STATEMENT OF

PATRICK CONWAY, MD, MSc
ACTING PRINCIPAL DEPUTY ADMINISTRATOR,
DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY, AND
CHIEF MEDICAL OFFICER,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

GAO'S 2016 DUPLICATION 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. Improving quality and enhancing efficiency 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.

CMS is using a multi-faceted approach to strengthen our 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 these efforts. Our work has 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.[1]

Improving the Health Care Delivery System

Today, almost 60 million Americans are covered by Medicare — and 10,000 become eligible for Medicare every day. For many years, Medicare was primarily a fee-for-service payment system that paid health care providers based on the volume of services they delivered, not the value of those services. In January 2015, the Administration announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they provide to patients. The Administration set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to alternative payment models (APMs) – such as Accountable Care Organizations (ACOs), advanced primary care medical homes, or bundled payment arrangements – by the end of 2016, and tying 50

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/index.html?redirect=/ReportsTrustFunds

percent of payments to these models by the end of 2018. The Administration 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 Reduction Programs. These goals for APMs and value-based payments are the first in the history of the Medicare program.

Over the past several years, CMS, through the Center for Medicare and Medicaid Innovation ("the Innovation Center"), has begun implementing many different payment models to test ways to improve the quality and value of care provided to beneficiaries in the Medicare program. Generally speaking, an APM is a model that holds providers accountable for the quality and cost of the care they deliver to a population of patients by providing a financial incentive to coordinate care for their patients. This helps ensure patients receive the appropriate care for their conditions and reduces avoidable hospitalizations, emergency department visits, adverse medication interactions, and other problems caused by inappropriate or siloed care.

Earlier this year, the Administration announced that it has already reached its first goal ahead of schedule: an estimated 30 percent of Medicare payments are tied to APMs as of January 2016, and millions of Medicare patients are benefitting from better coordinated and improved quality of care. [2] Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible. We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts:

- There has been a 17 percent reduction from 2010 to 2014 in the number of hospital acquired conditions, such as pressure ulcers, infections, and avoidable traumas, representing over 87,000 lives saved and $20 billion in cost savings.[3]
- Between April 2010 and May 2015, an estimated 565,000 readmissions were prevented across all conditions, compared to the readmission rate in the year prior to the passage of the Affordable Care Act (April 2009 to March 2010). That's 565,000 times that a patient didn't have to experience an extra hospital stay.[4]

[2] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-03-03.html
[3] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[4] http://www.hhs.gov/blog/2016/02/24/reducing-avoidable-hospital-readmissions.html

- Per-enrollee health care spending in Medicare has grown at near historically slow rates since 2010, and these low growth rates have translated into substantial reductions in government spending on healthcare. For instance, Medicare spent $473.1 billion less on personal health care expenditures between 2009 and 2014 than would have been spent if the 2000-2008 average growth rate had continued through 2014. In addition, if trends continue through 2015, that amount could grow to a projected $648.6 billion, savings that are greater than all of Medicare's spending for personal health care expenditures in 2015.[5]

We are also working to implement the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which supports the ongoing transformation of health care delivery by creating incentives for physicians and other clinicians to increase participation in rigorous Medicare payment and delivery models designed to improve quality and efficiency.

Strengthening Medicaid

The Medicaid program provides health insurance coverage for more than 70 million Americans, playing a particularly important role in providing coverage for low-income children, adults, pregnant women, people with disabilities, and seniors. The health benefits coverage Medicaid provides ranges from prenatal and pediatric care, to preventive care aimed at stemming chronic diseases, to long term care services and supports. Federal financial support and flexibilities in program rules, along with new tools and options made available through the Affordable Care Act, have helped provide a platform for CMS and states to adopt a range of improvements and innovations in their Medicaid programs.

