STATEMENT OF

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ON

GAO'S HIGH RISK REPORT

BEFORE THE
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Chairman Chaffetz, Ranking Member Cummings, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS') operation of the Medicare and Medicaid programs. We share this Committee's commitment to protecting beneficiaries and taxpayer dollars. Enhancing program integrity is a top priority for the administration and an agency-wide effort at CMS. As stewards of Medicare and Medicaid, two large, complex programs providing vital services to millions of Americans, CMS is making important strides in preserving Medicare and Medicaid for generations to come.

Medicare has been deemed "high risk" by the Government Accountability Office (GAO) in part due to the sheer size and complexity of the program. CMS pays 1.5 million providers for health care for 54 million beneficiaries under the Medicare program. GAO has also designated Medicaid as a "high risk" program due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. Additionally, the Office of Management and Budget has designated Medicare and Medicaid as "high priority" programs due to their annual improper payment rates, based on the annual dollar amount of improper payments relating to Medicare and Medicaid.

CMS is using a multi-faceted approach to strengthen these programs by more closely aligning payments with the costs of providing care, encouraging health care providers to deliver better care and better outcomes for their patients, and improving access to care for beneficiaries. We have instituted many program improvements and are continuously looking for ways to refine and improve our program integrity activities. These efforts have already helped extend the life of the Medicare Trust Fund, with the most recent Medicare Trustees Report projecting that the trust fund that finances Medicare's hospital insurance coverage will remain solvent until 2030, four years beyond what was projected in the previous year's report.

To assist in CMS' program integrity and program improvement activities, the President's Fiscal Year (FY) 2016 Budget includes a package of Medicare legislative proposals that will save a net

$423 billion over 10 years. The Budget includes an additional $201 million in mandatory and discretionary investments in FY 2016 to address healthcare fraud, waste, and abuse. The Budget also proposes legislative changes to improve the long-term sustainability of Medicare and Medicaid by increasing the efficiency of health care delivery without compromising the quality of care for the elderly, children, low-income families and people with disabilities.

Improving the Health Care Delivery System

Since the implementation of the Affordable Care Act, Medicare has drastically reduced its growth in spending. The years 2011, 2012, and 2013 saw the slowest growth in real per capita national health expenditures on record, spurred by slow growth in per-beneficiary spending throughout our health care system, including Medicare, Medicaid, and private insurance. Medicare spending per beneficiary was approximately flat in FY 2014, and from 2010 to 2014, Medicare spending per beneficiary grew at a rate that was two percentage points less per year than growth in gross domestic product per capita. [1] Looking forward, due primarily to the persistent slowdown in health care costs, the Congressional Budget Office now estimates that Federal spending on Medicare and Medicaid in 2020 will be $191 billion below the projections it made in August 2010.

Progress toward a safer health care system is being made, and the quality of care furnished to beneficiaries has improved, due in part to provisions of the Affordable Care Act such as Medicare payment incentives and the Department of Health and Human Services (HHS) Partnership for Patients initiative. These efforts have contributed to an estimated 50,000 fewer patient deaths in hospitals and approximately $12 billion in health care cost-savings due to a reduction in hospital-acquired conditions from 2010 to 2013. Preliminary estimates also show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17-percent decline in hospital-acquired conditions over the three-year period. In 2013 alone, almost 35,000 fewer patients died in hospitals, and approximately 800,000 fewer incidents of harm occurred, saving approximately $8 billion.[2]

[1] http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26.html
[2] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2013.html

Building on these successes, CMS has implemented numerous initiatives to improve quality, and reduce costs for Medicare and Medicaid beneficiaries by addressing improper payments, reducing waste, fraud, and abuse, and examining alternative payment methods. In addition, the President's FY 2016 Budget includes a package of proposals that are designed to encourage delivery system reform, including replacing the Medicare Sustainable Growth Rate Formula with annual payment updates and creating incentives for participation in high quality and efficient healthcare delivery systems. We will continue to gather and incorporate feedback from our many partners, including the GAO, as we move forward in strengthening Medicare and Medicaid and protecting beneficiaries.

Refining Medicare Payment Methods to Encourage Efficient Provision of Services

CMS is committed to reforming the Medicare payment system to provide predictable payments that incentivize quality and efficiency in a fiscally responsible way. Our efforts are focused on two main goals: (1) ensuring payments emphasize high-quality, high-value care, and (2) developing and implementing proven payment models to improve accountability for the care furnished to Medicare beneficiaries. CMS believes that finding better approaches to reward quality care that results in improved health outcomes instead of quantity of services, while not increasing overall costs, remains an urgent priority.

