Centers for Medicare & Medicaid Services
Summary of Plan for Improvement in the GAO High Risk Area

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Medicare

Problem: The Government Accountability Office (GAO) has designated Medicare as a high-risk program because its complexity and susceptibility to improper payments, added to its size, have led to serious management challenges. The Medicare program serves approximately 50 million beneficiaries with a total gross benefit expenditure of approximately $732 billion in 2012. Medicare faces increasing financial pressure and it is a critical Administration priority to increase the effectiveness and efficiency of the program. CMS administers Medicare and is responsible for implementing payment methods that encourage efficient service delivery, managing the program to serve beneficiaries and safeguard it from loss, and overseeing patient safety and care. CMS has implemented payment reforms in various parts of the program, such as Medicare Advantage, inpatient hospital, physician, home health, and end-stage renal disease services. The agency has implemented accountable care organizations and begun providing feedback to physicians on their resource use and is developing a value-based payment method for physician services that accounts for the quality and cost of care. CMS has made significant efforts to implement the requirements of recent legislation, guidance, and directives aimed at reducing improper payments. CMS has set key performance measures to reduce improper payments in fee-for-service Medicare, Part C, and Part D. Other recent CMS efforts to safeguard the integrity of the Medicare program include the implementation of predictive analytic technology to identity and prevent fraud in fee-for-service Medicare claims, the revalidation of billing privileges of all currently enrolled providers and suppliers to ensure compliance with CMS requirements, and enhanced coordination between CMS authority to suspend payments and nationwide law enforcement activities.

Goals

- Refining Medicare payment accuracy by reducing improper payments, and improving patient safety and quality of care;
- Improving Medicare program management by enhancing oversight of Medicare contractors, and Medicare Part C and D plans; and
- Enhancing program integrity by increasing the prevention and detection of fraud, waste and abuse.

Planned Actions and Milestones

Refining Medicare Payment Accuracy by Reducing Improper Payments, and Improving Patient Safety and Quality of Care

- ***2014 Home Health Prospective Payment System (HH PPS) Final Rule:*** The overall net impact of the provisions of this rule is an estimated decrease in payments to Home Health Agencies in CY 2014 of 1.05 percent. This estimated impact includes the combined effects of the 2.3 percent HH PPS payment update (home health market basket update),

as well as a reduction to the HH PPS rates to account for the rebasing of the HH PPS rates and refinements to the HH PPS Grouper. This will result in an estimated net decrease in payments to HHAs of $200 million in CY 2014 compared to HHA payments in CY 2013. The CY 2014 final rule was published on December 2, 2013.

- ***Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding:*** The contracts and payment amounts for the Round 1 re-bid expired on December 31, 2013. The new contracts and payment amounts for the Round 1 re-compete became effective on January 1, 2014. The Round 2 and the national mail order competition contracts and prices became effective on July 1, 2013.

  The CMS has also implemented a comprehensive real-time claims monitoring system to track health outcomes and beneficiary access to DMEPOS items paid under the competitive bidding program.

- ***Calendar Year (CY) 2014 End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and Quality Incentive Program (QIP):*** The ESRD PPS was implemented beginning with services furnished on or after January 1, 2011, and the first payment reductions under the ESRD QIP were implemented beginning with services furnished on or after January 1, 2012, as required by statute. On December 2, 2013, CMS published a final rule in the Federal Register updating the ESRD PPS for Calendar Year 2014 and establishing performance measures under the ESRD QIP for payment year (PY) 2016. This final rule implements a provision in the American Taxpayer Relief Act (ATRA) of 2012 that reduces payments to account for changes in the utilization of ESRD-related drugs and biologicals. The reduction will be phased in over multiple years to mitigate its impact on providers. Also, this final rule revised and added new clinical measures to the ESRD QIP measure set, including a new for hypercalcemia clinical measure, a new NHSN bloodstream infection clinical measure, and an expanded ICH CAHPS reporting measure that requires ESRD facilities to submit survey data to CMS. CMS projects that the estimated payments to ESRD facilities in CY 2014 will change by zero percent, compared with the estimated payments in CY 2013. This reflects the effect of a 3.2 percent ESRD bundled market basket update, the Affordable Care Act-required productivity adjustment of 0.4 percentage point, the ATRA-required drug utilization adjustment of -3.3 percent, a 0.4 percent overall estimated increase in outlier payment from the updates to the fixed dollar loss threshold and MAP amounts, and a 0.2 percent overall estimated increase in payments from the change in the blend of payments.

  The CMS is closely monitoring the results of the program since implementation to ensure that beneficiary access to appropriate supplies and equipment has not been compromised. CMS real-time claims monitoring has found no disruption in access to needed supplies for Medicare beneficiaries. Moreover, there have been no negative health care consequences to beneficiaries as a result of the implementation of the ESRD PPS. The QIP Monitoring and Evaluation team continues to evaluate the effect of the ESRD QIP on beneficiary outcomes such as access to care, hemoglobin levels, dialysis adequacy, hospital admissions, emergency department visits, and emergency dialysis. To date no discernable significant differences have been detected.

- Beneficiary hemoglobin levels
- Percentage of beneficiaries receiving blood transfusions
- Percentage of beneficiaries receiving intravenous (IV) iron
- Percentage of beneficiaries receiving erythropoietin-stimulating agents (ESAs)

- ***2014 Inpatient Hospital Prospective Payment System (IPPS) Final Rule:*** The FY 2014 IPPS/Long Term Care Hospital (LTCH) Final Rule implemented the following provisions:

    - *Hospital Update.* Applied a market basket update of 2.5 percent for FY 2014; applied a multifactor productivity adjustment of -0.5 percentage points and an additional -0.3 percentage statutory reduction; the rate is further decreased by -0.8 percent for a documentation and coding recoupment adjustment required by the American Taxpayer Relief Act of 2012 (see below) and by a 0.2 percent adjustment to offset the effect of the policy on inpatient admission and medical review criteria for hospital inpatient services.

        - Section 631 of the American Taxpayer Relief Act of 2012 requires CMS to recover $11 billion over the next four years to fully recoup documentation and coding overpayments for prior years. For FY 2014, CMS applied a -0.8 percent recoupment adjustment as the first step in this recovery process. CMS expects to make additional adjustments in FYs 2015, 2016 and 2017 in order to recover the full $11 billion.

    - *Medicare Disproportionate Share Hospitals (DSH).* Section 3133 of the Affordable Care Act, as amended, requires that instead of the amount that would otherwise be paid as the DSH adjustment, hospitals will receive 25 percent of the amount determined under the current Medicare DSH payment methodology beginning in FY 2014. The remainder, equal to 75 percent of what otherwise would have been paid as Medicare DSH, will become available for an uncompensated care payment after the amount is reduced for changes in the percentage of individuals that are uninsured. Each Medicare DSH hospital will receive an uncompensated care payment based on its share of uncompensated care relative to the uncompensated care for all Medicare DSH hospitals.

    - *Quality-Related Provisions.* The rule lays out the framework for the new Hospital-Acquired Condition Reduction Program, which will begin in FY 2015. The rule updates the measures and financial incentives in the Hospital Value-Based Purchasing (VBP) and Readmissions Reduction programs. It also updates measures for the Hospital Inpatient Quality Reporting, Inpatient Psychiatric Facility Quality Reporting, Long-Term Care Hospital (LTCH) Quality Reporting and PPS-Exempt Cancer Hospital Quality Reporting programs.

- *Part B Inpatient Billing in Hospitals.* The rule also finalizes provisions from a separate March 13, 2013 proposed rule that allows payment to hospitals for additional inpatient services under Medicare Part B for hospital inpatient admissions denied as not medically necessary under Part A. A hospital also can bill and be paid for these inpatient services under Part B if—after the patient has been discharged—it determines through self-audit (utilization review) that the patient should have not been admitted as an inpatient.

