

Medicare and
Medicaid Integrity
Programs

FY 2018
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Executive Summary

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2018 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report the use of appropriated funds and the effectiveness of the use of such funds for Medicare and Medicaid program integrity activities.¹

CMS is working to ensure that public funds are not diverted from their intended purpose: making accurate payments to legitimate entities for allowable services or activities on behalf of eligible beneficiaries of federal health care programs.

Medicaid and CHIP Program Integrity

States and the federal government share mutual obligations and accountability for the integrity of Medicaid and the Children's Health Insurance Program (CHIP). This includes the application of effective safeguards to ensure the proper and appropriate use of both federal and state dollars and the provision of quality care to some of the nation's most vulnerable populations. Recent years have seen a rapid increase in Medicaid spending at both the state and national levels, driven by several factors, including Medicaid expansion. While the responsibility for making proper payments in Medicaid primarily lies with the states, CMS plays a significant role in supporting state efforts to meet high program standards. **In FY 2018, federal and state collaborative program integrity efforts for Medicaid and CHIP resulted in estimated federal share² savings of \$1.3 billion (see Table 4 for activity-specific savings).**³

CMS believes that states understand best the unique needs of their residents and has committed to restoring balance to the federal and state partnership. CMS is fulfilling its commitment to flexibility through efforts that include relieving burdensome regulatory requirements, processing waivers and State Plan Amendments more quickly, and opening new avenues to state-led reforms through demonstrations. However, CMS must balance this new flexibility with a system

¹ Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Act and not all Medicaid program integrity activities are funded under section 1936 of the Act. As such, this report includes other Medicare and Medicaid program integrity activities to provide a more complete view of CMS's program integrity activities. For example, where applicable in this report, we have described activities conducted by the program integrity units of the states that enhance the overall integrity of the Medicaid program, even if they are not funded under section 1936 of the Act. In addition, for the purposes of this document, the term "provider" may refer to a provider, supplier, physician, or non-physician practitioner, and the term may represent an individual or an organization.

² The federal government and states jointly fund the Medicaid program. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). Therefore, program-integrity-related activities in Medicaid result in savings for both states and the federal government. As of FY 2018, CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

³ FY 2018 is the first year that CMS includes savings from the Medicaid and CHIP financial management project in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. In previous years, CMS reported on the project in the Health Care Fraud and Abuse Control Program Annual Report.

that holds states accountable for producing improvements in program outcomes, as well as appropriate federal and state oversight of program integrity to protect taxpayers.

In June 2018, CMS announced new and enhanced initiatives that create greater transparency in, and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states to protect taxpayer dollars. The initiatives in the Medicaid Program Integrity Strategy are based on the three pillars of flexibility, accountability, and integrity. To do so, the strategy includes stronger audit functions and oversight functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules.⁴ CMS also continued its supports of state program integrity activities in FY 2018 by providing education and training opportunities through the Medicaid Integrity Institute.

Medicare Program Integrity

CMS is committed to putting patients first in all of our activities and programs. To better empower patients and doctors, CMS must balance program integrity initiatives aimed at protecting beneficiaries and the Medicare Trust Funds with minimizing provider burden. In FY 2018, CMS continued to implement tools and work with law enforcement partners and other key stakeholders to help focus on prevention, early detection, and data sharing to prevent and reduce improper payments and promote program integrity.

In FY 2018, CMS's program integrity activities, including both the prevention and recovery of improper payments, saved Medicare an estimated \$12.0 billion and produced a return on investment of \$8.3 to 1 (see Table 3 for activity-specific savings).⁵ These activities help strengthen the integrity and sustainability of the Medicare program, while promoting quality and the efficient delivery and financing of health care.

Coordinated Activities in Program Integrity

CMS coordinates closely with a variety of other partners to meet its program integrity objectives, including, but not limited to, the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Department of Justice (DOJ), state law enforcement officials including those from state Medicaid Fraud Control Units (MFCUs), clinicians, and other federal agencies. Specifically, in FY 2018 CMS began a Major Case Coordination initiative that includes representation from the HHS-OIG, DOJ, and CMS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after the development of fraud leads.

⁴ <https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility>

⁵ In FY 2018, CMS updated the methodologies for specific Medicare savings metrics; thus, due to differing methodologies, some FY 2018 Medicare savings amounts are not directly comparable to amounts in previous reports. Appendix B of the FY 2018 Report to Congress on the Medicare and Medicaid Integrity Program provides information regarding which savings metrics underwent methodological changes.

JUNE 2018 HEALTH CARE FRAUD TAKEDOWN

In June 2018, the Attorney General of the United States, the Secretary of HHS, the HHS Office of Inspector General (HHS-OIG), the Centers for Medicare & Medicaid Services (CMS), and the Center for Program Integrity (CPI) at CMS announced a health care fraud enforcement action involving 601 charged defendants, including 165 doctors, nurses and other licensed medical professionals for their alleged participation in health care fraud schemes involving more than \$2 billion in false billings.

The 2018 takedown featured a large-scale federal and state partnership to combat health care fraud and the opioid epidemic. Enforcement activities took place across the nation, representing the largest multi-agency enforcement operation to date, both in terms of the number of defendants charged and loss amount.⁶

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public/private partnership between the federal government, state agencies, law enforcement entities, private health insurance plans, employer organizations, and health care anti-fraud associations. The purpose of the HFPP is to foster a proactive approach to detect and prevent health care fraud through the voluntary sharing of data and information between the public and private sectors. In FY 2018, the HFPP reached a membership level of 112 Partner organizations that includes public, private, and state partners. During FY 2018, the HFPP completed a number of studies using multiple partner data to address fraud, waste, and abuse. The HFPP held quarterly Regional Information Sharing Sessions throughout FY 2018. These sessions allow Partners to participate in case sharing sessions, listen to panel discussions, receive updates from law enforcement, and collaborate with members from across the Partnership. In May 2018, the HFPP released a white paper entitled “Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership”.⁷ In May 2018, the Partnership also hosted its annual Executive Board meeting, which focused on strategies to streamline, strengthen, and grow the Partnership, including a call to action to broaden the HFPP’s impact.

⁶ https://oig.hhs.gov/newsroom/media-materials/2018/takedown/2018HealthCareTakedown_FactSheet.pdf

⁷ The Healthcare Fraud Prevention Partnership white paper is available at <https://hfpp.cms.gov/hfpp-white-papers/hfpp-clinical-lab-services-white-paper.pdf>

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1. Introduction

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2018 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report the use of appropriated funds and the effectiveness of the use of such funds for activities conducted under the Medicare and Medicaid Integrity Programs.

Program integrity in Medicare and Medicaid concentrates on reducing improper payments, by either preventing or recovering erroneous payments. While fraud and abuse are also improper payments, it is important that not all improper payments constitute fraud, and improper payment estimates do not correlate to a rate of fraud.

CMS is the agency within the Department of Health and Human Services (HHS) responsible for administering the Medicare program consistent with title XVIII of the Act. CMS is also responsible for providing direction and guidance to, and oversight of, state-operated Medicaid programs and Children's Health Insurance Programs (CHIP) consistent with titles XIX and XXI of the Act, respectively, in addition to other federal health care programs and activities. The Medicare and Medicaid Integrity Programs help protect Medicare and Medicaid against improper payments and fraud, waste and

abuse.

The Medicare and Medicaid programs provide coverage for a large proportion of Americans each year. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 59 million beneficiaries in FY2018, while Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 73 million beneficiaries.⁸

The Center for Program Integrity (CPI) is primarily responsible for implementation of the Medicare Integrity Program and the Medicaid Integrity Program in CMS. While other areas of CMS also engage in program integrity-related activities,⁹ this report focuses on the program integrity activities led by, or which included significant involvement by CPI.

⁸ The 2018 CMS Agency Financial Report can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFORReport/Downloads/2018_CMS_Financial_Report.pdf

⁹ For example, the Office of Financial Management, the Center for Medicaid and CHIP Services, and the Center for Medicare also perform program integrity activities, such as the Medicare Secondary Payer (MSP) program and certain improper payment measurement programs.

During FY 2018, program integrity efforts resulted in estimated Medicare savings of \$12.0 billion and estimated Medicaid and CHIP federal share¹⁰ savings of \$1.3 billion,¹¹ thus demonstrating the effectiveness of CMS’s comprehensive approach to program integrity. This commitment to fiscal integrity allows CMS to focus on efforts to better serve patients and ensure that providers render high quality care. Section 1.3 of this report provides activity-specific Medicare, Medicaid, and CHIP savings, and Appendix B provides detailed methodologies for all savings metrics.

CMS Strategic Goals

To help achieve CMS’s overarching goal of putting patients first, CMS continuously works to meet its four strategic goals, which cut across programs and support functions throughout CMS to improve the quality and affordability of health care.¹²

1. Empower patients and doctors to make decisions about their health care.

When people are in charge of their health care, outcomes are better. CMS’s goal is to empower people to take ownership of their health care by ensuring that they have the information they need to make informed choices. We continue to bring our dedication, creativity, and compassion to all CMS’s work and initiatives.

2. Usher in a new era of state flexibility and local leadership.

Extending to states the freedom to design Medicaid programs that work for them allows them to meet the unique needs of their residents. CMS must ensure that we give states and their local communities the flexibility they need to design innovative, fiscally responsible programs for all of their populations.

CMS is supporting states by **promoting transparency and accountability, strengthened data, and innovative and robust analytic tools in Medicaid programs.**

3. Support innovative approaches to improve quality, accessibility, and affordability.

¹⁰ The Medicaid program is jointly funded by the federal government and states. The federal government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). Therefore, program-integrity-related activities in Medicaid result in savings for both states and the federal government. As of FY 2018, CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

¹¹ FY 2018 is the first year that CMS includes savings from the Medicaid and CHIP financial management project in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. In previous years, CMS reported on the project in the Health Care Fraud and Abuse Control Program Annual Report.

¹² In October 2019, CMS has developed a five-pillar program integrity strategy to modernize the Agency’s approach and protect its programs for future generations. These pillars, which will be described in additional detail in the FY 2019 Annual Report to Congress, include stopping bad actors, preventing fraud, mitigating emerging programmatic risks, reducing provider burden, and leveraging new technology. Additional information can be found at <https://www.cms.gov/blog/future-medicare-program-integrity>.

By using data-driven insights, CMS must always search for new ways to provide cost-effective care that improves patients' outcomes, including the use of value-based payments. CMS also has countless ways to support and drive innovation and enhance our use of technology to prevent fraud, waste, and the abuse of taxpayer dollars. CMS supports the development of innovative payment models through the application of risk assessments to identify potential vulnerabilities for fraud, waste, and abuse.

To support its program integrity efforts, CMS must **integrate, analyze, and share data to inform decision-making as the use of value-based payments and health care technology continue to grow.**

4. Improve the CMS customer experience.

Transforming to a patient-first perspective is not just about whom we serve, but how we serve all of our customers. We have a distinct role in how effectively services are rendered to our customers including beneficiaries, providers, states, and other stakeholders.

From a program integrity perspective, it is important for CMS to **clarify and simplify program requirements through collaboration, transparency, outreach, and education.**

CMS organized this report around these strategic goals, with each section detailing specific aspects of CMS's program integrity efforts. Four appendices at the end of this report provide additional information and references.

1.1. Reporting Requirements

This report fulfills the reporting requirements with respect to the Medicare and Medicaid Integrity Programs, the Medicare Fee-for-Service (FFS) Recovery Audit Contractors, the Medicare Advantage (MA or Part C) and Medicare Prescription Drug Part D Program (Part D) Recovery Audit Contractors, and the Medicaid Recovery Audit Contractors.¹³

As required by sections 1893(i)(2) and 1936(e)(5) of the Act, CMS must report to Congress the use of appropriated funds and the effectiveness of the use of such funds for activities conducted under the Medicare and Medicaid Integrity Programs.¹⁴ Section 1893(h)(8) of the Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare and Medicaid, including

¹³ CMS is subject to other requirements to report to Congress, such as on the use of Health Care Fraud and Abuse Control program funds. This report details activities that may also be subject to other reporting requirements.

¹⁴ Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Act and not all Medicaid program integrity activities are funded under section 1936 of the Act. As such, this report includes other Medicare and Medicaid program integrity activities to provide a more complete view of CMS's program integrity activities. For example, where applicable in this report, we have described activities conducted by the program integrity units of the states that enhance the overall integrity of the Medicaid program.

information on the performance of such contractors on identifying underpayments and overpayments and recouping overpayments, and an evaluation of the comparative performance of such contractors and savings to the program.

Medicare Funding

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)¹⁵ established mandatory funding for the Medicare Integrity Program, which provided a stable funding source for Medicare program integrity activities not subject to annual appropriations. The Patient Protection and Affordable Care Act¹⁶ increased the base funding level and applied an annual inflationary adjustment to that base funding level. This funding supports program integrity functions performed across CMS, including: Audits, Medicare Secondary Payer (MSP), Medical Review, Provider Outreach and Education, Benefit Integrity, and Provider Enrollment.

CMS receives additional mandatory funding under the Deficit Reduction Act of 2005 (DRA)¹⁷ and the Patient Protection and Affordable Care Act of 2010, as well as discretionary Health Care Fraud and Abuse Control (HCFAC) program funding, subject to annual appropriation. CMS obligated a total of \$1.4 billion in FY 2018 for the Medicare Integrity Program.

