: what am I getting for those services and how is it helping to preserve or improve my health?

I'm very optimistic that this shift will help us move away from certain misaligned incentives unique to a fee-for-service model. It represents a culture and mindset shift in healthcare as payment reform places more of the financial decision making—but also financial risk—on the provider side. It will lead to reducing unnecessary procedures and the misallocation of resources.

### On Leadership

I have to be pragmatic. As a political appointee, my time leading the Center is limited, so I need to set an agenda that guides the direction of the Center. Being successful within this context means building relationships and getting the career folks, who are going to be here long after I am gone, on board. They have to believe that the direction is right, so I engage in consensus-driven decision making—making sure the people who care and the people who are going to be impacted by the decisions have an opportunity to be involved. It's very important, because these activities may continue long after my opportunity to do this job ends. ■

To learn more about Center for Program Integrity, go to [www.cms.gov/about-cms/components/cpi/center-for-program-integrity.html](http://www.cms.gov/about-cms/components/cpi/center-for-program-integrity.html).



To hear *The Business of Government Hour* interview with Shantanu Agrawal, M.D., go to the Center's website at [www.businessofgovernment.org](http://www.businessofgovernment.org).



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