- *Chronically Ill/Medically Complex Criteria.* In the FY 2014 proposed rule, CMS included a discussion of recent research on the development of empirically-derived criteria for the identification of the chronically critically ill/medically complex (CCI/MC) population, presently treated in general acute-care hospitals and in LTCHs. The CCI/MC population identified by the project has been shown to have intensive service needs, high costs and negative margins in IPPS hospitals. Additionally, they typically have a predictable and consistent need for extended hospital-level care that can be met either from continued stays in the initial IPPS hospital in a step-down unit or from transfer to an LTCH. CMS expects to issue policy proposals to address the needs of the CCI/MC population in FY 2015, taking into account the LTCH provisions in the recently enacted Pathway for SRG Act of 2013.

- ***2014 Hospital Outpatient Prospective Payment System (OPPS) Final Rule:*** Regarding CMS's continuing efforts to update and strengthen its payment systems and improve quality of care and efficiency while restraining costs, the 2014 OPPS Final Rule implemented several provisions to advance these goals including the following:

  - *Items and Services to be "Packaged" or Included in Payment for a Primary Service*. For 2014, CMS finalized the following five new categories of packaged items and services:
    - Drugs, biologicals, and radiopharmaceuticals that function as supplies when used in a diagnostic test or procedure;
    - Drugs and biologicals that function as supplies; when used in a surgical procedure, including skin substitutes. Skin substitutes will be classified as either high cost or low cost and will be packaged into the associated surgical procedures with other skin substitutes of the same class;
    - Certain clinical diagnostic laboratory tests;
    - Certain procedures described by add-on codes;
    - Device removal procedures.

  - *Comprehensive APCs*. In addition to packaging the five categories of items and services mentioned above, CMS finalized a proposal to create 29 comprehensive APCs to replace 29 existing device-dependent APCs, with a complexity adjustment for the most complex multiple device claims. Comprehensive APCs provide a single payment for all services provided during a single patient encounter. CMS is delaying the implementation of the comprehensive APC policy until CY 2015.

- *Collapsing Five Levels of Visits to One*. The OPPS final rule streamlined the current five levels of outpatient clinic visit codes, replacing them with a single Healthcare Common Procedure Coding System (HCPCS) code describing all clinic visits. A single code and payment for clinic visits is more administratively simple for hospitals and better reflects hospital resources used during an outpatient visit.

- ***Physician Fee Schedule (PFS) Final Rule***: The CY 2014 PFS Final Rule with comment period implemented several changes to the fee schedule to ensure appropriate and efficient Medicare payments. Specifically:

  - *Misvalued codes.* CMS has been engaged in a vigorous effort over the past several years to identify potentially misvalued codes and, when codes are found to be misvalued, to revise the payment accordingly. The final rule adopts coding changes and revisions to relative values for hundreds of services that have been previously identified as potentially misvalued. In addition, the final rule identifies new potentially misvalued codes that will be evaluated in upcoming years.

  - *The Medicare Economic Index (MEI).* The MEI, which is used as part of the formula to determine how much physician payment rates increase annually, was revised to incorporate recommendations of a technical advisory panel. The revised MEI more accurately reflects the costs of a physician practice. The proportion of Relative Value Units(RVUs) in the PFS was also adjusted to reflect the new proportions in the revised MEI. Specifically, RVUs were shifted from practice expense to work RVUs, resulting in increased payment for services with relatively greater work as compared to practice expense. By making these adjustments, payments reflect the best information available on change in physician costs.

  - *Practice Expense.* CMS finalized several proposals to increase payment accuracy in the practice expense component of many services. In response to the CY 2013 PFS final rule, several commenters identified items inaccurately incorporated into PFS payment rates as direct practice expense costs. CMS believed that these items are more appropriately categorized as indirect PE costs, and finalized a proposal to remove the items as direct costs for the CY 2014 PFS rates. CMS also evaluated and made proposals on the basis of several recommendations from the AMA RUC. These changes resulted in greater standardization of pre-service staff times associated with certain procedure codes and updated assumptions regarding the kind of equipment items used in ultrasound services.

  - *Telehealth.* Several changes were made to the telehealth provisions in the final rule. Specifically, the final rule amends the regulations to add definition of rural HPSA for the purposes of qualifying as a telehealth originating site that includes HPSAs within MSAs that are in rural areas as defined by the Office of Rural Health. The final also adopts a regulation to determine geographic eligibility on an annual basis. CMS also added Transitional care management (TCM) services, care

management services post discharge, to the list of services that are paid when provided via telehealth for CY 2014.

- *Incident to.* To add clarity to and to enforce requirements that services be furnished in accordance with applicable state laws, the final rule includes condition of payment for services furnished "incident to" specifically requiring that such services be furnished in accordance with applicable state law.

- *Therapy caps.* The cap for therapy services applies to outpatient therapy services furnished in Critical Access Hospitals beginning in CY 2014. In order for therapy services to be provided in excess of this annual per beneficiary cap, the practitioner must attest to the medical necessity of the services and maintain appropriate documentation.

- *Quality.* Quality and cost measures were established for the new value-based modifier that will be used starting in 2015 to adjust physician payments for physician groups of 100 or more eligible professionals based on whether they are providing higher quality and more efficient care. The Physician Quality Reporting System and the e-Prescribing Incentive Program were also updated.

Improving Program Management: Fee-For-Service Contracting Practices and Reform

Milestones

In accordance with section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has effectuated Medicare contracting reform, replacing longstanding Medicare contractors (fiscal Intermediaries that processed Part A claims and carriers that processed Part B claims) with Medicare Administrative Contractors (MAC) that integrate the processing of Parts A and B claims. The use of competitive contract procedures and performance incentives has improved Medicare's administrative services to both beneficiaries and to health care providers, the latter of which use the MACs as their primary point-of-contact for conducting all claims-related business and obtaining information for their patients. Many of the changes brought about by the Affordable Care Act and the Improper Payments Elimination and Recovery Act of 2010 (IPERA) are implemented by the MACs. For example, as part of the prevention-based approach to reduce fraud and abuse, all currently enrolled providers and suppliers will have their enrollment record revalidated by 2015. To reduce improper payments, MACs will conduct additional prepayment reviews. To encourage the MACs to continue to perform at a high level of excellence, their contracts include performance requirements that must be met before their contracts may be renewed each year, and their past performance is taken into account should they be an offer or in the competitions for the follow-on contracts every five years.

Planned Actions and Challenges

- Initially, CMS anticipated that fifteen A/B MACs and four DME MACs would perform Medicare fee-for-service claims processing administration activities. In October 2010, in order to achieve further efficiencies in program management, CMS revised its strategy to consolidate from the initial fifteen A/B MAC jurisdictions to ten using a phased process that will take several years. As of December 2012:

    - All four Durable Medical Equipment (DME) MAC jurisdictions have been fully implemented;
    - Twelve of twelve- A/B MAC jurisdictions have been fully implemented (six of the original fifteen A/B MAC jurisdictions have been consolidated into three; and

    - MAC contracts will be re-competed no later than five years after contract award.

Improving Program Management – Measuring Improper Payments in Fee-for-Service

The CMS developed the Comprehensive Error Rate Testing (CERT) program to produce a Medicare FFS improper payment rate to comply with the requirements of the Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). CMS continues to enhance our program integrity efforts and improve our improper payment measurement programs. CMS continues to implement and refine Medicare improper payment rate measurement programs that comply with IPERIA.

The Medicare FFS improper payment rate for FY 2013 was 10.1 percent, or $36 billion. The FY 2013 net improper payment rate, which reflects the overall estimated monetary loss to the program and is calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, was 9.3 percent, or $33.2 billion.

Beginning with the FY 2012 AFR, CMS modified the reporting period by moving it back six months to more accurately measure the improper payment rate in the Medicare FFS program. As a result, the FY 2013 Medicare FFS reporting period consists of claims submitted between July 1, 2011 and June 30, 2012. In addition, in FY 2012, in consultation with OMB, CMS refined the improper payment methodology to account for the impact of rebilling denied Part A inpatient claims for allowable Part B services when a Part A inpatient hospital claim is denied because the services should have been provided as outpatient services. CMS continued this methodology in FY 2013. This approach is consistent with: (1) Administrative Law Judge (ALJ) and Departmental Appeals Board (DAB) decisions that directed HHS to pay hospitals under Part B for all of the services provided if the Part A inpatient claim was denied, and (2) recent Medicare policy changes that allow rebilling of denied Part A claims under Part B. In addition, CMS issued two policies pertaining to inpatient hospital claims that are expected to reduce improper payments. The ruling and subsequent regulation are described later in this document.