Because Medicaid is jointly funded by states and the Federal Government and is administered by states within Federal guidelines, both the Federal Government and states stewards of the program, and CMS and states work together closely to carry out these responsibilities. Under the Medicaid Federal-state partnership, the Federal Government sets forth a policy framework for the program and states have significant flexibility to choose options that enable them to deliver high quality, cost-efficient care for their residents. CMS is committed to working with states and

[5] https://aspe.hhs.gov/sites/default/files/pdf/190471/SpendingGrowth.pdf

other partners to advance efforts that promote health, improve the quality of care, and lower health care costs

CMS is working with states to strengthen the program's ability to serve its beneficiaries in some key areas, including modernizing the eligibility and enrollment process for Medicaid and CHIP to support a strong consumer experience; strengthening payment and delivery systems reform to encourage coordinated, high quality, patient-centered care; and strengthening program integrity efforts to better combat and prevent fraud, waste, and abuse.

In our implementation of the Affordable Care Act, CMS has substantially simplified and modernized Medicaid and CHIP rules and processes for most people who apply for Medicaid and CHIP, creating an enrollment process that helps eligible consumers enroll in Medicaid and CHIP and access their coverage more quickly and smoothly. These rules are designed to align and coordinate with policies and procedures established for people who enroll in qualified health plans through the Marketplace. Before these changes, consumers would often encounter a paper-dependent process that was unnecessarily complex and time intensive, sometimes involving long waits for a decision on a family's eligibility that posed logistical challenges for working families and could delay access to needed care.

Now, consumers can use a single, streamlined application to apply for Medicaid, CHIP, and qualified health plans through the Marketplace. Consumers can apply online, over the phone, or by mail, and can get help from application assistors in their communities, or via call centers that help people apply for coverage. CMS and states have established an electronic approach to verifying financial and non-financial information needed to determine Medicaid, CHIP, and Marketplace eligibility. States now rely on available electronic data sources to confirm data included on the application, facilitating faster eligibility decisions and promoting program integrity. In addition, simplified renewal processes help ensure that people retain Medicaid and CHIP coverage for as long as they are eligible, and that beneficiaries who remain eligible get needed services like prescription medications.

As the Government Accountability Office (GAO) has noted, providing accurate eligibility determinations and reviewing expenditure data to make sure funds for Medicaid enrollees are allocated appropriately are important safeguards for the Medicaid program. CMS works continuously to provide accurate eligibility determinations for enrollment in Medicaid and has implemented various internal controls to verify applicants' eligibility. In addition, CMS conducts various reviews of expenditure data to make sure state spending is appropriately matched with federal funds.

CMS has also taken steps to ensure that Marketplace consumers are not receiving duplicate coverage through a State Medicaid program. The Marketplaces have a multi-layer verification process for applications, including checking applicants' enrollment in non-employer sponsored Minimum Essential Coverage in real-time using the Data Services Hub's trusted data sources. This real-time verification process includes checking the applicant's enrollment in Medicaid or CHIP with state Medicaid or CHIP agencies, and other mechanisms intended to protect taxpayer funds.

CMS is also taking additional steps to address other issues identified by the GAO related to coverage gaps and duplicate coverage, to help prevent such occurrences. CMS is currently collecting data from state Medicaid and CHIP agencies through periodic data matching, which allows CMS to identify consumers who are enrolled in Marketplace coverage with advanced payments of the Premium Tax Credit (APTC) or Cost Sharing Reductions (CSR) and Medicaid or CHIP, and conduct outreach/notification to them, regarding ending their Marketplace coverage with APTC/CSR. CMS is also working to implement additional internal controls to reduce duplicate coverage including automatically ending Marketplace coverage with APTC or CSRs for consumers who are found also to have been determined eligible for Medicaid or CHIP, who do not end their Marketplace coverage with financial assistance themselves. CMS is also considering the frequency at which periodic checks for Medicaid and CHIP enrollment will be conducted.