For physician payments, CMS is working to improve payment policy through CMS' rulemaking process, including through the Medicare Physician Fee Schedule, while testing new payment models and delivery-system reforms that can help make physicians more accountable for the care they furnish.

CMS has made important strides to improve the accuracy of our physician payment system and to support primary care. Through the misvalued code initiative, CMS has taken an active approach to evaluating potentially misvalued payment codes and, when codes are found to be misvalued, acting to update and revise the payment accordingly. The Agency has established a particular focus on those Physician Fee Schedule services that have not been reviewed recently and those where there is a potential for misuse. CMS has adopted appropriate work Relative

Value Units and direct Physician Expense inputs for these services as a result of these reviews and continues aggressively to identify potentially misvalued services.

More broadly, CMS has begun testing several different payment models to help inform us as we begin to look for ways to improve Medicare payments in the long-term. We have outlined measurable goals and timelines to move the Medicare program toward paying providers based on the quality, rather than the quantity, of the services they provide. This is the first time in the history of the Medicare program that CMS has set explicit goals for alternative payment models and value-based payments. In alternative payment models, health care providers are accountable for the quality and cost of the care they deliver to patients. Providers have a financial incentive to coordinate care for their patients – which helps ensure patients receive the appropriate care for their conditions and reduces avoidable hospitalizations, emergency room visits, medication interactions, and other problems caused by gaps in care.

In 2011, Medicare made almost no payments to providers through alternative payment models, but today such payments represent approximately 20 percent of Medicare payments. CMS intends to expand upon this progress, and has set a goal of tying 30 percent of traditional, fee-for-service Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. CMS has also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016 and 90 percent by 2018 through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reductions Programs.

CMS has already seen promising results on cost savings relating to alternative payment models, with current ACO programs saving Medicare a combined total of $417 million. CMS expects these models to continue contributing to the unprecedented slowdown in health care spending. Moreover, initiatives like the Partnership for Patients, ACOs, Quality Improvement Organizations, and others have helped reduce hospital readmissions in Medicare by nearly eight percent– translating into 150,000 fewer readmissions between January 2012 and

December 2013 – and quality improvements have resulted in saving 50,000 lives and $12 billion in health spending from 2010 to 2013, according to preliminary estimates.[3]

Enhancing Program Integrity

CMS is committed to paying claims in an accurate and timely manner and has a comprehensive strategy in place to address the Medicare and Medicaid improper payment rates. For the Medicare program, these strategies include strengthening provider enrollment safeguards to confirm only legitimate providers are enrolled and preventing improper payments by using edits to deny claims that should not be paid. CMS also develops targeted demonstrations in areas with consistently high rates of improper payments and operates a Medicare fee-for-service Recovery Audit Program to identify, recover, and prevent improper payments.

Strengthening Provider Enrollment

Provider enrollment is the gateway to billing within the Medicare program, and CMS has put critical safeguards in place to make sure that only legitimate providers are enrolling in the Medicare program. The Affordable Care Act required CMS to revalidate all of the 1.5 million existing Medicare suppliers and providers under new risk-based screening requirements. CMS is on track to request the revalidation of all providers by March 2015. Since March 25, 2011, more than one million providers and suppliers have been subject to the new screening requirements, over 454,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and almost 27,000 providers and suppliers had their enrollment revoked.[4]

CMS continues to make improvements in its oversight of provider enrollment. For example, beginning September 2014, certain individuals required to complete enhanced screening as part of the provider enrollment process must also undergo a fingerprint-based criminal history check. This policy applies to owners of newly enrolling home health agencies (HHAs) and durable medical equipment suppliers. In December 2014, CMS issued a Final Rule that permits

[3] http://www.hhs.gov/news/press/2014pres/12/20141202a.html
[4] Deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

revocation of providers that demonstrate patterns or practices of abusive billing, prohibits the enrollment of providers that have unpaid debt to the Medicare program, and expands the list of felony convictions that could prevent an individual provider from participating in Medicare.