Based on an analysis of a statistical subset of inpatient claims submitted in error, CMS calculated an adjustment factor that reflects the difference between what was paid for the inpatient hospital

claims under Medicare Part A and what would have been paid had they been appropriately submitted as an outpatient claim under Medicare Part B. Application of the adjustment factor decreased the overall improper payment rate by 0.6 percentage points to 10.1 percent or $36 billion in projected improper payments. Additional information regarding these methodology changes and the adjustment factor can be found on pages 166-167 of HHS' FY 2012 AFR (available at: http://wayback.archive-it.org/3922/20131030171300/http:/www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

Improving Program Management: Measuring Improper Payments in Part C

Milestones

The CMS is improving payment accuracy and enhancing program integrity in the Part C (Medicare Advantage) program by continuing to measure the program error rate. The Part C error estimate declined from 11.4 percent (reported in FY 2012) to 9.5 percent (reported in FY 2013).

Unlike Medicare FFS, CMS makes prospective, monthly per-capita payments to Medicare Part C organizations and Medicare Part D plan sponsors. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, certain Part D prospective payments are reconciled against actual costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The FY 2013 Part C error rate is based the payment error related to risk adjustment purposes. The payment error related to risk adjustment reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

To address the error rate in the Part C program, CMS is engaged in outreach to, and education of, plans and providers, and has implemented contract-specific Risk Adjustment Data Validation (RADV) audits designed to estimate risk adjustment error in, and recover overpayments from specific Part C plans. The RADV audits have created a sentinel effect in the industry. Part C organizations are now more cognizant of the importance of properly documenting the clinical diagnoses they submit for payment-related purposes to CMS, and aware that failure to have proper documentation will result in CMS's identification and recovery of overpayments.

Planned Actions and Challenges

The CMS has implemented three key initiatives, described below, to improve payment accuracy in the Part C program: Contract-level audits; MAO guidance and training; physician outreach.

> **Contract-Level Audits:** CMS is proceeding with the RADV contract-level audits to recover over-payments. RADV audits, CMS' primary corrective action to recoup improper Part C payments, verify, through medical record review, the accuracy of enrollee diagnoses submitted by MA organizations for risk adjusted payments. CMS has observed a sentinel effect on the quality of risk adjustment data submitted for payment as

MAO recognize the potential financial impact of the audits, and MAO have greatly increased the number of self-reported overpayments since the introduction of the contract-level RADV audits.

On February 24, 2012, CMS released the *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits.* The notice clarifies the final audit methodology that will be implemented for audited contracts going forward. CMS expects to audit about 30 MA contracts each year. The RADV contract-level audits for payment year 2011, the first year for which CMS will conduct payment recovery based on extrapolated estimates, began in November 2013. The impact of conducting extrapolated recovery will be significant. As the overpayments identified for the beneficiaries in the sample will be applied to the entire MA contract.

Additionally, the CY 2007 contract-level RADV audits are in the final stages. CMS has thus far recovered (at the beneficiary level) $8.4 million. The remaining payment recovery for these audits will occur in FY 2014.

Medicare Advantage Organization Guidance and Training:

To improve the accuracy of CMS Part C payment error estimate, CMS refined its medical record submission and review rules and procedures to be more consistent with risk adjustment rules. Under the previous process MAO's were, with respect to each diagnosis, permitted to submit medical record documentation from only one visit or service. If CMS determined that the particular record did not support the diagnosis, the diagnosis was counted as an error even if the plan had other documentation that would support it.

To improve the accuracy of the payment error estimate, in an effort to assist MAO's with identification of appropriate records, CMS provided MAO's with findings detailing the validity of medical records submitted, to ensure they were suitable for the audits, and preliminary coding results. CMS provided interim feedback on the validity of medical records and on preliminary coding results so that MA organizations could submit documentation from another visit or service. The Medical record submission window was also extended to ensure sufficient time to collect documentation. These changes better ensure that the Part C error rate reflects the degree to which beneficiaries have or do not have diagnoses reported by the plan, rather than on the ability of the plan to select a single record out of multiple eligible records.

The CMS also conducts national training sessions for MAO that provide comprehensive information on submitting accurate risk adjustment data.

Physician Outreach: To improve medical record documentation prepared by physicians to support risk adjustment diagnoses, CMS has begun a program to better educate physicians on the risk adjusted payment CMS makes to MA contracts, its reliance on properly documented diagnoses for payment.

Improving Program Management: Measuring Improper Payments in Part D

Milestones

In FY 2013, CMS reported a payment error rate of 3.7 percent for the Medicare Prescription Drug program (based on payment year 2011), which will be used to monitor and correct improper payments. The FY 2013 Part D error rate presents the combined impact on Part D payments of four sources of payment error related to: low income subsidy status; incorrect Medicaid status; prescription drug event data validation; and direct and indirect remuneration. The composite payment error estimate remained relatively constant between FY 2011 and FY 2012 (3.1 percent).

Planned Actions and Challenges

The CMS has implemented actions to address the Part D error rate. CMS will continue national training sessions for Part D sponsors on Part D payment and data submission. Additionally, CMS will continue to provide plans with additional guidance to improve their collections of prescription documentation from pharmacies as well as establish formal outreach during the error rate measurement process. The low income subsidy (LIS) status error will be addressed by providing additional guidance to Part D sponsors to update beneficiary LIS statuses prior to reconciliation.

Enhancing Program Integrity: Reducing Medicare Fee-for-Service Improper Payments –

Milestones

Reducing the incidence of improper payments is a high priority for CMS. CMS has a comprehensive strategy in order to meet our improper payment reduction goals, including increased prepayment medical review, enhanced data analytics, expanded education and outreach to the provider and supplier communities, and expanded review of paid claims by the CMS Recovery Auditors.

The CMS developed an Error Rate Reduction Plan (ERRP) that outlines actions the agency will implement to prevent and reduce improper payments for all categories of error.

In addition to the ongoing corrective actions reported on pages 167-169 of HHS' FY 2012 AFR, CMS has implemented additional efforts to reduce improper payments in the Medicare FFS program as outlined below.

- ***Comparative billing reports (CBRs)*:** CMS develops and issues CBRs which compare a provider's or supplier's billing pattern for various procedures or services to their peers on a state and national level. On average, CMS issues over 50,000 CBRs a year on subjects such as physical therapy services, chiropractic services, ambulance services, hospice care, podiatry, sleep studies, diabetic supplies and spinal orthotics to providers. On an ongoing basis, CMS also issues reports known as PEPPER, or the Program for Evaluating Payment Patterns Electronic Report, that encourage Medicare inpatient hospitals to

analyze their billing patterns through a comparison to other providers in their state and in the nation.

- ***Increased Medical Review Efforts*:** CMS requires its Medicare review contractors to focus their medical review efforts on identifying documentation errors in certain error prone claim types, such as home health, hospital outpatient, skilled nursing facility (SNF), and nonhospital-based hospice claims. CMS continues to allow Medicare Administrative Contractors (MACs) and Medicare FFS Recovery Auditors to review more claim types than in previous years, while closely monitoring the decisions made by these contractors. The MACs' medical review activities resulted in a projected savings of $5.6 billion in FY 2013. In addition, CMS contracted with a Supplemental Medical Review/Specialty Contractor to perform medical reviews focused on vulnerabilities identified by CMS internal data analysis, the CERT program, professional organizations, and federal oversight agencies. The contractor evaluates medical records and related documents to determine whether claims were billed in compliance with Medicare coverage, coding, payment, and billing rules.

- ***Therapy Caps*:** CMS implemented the Medicare Part B Outpatient Therapy Cap Exceptions Process, which mandates manual medical review on claims when the beneficiary exceeds the annual $3,700 therapy threshold. On April 1, 2013, the Medicare FFS Recovery Audit program began prepayment manual medical review on therapy claims above the threshold in 11 demonstration states. In the remaining states, the Medicare FFS Recovery Audit program conducted the reviews on a post-payment basis.