CMS takes seriously our responsibility to assure that Federal Medicaid funds are appropriately spent. Oversight of states' financial management of their Medicaid programs is a critical

component of CMS' work. Consistent with recommendations from the GAO, CMS has taken several steps over the past few years to improve transparency into supplemental payments in Medicaid. In 2013, CMS began collecting annual Upper Payment Limit (UPL) data which includes provider specific information as well as the Disproportionate Share Hospital (DSH) specific reporting information. CMS reviews payment methodologies to determine compliance with statutory requirements and requires additional information or justification if needed. Provider ownership information is collected through survey and certification systems and CMS is exploring ways to efficiently incorporate this information into the review process.

CMS is also working to increase transparency in the section 1115 research and demonstration programs. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to approve demonstration projects that promote the objectives of the Medicaid and CHIP programs. As state and federal health policy is evolving rapidly, particularly in the area of payment innovation and delivery system reform, section 1115 demonstrations play a key role in States' ability to test new and innovative approaches. Section 1115 demonstrations must promote the objectives of the Medicaid program and all demonstrations are reviewed by CMS to determine whether these objectives are met. The demonstrations and programs reviewed by the GAO promote objectives such as including increasing and strengthening overall coverage of low-income individuals in the state and increasing the efficiency and quality of care through initiatives to transform service delivery networks.

In addition, CMS has implemented several initiatives to enhance transparency for section 1115 demonstrations. All section 1115 demonstrations are available publicly and include the specific terms and conditions that must be followed as a result of the demonstration. Additionally, any 1115 demonstration request is subject to a public notice and comment process at both the state and federal level. States are required to solicit meaningful public input in the development of a section 1115 demonstration request prior to submission to CMS. When completed 1115 submissions are submitted to CMS, we also facilitate public comment on the demonstration prior to approval or disapproval.

CMS also identified and made publicly available its long-standing criteria for assessing whether

section 1115 demonstrations are likely to promote Medicaid or CHIP objectives. CMS now clarifies in the terms and conditions that govern the demonstration how the approved program aligns with our published criteria.[6]

As the health care delivery system moves towards more integrated care and away from fee-for-service, states are increasingly moving to the use of managed care in serving Medicaid beneficiaries. Recognizing these changes, on June 1, 2015, CMS published in the Federal Register a proposed rule[7] to modernize Medicaid and CHIP managed care regulations to update the programs' rules and strengthen the delivery of quality care for beneficiaries. This proposed rule is the first major update to Medicaid and CHIP managed care regulations in more than a decade and a major part of CMS' efforts to strengthen delivery systems that serve Medicaid and CHIP beneficiaries. The proposed rule incorporates several core principles to update the regulations, specifically aligning with Medicare Advantage and private coverage plans, supporting state delivery system reform, promoting the quality of care, strengthening program and fiscal integrity, incorporating best practices for managed long-term services and supports programs, and enhancing the beneficiary experience.

Strengthening Program Integrity

Program integrity is an integral focus of our efforts at CMS to be good stewards of taxpayer funds, and as we work to ensure that Medicare and Medicaid beneficiaries receive high quality care. With the assistance and recommendations of the GAO and other external partners, CMS has made progress in our efforts to move away from a "pay-and-chase" model towards one focused on prevention. For example, CMS is utilizing our sophisticated predictive analytics technology, the Fraud Prevention System (FPS), to identify investigative leads to further protect the Medicare program from inappropriate billing practices and provide oversight on provider enrollment actions. In its first three years of implementation, CMS has identified approximately

[6] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/section-1115-demonstrations.html
[7] https://www.federalregister.gov/articles/2015/06/01/2015-12965/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered

$242 million in cost-avoidance savings from revoking provider billing privileges as a result of FPS leads.[8]

As required by MACRA and as the GAO has recommended,[9] CMS will eliminate the use of beneficiaries' Social Security Numbers on Medicare cards by April 2019. CMS has begun the process to redesign Medicare cards, thus removing the current SSN-based identifier, known as the Health Insurance Claim Number (HICN), and replacing it with a Medicare Beneficiary Identifier (MBI). When this work is complete, for the first time, CMS will be able to terminate a Medicare number as soon as we confirm that is has been compromised and issue a new number to a beneficiary, similar to how credit card companies address stolen card numbers. Being able to immediately deactivate a compromised MBI will enable CMS to quickly respond and better prevent further misuse of a compromised number.