Medicaid Funding

The DRA added section 1936 to the Act to establish the Medicaid Integrity Program and provided CMS with dedicated funding to operate the program. Under section 1936 of the Act, Congress appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. Beginning in FY 2011, the Patient Protection and Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.¹⁸ CMS obligated a total of \$84.4 million in FY 2018 for the Medicaid Integrity Program. In addition, CMS obligated a total of \$88.8 million in FY 2018 for Medicaid program integrity activities using discretionary HCFAC funds.

Appendix A provides further information on the obligations for program integrity activities for both Medicare and Medicaid. Please note that this report includes activities funded outside of the Medicare or Medicaid Integrity Programs. Activities such as CMS Innovation Center models, the Medicare Shared Savings Program (MSSP), and the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity.

¹⁵ Public Law 104-191.

¹⁶ Public Law 111-148 and Public Law 111-152 collectively constitute the Patient Protection and Affordable Care Act.

¹⁷ Public Law 109-171.

¹⁸ 42 U.S.C. 1396u-6(e)(1)(D).

1.2. Program Integrity in Medicare and Medicaid

CMS is the largest purchaser of health care in the world. Based on the latest 2018 projections, Medicare and Medicaid (including state funding) represent 37 cents of every dollar spent on health care in the United States — or, looked at from three different perspectives: 54 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 34 cents of every dollar spent on physician services.¹⁹

Medicare processes over one billion fee-for-service (FFS) claims a year, and accounts for approximately 15 percent of the federal budget. Since 1966, Medicare enrollment has increased from 19 million to over 59 million beneficiaries.²⁰

States and the federal government jointly fund the Medicaid program, as CMS provides specified matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid is the primary source of health care for more than 73 million beneficiaries, – or 22 percent of the U.S. population. Over 11.2 million people are dually eligible, that is, covered by both Medicare and Medicaid.²¹

As required by law, CMS and state Medicaid agencies procure contractors to conduct certain program integrity activities in the Medicare and Medicaid programs. Table 1 below summarizes each contractor and its distinct role and responsibility.

¹⁹ [CMS Financial Report Fiscal Year 2018, at page 2.](#)

²⁰ [Id. at page 2](#)

²¹ [Id. at page 3.](#)

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Zone Program Integrity Contractors (ZPICs) ²²	Medicare FFS	<ul style="list-style-type: none"> • Investigate leads generated by the Fraud Prevention System (FPS) and complaints from beneficiaries and a variety of other sources • Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse • Make recommendations to CMS for appropriate administrative actions (i.e., revocations and suspensions) to protect Medicare Trust Fund dollars • Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the Medicare Administrative Contractors (MACs) • Conduct medical review for program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exists within their respective jurisdictions • Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the FPS • Identify improper payments to be recovered
Unified Program Integrity Contractors (UPICs)	Medicare FFS and Medicaid	<ul style="list-style-type: none"> • Investigate leads generated by the FPS and complaints from beneficiaries and a variety of other sources • Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid • Make recommendations to CMS or states for appropriate administrative actions (i.e., revocations and suspensions) to protect Medicare Trust Fund and Medicaid dollars • Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the MACs • Conduct medical review for Medicare and Medicaid program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exist in Medicare and Medicaid • Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the Unified Case Management System • Identify improper payments to be recovered within Medicare and Medicaid

²² In FY 2018, CMS completed transitioning Medicaid and Medicare Program Integrity contracts to UPICs, which combined the functions of ZPICs and Medicaid Integrity Contractors (MICs).

Contractor	Program	Program Integrity Responsibilities
Medicare Administrative Contractors (MACs)	Medicare FFS	<ul style="list-style-type: none"> • Determine proper payment amounts, process and pay providers, suppliers, and individuals • Perform provider and supplier screening and enrollment • Audit the Medicare cost reports upon which CMS bases part of Medicare payments to institutional providers, such as hospitals and skilled nursing facilities • Conduct prepayment, post-payment medical review, and prior authorization • Analyze claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims types • Develop and implement prepayment edits • Provide beneficiary, provider, and supplier education, outreach, and technical assistance • Collect overpayment amounts identified through prepayment and post-payment review conducted by the MACs and other review contractors
Supplemental Medical Review Contractor (SMRC)	Medicare FFS	<ul style="list-style-type: none"> • Conducts nationwide medical review as directed by CMS • Notifies CMS and the MACs of identified improper payments and noncompliance with documentation requests
Medicare FFS Recovery Audit Contractors (RACs)	Medicare FFS	<ul style="list-style-type: none"> • Conduct post-payment audits to identify a wide range of improper payments • Improper payments are corrected by collecting identified overpayments and restoring identified underpayments • Make recommendations to CMS about how to reduce improper payments in the Medicare FFS program
Coordination of Benefits & Recovery (COB&R) Contractors	Medicare FFS Secondary Payer	<ul style="list-style-type: none"> • Identify, develop, and recover Group Health Plan and Non-Group Health Plan debts • Provide customer service to beneficiaries, providers, attorneys, insurers, and employers • Perform data collection and electronic data interchange • Conduct business analysis, quality assurance activities, and outreach and education to stakeholders • Provide system development and data center support for all coordination of benefits and recovery information systems
National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)	Medicare Part C and Part D	<ul style="list-style-type: none"> • Conduct data analyses of Part C and Part D issues leading to potential identification of improper payments and regulatory compliance • Coordinate Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement entities • Support CMS enforcement of Part C and Part D plan sponsors' compliance and fraud audits of providers
Part D RAC	Medicare Part D	<ul style="list-style-type: none"> • Conduct post-payment reviews of reconciled Part D Prescription Drug Events (PDEs) data to identify a wide range of improper payments

Contractor	Program	Program Integrity Responsibilities
State Medicaid RACs	Medicaid FFS and Managed Care	<ul style="list-style-type: none"> Contracted by state Medicaid agencies (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers
Audit Medicaid Integrity Contractors (MICs) ²³	Medicaid FFS and Managed Care	<ul style="list-style-type: none"> Conduct post-payment audits of all types of Medicaid providers and report identified overpayments to states for recovery Provide support to states for hearings and appeals of audits conducted under assigned task order(s) Phased out in early 2018

1.3. Measuring Program Integrity Success

1.3.1. Improper Payment Rates

As required by the Improper Payments Information Act of 2002 (IPIA), as amended,²⁴ CMS calculates an improper payment rate for Medicare FFS, Part C, and Part D; Medicaid; and CHIP. Table 2 provides the gross improper payment rates (including both overpayments and underpayments) and summarizes trends in the improper payment rates since 2012.²⁵ Section 5.1 of this report provides specific information on how each program measures improper payment.

Table 2: Reported Improper Payment Rates Trend for Reporting Years 2012-2018

Program	2012	2013	2014	2015	2016	2017	2018
Medicare FFS	8.5%	10.1%	12.7%	12.1%	11.0%	9.5%	8.1%
Part C	11.4%	9.5%	9.0%	9.5%	10.0%	8.3%	8.1%
Part D	3.1%	3.7%	3.3%	3.6%	3.4%	1.7%	1.7%
Medicaid	7.1%	5.8%	6.7%	9.8%	10.5%	10.1%	9.8%
CHIP	8.2%	7.1%	6.5%	6.8%	8.0%	8.6%	8.6%

While this report discusses many of the ways that CMS works to reduce the improper payment rates for Medicare, Medicaid, and CHIP, the FY 2018 HHS Agency Financial Report (AFR) also includes a comprehensive overview of the improper payment rates for

²³ In FY 2018, CMS completed transitioning Medicaid and Medicare Program Integrity contracts to UPICs, which combined the functions of ZPICs and Medicaid Integrity Contractors (MICs).

²⁴ Public Law 107-300, Public Law 111-204, and Public Law 112-248, respectively.

²⁵ After the enactment of Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), CMS began reporting the improper payment rates for CHIP in 2012. The 2012 and 2013 CHIP rates do not include results of all states. The 2012 CHIP rate represents one cycle because only 17 states had been sampled at that time. The 2013 CHIP rate represents two cycles because only 34 states had been sampled at the time. Beginning in and following 2014, the CHIP rate represents all three cycles of states.

CMS programs, as well as the corrective actions implemented in FY 2017 to reduce improper payments.²⁶

1.3.2. Medicare Savings

In FY 2018, CMS's Medicare program integrity activities saved an estimated \$12.0 billion.²⁷ This represents a return on investment of \$8.3 to 1.²⁸ Overall, 79.9 percent of the savings in FY 2018 resulted from the prevention of improper payments, while the remainder resulted from the recovery of improper payments. CMS provides activity-specific Medicare program integrity savings in Table 3, programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

²⁶ <https://www.hhs.gov/sites/default/files/fy-2018-hhs-agency-financial-report.pdf>, at page 194.

²⁷ In FY 2018, CMS updated the methodologies for specific Medicare savings metrics; thus, due to differing methodologies, some FY 2018 Medicare savings amounts are not directly comparable to amounts in previous reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

²⁸ The fiscal year return on investment for the Medicare Integrity Program is calculated by dividing the total Medicare savings by the total Medicare obligations.

Table 3: Medicare Savings

Type of Medicare Savings ^{a, b}	FY 2018 Savings (in millions)
Prevention Savings	
Automated Actions	
National Correct Coding Initiative (NCCI) Procedure-to-Procedure Edits	\$235.1
NCCI Medically Unlikely Edits	\$391.0
Ordering and Referring Edits	\$93.4
Fraud Prevention System Edits	\$57.8
MAC Automated Medical Review Edits	\$661.1
ZPIC/UPIC Automated Edits	\$36.5
Prepayment Review Actions	
Medicare Secondary Payer (MSP) Operations	\$7,666.5
MAC Non-Automated Medical Reviews	\$98.3
ZPIC/UPIC Non-Automated Reviews	\$34.1
Provider Enrollment Actions	
Revocations	\$225.6
Deactivations	\$107.6
Other Actions	
Medicare Part D Reconciliation Data Reviews	\$8.5
Total Prevention Savings ^c	\$9,615.6
Recovered Savings	
Overpayment Recoveries	
MSP Operations	\$1,056.2
MSP Commercial Repayment Center	\$125.3
MAC Post-Payment Medical Reviews	\$0.7
Medicare FFS RAC Reviews	\$58.1
SMRC Reviews	\$113.0
ZPIC/UPIC Post-Payment Reviews	\$191.5
Retroactive Revocations	\$0.3
Overpayments Related to Risk Adjustment Data	\$66.8
Medicare Part D Plan Sponsor Audits	\$37.0
Medicare Part D RAC Reviews	\$4.5
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	\$447.1
Cost-Based Plan Audits	\$2.3
Plan Penalties	
Medicare Part C and Part D Program Audits	\$3.0
Medical Loss Ratio Requirement	\$242.4
Other Actions	
Party Status Appeals	\$26.1
Law Enforcement Referrals	
ZPIC/UPIC Law Enforcement Referrals	\$32.8
NBI MEDIC Part C Law Enforcement Referrals	\$2.5
NBI MEDIC Part D Law Enforcement Referrals	\$10.0
Total Recovered Savings ^c	\$2,419.8
Total Savings (Prevention and Recovered)	\$12,035.4

^a Appendix B provides detailed methodologies for all metrics listed in this table.

^b The Midwestern and Northeastern UPIC jurisdictions were operational throughout FY 2018. Five ZPIC zones remained active until the Southeastern, Southwestern, and Western UPIC jurisdictions became operational in the third quarter of FY 2018.

^c Savings values do not add to totals due to rounding.

1.3.3. Medicaid and CHIP Savings

States and CMS share responsibility for Medicaid and CHIP program integrity, thus ensuring proper use of both federal and state dollars. As such, CMS and the states collaborate to combat improper payments through multiple strategies. CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from the Medicaid and CHIP financial management project and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. In FY 2018, these efforts resulted in estimated federal share²⁹ savings of \$1.3 billion. CMS provides activity-specific Medicaid and CHIP federal share savings in Table 4,³⁰ programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

Table 4: Medicaid and CHIP Savings

Type of Medicaid and CHIP Savings ^a	FY 2018 Federal Share Savings (in millions)
Medicaid and CHIP Financial Management Project ^b	
Averted Medicaid and CHIP Federal Financial Participation	\$507.2
Recovered Medicaid and CHIP Federal Financial Participation	\$357.8
State-Reported Medicaid Overpayment Recoveries	
Audit MIC/UPIC Recoveries ^c	\$14.3
State Medicaid RAC Recoveries	\$47.6
Office of Inspector General Compliant False Claims Act Recoveries	\$8.1
Other State Program Integrity Recoveries	\$350.9
Total Savings	\$1,285.9
^a Appendix B provides detailed methodologies for all metrics listed in this table.	
^b FY 2018 is the first year that CMS includes savings from the Medicaid and CHIP financial management project in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. In previous years, CMS reported on the project in the Health Care Fraud and Abuse Control Program Annual Report.	
^c Audit MICs operated for part of FY 2018, until CMS completed the transition from Audit MICs to UPICs.	

²⁹ As of FY 2018, CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

³⁰ Medicaid savings may differ in the HHS Agency Financial Report compared to the Report to Congress on the Medicare and Medicaid Integrity Programs because CMS accessed the data from Form CMS-64 at different points in time.