Planned Actions and Challenges

Of particular importance are three corrective actions that CMS believes will have a considerable effect in preventing and reducing improper payments in the future:

- ***Inpatient Hospital Policies*:** CMS implemented two major policies pertaining to inpatient hospital claims that are expected to reduce improper payments. First, CMS issued an interim measure, CMS Ruling 1455–R (78 FR 16614 (, Mar. 13, 2013)), that ended a demonstration project allowing hospital participants to bill for inpatient Part B claims when their Part A claims were denied as not reasonable and necessary, but expanded this concept for all hospitals. Proposed Rule 1455-P (78 FR 16632, (issued on Mar. 13, 2013)), as finalized in 1599-F (78 FR 50495, issued on August 2, 2013), permitted inpatient Part B billing within one year from the date of service. The final rule, which also clarified and modified CMS policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A and how Medicare review contractors will assess hospital inpatient claims for payment purposes, became effective (and Ruling 1455-R became inapplicable), on October 1, 2013.

- ***Recovery Audit Prepayment Review*:** On September 1, 2012, CMS implemented a three year demonstration to allow Medicare FFS Recovery Auditors to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The Recovery Auditors will conduct prepayment reviews on certain types of claims that have

historically had high rates of improper payments. These reviews will focus on a total of 11 states including 7 that historically have had disproportionately high percentages of fraud and error-prone providers (Florida, California, Michigan, Texas, New York, Louisiana, and Illinois), and four that have high claims volumes of short inpatient hospital stays (Pennsylvania, Ohio, North Carolina, and Missouri). This demonstration seeks to develop improved methods to investigate and prosecute fraud in order to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments. This demonstration will also help lower the error rate by preventing improper payments from being paid in the first instance, rather than the traditional "pay and chase" methods of looking for improper payments after they occur. CMS has already saved approximately $22.3 million in improper payments from being made through this prepayment demonstration.

- ***Prior Authorization of Power Mobility Devices (PMDs)*:** On September 1, 2012, CMS instituted a prior authorization demonstration program in seven states aimed at establishing improved methods for investigating and prosecuting fraud in the provision of power mobility devices. The prior authorization reviews are being performed timely, industry feedback has been positive, and we have received no complaints from the beneficiaries we serve. Since implementation, CMS has observed a decrease in the expenditures for power mobility devices in demonstration and non-demonstration states. Overall, spending for PMDs has decreased by $117 million[1] since the inception of the demonstration. While a portion of the decrease may be due to continuous supplier education and other initiatives[2] to prevent fraud and improper payments, the majority can be attributed to the new prior authorization requirements. CMS continues to closely monitor and evaluate the effectiveness of the demonstration and plans to analyze demonstration data to assist in the investigation and prosecution of fraud.

Enhancing Program Integrity Through the Prevention and Detection of Fraud, Waste and Abuse -

The CMS has implemented many of the new anti-fraud authorities provided in the Affordable Care Act and the Small Business Jobs Act of 2010 (P.L.111-240) to strategically combat fraud, waste, and abuse, and combined with additional tools, has developed a comprehensive strategy to prevent and detect fraud and abuse. The strategy requires CMS to work closely with states, our law enforcement partners, the private sector, health care providers and contractors. In order to protect taxpayer dollars in the Medicare and Medicaid programs, CMS has a comprehensive program integrity approach centered on prevention and detection, innovative anti-fraud technologies, provider risk-based strategy, and greater collaboration with our fraud fighting partners in the private sector and law enforcement.

[1] This assumes that the monthly expenditures for PMDs would have remained constant at $32 million per month.
[2] Another factor contributing to the ongoing reduction in expenditures for PMDs would be the reduction in payment amounts, fraud and abuse associated with implementation of the DMEPOS competitive bidding program in 9 of the largest metropolitan areas in January 2011 and an additional 100 large metropolitan areas in July 2013. This program is reducing expenditures for approximately half of the beneficiaries receiving PMDs nationwide. Finally, the ongoing reduction in expenditures for PMDs can also be attributed to the elimination of the lump sum purchase option for standard power wheelchairs, which took effect on January 1, 2011. This change significantly reduces expenditures for power wheelchairs used on a short term basis.

The Fraud Prevention System

The Fraud Prevention System (FPS) is the state-of-the-art predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA). Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare 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.

The FPS provides a comprehensive view of Medicare FFS provider, supplier, and beneficiary activities in order to identify and analyze provider and supplier networks, billing patterns and beneficiary utilization patterns, and detect patterns that represent a high risk of fraudulent activity. The FPS is fully integrated with the Medicare FFS claims processing system and also pulls in other data sources, including compromised beneficiary Medicare identification numbers and complaints that are made through the 1-800-MEDICARE call center.

The FPS technology is one part of the process of identifying providers and suppliers for investigation and taking action to protect the Medicare Trust Funds. CMS undertakes critical activity to identify and prioritize models for use in the FPS and to work the leads that are generated by the technology based on the models.

Enhanced Provider Enrollment and Automated Provider Screening*:*

To strengthen and help implement the new provider enrollment requirements under the Affordable Care Act, CMS launched the Automated Provider Screening (APS) system in December 2011. The APS is designed to verify the data submitted on enrollment applications against independent commercial and health care data to establish eligibility for enrollment into Medicare. APS is also designed to assess the risk of potential fraud of each individual and organization, and returns the results and supporting data to a web-based user interface accessible to CMS and its designees. CMS is continuing to evaluate APS' ability to effectively identify bad actors through ongoing pilot testing.

The CMS has implemented additional screening requirements under the Affordable Care Act. Categories of providers and suppliers in the "moderate" level of risk are required to undergo an on-site visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded on-site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. In addition to announced and unannounced site visits, regulations require providers and suppliers that are assigned to "high" level screening based on their risk of fraud to be subject to fingerprint-based criminal background checks as part of the Medicare enrollment process. CMS is currently working on the procurement of a fingerprint contractor and expects to implement this requirement by Q3 FY 2014.

The National Supplier Clearinghouse (NSC) is the Medicare contractor responsible for reviewing and processing applications from organizations and individuals seeking to become

suppliers of durable medical equipment, prosthetics, orthotics, and suppliers (DMEPOS) in the Medicare program. This process includes conducting on-site visits, enumerating DMEPOS suppliers and implementing safeguards to ensure only legitimate suppliers enter and/or remain in the Medicare program. Through the course of its work, the NSC has conducted thousands of site visits to verify enrollment application information and has been a major force in preventing fraudulent providers from participating in the Medicare program. The NSC contract is currently being re-competed and has a target award date in Q2 of FY2014.

The CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 2011, CMS enrolled or revalidated enrollment information for nearly 535,000 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. As a result of revalidation and other proactive initiatives, CMS has deactivated 225,963 enrollments and revoked 16,358 enrollments nationwide.

The Integrated Data Repository (IDR) and One Program Integrity (One PI)*:*

To complement the work described above, CMS continues to enhance the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data, including claims, beneficiary, and prescription drug event (PDE) data. CMS is using the IDR to provide broader and easier access to data for our partners while strengthening and supporting CMS's analytical capabilities. The IDR contains Medicare provider, supplier, beneficiary and claims data for Medicare Parts A, B, and D back to January 2006. In FY 2012, CMS expanded the IDR to include shared systems data, providing access to Part A, Part B, and durable medical equipment (DME) claims data from both before and after final payment has been made. This permits testing of prepayment analytics on historical data that can be used to develop analytic models that can be used in the FPS. CMS is working to integrate new data sources into the IDR. CMS is now requiring Medicare Advantage organizations to submit encounter data for dates of service January 3, 2012 and later. CMS is also working to incorporate state Medicaid data into the IDR, while working with states to improve the quality and consistency of the data from each state.

Users may access the IDR through One Program Integrity ("One PI"), CMS's centralized portal that provides CMS contractors and law enforcement with a single access point to Medicare data, as well as analytic tools to review the data. In FY 2012, CMS trained 275 contractors and 44 law enforcement staff to effectively use One PI, and since October of 2010, a total of 886 program integrity contractors and CMS staff, including 108 law enforcement personnel, have been trained. Additionally in FY 2012, CMS offered mobile, on-site training on One PI for our program integrity contractors, training large groups of contractor staff while reducing travel costs related to this training.