CMS is using its moratorium authority provided in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers in certain geographic areas that face a high risk of fraud. In July 2013, CMS announced temporary moratoria on new HHAs in and around Miami and Chicago, and ground‐based ambulances in and around Houston. In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in Philadelphia. CMS is required to re-evaluate the need for such moratoria every six months and on January 29, 2015, CMS extended these existing moratoria for an additional six months. In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of billing privileges of HHAs and ambulance companies, as well as working with law enforcement to support investigations and prosecutions.

Targeting High Risk Areas

CMS has developed targeted demonstrations to reduce improper payments for items and services at high risk for fraud, waste, and abuse, such as Power Mobility Devices (PMDs), where CMS found that over 80 percent of claims for PMDs did not meet Medicare coverage requirements.[5] CMS implemented the Medicare Prior Authorization of PMDs Demonstration in seven high risk states in September 2012.[6] Since implementation, CMS has observed a decrease in expenditures for PMDs in both demonstration and non-demonstration states. Based on claims processed as of November 14, 2014, monthly expenditures for the PMDs included in the demonstration decreased from $20 million in September 2012 to $6 million in June 2014 in the

[5] http://cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/MedicareFFS2011CERTReport.pdf

[6] The seven states are: CA, IL, MI, NY, NC, FL and TX

non-demonstration states and from $12 million to $3 million in the demonstration states.[7] CMS expanded the demonstration to an additional 12 states on October 1, 2014.[8]

CMS is also testing whether prior authorization helps to reduce unnecessary expenditures, while maintaining or improving quality of care. CMS issued a proposed rule in May 2014 to establish a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization. Additionally, CMS recently implemented a prior authorization model for repetitive scheduled non-emergent ambulance transport in New Jersey, Pennsylvania, and South Carolina.[9] Beginning March 1, 2015, CMS will also begin implementing a prior authorization demonstration program for non-emergent hyperbaric oxygen therapy in Illinois, Michigan, and New Jersey.[10] CMS believes using a prior authorization process will help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid.

While the private sector widely uses prior authorization to control fraud, waste and abuse, CMS is seeking authority to expand the use of this tool. The President's FY 2016 Budget includes a proposal that would build on the success of the prior authorization demonstrations by giving CMS the authority to require prior authorization for all Medicare fee-for-service items that it determines are at the highest risk for improper payments.

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

[7] https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/PMDDemoDecemberStatusupdate12302014.pdf

[8] http://www.gpo.gov/fdsys/pkg/FR-2014-07-29/pdf/2014-17805.pdf; the twelve states are: AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA

[9] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Repetitive-Scheduled-Non-Emergent-Ambulance-Transport-.html

[10] http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Non-emergent-Hyperbaric-Oxygen.html

July 2012. The partnership now includes 38 organizations. 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 the following four studies to date – 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 identification of continuing challenges faced by current and new members.

The President's FY 2016 Budget proposal includes 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 for gifts to be made to support the HFPP directly, and allow both public and private partners to support the anti-fraud program.

Improving Program Management

Building on its expert knowledge from investigators and analysts, CMS is leading the government and healthcare industry in systematically applying advanced analytics to claims on a nationwide scale. Since 2011, CMS has been using its Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis by using predictive algorithms and other sophisticated analytics to analyze every Medicare fee-for-service claim against billing patterns. The system also incorporates other data sources, including information on compromised Medicare cards and complaints made through 1-800-MEDICARE. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS' 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. To better protect seniors and the Medicare program against compromised Medicare cards,[11] President's FY 2016 Budget proposes $50 million to support the removal of Social Security Numbers from Medicare cards so that millions of beneficiaries will no longer have to fear that their personal identification numbers could be used against them due to a lost, stolen, or misused Medicare card.

In its second year of operation, CMS' 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. Importantly, these joint efforts have also led to a measurable decrease in expenditures in areas of focus. For example, there has been a dramatic decline in payment for home health care in Miami and throughout Florida. In 2009, claims to Medicare for home health services in Florida were $3.4 billion, and Medicare paid approximately $2.9 billion for home health care services. Just two years later, in 2011, billings to Medicare had dropped to $2.3 billion, a difference of $1.1 billion.

The President's FY 2016 Budget proposes to build on recent progress demonstrated by joint efforts between DOJ and HHS by increasing support for the Health Care Fraud and Abuse Control program. Billions of dollars in deficit savings over the next 10 years from curtailing improper payments will be realized if the levels of administrative expenses for program integrity envisioned in the Balanced Budget and Emergency Deficit Control Act of 1985 continue to be provided.