2. Empower Patients and Doctors to Make Decisions about Their Health Care

Balance Program Integrity Initiatives Aimed at Protecting Beneficiaries and the Medicare Trust Funds while Minimizing Provider Burden

2.1. Medicare Fee-for-Service Medical Review

Consistent with sections 1815(a), 1833(e), 1862(a)(1), and 1893 of the Act, CMS is required to protect the Medicare Trust Funds by taking corrective actions to prevent and reduce improper payments. CMS contracts with a variety of medical review contractors, including the MACs and SMRC, to perform medical review for claims paid by the Medicare FFS program.³¹ Medical review involves both automated and manual processes to ensure that only claims for items and services that meet all Medicare coverage, payment, and coding requirements are paid. Medical review activities concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing (CERT) results, and oversight agency findings that indicate questionable billing patterns. CMS continues to enhance medical review efforts and encourages the MACs to incorporate increased provider feedback processes, such as one-on-one education and medical review results notifications that incorporate more detail in an effort to encourage proper billing.

Targeted Probe and Educate

CMS's Targeted Probe and Educate (TPE) program helps providers and suppliers reduce claim denials and appeals through one-on-one education by the MAC. As part of TPE, the MACs focus on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the conclusion of each round. Providers/suppliers are also offered individualized education during each round of review to more efficiently fix simple problems. The goal of TPE is to help providers and suppliers quickly improve their ability to meet Medicare's payment policies. TPE also reduces burden on those providers and suppliers who, based on data analysis, are already submitting claims that are compliant with Medicare policy.³² TPE began as a pilot focused on home health claim reviews in the fall of 2017, and in FY 2018 expanded to all MAC jurisdictions for other items and services.

Supplemental Medical Review (Post-payment)

The role of the SMRC is to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rate. One of the SMRC's primary tasks is conducting nationwide

³¹ The ZPICs/UPICs also perform medical review, as discussed in section 2.3, as well as the Recovery Audit Contractors, as discussed in section XX.

³² *Targeted Probe and Educate Qs & As* can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/TPE-QAs.pdf>

medical review of Medicare Part A, Part B and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims as directed by CMS. The focus of the reviews may include, but are not limited to, issues identified by CMS internal data analysis, the CERT program, professional organizations, and other Federal agencies, such as the OIG/GAO. Medical records and related documents are reviewed to determine whether claims were billed in compliance with Medicare's coverage, coding, and payment rules.

In FY2018, medical review activities continued on a small scale to facilitate contract closure and the procurement and award of a new contract. The scope of the new SMRC contract was expanded to provide support to a variety of CPI initiatives. Under the new contract, the SMRC will provide nationwide medical review activities to support program integrity efforts to identify potential fraud, waste and abuse as well as to provide support to Healthcare Fraud Prevention Partnership (HFPP) efforts to reduce health care fraud, waste and abuse across public-private sectors. The SMRC will continue to perform medical review activities to support the work of the OIG/GAO and CERT program as well as work performed by CMS.

2.2. Unified Program Integrity Contractors

One way CMS investigates instances of suspected fraud, waste, and abuse in Medicare, as well as Medicaid, is through the activities of the UPICs. The UPICs develop investigations and take actions to prevent inappropriate payments from being made to Medicare providers and suppliers. UPICs undertake activities including provider and beneficiary interviews and site visits, initiating appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and performing program integrity review of medical records and documentation. While a variety of other contractors also perform medical review, UPIC reviews are uniquely focused on fraud detection and investigation. For example, the UPICs look for possible falsification of documents that may be associated with an attempt to defraud the Medicare program.

Various UPIC administrative actions result in Medicare savings, including automated edit claim denials, non-automated review claim denials, provider revocations and deactivations, overpayment recoveries, and law enforcement referrals.³³ In addition, in FY 2018, the UPICs implemented 373 payment suspensions based upon reliable information that an overpayment existed or credible allegations of fraud.

The FPS is one source of leads for UPICs. The FPS is a predictive analytics technology required by the Small Business Jobs Act of 2010, and it runs sophisticated algorithms against Medicare FFS claims nationwide. When FPS models identify aberrant activity or patterns, the system automatically generates and prioritizes leads for further review and investigation by UPICs. Based on the results of all information collected, the UPICs coordinate with CMS and the MACs in taking appropriate administrative action to recover improper payments and prevent future loss of funds, or the UPICs refer the case to law enforcement.³⁴

³³ Table 3 provides ZPIC/UPIC savings, which include the amounts for ZPIC/UPIC automated edits, non-automated reviews, post-payment reviews, and law enforcement referrals, as well as portions of the amounts for revocations and deactivations.

³⁴ ZPIC/UPIC savings in Table 3 include amounts attributable to FPS leads.

UPIC Transition

In FY 2016, CMS began consolidating the Medicare and Medicaid program integrity functions performed by the predecessor investigative ZPICs, including Medicare-Medicaid Data Match (Medi-Medi) activities, and the Audit Medicaid Integrity Contractors (MICs)³⁵ into the UPIC contracts. The UPICs merge these separate contracting functions into a single contractor with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations in a specific geographic area.

In FY 2018, CMS finalized the awards for the remaining UPIC jurisdictions. Currently all UPICs are fully operational and are carrying out program integrity activities.

Table 5: Unified Program Integrity Contractors Transition Schedule

UPIC Jurisdiction	Contractor	Award Date	Operational Date
Midwestern	AdvanceMed Corporation	6/1/16	10/20/17
Northeastern	SafeGuard Services LLC	11/1/16	2/1/17
Western	Qlarant Integrity Solutions	2/16/17	5/1/18
Southeastern	SafeGuard Services LLC	8/4/17	6/1/18
Southwestern	Qlarant Integrity Solutions	9/15/17	4/1/18

Medicaid

To better coordinate Medicare and Medicaid program integrity audit and investigation work, in FY 2018 CMS completed its shift of Audit MIC workload to the UPICs. More information on the National Medicaid Audit Program is in section 3.4.

2.3. Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program ensures that when Medicare is a secondary payer (the provider of coverage that pays after another “primary” insurance), Medicare does not pay, or recovers Medicare funds that were paid conditionally, once another individual or entity is determined to be primarily responsible for payment.

³⁵ More information on the National Medicaid Audit Program, including the UPIC’s role in Medicaid program integrity, can be found in section 3.4.

Medicare, Medicaid, and SCHIP Extension Act

Sections 1862(b)(7) and (8) of the Act, as added by section 111 of the Medicare, Medicaid, and SCHIP (State Children’s Health Insurance Program) Extension Act of 2007 (MMSEA),³⁶ added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under Group Health Plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers’ compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance. The mandatory insurer reporting requirements continue to be the primary source of new MSP information reported to CMS from group health plans and other insurers, and the annual number of new MSP records posted to CMS’s systems remains more than twice the number posted before this provision's implementation.

Commercial Repayment Center (CRC) Recovery Auditors

The Commercial Repayment Center (CRC) Recovery Auditor recovers Part A and Part B payments made by the Medicare program when another entity had primary payment responsibility. There are two broad situations where the CRC makes recoveries. The first is when a beneficiary has or had coverage through an employer-sponsored GHP. The CRC generally recovers Medicare’s mistaken payments in this situation from employers. The second situation is the recovery of certain conditional payments where an applicable plan (a Non-GHP entity such as a liability insurer, no-fault insurer, or workers’ compensation entity) had primary payment responsibility. In this situation, the CRC recovers Medicare payments from the applicable plan.

2.4. Part C and Part D Program Integrity

2.4.1. Medicare Drug Integrity Contractor

The National Benefit Integrity Medicare Drug Integrity Contract (MEDIC) is CMS’s benefit integrity contractor tasked with detecting and preventing fraud, waste, and abuse in Medicare Advantage (MA) and Part D. The MEDIC supports CMS’s efforts through a variety of functions including investigations and referrals of potential cases of fraud to law enforcement, proactive data and investigative analysis, identification of potential program vulnerabilities to CMS, and health plan audits. As part of its work, the MEDIC identifies trends, anomalies, and questionable provider and pharmacy practices, including aberrant opioid prescriptions. Examples include:

- Quarterly Pharmacy Risk Assessment, which categorizes pharmacies as high, medium, or low risk
- Outlier Prescriber Assessment, which provides a peer comparison of the prescribing of Schedule II controlled substances
- Pill Mill Doctor Project, which identifies prescribers with a high risk of fraud, waste and abuse in prescribing Schedules II-IV controlled substances

³⁶ Public Law 110-173.

- Improper payments for drugs inappropriately paid under the Part D program without a medically accepted indication (e.g., Transmucosal Immediate Release Fentanyl³⁷)

CMS is addressing the issue of drug diversion by identifying consistent thresholds across programs to flag providers as “high prescribers” and patients as “high utilizers” who may require additional scrutiny. The MEDIC assists law enforcement and Part C and Part D plans in addressing drug diversion through data analysis and results of the Pill Mill Doctor Project. For example, in responding to requests for information from law enforcement, the MEDIC is conducting invoice reconciliations, impact calculations, and reviews of medical records.

In April 2015, CMS and the MEDIC launched the Predictive Learning Analytics Tracking Outcome (PLATOTM) system. PLATOTM is a voluntary, web-based tool designed to assist MA and Part D plan sponsors in identifying and addressing potential fraud, waste, and abuse, as well as to encourage information sharing between plan sponsors and CMS.

By providing users with monthly-updated national Part D summary information, PLATOTM yields an overall picture of provider activity and allows plan sponsors to identify suspicious pharmacies and providers, and overcomes the constraint of plan sponsors being limited to only their drug claims processing information. In addition, PLATOTM provides plan sponsors with the opportunity to report their administrative and investigative actions taken against subjects, which serves to alert other plan sponsors to questionable activity. Examples of actions that may be entered into PLATOTM include terminations, payment suspensions, post-payment reviews, and referrals to law enforcement. CMS’s federal law enforcement partners also use PLATOTM.

2.4.2. Part C and Part D Program Oversight

In FY 2018, CMS continued to strengthen MA and Part D oversight. As part of the program integrity oversight of MA and Part D programs, CMS evaluates plan sponsors’ operations for compliance with federal regulations and guidance. All MA and Part D plan sponsors are required to have an effective program to prevent, detect, and correct MA and Part D non-compliance and fraud, waste, and abuse. These programs consist of written policies, procedures, and standards that articulate the organizations’ commitment to complying with all applicable federal and state standards, including the prevention and detection of fraud and abuse in the MA and Part D programs. Specifically, MA and Part D plan sponsors must have a properly trained, compliance officer vested with the daily operations of the compliance program, provisions for internal monitoring and auditing, and oversight of their first-tier downstream and related entities, as well as other requirements. Plan sponsors’ compliance programs must include measures to prevent, detect, and correct noncompliance with CMS’ program requirements, as well as measures that prevent, detect, and correct fraud, waste, and abuse. In FY 2018, CMS continued to enhance its data analytic capabilities and improved coordination with law enforcement to provide a more comprehensive assessment of program integrity activities in the MA and Part D programs.

³⁷ *CMS Opioid Misuse Strategy 2016*, available at <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf>.

2.4.3. Medicare Part C and Part D Marketing Oversight

CMS takes compliance action against MA organizations and Part D plans, Section 1876 Cost Plans,³⁸ and Medicare-Medicaid Plans that fail to send timely and accurate Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents to Medicare enrollees. The ANOC provides Medicare enrollees with a description of changes in the enrollee's existing coverage, costs, or service area that will become effective the following January. The EOC details health care benefits covered by the plan, available services, and cost sharing. Both documents provide Medicare enrollees with vital information that can influence their ability to make informed choices concerning their Medicare health care and prescription drug options.

CMS performs annual timeliness reviews of ANOC documents and accuracy reviews of ANOC and EOC documents to ensure that Medicare enrollees receive accurate information within specified deadlines. CMS issues notices, such as Notices of Non-Compliance, Warning letters, and Ad-Hoc Corrective Action Plans, to MA organizations and Part D sponsors for sending late and/or inaccurate ANOC and EOC documents. CMS may determine a civil money penalty (CMP) should be imposed when an MA organization or Part D plan sponsor substantially fails to comply with program and/or contract requirements involving ANOC and EOC documents.

2.4.4. Part C and Part D Audits

CMS conducts program audits of MA organizations, Part D plan sponsors, and organizations offering Medicare-Medicaid plans to evaluate their delivery of health care items, services, and drugs to beneficiaries. Routine program audits in 2018, as well as in prior years, occurred at the parent organization level to maximize Agency resources when conducting a comprehensive audit of a plan's operation. Therefore, all MA, MA Prescription Drug (MA-PD), Medicare-Medicaid Plan, and standalone prescription drug plan (PDP) contracts owned and operated by the parent organization were included in the scope of the 2018 audits. The audits evaluated sponsor compliance in the following program areas:

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans Model of Care
- Medicare-Medicaid Plan – Service Authorization Requests, Appeals and Grievances
- Medicare-Medicaid Plan - Care Coordination and Quality Improvement Program Effectiveness

Plans subject to routine audits have all program areas reviewed except where a protocol was not applicable to their operation. For example, if a sponsor does not operate a Special Needs Plan then it would not have a Model of Care audit performed. Likewise, a stand-alone PDP does not

³⁸ Section 1876 cost plans are operated by a legal entity licensed as an HMO in accordance with a Medicare managed care risk or cost reimbursement contract under Section 1876 of the Social Security Act and Title 42, Part 417 of the Code of Federal Regulations

have the Part C Organization Determinations, Appeals, and Grievances protocol applied because it does not offer the Part C benefit.