Planned Actions and Challenges

In 2013, CMS is exploring ways to expand the use of FPS to increase savings. For example, CMS is piloting providing leads to the Medicare Administrative Contractors for medical review and rejecting claims directly by the FPS that are not supported by Medicare policy. CMS may expand these pilot projects nationally to improve fraud, waste, and abuse prevention and detection. CMS will also evaluate the feasibility of expanding predictive analytics technology to Medicaid.

In 2013, CMS is refining the methodology for calculating return on investment to address recommendations made by the OIG in its certification of the first implementation year savings results. CMS will calculate the results for the second year of the program based on the revised methodology. These findings will be published in the upcoming Report to Congress.

Healthcare Fraud Prevention Partnership (HFPP)

One of the Secretary's key health care fraud prevention initiatives is to establish an ongoing partnership with the private sector to fight fraud across the health care system. Data collected and shared across payers can assist payers in evaluating trends, recognizing patterns consistent with potential fraud, and potentially uncover schemes or bad actors they could not otherwise identify using only their own information. The Healthcare Fraud Prevention Partnership (HFPP) is the groundbreaking public/private partnership between the government and private sector insurance payers. The purpose of the partnership is to exchange data and information between the partners to help improve capabilities to fight fraud, waste and abuse in the health care industry. Current partners include federal agencies (HHS-OIG, DOJ, FBI, and CMS), states, private plans and associations. The partnership's first information sharing study included exchanging codes and code combinations frequently associated with fraud, waste or abuse, as well as fraud schemes and descriptions. Additional studies are underway and the partnership is poised for the procurement of the data-exchange entity, the Trusted Third Party (TTP), as well as expansion to new partners.

The HFPP is a demonstrated example of effective departmental collaboration between HHS and DOJ to work together to create a strong partnership with the states and private payers to detect fraud, waste and abuse.

Several key HFPP milestones occurred in FY'2013, including the signing of the Healthcare Fraud Prevention Partnership Charter by Secretary Sebelius and Attorney General Holder, and the second HFPP Executive Board meeting that took place on April 1, 2013. The Board Meeting was followed immediately by two days of working sessions with committees the CMS' Program Integrity Command Center. More than 60 participants representing over 20 partnership organizations attended the working sessions. In total, more than a dozen meetings were held, including four in-person meetings that proved highly effective in distilling the critical spirit of collaboration and partnership.

The HFPP has successfully completed a significant pilot information exchange in which 11 entities, including CMS, contributed fraud related data for aggregation and analysis,. Many participants realized immediate cost savings and implemented additional administrative actions.

Specifically, CMS conducted an analysis on the ~1,400 identified codes and 786 code combinations which were shared in the first study. Many code combinations reflected issues identified by other payers (e.g., unbundling of ultrasounds). Working in conjunction with payment policy staff, CMS evaluated which code combinations could have edits installed to prevent unbundling or duplicate billing. As a result, 145 edits were put in place on July 1, 2013 (additional edits will be introduced in 2014) and CMS' analysis of the shared fraud schemes resulted in 2 qualitative drug screen edits that were implemented in July 2013, resulting in a cost savings of $8.3 million.

Numerous investigations were initiated based on this exchange, resulting in uncovering at least one coordinated network. As a result, 11 revocations have been completed to date, which amounts to an estimated $27.4 million in avoided costs associated with these providers over the next three years while their billing privileges are revoked. In addition, a payment suspension, estimated at $1.57 million is also in place due to this HFPP study. Cumulatively CMS estimates savings from this HFPP first study to be $9.8 million in savings and a potential $27.4 million in avoided costs. Two additional studies are underway that include exchanging lists of non-operational provider entities (also known as "false store fronts") and provider-entity revocation/termination lists for reasons associated with fraud, waste or abuse. Future data exchanges, both non-identifiable and identifiable, will significantly expand in complexity and require substantial technologies and infrastructure including relevant contactors and a data exchange partner to serve as a Trusted Third Party.

The CMS added additional partners to the HFPP and is targeting further expansion of the partnership to include additional willing public and private payers once the technical and legal components of the program are in place. The increase in members providing data will increase the resources necessary for the trusted third party contractor to process and store the increased number of claims data from the new members. Additional information about the partnership can be found at http://hfpp.cms.gov.

Enhancing Program Integrity in Parts C and D

Milestones

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performs Part C and Part D program integrity activities, including proactive data analysis, law enforcement support, referrals to law enforcement, complaint intake, identification of program vulnerabilities, and investigation of Part C and Part D fraud, waste and abuse. CMS uses the Outreach and Education MEDIC to provide Part C and D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups.

For FY 2013, the NBI MEDIC received 453 requests to support law enforcement, completed 391 referrals to law enforcement, received over 13,000 calls via their toll-free hotline and initiated over 1,400 investigations of Part C and Part D fraud, waste and abuse. Likewise in FY 2013, the NBI MEDIC identified inappropriate payments attributed to vulnerabilities exceeding over $100 million in Fiscal Year 2013. Vulnerabilities identified and addressed included inappropriate Part D payments associated with deceased prescribers, payments for Part D drugs involving

veterinarians, inappropriate Part D payments for drugs connected to a Part A Hospice stay, and payments for Transmucosal Immediate Release Fentanyl (TIRF) Drugs lacking the proper cancer diagnosis.

To proactively address drug diversion and subjects potentially engaged in fraud, waste, and abuse, the NBI MEDIC completed the 2011 and 2012 Pharmacy Risk Score Projects and the 2012 Prescriber Risk Score Project to share with the plan sponsors. For the National Pharmacy Risk Score Projects, the NBI MEDIC developed several measures to assess the risk level (low, medium, or high) of nearly 60,000 retail pharmacies and evaluated the billing patterns of the pharmacies identified.

The Affordable Care Act requires CMS to implement Recovery Audit Contractor (RAC) provisions in Parts C and D. On January 13, 2011, CMS signed a contract to implement a Part D RAC that will identify improper payments previously paid to providers in reconciled Medicare claims and to provide information to CMS to help prevent future improper payments. Initial areas of focus for the RAC include payments to plans for drugs prescribed by excluded prescribers, underpayments and overpayments. In June 2012, the Part D RAC notified Part D Plan Sponsors of identified overpayments related to a review of 2007-2008 PDE data to identify excluded individuals and entities, and recoupment. Based upon these reviews, the Part D RAC recovered $1,865,110 in FY2013. In August 2013, the Part D RAC notified Part D Plan Sponsors of identified overpayments related to a review of 2008-2011 PDE data to identify excluded individuals and entities, and recoupment began in January 2014. As a result, $338,530.96 has been recouped thus far in FY2014.

The Part C RAC will identify improper payments related to coordination of benefits in ESRD, Hospice and Medicare Secondary Payer (MSP), and provide information to CMS to help prevent future improper payments. CMS anticipates awarding the Part C RAC contract in 2014.

Planned Actions and Challenges

Based upon these reviews, the Part D RAC recovered $1,865,110 in FY2013. In August 2013, the Part D RAC notified Part D Plan Sponsors of identified overpayments related to a review of 2008-2011 PDE data to identify excluded individuals and entities, and recoupment began in January 2014. As a result, $338,530.96 has been recouped thus far in FY2014. Additionally, the Part D RAC will continue its review of excluded providers as well as data associated with unauthorized prescribers and schedule drug refill errors.

Improving Program Management – Managing IT and IT Security

Milestones

The CMS Chief Information Officer, in concert with the CMS Office of Information Services, has established and maintains robust IT investment management policies, procedures and practices, including a dynamic Enterprise Architecture program and Governance model, and a comprehensive information security program for all CMS information systems. In particular, the agency has implemented an expedited system lifecycle, post-implementation reviews of major systems, and a comprehensive CMS information system inventory. These measures support information security, records management, continuity of operations, the OMB Financial Management Systems Inventory, and all CMS IT initiatives, including those required under Health Information Technology for Economic and Clinical Health Act and the Affordable Care Act.