[11] MEDICARE INFORMATION TECHNOLOGY: Centers for Medicare and Medicaid Services Needs to Pursue a Solution for Removing Social Security Numbers from Cards. GAO-13-761: Published: Sep 10, 2013. Publicly Released: Oct 17, 2013.

Medical Review

Medicare receives about 3.3 million fee-for-service claims each day, or 1.2 billion claims a year. In keeping with statutory requirements to promptly pay claims, our processing systems were built to quickly process claims and remit payment. Due to the significant cost associated with conducting a medical review of an individual claim, CMS relies heavily on automated edits to identify inappropriate claims. CMS has designed its systems to detect anomalies on the face of the claims, and through these efforts, we are correctly paying submitted claims nearly 100 percent of the time. For example, CMS is using the National Correct Coding Initiative (NCCI) to stop claims that never should be paid in Medicare Part B and Medicaid. This program prevents payments for services such as hysterectomy for a man or prostate exam for a woman. The use of the NCCI procedure-to-procedure edits saved the Medicare program $530 million in FY 2013.

The Recovery Audit Program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. CMS uses Recovery Auditors, as required by law,[12] to identify and correct improper payments by reviewing claims on a post payment basis. CMS responds to the vulnerabilities identified by the Recovery Auditors by implementing actions that will prevent future improper payments nationwide. Since full implementation in FY 2010 through the fourth quarter of FY 2013, the Recovery Auditors have returned over $5.4 billion to the Medicare Trust Fund. Additionally, CMS Medicare Administrative Contractors (MACs) review claims and conduct provider education to help providers avoid documentation errors and other sources of improper payments, including articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention. Other efforts include system edits for improper payments that can be automatically prevented prior to payment. CMS encourages collaboration between Recovery Auditors and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments.

[12] The Recovery Auditor demonstration project was required by section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and the Congress expanded the program in section 302 of the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national recovery audit contractor program by January 1, 2010.

CMS strives to manage programs in an efficient manner that balances the need to limit burden on Medicare providers with our responsibility to protect Trust Fund dollars. CMS has carefully evaluated the Recovery Audit program, and announced a number of changes to it in response to industry feedback.[13] CMS is confident that these changes will result in a more effective and efficient program through enhanced oversight, reduced provider burden, and more program transparency. These changes will be effective with each new contract award beginning with the Durable Medical Equipment, Home Health and Hospice Recovery Audit contract awarded on December 30, 2014.[14] The President's FY 2016 Budget also includes a proposal to permit CMS to retain a portion of recovered funds to implement corrective actions identified through the Recovery Audit program.

Improving Part D Oversight

CMS also continues to refine our Medicare Part D program integrity efforts and enhance our oversight of the Medicare Drug Integrity Contractor (MEDIC), which is charged with identifying and investigating potential fraud and abuse, and developing cases for referral to law enforcement agencies. The MEDIC has implemented a new proactive data analysis effort to identify potential program vulnerabilities, which has a resulted in the recovery of $51 million in improper payments from one study alone. CMS issued a final rule that established a new revocation authority for abusive prescribing patterns that requires prescribers of Part D drugs to enroll in Medicare or have a valid opt-out affidavit on file by December 2015. Additionally, CMS may now also revoke a prescriber's Medicare enrollment if his or her Drug Enforcement Administration (DEA) Certificate of Registration is suspended or revoked, or the applicable licensing or administrative body for any State in which a physician or eligible professional practices has suspended or revoked the physician or eligible professional's ability to prescribe drugs.[15]

[13] See http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf.
[14] Due to a post-award protest filed at the Government Accountability Office (GAO), CMS has delayed the commencement of work under the national DMEPOS/HH&H, Region 5, Recovery Audit contract.
[15] http://oig.hhs.gov/oei/reports/oei-02-09-00608.pdf

The President's FY 2016 Budget includes a proposal to give the Secretary the authority to establish a requirement that high-risk Medicare beneficiaries only use certain prescribers and/or pharmacies to obtain controlled substance prescriptions, similar to many state Medicaid programs. Currently, CMS requires Part D sponsors to conduct drug utilization reviews, which assess the prescriptions filled by a particular enrollee. These efforts can identify overutilization that results from inappropriate or even illegal activity by an enrollee, prescriber, or pharmacy. However, CMS' statutory authorities to take preventive measures in response to this information presently are limited. Under the President's FY 2016 Budget proposal, the Medicare program would still be required to ensure that beneficiaries retain reasonable access to services of adequate quality.