In 2018, CMS cited an average of 13 conditions of noncompliance per sponsor audited, which was similar to 2017 where CMS cited an average of 12 conditions per audited sponsor. Sponsors are required to correct cited deficiencies and undergo validation to ensure compliance before the program audit is closed.

Sections 1857(d)(1) and 1860D-12(b)(c) of the Social Security Act require the HHS Secretary to provide for the annual audit of financial records of at least one-third of the Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs) and Program of All-inclusive Care for the Elderly (PACE) organizations. The one-third financial audit program examines the health plans' financial records, data relating to costs, Medicare utilization, and the computation of the bids. During FY 2018, CMS completed 207 audits of MAOs and PDPs for the contract year 2016.

In general, program and financial audits give CMS reasonable assurance that MA and Part D plans deliver benefits in accordance with the terms of their contract and plan benefit package. However, CMS also has authority to take compliance and enforcement actions, up to and including termination, if warranted, for findings that involve direct beneficiary harm or the potential to result in such harm.

CMS is committed to transparency with respect to audit materials, performance, and results, including any enforcement actions that may take place. Program audits, and the consequences of possible enforcement actions, continue to drive improvements in the industry and increase sponsors' compliance with core program functions in the MA and Part D programs.

2.4.5. Medicare Part D Reconciliation Data Reviews

Part D plans receive monthly prospective payments from CMS. During benefit-year-end reconciliation, CMS compares its prospective payments to a plan with the plan's actual cost data, submitted through prescription drug event (PDE) records and direct and indirect remuneration (DIR) reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payments, which limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Risk corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending. To promote accuracy in the plan-reported data, CMS validates both PDE and DIR data in advance of reconciliation and works with the plans to resolve any issues.

2.4.6. Medical Loss Ratio Requirement

A medical loss ratio (MLR) represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, as opposed to other expenses that do not directly impact patient care or quality, such as marketing, profits, salaries, administrative expenses, and agent commissions. MA organizations and Part D sponsors must report the MLR for each contract they have with CMS. A contract must have a minimum MLR of at least 85% to avoid financial and other penalties. The minimum MLR requirement is intended to create

incentives for MA organizations and Part D sponsors to reduce overhead expenses, ensure that taxpayers and enrolled beneficiaries receive value from Medicare plans.

If a MA organization or Part D sponsor has an MLR for a contract year that is less than 85%, meaning that less than 85% of revenue is used for patient care or quality improvement, the MA organization or Part D sponsor owes a remittance to CMS. CMS deducts the remittance from the regular monthly plan payments to the MA organization or Part D sponsor. Further MLR-related sanctions on MA organizations and Part D sponsors may include a prohibition on enrolling new members after three consecutive years and contract termination after five consecutive years of failing to meet the minimum MLR requirement.

2.4.7. Compliance Enforcement in Medicare Part C and Part D

CMS has the authority to take enforcement or contract actions when CMS determines that an MA organization or Part D plan sponsor:

- Substantially fails to comply with program and/or contract requirements;
- Carries out its contract with CMS in a manner inconsistent with the efficient and effective administration of the MA and Part D program requirements; or
- No longer substantially meets the applicable conditions of the MA and Part D programs.

Enforcement and contract actions may include:

- Civil Money Penalties (CMPs);
- Intermediate Sanctions (e.g., suspension of marketing, enrollment, and payment); and
- Contract Terminations.

In FY 2018, CMS issued 21 CMPs to MA organizations and Part D plans placed one Part D sponsor under enrollment sanctions.³⁹

Starting with audits conducted in 2017 (based on contract year 2015), CMS began to evaluate the findings of noncompliance from financial audits for potential enforcement actions, in accordance with applicable regulations.

2.5. Medicare and Medicaid National Correct Coding Initiative

Medicare National Correct Coding Initiative

Given the volume of claims processed by Medicare each day, and the cost associated with conducting medical review of an individual claim, CMS uses automated edits to help prevent improper payment without the need for manual intervention. CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment for billing code pairs that should not be reported together by the same provider for the same beneficiary for the same date of service.

³⁹ Medicare Part C and Part D enforcement notices are available at <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html>.

NCCI Medically Unlikely Edits (MUEs) prevent payment for an inappropriate quantity of the same service rendered by the same provider for the same beneficiary on the same date of service. NCCI edit tables are refined and updated quarterly.⁴⁰

Medicaid NCCI

Section 1903(r) of the Act requires states to use NCCI methodologies to process applicable Medicaid claims. CMS continues to provide assistance for State Medicaid Agencies (SMAs) to use NCCI methodologies in their Medicaid programs. Similar to that for Medicare, the Medicaid NCCI edit tables are refined and updated quarterly.⁴¹

2.6. Integrated Data Repository and the One Program Integrity Portal

The Integrated Data Repository (IDR) contains Medicare Part A, Part B (including DME), MA (encounter), and Part D claims, beneficiary, and provider data. This robust data warehouse supports program integrity analytics, such as the development of FPS models.

CMS continues to integrate new data sources into the IDR. CMS is working to incorporate state Medicaid data into the IDR through standard Transformed Medicaid Statistical Information System (T-MSIS) data formats, while also working with states to improve the quality and consistency of the data from each state.

CMS uses the One Program Integrity (One PI) web-based portal in conjunction with the IDR to provide access to robust business intelligence analytical tools and to facilitate data sharing with program integrity contractors and law enforcement. One PI provides a single access point to the data within the IDR, as well as analytic tools to review the data.

2.7. Partnership and Collaboration with Law Enforcement

2.7.1. Major Case Coordination

In FY 2018, CMS began a Major Case Coordination initiative that includes representatives from the HHS-OIG, DOJ, and CMS. This initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads. Through early coordination, CMS is able to implement appropriate administrative remedies quickly and refer potential fraud matters to law enforcement partners for potential civil or criminal action. This serves to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs. This venue also facilitates the identification of program vulnerabilities that can be addressed through policy changes or enhanced oversight efforts.

⁴⁰ See sections 1.1 and 1.2 of Appendix B for further information regarding NCCI PTP edits and MUEs.

⁴¹ These Medicaid NCCI edit tables and other resources are located on the Medicaid website (<https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>).

2.7.2. Medicare Fraud Strike Force

The Medicare Fraud Strike Force (Strike Force) is a key component of the joint HHS and DOJ Health Care Fraud Prevention and Enforcement Action Team, known as “HEAT,” composed of interagency teams of analysts, investigators, and prosecutors that focus on the worst offenders in regions with the highest known concentration of fraudulent activities. The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud “hot spots”—cities for which there is evidence of high levels of billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. The Strike Force expanded operations to a total of eleven areas in the United States.⁴² During FY 2018, CMS made 258 referrals to law enforcement through the Major Case Coordination meetings, and 54 referrals to the Strike Force.

In June 2018, the Attorney General of the United States, the Secretary of HHS, the HHS-OIG and the Center for Program Integrity (CPI) at CMS announced a health care fraud enforcement action involving 601 charged defendants, including 165 doctors, nurses and other licensed medical professionals for their alleged participation in health care fraud schemes involving more than \$2 billion in false billings. The 2018 takedown featured a large-scale federal and state partnership to combat health care fraud and the opioid epidemic. Enforcement activities took place across the nation, representing the largest multi-agency enforcement operation to date, both in terms of the number of defendants charged and loss amount.⁴³

2.7.3. Command Center

The Command Center opened in July 2012 and provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from HHS-OIG and the DOJ, including the Federal Bureau of Investigation (FBI), state law enforcement officials, clinicians, and CMS fraud investigators to collaborate in real time before, during, and after the development of fraud leads.

In FY 2018, CPI conducted 30 missions in the Command Center that included participants from CMS and CMS partners. In addition, CPI also used the Command Center for the MCC initiative (referenced in Section 2.7.1). The Command Center’s collaborative environment allow multi-disciplinary teams of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. These collaborative activities enable CMS to more quickly and efficiently take administrative actions such as revocations of Medicare billing privileges and payment suspensions.

2.8. Medicare-Medicaid Data Match

The Medicare-Medicaid Data Match (Medi-Medi) activities support the integration of Medicaid and Medicare investigations and audits where possible. Medi-Medi functionality matches Medicaid and Medicare claims and other data to identify improper billing and utilization

⁴² A geographical listing of the Strike Force locations can be found at <https://oig.hhs.gov/fraud/strike-force/>

⁴³ The 2018 HealthCare Takedown Factsheet can be found at https://oig.hhs.gov/newsroom/media-materials/2018/takedown/2018HealthCareTakedown_FactSheet.pdf

patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the Medi-Medi program an important tool in identifying and preventing aberrant billing practices and other schemes across both programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. Participation in these activities is optional for the states. However, CMS works diligently to identify which states would benefit the most, taking into account factors such as state Medicaid recipient population, total Medicaid expenditures, and managed care contractual arrangements that allow for overpayment recovery. Each state's participation in Medi-Medi activities is designed to accommodate the individual complexity of that state's Medicaid program and associated program integrity efforts. During FY 2018, CMS collaborated with states that account for most of the expenditures in Medicaid, including Alabama, Arizona, Arkansas, California, Florida, Georgia, Kentucky, Louisiana, Mississippi, Missouri, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, West Virginia, and Wyoming.

CMS's Medi-Medi data matching activity and subsequent collaboration with state Medicaid agencies has produced various law enforcement referrals on a variety of subjects, including individual health care providers, opioid prescribers, clinical labs, and hospitals. In certain instances, law enforcement cases have produced significant results from the support CMS has provided.

For example, CMS was able to supplement its data matching activity with investigative activities such as analysis of OIG-Hotline complaints, Fraud Prevention System alerts, provider and beneficiary interviews, and prepayment and post-payment medical reviews. In one particular investigation that involved Medi-Medi data matching and coordination with the state, law enforcement charged a physician for his role in a \$240 million health care fraud and international money-laundering scheme. The charges included one count of conspiracy to commit health care fraud, five counts of health care fraud, and one count of conspiracy to commit money laundering related to a massive fraud scheme that jeopardized the health and wellbeing of innocent children, elderly, and disabled victims. In another situation, CMS opened an investigation based on proactive data analysis of claims that identified a facility inappropriately billing services provided to Medicare and Medicaid beneficiaries who were admitted as inpatients for scheduled surgical procedures, but where the services were appropriate for outpatient payment. CMS performed a post-payment medical review and referred the provider to law enforcement, and, ultimately, the hospital agreed to pay the United States just under \$2 million to resolve allegations that it improperly billed government healthcare programs.

2.9. Medicare Provider Cost Report Audits

Auditing of cost reports is one of CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, skilled nursing facilities, and end-stage renal dialysis facilities. Although many of these providers have most of their claims paid through a prospective (bundled) payment system, reimbursement of several items continues on an interim basis, subject to final payment after a cost reconciliation process. These providers submit an annual Medicare cost report that, after the settlement process, forms the basis for reconciliation and final payment to the provider. The cost report includes calculations of the final payment

amount for items such as graduate medical education, disproportionate share hospital (DSH) payments, and Medicare bad debts.

This cost report audit process provides a method to detect improper payments as well as reasons these improper payments have occurred. These reasons for improper payments provide insight into potential payment vulnerabilities, the recognition of which can strengthen and focus the program integrity response.

The audit process includes the timely receipt and acceptance of provider cost reports, the performance of desk reviews, and audits of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines whether providers have been paid properly, in accordance with CMS regulations and instructions. During FY 2018, the MACs received and accepted approximately 53,909 Medicare cost reports (see Table 3: Medicare Savings). This includes initial cost report filings as well as amended filings. Approximately 21,790 cost reports were tentatively settled and approximately 18,540 cost reports were desk reviewed. In addition, the MACs completed approximately 554 audits.

2.10. Medicare Shared Savings Program

Under the Medicare Shared Savings Program, Medicare providers and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare FFS payments under Part A and Part B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements or owe shared losses if it increases costs. The Shared Savings Program incentivizes ACOs and their providers and suppliers to better coordinate care to improve quality and reduce growth in expenditures.

CMS has developed a streamlined provider and supplier screening process to enhance program integrity efforts for the Shared Savings Program that relies in part on safeguards associated with Medicare FFS enrollment.

These provider' screenings are facilitated by the electronic capture and exchange of provider information including, but not limited to, enrollment status, reassignment details, current/previous Medicare Exclusion Database sanctions, payment suspensions, and FPS alerts. CMS may deny an application or impose additional safeguards on ACO participants whose screening reveals a history of program integrity issues or affiliation with individuals or entities that have a history of program integrity issues.

2.11. Federally-Facilitated Exchange ⁴⁴

In FY 2018, CMS significantly enhanced the program integrity operations for the Federally Facilitated Exchange (FFE) by establishing operations of the Marketplace Program Integrity Contractor (MPIC). During the year, the MPIC screened more than 8,000 complaints of alleged fraud and/or potential noncompliance with FFE rules, conducted data analysis projects to identify agents and brokers at high-risk for noncompliance, checked the licensure status of

⁴⁴ The Federally-facilitated Exchange (FFE) is separate from the Medicare and Medicaid programs. It is included here to provide a more complete view of CMS's program integrity activities.

thousands of insurance agents and brokers actively assisting consumers on the FFE, and initiated more than 80 investigations of possible fraud. CMS also conducted its first Major Case Coordination meeting focusing on MPIC investigations with the Office of Inspector General, where the details regarding several of the most egregious cases were shared.