Planned Actions and Challenges

The CMS' Enterprise Information Security Group (EISG) has further developed and implemented a comprehensive Risk Management Framework (RMF), and Enterprise Vulnerability Management (EVM) and Continuous Monitoring programs, to enhance the information security of the CMS Enterprise. CMS has also created the CMS Enterprise Security Operations Center (ESOC). In conjunction with HHS' Computer Security Incident Response Team (CSIRT), the CMS SOC detect and protect the CMS IT Enterprise from, various types of cyber security attacks, malware, and unauthorized usage. In addition, the CMS EISG RMF initiative focuses on tightly integrating information security into its data management programs as part of CMS' initiative for modernizing CMS computer and data systems to support improvements in health care delivery.

The CMS Office of Information Services, Enterprise Architecture & Strategy Group, Division of Enterprise Architecture (DEA) will continue to support all CMS IT initiatives, projects, and programs. This includes the performance of key functions in support of strategic planning, governance, program management, information privacy and security, disaster recovery and continuity of operations. The DEA will actively provide assistance to all components across the CMS enterprise on important measures that, for example, create greater transparency, audit claims and episodes to verify correct payments, and develop processes for information security incident handling and breach analysis. DEA will also continue its enterprise-wide efforts to appropriately inventory CMS IT systems and participate in disaster recovery and continuity of operations efforts, in support of IT security at CMS.

Program Integrity – Improving the Medicare Secondary Payer Program

The CMS is striving to strike the appropriate balance between protecting the Medicare Trust Funds and promoting the well-being of Medicare beneficiaries, while working to improve the MSP process. To that end, CMS has taken steps to improve and streamline the MSP program. CMS has provided educational materials to the industry in the form of free computer-based

training modules, posted guidance in a downloadable format on our website, and provided technical assistance to stake holders.

The CMS is restructuring its MSP contracting operations by consolidating MSP information, providing stakeholders with one central point of contact and one single website for all aspects of MSP policy and operations. CMS will take advantage of the opportunities provided by the new contracting strategy to implement numerous systems and operational enhancements that will improve the quality and timeliness of customer service. For example, CMS is developing numerous self-service tools via secure web portals for insurers, employers, beneficiaries, and attorneys to streamline coordination of benefit and recovery processes. In addition, CMS is modifying call center scripts at the MSP contractors and 1-800-Medicare, and simplifying policy manuals and on-line resources. CMS is enhancing outreach activities by hosting webinars and performing national teleconferences.

The CMS has implemented two recovery thresholds, and will continue to monitor and evaluate the data received from recently implemented mandatory insurer reporting to determine if these thresholds should be adjusted and whether additional thresholds can be implemented. CMS has also revised recovery correspondence that is issued to beneficiaries to ensure that rights and responsibilities are more clearly communicated. CMS plans to continue revising MSP correspondence so it can be easily understood by Medicare beneficiaries.

The CMS and its integration contractor will monitor and measure the effectiveness of the new contracting strategy in various ways, including tracking cost avoided savings and recoveries, implementing quality assurance plans at our contractors, and monitoring various contractor performance and quality metrics. In addition, CMS oversight will include user surveys that allow for public input, questions to dedicated internet mailboxes, and completion of on-line questionnaires.

Centers for Medicare & Medicaid Services
Summary of Plan for Improvement in the GAO High Risk Area

Medicaid

Problem: Over the past several years GAO has taken issue with state financing arrangements for the Medicaid program that it believes are improper and/or inconsistent with the federal statute. GAO acknowledges that CMS has made improvements in this area, but believes that further efforts should be undertaken to strengthen the fiscal accountability of the Medicaid program. Additionally, GAO continues to believe CMS could better incorporate the use of key Medicaid data systems into its oversight of state claims and could clarify and communicate its policies in several areas, including supplemental payment arrangements.

Goals:

- Issue guidance to clarify allowable financing arrangements consistent with Medicaid payment principles;
- Determine what systems projects are needed to further enhance data analysis capabilities;
- Ensure that waiver programs are financed appropriately; and
- Improve fiscal integrity and financial management.

Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles (GAO-07-214)

The CMS has taken steps to strengthen the fiscal accountability of the Medicaid program. We have developed a financial management strategic plan for Medicaid, and incorporated the use of key Medicaid data systems into its oversight of states' claims, and clarified or communicated its policies in several high risk areas, including supplemental payment arrangements.

Milestones

- **Strengthen the Fiscal Accountability of the Medicaid program. (GAO-07-214):** On May 29, 2007, CMS promulgated the final rule, Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership (CMS-2362-F), to clarify the appropriate Medicaid state financing sources, including intergovernmental transfers and certified public expenditures. On June 30, 2008, Public Law 110-252, the Supplemental Appropriations Act, 2008, was enacted. This law prevented CMS from finalizing and/or implementing the Cost Limit for Providers rule until after March 31, 2009. Section 5003(d) of Public Law 111-5, the American Recovery and Reinvestment Act of 2009, conveyed Congressional opposition to finalizing several rules, including the Cost Limit for Providers rule.

  In addition, on May 23, 2008, the United States District Court for the District of Columbia upheld a Congressional moratorium on rulemaking and invalidated the Cost Limit for Providers rule. *Alameda County Medical Center, et al. v. Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, et al.*, 559 F. Supp. 2d 1 (2008). On November 30, 2010 CMS removed the regulations from the Code of Federal Regulations and reinstated the prior regulatory language.

As required under section 7001(c)(2) of the Supplemental Appropriations Act, 2008 (Public Law 110-252), CMS retained an independent contractor to provide additional information in a report to Congress and CMS on the policy and financial impact of certain proposed and final Medicaid regulations placed under moratorium by Congress. This report is titled *Analysis of Impact and Issues Related to Four Medicaid Regulations*, and was published in 2009. In addition, CMS has recommended to the GAO that this recommendation be marked as met and closed.

The CMS continues to use the state plan submission process to monitor and collect information to assure state financing arrangements are consistent with Medicaid payment principles. CMS is using the findings from the congressionally mandated report, court decisions, and Congressional guidance to guide future regulatory activities.

In federal fiscal year 2010, CMS instituted enhanced expenditure reporting capabilities to facilitate improved information on Medicaid supplemental payments. As part of the CMS-64 form, new expenditure reporting lines were added to capture state reported expenditures for inpatient hospital, outpatient hospital, nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and physician services. CMS continues to work with states to improve the reporting accuracy of these expenditures.

Finally, on March 18, 2013, CMS issued a State Medicaid Director's Letter (SMD #13-003) that discusses the mutual obligations of the state and federal governments to implement safeguards and ensure proper and appropriate use of Medicaid dollars. In part, the letter mandates that states submit annually methods and data to demonstrate that Medicaid payments for applicable services are below federal upper payment limits. Prior to this issuance, states only submitted demonstrations when requesting to change or update service payment methodologies in the Medicaid state plan. Beginning in 2013, states are required to submit the annual demonstrations for inpatient hospital services, outpatient hospital services, and nursing facilities. In 2014 and annually thereafter, states are required to submit annual UPL demonstrations for the services listed above and clinics, physician services (for states that reimburse targeted physician supplemental payments), intermediate care facilities for the developmentally disabled (ICF/DD), psychiatric residential treatment facilities and institutes for mental disease (IMDs). Additionally, states are asked as part of the submission to identify the source of non-federal funding for the payments described in the UPL. Along with the annual requirement, CMS has issued UPL guidance materials on the Medicaid.gov website to promote reasonable UPL methods and consistency across states.

<u>Further Enhance Data Analysis Capabilities</u> (GAO-06-705)

In response to the priorities set by the Medicaid and CHIP Business Information Solutions (MACBIS) Council, CMS is working to streamline the current data and systems environment to minimize the data requests, align data definitions and standards, and create an enhanced operational IT environment to store and to support the use of Medicaid and CHIP data. Data and systems reform are being addressed for four types of data: 1) operations data including fee-for-service claims, encounters, and beneficiary and provider eligibility and enrollment; 2) program

data comprised of program characteristics about eligibility structure, benefit structure, and payments; 3) performance data around the business functions of timely determinations and payment; and 4) quality data about the quality of care.