Provider Enrollment in Medicare

CMS is strongly committed to protecting the integrity of the Medicare program, including making sure only qualified providers and suppliers are enrolled in Medicare. The Affordable Care Act provided tools, including the use of risk-based screening of providers and suppliers, to enhance our ability to screen providers and suppliers upon enrollment and identify those that possibly may be at heightened risk for committing fraud.

We are seeing real results from our efforts, and we estimate that Affordable Care Act authorities have saved the Medicare program $1.4 billion from revocations since March 2011, protecting both beneficiaries and the Medicare Trust Funds. These actions are part of a larger set of provider enrollment and screening activities which have saved the Medicare program $2.4 billion in avoided costs.[10] These savings reflect the actions CMS has taken to deactivate billing

[8] Report to Congress: Fraud Prevention System Third Implementation Year. Available at: http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html
[9] http://www.gao.gov/products/GAO-13-761
[10] These savings estimates use the same methodology as the identified "costs avoided by revoking billing privileges" savings measure that was certified by the OIG in the 2nd and 3rd Year FPS Reports to Congress. Please see CMS' Report to Congress: Fraud Prevention System Third Implementation Year, for more information (available at: http://www.cms.gov/About-CMS/Components/CPI/Center-for-program-integrity.html). While these particular

privileges for more than 543,100 providers and suppliers that do not meet Medicare requirements, and to revoke the enrollment and billing privileges of an additional 34,800 providers and suppliers since 2011.[11]

Additionally, increased screening efforts have led CMS to deny 7,293 applications in the last 12 months (February 2015-February 2016) based on improved enrollment screening, preventing these providers or suppliers from ever submitting a claim.

In addition to implementing the tools provided by the Affordable Care Act, we are strengthening our strategies designed to reinforce provider screening activities by increasing site visits to Medicare-enrolled providers and suppliers, enhancing and improving information technology (IT) systems, and implementing continuous data monitoring practices to help make sure practice location data are accurate and in compliance with enrollment requirements.

A recent GAO report[12], which identified areas for improvement in our Provider Enrollment, Chain, and Ownership System (PECOS) – the IT system for Medicare enrollment – regarding verification of provider or supplier practice locations, helped CMS target our efforts to further enhance our provider screening activities. We appreciate the GAO's work in this area and are using the GAO's findings to support our broader provider screening enhancements.

When enrolling in Medicare, providers and suppliers (including physicians and non-physician practitioners) are required to supply on their application the address of the location from which they offer services. As a result of our continuous review of policies, we have put into practice four tactics to strengthen strategies designed to reinforce provider and supplier screening activities.

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estimates have not been certified by the OIG, they reflect comparable calculations applied to actions taken under authorities provided in both the Affordable Care Act and CMS' previously existing authorities.

[11] Deactivated providers and suppliers have their Medicare billing privileges stopped; however, their billing privileges can be restored upon the submission and approval of an updated enrollment application. Revoked providers and suppliers have their Medicare billing privileges terminated and are barred from re-entering the Medicare program for a period of one to three years, depending on the severity of the revocation.

[12] http://www.gao.gov/products/GAO-15-448

We're increasing the number of site visits to Medicare-enrolled providers and suppliers, initially targeting those providers and suppliers receiving high reimbursements by Medicare that are located in high risk geographic areas. We're enhancing our address verification software in PECOS to better detect vacant or invalid addresses or commercial mail reporting agencies (CMRAs). Starting this year, CMS will replace the current PECOS address verification software with new software that includes Delivery Point Verification (DPV) in addition to the existing functionality. This new DPV functionality will flag addresses that may be vacant, CMRAs or invalid addresses. CMS has started to continuously monitor and identify addresses that may have become vacant or non-operational after initial enrollment. This monitoring is done through monthly data analysis that validates provider and supplier enrollment practice location addresses against the U.S. Postal Service address verification database. Beginning last month (March 2016) we've also begun deactivating providers and suppliers that have not billed Medicare in the last 13 months.[13] This approach will remove providers and suppliers with potentially invalid addresses from PECOS without requiring site visits. This work will strengthen the integrity of the Medicare program while minimizing burden on the provider and supplier community.