In FY 2018, CMS also continued to improve successful program integrity activities initiated in previous years, such as the review and resolution of consumer complaints alleging unauthorized or fraudulent enrollment into FFE plans that they did not know about and did not want or need. When criteria developed by CPI are met, CMS works with issuers to cancel fraudulent health insurance policies in order to alleviate unwarranted tax liabilities for consumers. In FY 2018, CMS cancelled more than 1,800 unauthorized enrollments due to suspected fraud.

Other fraud allegations come to CMS from issuers whose own data analytics reveal potentially fraudulent enrollments, such as those associated with sober home schemes. In FY 2018, CMS approved the cancellation (i.e., rescission) of almost 200 health insurance policies. Rescinding policies associated with sober home schemes protects issuers from high dollar fraudulent claims, which in turn helps safeguard the integrity of health plans participating in the FFE.

CMS also continued to support law enforcement agencies around the country, investigating possible fraud impacting consumers and issuers participating in the FFE, by servicing requests for FFE data and program information. In addition, CMS refers cases to law enforcement and/or regulatory agencies, such as states' Departments of Insurance, for investigation or to take actions within their jurisdictions.

2.12. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Competitive Bidding⁴⁵

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which requires that Medicare replace the previous fee schedule payment methodology for select DMEPOS items with a competitive bid process.

Under the DMEPOS Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items to people with Medicare living in, or visiting competitive bidding areas. Medicare payment is not made for claims for items subject to the program that are submitted by entities other than contract suppliers and certain exempted suppliers, thereby reducing the ability of entities to commit fraud and allowing for better oversight of suppliers receiving payment.

⁴⁵ The DMEPOS Competitive Bidding Program was initially required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) [Public Law 108-173], modified by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) [Public Law 110-275], and expanded by the Patient Protection and Affordable Care Act. It is an administrative program and is neither a specific program integrity activity nor is it funded from program integrity obligations. The program is mentioned in this report because it represents CMS's proactive approach to preventing improper payments.

The savings experienced as a result of the DMEPOS Competitive Bidding Program predominantly come from lower payments and decreased unnecessary utilization.⁴⁶

The Medicare DMEPOS Competitive Bidding Program works with other fraud, waste, and abuse initiatives and is currently saving over \$2 billion per year without negatively impacting health outcomes.⁴⁷

Importantly, the program maintained beneficiary access to quality products from licensed and accredited suppliers in all competitive bidding areas, while at the same time reducing overutilization of DMEPOS items and services.

DMEPOS Prior Authorization

Building on the Prior Authorization of PMDs Demonstration, CMS issued a DMEPOS prior authorization final rule in FY 2016 that establishes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization.⁴⁸ The rule defines unnecessary utilization as “the furnishing of items that do not comply with one or more of Medicare’s coverage, coding, and payment rules.” The rule also establishes a list of DMEPOS items that could be subject to prior authorization before items or services are provided and payment is made.

In FY 2017, CMS began implementing prior authorization for two types of group 3 power wheelchairs (HCPCS codes K0856 and K0861) in a staggered approach. On March 20, 2017, prior authorization began in Illinois, Missouri, New York, and West Virginia. On July 17, 2017, CMS expanded prior authorization for these two types of power wheelchairs nationwide. On September 1, 2018, CMS implemented prior authorization nationwide for 31 types of PMDs that were previously included in the PMD Demonstration.⁴⁹

2.13. Party Status Appeals

When Medicare beneficiaries or providers disagree with a coverage or payment decision made by Medicare, a MA plan, or a Part D plan, they have the right to appeal.⁵⁰ Although the HHS continues to strengthen Medicare program integrity to combat all improper payments, including fraud, waste, and abuse, the Agency remains equally committed to protecting the rights of Medicare beneficiaries, providers, and suppliers through the Medicare appeals process.

The Act establishes five levels to the Medicare appeals process: (1) redetermination by a MAC, (2) reconsideration by a Qualified Independent Contractor (QIC), (3) hearing by an Administrative Law Judge (ALJ) in the HHS Office of Medicare Hearings and Appeals

⁴⁶ All DMEPOS Competitive Bidding Program contracts expired on December 31, 2018. Starting January 1, 2019, there will be a temporary gap in the DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020. During the temporary gap, any Medicare enrolled DMEPOS supplier may furnish DMEPOS items and services to people with Medicare.

⁴⁷ https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html

⁴⁸ CMS–6050–F, 80 FR 81674 (Dec. 30, 2015).

⁴⁹ 83 FR 25947 (June 5, 2018).

⁵⁰ *HHS Primer: The Medicare Appeals Process* at <https://www.hhs.gov/sites/default/files/dab/medicare-appeals-backlog.pdf>

(OMHA), (4) review by the Medicare Appeals Council in the HHS Departmental Appeals Board (DAB), and (5) judicial review in U.S. District Court.⁵¹

CMS's party status appeals initiative occurs at Level 3 of the appeals process, which is a hearing before an ALJ. CMS regulations allow for Qualified Independent Contractors (QICs), which represent Level 2 of the appeals process, to participate in ALJ hearings either as a party or as a "non-party" participant.

While "non-party" participation limits the QIC to submitting written position papers and to appearing at the hearing to answer questions, participation as a party allows the QIC additional opportunities to represent its position related to its decision-making by providing the QIC the right to call witnesses, provide testimony, and present evidence.

Generally, the QICs will invoke party status when there is a significant amount in controversy at issue, there are national policy implications, or there are areas of particular interest for CMS. CMS funds QICs' participation as a party in ALJ hearings in accordance with 42 CFR § 405.1012. When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully upholds the prior decision or dismisses the case, CMS considers the estimated amount in controversy as savings. Data shows ALJ overturn rate is lower in cases in which the QIC participates as a party.⁵²

CMS also actively participates in an HHS intra-agency appeals workgroup. CMS and our HHS partners are implementing initiatives with the goal of improving the efficiency of the appeals process. More information about the appeals process and workload are on the Office of Medicare Hearings and Appeals website (<https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf>).

2.14. Recovery Audit Programs (Medicare Fee-for-Service, Medicaid, Part C, and Part D)

2.14.1. Medicare FFS

Section 1893(h) of the Act requires the establishment of a nationwide Medicare FFS Recovery Audit Program, and Recovery Audit Program contractors are known as RACs. The mission of the Medicare FFS Recovery Audit Program is to identify and correct overpayments made on claims for health care items and services provided to beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement corrective actions that will prevent future improper payments.

As required by section 1893(h), RACs are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to, providers. The RACs negotiate their contingency fees at the time of the contract award. The base contingency fees range from 10.4 – 14.4 percent for all claim types except DME, where it

⁵¹ <https://www.hhs.gov/sites/default/files/omha/files/medicare-appeals-backlog.pdf>

⁵² In FY 18, the overall adjudicated reversal rate by the ALJ was 47.9 percent. However, in that same period, in cases in which the QIC participated as a Party, the adjudicated reversal rate was 25.6 percent. In sum, when the QIC participated as a Party in an ALJ hearing, the overturn rate was 22.3 percentage points lower.

ranges from 15.4 – 18.9 percent. The RAC must return the contingency fee if an improper payment determination is overturned at any level of appeal.

The original FFS RAC contractors (Regions A, B, C, and D) stopped reviewing new claims as of July 31, 2016 in anticipation that new RAC contracts would be awarded soon after. Per the FFS RAC Statement of Work (SOW), from August 2016 until January 31, 2018, the original FFS RACs were in their “contract closeout and reconciliation” period, which involved administrative activities only (no reviews). These activities included CMS recoupment of funds from providers on improper payments, RAC invoicing for contingency payments on eligible claims, allowing the RACs to support the appeal process, and allowing CMS to recoup contingency fees from overturned appeals.

New FFS RAC contracts (Regions 1, 2, 3, 4, and 5) were awarded on October 31, 2016.

Results

Table 6 breaks out overpayments collected, underpayments restored, and amounts overturned on appeal in the FFS RAC regions in FY2018, including both old and new.

Table 6. RAC Performance

FFS RAC Region/Name	Collected Overpayments (in millions)	Restored Underpayments (in millions)	Overturned on Appeal^a (in millions)
1/ Performant	6.29	1.69	0.45
2/ Cotiviti	18.85	2.97	1.42
3/ Cotiviti	13.83	2.37	0.96
4/ HDI/HMS	26.03	0.64	4.23
5/ Performant	8.03	0	0.17
Totals^b	73.03	7.67	7.23
<p>Note: Payments made to providers under the Hospital Appeal Settlement process resulted in reduced collected overpayments. Because these reductions could not always be offset by other collected amounts, some resulted in an overall negative amount being reported.</p> <p>^a Overturned amounts include collected overpayments from previous FYs.</p> <p>^b Savings values may not add to totals due to rounding.</p>			

In FY 2018, the program identified approximately \$89 million in overpayments and recovered \$73 million. Additional results and analysis of Recovery Audit Program data are available for download at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program>.

FFS RAC Appeals

Providers who disagree with a RAC's improper payment determination may utilize the multilevel administrative appeals process under section 1869 of the Act. Recovery Audit Program appeals follow the same appeal process as other Medicare claim determinations. Throughout the first four levels of the appeals process, in FY 2018, there were 30,403 appeal decisions rendered for claims with overpayments identified by the RACs. Claims may have had initial overpayment determinations made prior to FY 2018 and appealed claims may be counted multiple times if the claim had appeal decisions rendered at multiple levels during FY 2018. For example, if a claim was appealed to the first level and received a decision in FY 2018, then appealed to the second level and received a decision in FY 2018, both decisions are counted. Of the 30,403 total appeals decided in FY 2018, 14,529 decisions, or 47.8 percent were overturned with decisions in the provider's favor (see Table 7).

Table 7. RAC Appeals

Appeal Level	Total Decisions in FY 2018	Favorable/ Partially Favorable Decision	Percent Overturned
1 (MAC)	7,271	4,032	55.5%
2 (QIC)	1,897	494	26%
3 (ALJ)	21,184	10,000	47.2%
4 (Departmental Appeals Board (DAB))	51	3	5.9%
Totals	30,403	14,529	47.8%

Oversight

CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program and CMS regularly evaluates the RACs' performance and adherence to program requirements. Staff members go on location to observe medical reviews, information technology systems, and customer service areas. In addition to onsite visits, CMS conducts desk audits on claims to confirm that all aspects of the review process were correctly completed and documented. The RACs also engage in regular meetings with the MACs, provider groups, and other stakeholders to discuss review topics and issues. If there are performance concerns, CMS notifies the RAC and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Reporting System (CPARS) for an overall performance rating for the year. These results are available to all federal agencies that wish to procure contracts with these entities.

2.14.2. Part C and Part D

Section 1893(h) of the Act expands the RAC program to Medicare Part C and Part D.

The primary corrective action on Part C payment error has been the contract-level Risk Adjustment Data Validation (RADV) audits. RADV verifies that diagnoses submitted by MA organizations for risk-adjusted payment are supported by medical record documentation. The RADV program is currently operational with the support of contractors. In 2015, HHS issued a

Request for Information on the proposal to place RADV under the purview of a Part C RAC as part of the effort to effectively implement a successful Part C RAC program. In the responses, the MA industry expressed concerns of burden related to the high overturn rate in the early experience of the FFS RAC program. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the MA appeal process.⁵³

CMS believes that the contract-level RADV program performs the functions of the Part C RAC, and the proposed scope of the Part C RAC has been subsumed by an updated RADV methodology that targets payment error using historical payment error data.

Similarly, CMS believes that the Medicare Drug Integrity Contractor (MEDIC) performs the functions of the Part D RAC. The MEDIC's primary focus is to conduct program integrity activities aimed to reduce fraud, waste, and abuse in Parts C and D. The workload of the MEDIC is substantially similar to that of the RAC and the MEDIC has a robust program to identify improper payments.

The Part D RAC program became operational in FY 2012. Since its launch, the Part D RAC has recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers and improper refills of Drug Enforcement Agency scheduled drugs. The Medicare Part D RAC contract ended in December 2015, but an administrative and appeals option period allowed the RAC to complete work on outstanding audit issues until the end of December 2018. Because the option period does not permit new audit work, the Part D RAC identified no new improper payments during FY 2018.

2.14.3. Medicaid

Section 1902(a)(42) of the Act requires states to establish Medicaid RAC programs. Each state has the flexibility to tailor its RAC program, where appropriate, with guidance from HHS. Presently, 31 states have HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration and issues related to procurement. Seventeen states and the District of Columbia currently have operational RAC programs.

2.15. Program Integrity Board

CMS established an agency-wide Program Integrity Board (PI Board) comprised of CMS executive leaders to identify, prioritize, and address vulnerabilities to prevent improper, wasteful, abusive, and potentially fraudulent payments in the Medicare and Medicaid programs. The PI Board directs and tracks corrective actions to address identified high-priority vulnerabilities to resolution.