Improving Oversight of Medicaid's Fiscal and Program Integrity

Medicaid consists of 56 distinct programs, one in each U.S. state and territory, covering acute health care, long-term care, and other services for millions of low-income Americans. CMS is responsible for overseeing the program at the Federal level, while states administer their respective programs' day-to-day operations. This federal-state partnership is central to the success of the Medicaid program, but it depends on clear lines of responsibility and shared expectations. CMS takes seriously our role in overseeing the financing of Medicaid programs, and we continue to look for ways to refine and further improve our processes.

CMS has undertaken several initiatives over the last several years that build upon our existing programs and tools, such as improving data analytic capacity and overseeing non-federal share funding. CMS' Medicaid Integrity Program provides the assistance of Federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance supported state efforts to collect $944.4 million in total collections in FY 2014. The President's FY 2016 Budget also includes a number of Medicaid program integrity proposals that strengthen HHS's and the states' ability to fight fraud, waste and abuse in the Medicaid program.

Additionally, CMS has worked with states to improve Medicaid and CHIP data and data analytic capacity through the Medicaid and CHIP Business Information Solutions (MACBIS)

initiative. This initiative includes changes to the Medicaid Statistical Information System (MSIS), which will be known as Transformed-MSIS or T-MSIS. The enhanced data available from T-MSIS will support improved program and financial management and enhance the ability to identify potential fraud. T-MSIS will not only allow CMS to acquire higher quality data, but it will also reduce state data requests. States will move from MSIS to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format in 2015.

As capitated managed care arrangements have become a commonly used approach to Medicaid service delivery and are expected to grow in the coming years as new beneficiaries enroll, CMS has increased our oversight of the process used to ensure that rates set are actuarially sound. For the 2014 contract year, CMS, in collaboration with CMS' Office of the Actuary (OACT), issued a rate-setting consultation guide; held in-depth consultation meetings with states and their consulting actuaries to discuss that guidance; and identified key elements that should be described in the filed rate methodologies. As a result, CMS updated and further refined the rate-setting guidance for the 2015 contract year. We continue to work closely with states during this review process in order to make certain they meet all requirements, and are committed to improving our oversight across all capitated contracting arrangements through new initiatives that increase transparency.

Moving Forward

CMS is dedicated to making historic strides toward the goals of promoting better care, protecting patient safety, reducing health care costs, and allowing beneficiaries to get the right care when they need it. The past several years have brought numerous impressive gains in these areas, but more work remains. Strengthening and improving upon programs that provide vital services to millions of Americans, such as Medicare and Medicaid, is a continuous process, and at CMS we take seriously our responsibilities to taxpayers and beneficiaries. We will continue to work with stakeholders to establish new initiatives and expand upon our existing programs to fight fraud, reduce improper payments, examine alternative payment methods, and improve oversight. We look forward to working with this Committee to further improve Medicare and Medicaid.

Biography

Shantanu Agrawal is a Board-certified Emergency Medicine physician and Fellow of the American Academy of Emergency Medicine. He is currently serving as an appointee for the Obama Administration as Deputy Administrator for Program Integrity and Director of the Center for Program Integrity at the Centers for Medicare & Medicaid Services (CMS). His focus is to improve healthcare value by lowering the cost of care through the detection and prevention of waste, abuse, and fraud in the Medicare and Medicaid programs. Prior to this role, Dr. Agrawal served as Chief Medical Officer of the Center for Program Integrity, where he helped to launch new initiatives in data transparency and analytics, utilization management, assessment of novel payment models, and a major public-private partnership between CMS and private payers.

Prior to joining CMS, Dr. Agrawal was a management consultant at McKinsey & Company, serving senior management of hospitals, health systems, and biotech and pharmaceutical companies on projects to improve the quality and efficiency of healthcare delivery. Dr. Agrawal has also worked for a full-risk, capitated delivery system as the head of clinical innovation and efficiency. He has published articles in *JAMA, New England Journal of Medicine*, *Annals of Emergency Medicine*, among others, and has given national presentations on health care policy and the cost of care.

Dr. Agrawal completed his undergraduate education at Brown University, medical education at Cornell University Medical College, and clinical training at the Hospital of the University of Pennsylvania. He also has a Masters degree in Social and Political Sciences from Cambridge University. Dr. Agrawal has continued to work clinically both in academic and community settings and holds an academic position in Washington DC.