Conclusion

CMS is dedicated to promoting better care, protecting patient safety, reducing health care costs, and providing people with access to the right care, when and where they need it. This includes continually strengthening and improving Medicare and Medicaid programs that provide vital services to millions of Americans. We take our responsibility to deliver better care at a better value seriously. We greatly appreciate the work of the GAO and this Committee and look forward to working together towards our mutual goals of providing value and quality care to beneficiaries and taxpayers.

[13] Note: Providers and suppliers that may be exempted from the deactivation for non-billing include: those enrolled solely to order, refer, prescribe; or certain specialty types (e.g., pediatricians, dentists and mass immunizers (roster billers)).

Patrick H. Conway, MD, MSc

Acting Principal Deputy Administrator
Deputy Administrator for Innovation and Quality, Centers for Medicare and Medicaid Services
Chief Medical Officer, Centers for Medicare and Medicaid Services

Patrick Conway, MD, MSc, is the CMS Acting Principal Deputy Administrator and Deputy Administrator for Innovation and Quality & CMS Chief Medical Officer. As the CMS Acting Principal Deputy Administrator and CMS Chief Medical Officer, Dr. Conway is responsible for overseeing the programs that serve the over 130 million Americans that access health care services through Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. He and the CMS team focus on health system transformation by improving quality, health outcomes, access and affordability, combatting health care fraud and reducing health disparities. He is a national and international leader in health system transformation and improvement.

As the Deputy Administrator for Innovation and Quality, Dr. Conway leads the Center for Medicare and Medicaid Innovation (CMMI) at CMS. The CMS Innovation Center is responsible for testing numerous new payment and service delivery models across the nation. Models include accountable care organizations, bundled payments, primary care medical homes, state innovation models, and many more. Successful models can be scaled nationally. The CMS Innovation Center budget is $10 billion over 10 years.

Previously, he was Director of Hospital Medicine and an Associate Professor at Cincinnati Children's Hospital. He was also AVP Outcomes Performance, responsible for leading measurement, including the electronic health record measures, and facilitating improvement of health outcomes across the health care system. Other relevant experience includes previous work as the Chief Medical Officer at the Department of Health and Human Services (HHS) in the Office of the Assistant Secretary for Planning and Evaluation. In 2007-08, he was a White House Fellow assigned to the Office of Secretary in HHS and the Director of the Agency for Healthcare Research and Quality. He also served as Executive Director of the Federal Coordinating Council on Comparative Effectiveness Research coordinating the investment of the $1.1 billion for CER in the Recovery Act. He was a Robert Wood Johnson Clinical Scholar and completed a Master's of Science focused on health services research and clinical epidemiology at the University of Pennsylvania and Children's Hospital of Philadelphia. Previously, he was a management consultant at McKinsey & Company, serving senior management of mainly health care clients on strategy projects.

In 2014, he was elected to the Institute of Medicine (IOM) recognizing individuals who have demonstrated outstanding professional achievement. Election to the IOM is considered one of the highest honors in the fields of health and medicine. He has published articles in journals such as JAMA, New England Journal of Medicine, Health Affairs, and Pediatrics and given national presentations on topics including health care policy, quality of care, comparative effectiveness, hospitalist systems, and quality improvement. He is a practicing pediatric hospitalist and was selected as a Master of Hospital Medicine from the Society of Hospital Medicine. He has received the President's Distinguished Senior Executive Rank and HHS Secretary's Distinguished Service awards. These are the President's and Secretary's highest distinction for executive excellence. He completed pediatrics residency at Harvard Medical School's Children's Hospital Boston, graduated with High Honors from Baylor College of Medicine, and graduated summa cum laude from Texas A&M University.