The PI Board also establishes smaller working groups—referred to as Integrated Project Teams (IPTs)—to focus on specific projects to address the identified vulnerabilities. For example, an Improper Payments Workgroup periodically collects data from improper payment reports and formulates action plans for review by the PI Board. All of the approved IPTs work

⁵³ 42 C.F.R. § 423.2600.

independently under the directive of the PI Board and provide regular updates. In FY 2018, the workgroups made significant strides, including:

- Documentation Requirements Simplification (DRS) IPT: The PI Board approved the DRS IPT goals of clarifying, simplifying, and/or eliminating documentation requirements that are unnecessary or where the burden outweighs the benefit. The PI Board also approved the operational structure of the initiative and informed topic selection and prioritization. This structure includes the Documentation Requirements Simplification Change Control Board, which facilitates stakeholder engagement and drives decision-making. The DRS IPT completed eight improvement projects in FY 2018 that reduced provider burden,⁵⁴ and included the following topics: signatures and initials, proof of delivery, Inpatient Rehabilitation Facility (IRF) definition of intensive rehabilitation, immunosuppressive drugs, E/M student documentation, therapeutic shoes, preliminary/verbal DMEPOS orders, and written orders prior to delivery received.
- Medicaid PI Strategy IPT: The PI Board approved the Medicaid PI Strategy IPT to develop and implement an approach to improve Medicaid program integrity through greater transparency and accountability, strengthened data, and innovative and robust analytic tools. The Medicaid PI Strategy IPT regularly briefed the PI Board, which provided substantial input to help inform Medicaid PI initiatives to hold states accountable and assist them with protecting Medicaid resources. These initiatives include stronger audit functions, enhanced oversight of state-managed care programs, increased beneficiary eligibility oversight, expanded use of data for program integrity purposes, and stricter enforcement of state compliance with federal rules.⁵⁵

⁵⁴ The 2018 HHS Agency Financial Report, <https://www.hhs.gov/sites/default/files/fy-2018-hhs-agency-financial-report.pdf>, at 190.

⁵⁵ *Id.* at 190.

3. Usher in a New Era of State Flexibility and Local Leadership

Share Best Practices with States and Increase Flexibility in Program Integrity Approaches While Improving Accountability in Medicaid Programs

3.1. Medicaid Program Integrity Strategy

The federal-state partnership is central to the success of the Medicaid program. While states have primary responsibility for direct oversight of their programs, CMS plays a critical role in ensuring that states are compliant with federal statute and regulations. As a result, CMS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. In June 2018, CMS announced a new Medicaid Program Integrity Strategy⁵⁶ based on the three pillars of flexibility, accountability, and integrity. The strategy seeks to reduce Medicaid improper payments across states to protect taxpayer dollars.⁵⁷ The strategy includes new and enhanced initiatives that will create greater transparency and accountability for Medicaid program integrity performance, enable increased data sharing and robust analytic tools, and seek to reduce Medicaid improper payments across states. This strategy was developed with input from stakeholders, including clinicians, Congress, and patients. Insight and recommendations from GAO and HHS-OIG have also contributed to these efforts.

The initiatives include increased beneficiary eligibility oversight, stronger audit functions, and enhanced enforcement of state compliance with federal rules. Specific examples of new or enhanced initiatives include, but are not limited to, the following:

- Strengthening the program integrity focus of audits of state claiming for Federal match funds and rate setting
- Conducting new audits of state beneficiary eligibility determinations
- Optimizing state-provided claims and provider data
- Offering provider screening for states on an opt-in basis
- Providing Medicaid provider education to reduce improper payments

3.2. Medicaid Integrity Institute

The Medicaid Integrity Institute's (MII) mission is to provide effective training tailored to meet the ongoing needs of State Medicaid Program Integrity employees, with the goal of raising national program integrity performance standards and professionalism, at no cost to states.⁵⁸ By embracing and utilizing sound learning methodology and instructional design, coupled with

⁵⁶ *The State Medicaid Program Integrity Strategy Factsheet*, <https://www.medicaid.gov/state-resource-center/downloads/program-integrity-strategy-factsheet.pdf>

⁵⁷ <https://www.cms.gov/blog/medicaid-program-integrity-shared-and-urgent-responsibility>

⁵⁸ <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/MedicaidIntegrityInstitute.html>

progressive technology, the MII training staff endeavors to provide outstanding professional education to State Medicaid Agency staff.

This meets, in part, CMS's obligation under Section 1936 of the Act to provide support and assistance to help states combat provider fraud and abuse. The MII develops a comprehensive program of study that addresses various aspects of Medicaid program integrity, including fraud investigations, data mining and analysis, provider enrollment, managed care oversight, emerging trends, and case development. Instructors at the MII include Medicaid program administrators and subject matter experts, CMS staff, federal and state law enforcement officers, private consultants, and academics. The MII has also established a Certified Program Integrity Professional (CPIP) designation for state employees who complete a rigorous curriculum of three courses covering Basic Skills and Techniques in Medicaid Fraud Detection, Program Integrity Fundamentals, and Specialized Skills and Techniques in Medicaid Fraud Detection. As of September 30, 2018, 393 state employees from 47 states, the District of Columbia, and Puerto Rico have received the CPIP credential.

In FY 2018, the MII continued to provide content that was responsive to state program integrity needs, highlighted emerging trends and strategies, and featured states' effective practices. Specifically, CMS supports states in their efforts to combat Medicaid provider fraud, waste, and abuse, as well as beneficiary fraud. MII includes functionally diverse state Medicaid-related participants to encourage cross-functional partnerships that will achieve program integrity outcomes. In the spring of 2018, CMS held educational webinars for Medicaid program integrity personnel, featuring topics like prior authorization, and third party liability. CMS also established voluntary state technical assistance and data compare services to provide more resources to states that want to rely on CMS data and information. From the first course in FY 2008 through FY 2018, the MII has provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 8,887 enrollments in 187 courses and 17 workgroups. Notably, in FY 2018, staff from the Medicaid program from the U.S. Virgin Islands attended their first course.

In FY 2018, the MII provided onsite training with 866 state employees enrolled in 17 courses and 3 workgroups focusing on topics such as:

- Trends in Medicaid: Opioids
- Trends in Medicaid: Third Party Liability
- Trends in Medicaid Beneficiary Eligibility and Fraud
- Interactions between Medicaid Fraud Control Units (MFCUs) and Program Integrity Units (PIUs) Symposium
- Program Integrity Partnership in Managed Care Symposium
- Coding for Non-Coders
- Data Experts Symposium

MII Advisory Group Meeting

The FY 2018 advisory group meeting included discussion of vulnerabilities, CMS and state priorities, mitigation strategies, and how to tailor courses to match vulnerabilities within the program. Examples of emerging trends and high priority areas that were identified included beneficiary eligibility and fraud; opioid misuse; managed care; high risk services; specialty focuses such as value based services, third party liability, dental, behavioral health, and long-term care; and auditing for managed care.

Compendium of Promising Practices on Opioids

Opioid overdoses increased by roughly 30 percent across the US in just 14 months between 2016 and 2017, according to a report by the US Centers for Disease Control and Prevention (CDC). A unique challenge of the opioid epidemic is that it involves both legally obtained prescription drugs and illicit substances such as fentanyl and heroin, which share similar chemical properties and induce comparable physiological effects. Thus, a variety of approaches to policy, prescribing and dispensing practices, treatment, law enforcement, and public awareness campaigns is needed to change the direction of the alarming opioid misuse and overdose trends.⁵⁹

In response to this deadly epidemic, federal and state partners came together at the MII in Columbia, South Carolina to strategize and share perspectives to identify promising practices to help mitigate opioid abuse and misuse. Subject matter experts from 5 federal agencies and 39 states, plus the District of Columbia, identified and prioritized the most crucial opioid vulnerabilities shared among the states. Presenters discussed provider, beneficiary, and industry strategies and promising practices regarding opioid vulnerabilities, mitigation activities, and pertinent challenges. Mitigation activities and potential promising practices were outlined to address the vulnerabilities through policy, technical development, innovative payment models and programs, data analysis, outreach and partnerships, and fraud reduction. Gaps and challenges to implementing these promising practices were also identified for this compendium.

3.3. State Program Integrity Reviews

State program integrity reviews help CMS provide effective support and assistance to states in their efforts to combat fraud, waste, and abuse. Through these reviews, CMS assesses the effectiveness of the state's program integrity efforts, including compliance with federal statutory and regulatory requirements. Onsite reviews have focused on specific areas of program integrity concern, including oversight of managed care organizations, provider screening and enrollment, personal care services, and non-emergency medical transportation.

To supplement the focused onsite reviews, CMS also initiated desk reviews of state program integrity efforts during FY 2018. These reviews allow CMS to increase the number of states that receive such customized program integrity oversight by conducting offsite reviews of documentation submitted by states on specified topics. Desk review topics in 2018 included

⁵⁹ The *Medicaid Integrity Institute Compendium of Promising Practices* can be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/MII-Compendium-of-Promising-Practices.pdf>

provider terminations, opioids, and implementation status of Payment Error Rate Measurement (PERM) corrective action plans and states' program integrity corrective action plans. In 2018 CMS conducted 12 onsite focused reviews and 59 desk reviews in 46 states.

3.4. Guidance and Technical Assistance

CMS continues to facilitate the Fraud, Waste & Abuse (FWA) Technical Assistance Group (TAG) call. This monthly call is comprised of a TAG Chair, and regional chairs made up of state program integrity directors and staff. These calls cover events of interest to the PI community, and facilitate group discussions on policy and operational matters, such as best practices and fraud trends. States are able to use this venue to solicit guidance and technical assistance from federal and state partners. As a result of this FWA TAG call, several subgroups have been established to address focused topics. As of FY2018, there are six subgroups that are focused on small states, provider enrollment, managed care, data analytics, beneficiary fraud, and value based payments.

CMS also provides guidance and technical assistance in other ways. In March 2016, CMS published the Medicaid Provider Enrollment Compendium (MPEC) to help states to implement various provider enrollment requirements, including provider site visit and fingerprint-based criminal background check requirements. In July 2018, CMS updated the MPEC to clarify guidance regarding the enrollment of Medicaid Managed Care network providers with the states. CMS also provides education and outreach via numerous webinars and training calls, as well as presentations at the MII. In addition, CMS conducts state site visits to review and advise states about implementation challenges in provider screening and enrollment. (See Section 4.3 for additional information on Medicaid provider enrollment oversight.)

3.5. National Medicaid Audit Program

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers and to audit providers' claims to identify overpayments. This work had been undertaken by Audit Medicaid Integrity Contractors, but to better coordinate Medicare and Medicaid program integrity audit and investigation work, CMS transitioned the workload to the UPICs. The UPICs are continuing to focus on providing effective support and assistance to states through collaborative audits. Collaborative audits are an effective way to augment a state's audit capacity by leveraging the resources of CMS and its UPICs, resulting in more timely and accurate audits. As part of the transition, the UPICs have met with each state to identify areas of collaboration. In FY 2018, the UPICs initiated 280 investigations/audits in 27 states and CMS sent Final Findings Reports to 18 states. These investigations/audits resulted in recoveries for both the federal government and the states.⁶⁰ The most common collaborative audits were in the areas of hospice services, non-emergency medical transportation services, and general hospital services.

In addition to collaboration with states, CMS also assisted federal law enforcement agencies such as HHS-OIG and the FBI through audit work.

⁶⁰ This report provides the federal share of Audit MIC/UPIC recoveries in Table 4: Medicaid and CHIP Savings.

3.6. Medicaid and CHIP Business Information Solutions

The Medicaid and CHIP Business Information Solutions (MACBIS) is a CMS enterprise-wide initiative to modernize and transform the information and data exchanges with states and other key stakeholders. This initiative creates a more robust and comprehensive information management strategy—a “transformed data state”—to integrate Medicaid and CHIP operational, quality, and performance data for the first time. CMS will use the data to support detection of fraudulent patterns in state Medicaid programs, as well as to conduct comparative analytics across state lines and between the Medicare and Medicaid programs. States will be able to analyze their own program data along with other information in the CMS data repositories, including certain Medicare data pertaining to beneficiaries in their states, in order to identify potential anomalies for further investigation. As appropriate, CMS will take action to incorporate data from T-MSIS, as it is received from states, into both Medicaid-specific and multi-program analytics.

The Medicaid Statistical Information System (MSIS) data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 states and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the MACBIS Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP.

The MACBIS initiative is comprised of four key areas of improvement to help prevent fraud, waste, and abuse; program data, operational data, quality data, and business process performance data. States’ T-MSIS implementation began on a rolling basis starting April 2016. Access to high quality, timely data is essential for ensuring robust monitoring and oversight of the Medicaid and CHIP programs. Over the last 5 years, together CMS and states have produced the T-MSIS dataset and, for the last two years, have been working collaboratively to improve the quality of the data. As of 2018, all states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are submitting T-MSIS data. CMS monitors ongoing monthly T-MSIS data submissions and works with the remaining U.S. territories not yet submitting data.