The Medicaid Statistical Information System (MSIS) is the primary vehicle for collection of operations data from states today. CMS is implementing the Transformed MSIS (T-MSIS) with states on a rolling basis, with the goal of having all states submitting data monthly by July 1, 2014. T-MSIS modernizes and enhances the way states will submit operational data about beneficiaries, providers, claims, and encounters and will be the foundation of a robust state and national analytic data infrastructure. Since 2011 CMS has been working with pilot states and other stakeholders to refine and enhance the MSIS data set and to modernize the ongoing submission and quality review process for the dataset. The result is of this effort is Transformed-MSIS (T-MSIS), which encompasses the set of data produced in the daily operation of the Medicaid and CHIP programs. These are the data about enrollees, services, and costs, including: fee-for-service (FFS) claims, encounters performed under managed care arrangements, beneficiary eligibility and demographic information, and provider enrollment data. States are transitioning at different points of time, and all states are expected to submit timely T-MSIS by July 1, 2014.

Concurrently, CMS is preparing to launch a new system MACPro, for the collection of Medicaid and CHIP Program information. This system will be a web based system to receive and adjudicate state program changes. The system will be released in phases and is scheduled to be available to states in 2014.

Both of these new systems have been mapped to a Medicaid and CHIP data model resulting in a much higher degree of standardization across state systems. CMS has developed a high-level multi-year plan for system integration and retirement that will streamline data feeds and set up a single source for Medicaid and CHIP data. Business intelligence tools are being designed to layer on top of the data streams, thereby enabling integrated analysis and reporting for both CMS and the states.

Ensure Waiver Programs Are Financed Appropriately (GAO-08-87)

- **CMS has made efforts to review Section 1115 Demonstrations in accordance with program objectives and mitigate budget neutrality risk.** The Secretary of HHS has authority to allow states to test new ideas for achieving program objectives. The Department, in conjunction with the Office of Management and Budget, reviews, negotiates, and makes decisions on awarding proposals from states.

  The CMS continues to provide states with technical assistance in accordance with budget neutrality principles and will continue to seek ways to improve the process to ensure that approved programs are budget neutral.

  The CMS, in support of a performance measure, implemented an improved program for monitoring budget neutrality, in which the budget neutrality status of all 1115 demonstrations is routinely reviewed. CMS exceeded its goal for completing targeted

budget neutrality reviews since FY 2006; including the most recent FY12 reporting cycle, and expects that the 2013 goal will be met as well.

Improve Fiscal Integrity and Financial Management (GAO-09-628T)

- **CMS has worked to strengthen program integrity.** The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program and appropriated funds to combat provider fraud and abuse and to provide effective support and assistance to states.

  The Medicare Integrity Program encompasses a wide variety of CMS activities to support states' efforts to prevent improper payments and fraud in their Medicaid programs. In 2010, the Center for Program Integrity was formed to integrate Medicaid and Medicare program integrity efforts and has allowed for a centralized approach that enables CMS to develop more strategic and coordinated initiatives for fighting fraud and abuse.

  In FY 2013, CMS continued to expand collaborative audits with states advanced the implementation of program integrity provisions of the Affordable Care Act, and supported states' efforts to reduce improper payments. By the end of FY 2013, CMS exceeded its goal of expanding collaborative audits to 30 states, by assigning a cumulative total of over 500 collaborative audits with 32 states that represent approximately 72 percent of all Medicaid expenditures. More importantly, federal audits have identified over $50 million in Medicaid overpayments since inception.

  To fulfill the requirement in Section 1936 of the Social Security Act to provide support and assistance to state Medicaid program integrity efforts, CMS has conducted triennial comprehensive reviews of state program integrity operations to identify problems that warranted improvement or correction in state operations. In the reviews, CMS also highlights noteworthy state best practices. By the end of FY 2013, CMS completed 110 comprehensive program integrity reviews, including every state, Puerto Rico and the District of Columbia at least twice.

  The Medicaid Integrity Institute (MII) provides training tailored to meet the needs of state Medicaid Program Integrity employees, with the goal of raising national program integrity performance standards and professionalism. The MII is widely acclaimed by state officials, and has trained 4,278 state employees through 95 courses and six workgroups from its inception in 2008 through September 30, 2013. CMS plans to enhance the educational opportunities provided through MII in FY 2014 by expanding course offerings, and distance learning through webinars to train even more state program integrity staffing FY 2013, MII began offering a credentialing program for state Medicaid program integrity employees to certify professional qualifications. As of the end of FY 2013, 59 state employees in 28 states received the credential of Certified Program Integrity Professional. The MII also hosts the Regional Information Sharing System, which is a secure website available to state Medicaid program integrity staff across the country to share information and facilitate collaboration.

- **Medicaid Disproportionate Share Hospital (DSH) audit and reporting requirements.** Section 1001(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a requirement for states to submit an

annual independent certified audit report to CMS that verifies information about state DSH payments. The MMA also added additional requirements to annual state DSH reporting.

On December 19, 2008, CMS published a final rule implementing section 1001 of the MMA, requiring annual state reports and audits to ensure the appropriate use of Medicaid DSH payments and compliance with the DSH limit imposed at section 1923(g) of the Social Security Act.

CMS provided a transition period in the final rule to ensure a period for developing and refining reporting and auditing techniques. After the transition period (beginning with audits of state plan rate year 2011 due to CMS on December 31, 2014), FFP will not be available for expenditures for DSH payments that are found in the audit to exceed the hospital-specific DSH limit.

The CMS conducts preliminary reviews of all state audit and report submissions (state plan rate years 2005 – 2009 are complete) to ensure state compliance with federal submission requirements. In fiscal years 2011, 2012, and 2013 CMS conducted in-depth reviews of various states and hospitals throughout the country in an attempt to obtain a nationwide representation of audit implementation.

The results of the preliminary and on-site reviews will inform the development of national and state-specific guidance designed to ensure: 1) consistent national practice; 2) proper audit implementation after the regulatory transition period; and 3) the opportunity for states to develop and refine audit procedures and state DSH payment methodologies. Collectively, the review processes and associated national guidance aim to ensure the appropriateness of state DSH payments while limiting circumstances in which DSH payments that exceed federal statutory limits must be recouped from states and hospitals.

Planned Actions and Challenges

The CMS is reconfiguring the approach to the review and audit of Medicaid providers through CMS contractors. This reconfiguration includes overhauling contractor structure and improving the identification of audit targets by discontinuing activities that have not proven to be cost-effective and instituting new approaches that focus on efficient contractor structure, better Medicaid claims data, and improved coordination between Medicare and Medicaid contractors and states. Moving forward, CMS is developing a Unified Program Integrity Contractor (UPIC) strategy that restructures and consolidates the current Medicare and Medicaid program integrity audit and investigation work. The overarching goal of the UPIC is to integrate these program integrity functions by implementing a contracting strategy that improves our relationships with providers, leverages existing resources, and enhances our cooperative efforts with partners. The UPIC concept consolidates the work of the Medicaid Integrity Contractors (MICs) and the Medicare Zone Program Integrity Contractors (ZPICs), including their Medicare-Medicaid Data Match work.

FY 2014 will be a transition period in the assessment of state program integrity activities during which CMS will conduct focused reviews of high-risk program integrity areas rather than comprehensive state reviews. Focused reviews will examine areas such as managed care in Medicaid expansion states, enhanced provider screening and enrollment activities required by the Affordable Care Act, and personal care services. CMS currently plans to resume comprehensive state program integrity reviews on a four-year cycle in FY 2015.

The CMS is also working with states to assess their program integrity vulnerabilities and design appropriate strategies for improvement by:

- Evaluating states with identified vulnerabilities for participation in collaborative audit projects and joint "boots-on-the-ground" site visits to investigate appropriate provider targets and help train state staff;
- Supporting states use of corrective action plans to address vulnerabilities identified by program integrity reviews;
- Developing toolkits to address the most frequent findings observed during the comprehensive program integrity reviews;
- Providing technical assistance to improve states' program integrity capabilities by issuing best practice documents and guidance on policy and regulatory issues, and through conference calls to discuss Medicaid program integrity issues; and
- Expanding capabilities to support states with their program integrity oversight of managed care and other payment arrangements.