T-MSIS is an expansion of the existing CMS MSIS data and extract process. T-MSIS supports data-driven program and policy decision-making, improves data integrity and effective management oversight, and strengthens Medicaid and CHIP fiscal and programmatic integrity. On August 10, 2018, CMS released State Health Official (SHO) letter 18-008⁶¹ announcing CMS’s intent to share T-MSIS research-ready files publicly in calendar year 2019, a great step toward improved transparency. This letter also outlined the importance of quality data reporting for states’ Medicaid and CHIP programs. To improve the quality of the T-MSIS data, CMS has established a number of high priority data areas; Medicaid managed care data are among our highest priority areas. CMS state liaisons and technical assistants are aggressively working with each state to address and resolve managed care data issues. An integrally related effort known as MACPro, which stands for the Medicaid and CHIP Program, collects program data to automate state plan amendments review and approvals and assist enterprise-level considerations. The

⁶¹ T-MSIS State Health Official Letter, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho18008.pdf>

MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

The following represent some of the major milestones achieved in FY 2018:

Overall Investment Achievements

- The Analytic & Reporting Environment for Medicaid and CHIP (AREMAC) (data warehouse) delivered first production use by users and received authority to operate
- Quarterly roadmaps for production of public Research Identifiable Files (RIFs) and data analytics products
- Produced objective measures for T-MSIS data quality and missingness reports (data usability)
- Successfully provided technical assistance to remaining state entities progressing to T-MSIS go-live and partnered with production states to assist in ongoing operations and remain current on their monthly submissions – all states current as of FY 2018
- Released a State Health Official (SHO) letter 18-008 on August 10, 2018 announcing CMS's intent to make T-MSIS research ready files available in calendar year 2019
- Developed and promoted to production the 2018 Quality Measures (Adult, Child, and Health Homes Core Sets) for state submission and made data available via the Measure by Measure report for CMS
- Developed and promoted to production MACPro User Management Phase I, which includes User Profile, Role Request and Role Approval features
- Developed and promoted to production MACPro the Micro-Strategy Business Intelligence (BI) Tools for Enhanced Reporting
- Developed and promoted to production MACPro Shareable PDFs (Print and Document Sharing Capabilities)
- Developed, implemented, and released the Medicaid State Plan encompassing Reviewable Units for ABD and Medically Needy Eligibility Groups; Family and Adult Eligibility Group and the remaining eligibility and enrollment processes

4. Support Innovative Approaches to Improve Quality, Accessibility, and Affordability

Integrate, Analyze, and Share Data to Inform Decision Making

4.1. Provider Enrollment

Provider enrollment is the gateway to the Medicare and Medicaid programs, and careful and appropriate provider enrollment screening techniques are the key to preventing ineligible providers and/or suppliers from entering either program. Payments to potentially fraudulent providers, either directly via FFS arrangements, or through managed care plans, divert Medicare and Medicaid funds from their intended purpose, may deprive beneficiaries of needed services, and/or might harm beneficiaries who receive unnecessary care. Identifying overpayments due to fraud—and recovering those overpayments from providers that engaged in the fraud—is resource-intensive and can take several years. By contrast, keeping ineligible entities and individuals from enrolling as providers in Medicare and state Medicaid programs allows the programs to avoid paying inappropriate claims to such parties and then later having to attempt to identify and recover those overpayments, which often is a burdensome and costly process. Provider screening identifies such individuals and entities before they are able to enroll and start billing.

CMS’s role in the provider and supplier enrollment process differs between the Medicare and Medicaid programs. CMS directly administers Medicare and oversees the provider enrollment and screening process for providers and suppliers participating in the Medicare FFS program. CMS uses provider and supplier enrollment information in a variety of ways, such as claims payment and fraud prevention programs. States directly oversee the provider screening and enrollment process for their Medicaid programs, and CMS provides regulatory guidance and technical assistance to states.

Medicare Provider Screening and Site Visits

As required by law⁶², CMS established three levels of provider and supplier enrollment risk-based screening: “limited”; “moderate”; and “high”; and classification by provider- and supplier-types, subject to upward adjustment in certain circumstances.⁶³

Providers and suppliers designated in the “limited” risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider- or supplier-specific requirements. Providers and suppliers designated in the “moderate” risk category are subject to unannounced site visits in addition to all the requirements in the “limited” screening level. Providers and suppliers in the “high” risk category are subject to fingerprint-based criminal background checks (FCBCs) in addition to all of the requirements in the “limited”

⁶² Sec. 6401 Public Law 111–148

⁶³ 76 FR 5862 (Feb. 2, 2011).

and “moderate” screening levels. In FY 2018, CMS denied approximately 809 enrollments and revoked 5 enrollments because of the FCBCs or a failure to respond to a request for fingerprints.

The Advanced Provider Screening (APS) system automatically screens all current and prospective providers and suppliers against a number of data sources, including provider and supplier licensing and criminal records, to identify and highlight potential program integrity issues for proactive investigation by CMS. APS continuously monitors all providers and suppliers against external licensure and criminal data sources to alert CMS of any actionable changes to licensure information or of any criminal flags. In FY 2018, APS conducted more than one million screenings. These screenings generated more than 29,000 License Continuous Monitoring alerts and more than 560 Criminal Continuous Monitoring alerts, which resulted in approximately 119 revocations due to felony convictions and over 250 revocations due to licensure issues.

Site visits are a screening mechanism used to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The CMS-authorized site visit contractors validate that the provider or supplier complies with Medicare enrollment requirements during these visits. In FY 2018, there were 36,113 site visits conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 36,757 conducted by the National Supplier Clearinghouse, which conducts site visits for Medicare DME suppliers. This work resulted in about 140 revocations due to non-operational site visit determinations for all providers and suppliers.

CMS’s provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2018, **CMS deactivated over 158,000 enrollments and revoked about 1,950 enrollments.**⁶⁴ The site visit and revalidation requirements⁶⁵ have contributed to the deactivation⁶⁶ and revocation⁶⁷ of more than one million enrollment records since CMS started implementing these screening and enrollment requirements.

Provider Revalidation

In FY 2018, CMS continued its revalidation efforts, which includes regular revalidation cycles for all existing two million Medicare providers and suppliers. DMEPOS suppliers are required to revalidate every three years and all other providers and suppliers are required to revalidate every five years. These efforts ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Similarly, states are also required to revalidate Medicaid providers at least every five years. States may rely on Medicare revalidation results in order to meet revalidation requirements for dually participating providers and suppliers.

⁶⁴ We note that revalidation results are point-in-time results, as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

⁶⁵ Revalidation requires providers and suppliers to resubmit and recertify the accuracy of their enrollment information to maintain their Medicare billing privileges and for reevaluation under new screening guidelines.

⁶⁶ Deactivation means the provider’s or supplier’s billing privileges are stopped but can be restored upon the submission of updated information. See 42 CFR § 424.540.

⁶⁷ Revocation means the provider’s or supplier’s billing privileges are terminated. See 42 CFR § 424.535.

In FY 2018, CMS initiated revalidation for more than 500,000 providers and suppliers. Of those revalidated, close to 210,000 successfully completed revalidation and approximately 40,000 have been deactivated. The remaining provider revalidations are currently pending processing by the MAC.

Enrollment Special Study

The Enrollment Special Study is a project designed to utilize and expand the existing programmatic infrastructures to take administrative actions under existing CMS authorities by conducting site verifications of potentially high-risk provider and supplier types. The study was limited to certain provider and supplier types located in southern Florida. CMS used information obtained during site verifications to determine if providers met enrollment requirements and to calculate a fraud level indicator.

Since inception in July 2009, this project has produced positive results; including an increased number of revocations, deactivations, and prepayment edit savings. The project has also provided valuable information that CMS has used to identify and implement programmatic changes that have proven successful to deter and prevent Medicare fraud.

In late 2017, CMS expanded the scope to include parts of Texas and Louisiana. From September 1, 2017 through September 30, 2018, the MACs covering Florida, Texas, and Louisiana (First Coast Service Operations and Novitas Solutions) conducted 4,234 site visits to verify providers' and suppliers' operational status, revoked 1 provider, denied 617 providers, and brought 141 providers into compliance.

4.2. Provider Enrollment, Chain and Ownership System (PECOS) and National Plan and Provider Enumeration System (NPPES) Improvements

The Provider Enrollment, Chain, and Ownership System (PECOS) is the Internet-based system that providers and suppliers use to enroll, revalidate, or make changes to their enrollment information in the Medicare FFS program. CMS made significant improvements to the system to make it easier for providers and suppliers to access and use the system. In FY 2018, CMS engaged providers and suppliers regularly to better understand the challenges users face and prioritized the improvements based upon the information learned through:

- Sponsoring quarterly focus groups with providers and suppliers
- Organizing the National Provider Enrollment Conference
- Conducting education and outreach through listservs, CMS.gov, PECOS homepage, Medicare Learning Network® (MLN) Matters Articles, change requests, and national provider calls

In FY 2018, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including the following changes:

- Implemented a new workflow process that expedites the enrollment process for users by implementing upload signature feature

- Updated provider interface with the newer version of CMS 588 Electronic Funds transfer Authorization agreement
- Implemented an enhancement that simplifies how providers and suppliers report adverse legal actions
- Implemented an enhancement that allows providers and suppliers to view their revalidation application status
- Enhanced the workflow for end users to improve the experience and reduce the user burden

The National Plan and Provider Enumeration System (NPES) supplies the National Provider Identifier (NPI) numbers to health care providers, maintains their NPI record, and publishes the records online.

In FY 2018, CMS made changes to the NPES and enhanced features for managing and enumerating NPIs. The enhancements include:

- Collection of electronic address information to support interoperability efforts and to enable secure provider-to-provider communication
- The ability for users to add multiple contacts
- Optimization of bulk upload and bulk enumeration for large organizations

4.3. Medicaid Provider Enrollment Oversight

As part of its oversight role in Medicaid, CMS works closely with SMAs to provide regulatory guidance, technical assistance, and other support with respect to provider enrollment. SMAs can comply with Medicaid screening requirements by using CMS's screening results for dually enrolling providers, thus eliminating the need and burden associated with states re-screening such applicants. States may use Medicare screening data, including site visits, payment of application fees, and FCBCs. For Medicaid-only FFS providers, SMAs at a minimum must follow the same risk-based screening procedures followed by Medicare when enrolling providers and suppliers.

State Medicaid programs are required to terminate any provider that has been terminated “for cause” by Medicare or another state Medicaid program or CHIP.⁶⁸ Additionally, CMS has the discretionary authority to revoke Medicare billing privileges when a state has terminated a provider's or supplier's Medicaid billing privileges for cause. To meet this requirement, CMS has established a process for states to report and share information about Medicaid terminations. States may report to CMS all “for cause” Medicaid terminations of providers who have exhausted all applicable appeal rights, or for whom the timeline for appeal has expired, for inclusion in the CMS provider termination system.

CMS continued its efforts to assist states with their required screening by providing guidance through the Medicaid Provider Enrollment Compendium (MPEC), a policy manual that, among other things, contains clarified guidance regarding how SMAs may, in certain circumstances,

⁶⁸ Medicare denial of enrollment is governed by 42 CFR § 424.530. Medicare revocation of enrollment is governed by 42 CFR § 424.535. Medicaid denial or termination of enrollment is governed by 42 CFR § 455.416.

rely on Medicare provider screening activities in lieu of conducting their own.⁶⁹ In FY 2018, CMS continued to promote the SMA's use of the Data Compare service that allows the SMAs to identify dually enrolled providers already screened and revalidated by Medicare and rely on Medicare's screening results. For some SMAs, this process could reduce their revalidation workload by up to 70 percent. At the close of FY 2018, 24 SMAs had taken advantage of the Data Compare service. In addition, CMS participated in enrollment conference calls with states and provided webinar trainings on states' use of TIBCO,⁷⁰ a managed file transfer internet server that CMS uses to provide revocation, termination, and enrollment data to the states, and on PECOS. CMS also conducts provider enrollment and termination outreach and education at the MII. The most recent course was in May 2019. Similar outreach and education opportunities are presented annually at meetings of the National Association for Medicaid Program Integrity.

CMS also began training states on the use of the CMS Data Exchange (DEX) System, which in FY 2018 replaced TIBCO as the platform for exchanging Medicaid termination and Medicare revocation data between states and Medicare. By the end of FY 2018, all 50 states were provided access and were utilizing the DEX system. The system not only streamlines states' access to termination and revocation data but it also provides states with access to the Social Security Administration's Death Master File, a required database check at initial enrollment and revalidation. The system also supports the transfer of larger data files, which has helped augment the use of the data compare service.

The State Assessment Support Contractor assists SMAs with the implementation of enrollment processes and sharing of best practices between SMAs. The contractor, with support of CMS representatives, conducts a detailed review of the SMA's enrollment processes at the SMA's request. The focused review and subsequent brainstorming sessions assist the SMA in assessing their current progress to meeting the enrollment and screening requirements and provides recommendations to improve their processes. The emphasis during this assessment is not only on statutory and regulatory compliance but also includes a review of the SMA's current processes to determine opportunities to become more efficient in other areas of their program. In FY 2018, CMS continued to perform detailed reviews and compliance assistance site visits, and has visited 32 states since the FY 2016 implementation.

4.4. Provider Enrollment Moratoria

CMS has used the authority provided to the Secretary in section 1866(j)(7) of the Act to temporarily prevent the enrollment of new Medicare, Medicaid, and CHIP providers and suppliers, including categories of providers and suppliers, where the Secretary has determined such temporary moratoria are necessary to combat fraud, waste, or abuse. In July 2013, CMS announced temporary moratoria on the enrollment of new Home Health Agencies (HHAs) and Part B ground ambulance suppliers in Medicare in three "fraud hot spot" metropolitan areas of the country: in and around Miami, Florida and Chicago, Illinois (HHAs and HHA Sub-units),

⁶⁹ The MPEC is available at <https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf>.