Support States' Efforts to Reduce Medicaid Improper Payments

Milestones

- In collaboration with the states, CMS is working to address improper payments. CMS measures improper payments annually through the Payment Error Rate Measurement (PERM) program, identifies and classifies types of errors and shares this information with each state. States then conduct an analysis to determine the root causes for improper payments to specifically identify why the errors occur, which is a necessary precursor to developing and implementing effective corrective actions. CMS works closely with states following each measurement cycle to develop state-specific corrective action plans. States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. In addition to its error rate measurement activities, CMS is implementing national and state-focused activities to decrease Medicaid and CHIP improper payments. Examples include expanded education and outreach to the provider community, state education through the MII, and review of paid claims by Medicaid Integrity Contractors (MICs). Together, these efforts will result in more accurate claim payments and a reduction of waste and abuse in the Medicaid program and CHIP.

  To support states' efforts to reduce Medicaid improper payments, CMS educates Medicaid service providers, managed care entities, Medicaid beneficiaries, and other stakeholders about issues of Medicaid program integrity and quality of care. CMS'

Education MIC collaborates with states, conducts research, performs outreach, and provides training sessions on identified topics to the targeted Medicaid audiences as approved by CMS. In early September 2013, CMS launched a new online resource for Medicaid Program Integrity Education (http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html), including print and electronic media, toolkits, train-the-trainer guides, webinars, videos, and other innovative strategies for promoting best practices and enhancing awareness of Medicaid fraud, waste, and abuse. Tools and resources available online include:

- Pharmacy Education Materials - Drug Diversion Toolkit; dosing charts and fact sheets for the top five therapeutic drug classes identified as having the highest potential improper payment rates.
- Provider Education Toolkits - Toolkits on topics including managed care, dental compliance, identity theft, drug diversion, and fraud awareness.
- Beneficiary Education Toolkits - Information on beneficiary card sharing and fraud reporting.

In addition to these online resources, CMS has conducted webinars on these topics that have been attended by program integrity staff from 51 Medicaid programs. State staff are trained to use the above resources to conduct ongoing education of providers and beneficiaries in their states on these important Medicaid program integrity issues.

The CMS has also implemented Executive Order 13520, Reducing Improper Payments, which requires that certain federal programs - including Medicaid - that already report an annual measurement of improper payments develop supplemental measures of payment error. CMS has initiated Medicaid supplemental measurement projects to more accurately reflect performance and improvement in reducing Medicaid improper payments. For example, CMS has implemented a payment accuracy improvement project in the area of pharmacy education that will measure the extent to which education targeted at physicians with aberrant prescribing practices can reduce the number of prescriptions that exceed recommended dosages. The Education MIC prepared educational materials designed to reduce overprescribing for five therapeutic drug classes that have been identified as having the highest potential improper payment rates. The educational intervention has been completed in three states, which are expected to submit results beginning in March 2013.

The FY 2013 Medicaid improper payment error rate is 5.8 percent, totaling $14.4 billion in improper payments. This represents a drop in the improper payment rate from FY 2012 (7.1 percent or $14.4 billion).[3] In addition, CMS has devoted significant effort and resources to implementing the Medicaid program integrity provisions of the Affordable Care Act. CMS has issued guidance to facilitate state implementation and reporting for provisions including the Medicaid Recovery Audit program and the final rule the Medicaid Recovery Audit program became effective on January 1, 2012. As of

[3] The 2013 national Medicaid and CHIP error rates account for two changes in the error rate calculation methodology related to recommendations from the HHS Office of Inspector General and Government Accountability Office audits.

September 30, 2013, 45 states and the District of Columbia had implemented Medicaid RAC programs. States reported a total federal and state share combined amount of Medicaid RAC recoveries of $124.3 million in FY 2013.

The CMS has granted exception for implementation delay in five states and five U. S. territories have complete exemption requests for the recovery audit program. CMS continues to provide technical assistance and support to states to facilitate the implementation of their respective recovery audit programs. For example, CMS has conducted several all-state calls and webinars covering topics such as lessons learned from the Medicare Recovery Audit program.

The CMS calculated and reported in the FY 2013 Agency Financial Report, the national CHIP error rate that is based on measurements that were conducted in fiscal years 2012 and 2013. The FY 2013 national CHIP error rate is 7.1 percent or $0.6 billion in estimated improper payments. FY 2013 was the second year of CHIP measurement since 2008 so the CHIP error rate only includes information from 34 states. A baseline CHIP error rate based on all 50 states and the District of Columbia will be reported in 2014.

Planned Action and Challenges

- To prepare for the expansion of the Medicaid program, CMS will leverage DRA funding to support the coordination of Medicaid program integrity initiatives across the agency. In FY 2014, CMS will begin a cross-component review of states' rate setting in managed care and home and community based services, including assessment of the accuracy and quality of data used by states to support rate setting. The results of these reviews will be used for CMS oversight of states' rate setting to ensure that appropriate mitigation strategies are developed and to provide information for subsequent approvals of rates for Medicaid waivers. In addition, CMS will leverage resources of the Medicaid Integrity Program during FY 2014 to improve state accountability for upper payment limit demonstrations and supplemental provider payments, including Medicaid disproportionate share hospital payments. CMS will also use a portion of DRA funding to support the development of the information technology infrastructure necessary to provide reliable data for CMS to assess expenditures, measure performance, and prevent improper payments in accordance with the priorities set by the MACBIS Council.

  The CMS continues to support state efforts to employ program integrity provisions of the Affordable Care Act to fight fraud, waste, and abuse in their Medicaid programs. For example, to facilitate states' compliance with Section 6501 of the Affordable Care Act, CMS has improved the process for sharing information on terminated providers. CMS is making the OnePI portal available to Medicaid and CHIP staff and state terminations. Moving forward, Medicaid termination letters will also be available for download. These activities combined with the other efforts of the Medicaid Integrity Program, represent a comprehensive approach to combat provider fraud and abuse.

<u>Overseeing Patient Safety and Care - Nursing Homes</u> (GAO-07-241/GAO-06-117)

Milestones

- **CMS has worked to ensure Nursing home resident health and safety:** In the 10th statement of work, Quality Improvement Organizations (QIOs) will work to reduce Healthcare Acquired Conditions (HACs) by 40 percent in nursing homes. The initial phase (Phase I) of the nursing home work included QIOs providing direct technical assistance to nursing homes with high rates of Pressure Ulcers and Physical Restraints. This Phase I work continued for the first 27 months of the QIO contract. At the eighteenth month of the contract, CMS launched a National Nursing Home Learning and Action Network called the National Nursing Home Quality Care Collaborative. The collaborative methodology assists nursing homes in further expanding their work to incorporate overall Quality Improvement practices while working to reduce high volume, high cost HACs. The identification of those HACs includes unnecessary use of Antipsychotic Medication in residents with dementia, falls, pressure ulcers, and urinary tract infections.

- **CMS has provided technical assistance on nursing home Quality Assurance and Performance Improvement Activities (QAPI):** CMS has devoted a significant effort to provide technical assistance to implement Quality Assurance and Performance Improvement (QAPI) activities within nursing homes to improve the quality of care and quality of life for residents. In June 2013, CMS launched the nursing home QAPI website, and will continue to make additional quality tools and training available for providers in the coming months.

- **CMS has released additional surveyor guidance and training regarding appropriate dementia care and the use of antipsychotic medications.** In May 2013, CMS released the third in a series of mandatory trainings for surveyors on the components of good dementia care for nursing home residents; assessments of non-compliance; and determinations of scope and severity. CMS also released revisions to the interpretive guidelines and specific surveyor worksheets to guide surveyors in activities during the survey process. All of these activities are part of the *National Partnership to Reduce the Unnecessary Use of Antipsychotic Medications* a campaign that began in early 2012.

<u>Ensuring that Medicaid Beneficiaries Obtain Adequate Access to Medical Care</u> (GAO-12-946/ GAO 13-55)

The report did not issue any specific recommendations. CMS, however, is engaged in a number of efforts, through the collection and reporting on core measures and the supporting Technical Assistance contractor, to monitor access and quality of care for Medicaid beneficiaries. We have launched two nationwide improvement efforts (one in oral health and the other in maternal and infant health) to support state efforts in improving access and quality in those areas. CMS also requires that states furnish supporting information for Medicaid access to care when implementing rate cuts to state plan services. Depending upon of the rate reductions request as

well as potential issues presented in the state information, CMS may require states to implement plans to monitor data and make necessary adjustments to address access issues that arise after approval of the reductions.