⁷⁰ TIBCO refers to TIBCO Software Inc., the company that supplies the software used in this provider enrollment application.

and in and around Houston, Texas (Part B ground ambulance suppliers).⁷¹ The moratoria also applied to Medicaid and CHIP in those geographic areas. In January 2014, CMS extended these moratoria by 6 months and expanded the moratoria to include HHAs in the areas surrounding Fort Lauderdale, Florida; Dallas and Houston, Texas; and Detroit, Michigan; and Part B, Medicaid, and CHIP ground ambulance suppliers in and around Philadelphia, Pennsylvania.⁷² CMS continued to extend these moratoria in 6-month increments.⁷³

In each moratorium area, CMS prohibited the new enrollment of HHAs and ground ambulance suppliers while we took administrative actions, such as deactivations and revocations of HHAs and ground ambulance companies, as well as worked with law enforcement to support investigations and prosecutions. Beneficiary access to care in Medicare, Medicaid, and CHIP is of critical importance to CMS and its state partners, and CMS carefully evaluated access for the target moratorium locations with every imposition and extension of the moratoria. Prior to imposing and extending these moratoria, CMS reviewed Medicare data for these areas and found no concerns with beneficiary access to HHAs or ground ambulance suppliers. CMS also consulted with the appropriate SMAs and State Departments of Emergency Medical Services to determine if the moratoria would create access to care concerns for Medicaid and CHIP beneficiaries. All of CMS's state partners were supportive of CMS's analysis and proposals, and together with CMS, determined that these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries.

In July 2016, CMS announced the 6-month extension and statewide expansion of the moratoria on the enrollment of HHAs in Florida, Illinois, Michigan, and Texas and of Part B non-emergency ground ambulance suppliers in Texas, New Jersey, and Pennsylvania. In addition, CMS announced the lifting of the moratoria on all Part B emergency ground ambulance suppliers. These moratoria, and the changes described in the document, also applied to the enrollment of HHAs and non-emergency ground ambulance suppliers in Medicaid and CHIP.⁷⁴

In conjunction with the extension and expansion of the moratoria, CMS implemented the Provider Enrollment Moratoria Access Waiver Demonstration (PEWD) for HHAs and Part B non-emergency ground ambulance suppliers in the geographic locations subject to moratoria. The PEWD also applies to Medicaid and CHIP. The PEWD includes heightened screening and investigations of certain providers and suppliers, and allows CMS to make exceptions to a statewide moratorium based primarily on beneficiary access to care, so long as the provider or supplier passes the enhanced screening measures.

Finally, on January 29, 2017,⁷⁵ July 28, 2017,⁷⁶ January 29, 2018,⁷⁷ and July 29, 2018,⁷⁸ CMS extended the statewide moratoria of HHAs in Florida, Illinois, Michigan, and Texas, and Part B

⁷¹ 78 FR 46339 (July 31, 2013).

⁷² 79 FR 6475 (Feb. 4, 2014).

⁷³ 81 FR 5444 (Feb. 2, 2016).

⁷⁴ 81 FR 51120 (Aug. 3, 2016).

⁷⁵ 82 FR 2363 (Jan. 9, 2017).

⁷⁶ 82 FR 35122 (July 28, 2017).

⁷⁷ 83 FR 4147 (Jan. 30, 2018).

⁷⁸ 83 FR 37747 (Aug. 2, 2018).

non-emergency ground ambulance suppliers in New Jersey, Pennsylvania, and Texas for an additional 6 months. These extensions also applied to Medicaid and CHIP.

4.5. Demonstrations and Models

CMS conducts a number of innovative demonstrations and models designed to develop or demonstrate improved methods for the investigation and prosecution of potential fraud in the provision of care or services and to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care.⁷⁹

Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967⁸⁰ authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program.

Prior Authorization of Power Mobility Devices (PMDs)

The Medicare Prior Authorization of Power Mobility Devices (PMDs) Demonstration began on September 1, 2012 in California, Illinois, Michigan, New York, North Carolina, Florida, and Texas. On October 1, 2014, the demonstration increased in geographic scope to include Maryland, New Jersey, Pennsylvania, Indiana, Kentucky, Ohio, Georgia, Tennessee, Louisiana, Missouri, Washington, and Arizona.

After implementation of this demonstration, the Centers for Medicare & Medicaid Services (CMS) observed a decrease in expenditures for PMDs in both the demonstration states and non-demonstration states. Based on claims processed from the inception of the pilot on September 1, 2012 through April 30, 2018, monthly expenditures for the PMD codes included in the demonstration decreased as follows:

- From \$11.5 million in September 2012 to \$1.8 million in April 2018 in the original 7 demonstration states
- \$10.4 million in September 2012 to \$1.8 million in April 2018 in the 12 additional expansion states
- \$9.7 million in September 2012 to \$2.0 million in April 2018 in the non-demonstration states

The Prior Authorization of PMDs Demonstration ended as scheduled on August 31, 2018. On September 1, 2018, CMS added 31 of the items previously included in the PMD Demonstration to the Required Prior Authorization List as defined in 42 CFR 414.234(c)(1) as a condition of

⁷⁹ While these demonstrations and models contribute towards CMS's program integrity objectives, they are not part of the Medicare or Medicaid Integrity Programs. These demonstrations and models are supported by other sources and authorities.

⁸⁰ Public Law 90-248.

payment under the Prior Authorization Process for Certain Durable Medical Equipment, Prosthetic, Orthotics, Supplies (DMEPOS) Items nationwide.⁸¹

Pre-Claim Review Demonstration for Home Health Services

CMS implemented a Pre-Claim Review Demonstration for Home Health Services in Illinois, from August 2016 until March 2017, when it was paused. Under the demonstration, CMS reviewed pre-claim review requests and provisionally affirmed the requests as likely meeting Medicare rules and requirements prior to claim submission. Taking into account stakeholder feedback on this demonstration, CMS paused the demonstration to consider a number of structural improvements.⁸² In May 2018, CMS announced its intention to implement a revised demonstration, known as the Review Choice Demonstration for Home Health Service, described in detail below.

Review Choice Demonstration for Home Health Services

CMS announced its intention to implement a revised Review Choice Demonstration for Home Health Services through a Paperwork Reduction Act (PRA) notice with public comment period.⁸³ The revised demonstration offers providers increased flexibility and choice, as well as risk-based changes to reward providers who show compliance with Medicare home health policies. The demonstration gives providers in the demonstration states an initial choice of three options – pre-claim review, post payment review, or minimal post payment review with a 25 percent payment reduction for all home health services. A provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the Demonstration. CMS will implement the demonstration beginning in FY 2019, for the Home Health and Hospice Medicare Administrative Contractor (HH/H MAC) Jurisdiction M (Palmetto GBA) providers operating in Illinois, Ohio, North Carolina, Florida, and Texas for five years, with the option to expand to other states in the Palmetto/JM Jurisdiction. The revised demonstration will assist in developing improved methods to identify, investigate, and prosecute potential fraud in order to protect the Medicare Trust Funds, potentially reduce the rate of improper payments, and improve provider compliance with Medicare rules and requirements.

⁸¹ Medicare Prior Authorization of Power Mobility Devices Demonstration Status Update (Posted 10-29-2018) available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/Status-Update-Oct-2018.pdf>

⁸² Additional information about this demonstration is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Choice-Demonstration/Review-Choice-Demonstration-for-Home-Health-Services.html>.

⁸³ 83 FR 25012 (May 31, 2018)

Models

Section 1115A of the Act authorizes the Secretary, through the Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models in order to reduce program expenditures while preserving or enhancing the quality of care furnished to beneficiaries.

Prior Authorization for Non-Emergent Hyperbaric Oxygen Therapy

Launched in FY 2015, this model tested whether prior authorization reduces expenditures while maintaining or improving quality of care for non-emergent hyperbaric oxygen services. The model was also intended to help ensure services complied with applicable Medicare coverage, coding, and payment rules before the services were rendered and claims were paid. Prior to implementing the model, spending on outpatient hyperbaric oxygen therapy in the model states averaged \$1.69 million per month. Based on data from the model's first two years, spending decreased to an average of \$943,231 per month.⁸⁴ The demonstration ended as scheduled in February 2018.

Prior Authorization for Repetitive Scheduled Non-Emergent Ambulance Transport

In FY 2017, CMS continued implementing a Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport. This began as a three-year model on December 1, 2014 for transports occurring on or after December 15, 2014 in Pennsylvania, New Jersey, and South Carolina.⁸⁵ Then, as required by section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),⁸⁶ beginning January 1, 2016, five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia were included in the model.⁸⁷ On December 4, 2017 and again on November 30, 2018, CMS announced that the model would be extended for one additional year to allow CMS to continue to evaluate the model and determine if the model meets statutory requirements for nationwide expansion under MACRA. The model is currently scheduled to end in all states on December 1, 2019.^{88,89}

Expenditure data reflects that in the model's first two years, average spending in the initial three states decreased from \$18.9 million to \$6.0 million per month, while data from the first year of the model for the additional states reflects that average spending decreased from \$5.7 million to \$3.1 million per month.⁹⁰

⁸⁴ Additional information about this demonstration is available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Non-Emergent-Hyperbaric-Oxygen.html>.

⁸⁵ 79 FR 68271 (Nov. 14, 2014)

⁸⁶ Public Law 114-10.

⁸⁷ 80 FR 64418-19 (Oct. 23, 2015)

⁸⁸ 82 FR 58400 (Dec. 12, 2017)

⁸⁹ 83 FR 62577 (Dec. 4, 2018)

⁹⁰ The most current outcomes and status of this model, including the first interim evaluation report, are available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Prior-Authorization-of-Repetitive-Scheduled-Non-Emergent-Ambulance-Transport-.html>.

5. Improve the CMS Customer Experience

Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education

5.1. Improper Payment Rate Measurement

The Improper Payments Information Act of 2002 (IPIA), 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)⁹¹ requires each agency to:

- Periodically review programs it administers
- Identify programs that may be susceptible to significant improper payments
- Estimate the amount of improper payments
- Submit those estimates to Congress
- Report on actions the agency is taking to reduce improper payments

All improper payments are not necessarily expenses that should not have occurred, and therefore, do not represent funding that the Federal Government would not have spent. Most improper payments are either unintentional payment errors or instances where payment documentation is insufficient and the reviewer is unable to determine if a payment is proper. While fraud and abuse are also improper payments, it is important that not all improper payments constitute fraud, and improper payment estimates do not correlate to a rate of fraud. Although fraud may be one cause of improper payments that always results in a monetary loss to the Federal Government, a payment made to an ineligible recipient or a payment made in the wrong amount resulting in an overpayment is also considered monetary loss. However, an underpayment does not represent a monetary loss to the Federal Government. Improper payment rates in this section include both overpayments and underpayments.⁹²

Medicare Fee-for-Service

The Medicare FFS program has been identified as being at high risk for improper payments. To comply with the IPIA, CMS established the Comprehensive Error Rate Testing (CERT) program to calculate the improper payment rate in the Medicare FFS program. The CERT program considers any payment that should not have been made or was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment.⁹³ The program evaluates a stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules, utilizing medical review professionals to review the claim and submitted documentation

⁹¹ Public Law 107-300, Public Law 111-204, and Public Law 112-248, respectively.

⁹² The 2018 HHS Agency Financial Report, <https://www.hhs.gov/sites/default/files/fy-2018-hhs-agency-financial-report.pdf> at 188.

⁹³ *Id.* at 198.

to make a determination of whether the claim was appropriately paid or denied in accordance with such rules. CMS publishes the national Medicare FFS improper payment rate in the HHS Agency Financial Report (AFR) on an annual basis.

The national Medicare FFS estimated improper payment rate for FY 2018 was 8.12 percent or \$31.62 billion in gross improper payments; this represents the lowest Medicare FFS improper payment rate since 2010 and a \$4.59 billion decrease in estimated improper payments as compared to 2017.⁹⁴ Improper payments for home health, inpatient rehabilitation facility (IRF), Skilled Nursing Facility (SNF), and hospital outpatient claims were the major contributing factors to the FY 2018 Medicare FFS improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.

Medicaid

The Medicaid program and CHIP have been identified as being at high risk for improper payments. To comply with the IPIA, CMS established the Payment Error Rate Measurement (PERM) program to estimate national improper payment rates in Medicaid and CHIP. The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. CMS measures Medicaid and CHIP improper payment rates using three 17-state cycles so that each state is reviewed once every three years.

The FY2018 national Medicaid improper payment rate, based on measurements conducted in fiscal years 2016, 2017, and 2018, was 9.8 percent, representing an estimated \$36.3 billion in improper payments, including both the federal and state share. The national Medicaid component improper payment rates in FY 2018 were:

- Medicaid FFS; 14.3 percent
- Medicaid managed care; 0.2 percent
- Medicaid eligibility; 3.1 percent

The FY 2018 national CHIP improper payment rate, based on measurements conducted in 2016, 2017, and 2018, was 8.6 percent, representing \$ 1.4 billion in estimated improper payments, including both the federal and state share. The national CHIP component improper payment rates were:

- CHIP FFS: 12.6 percent
- CHIP managed care; 1.2 percent
- CHIP eligibility; 4.2 percent

Since FY 2014, errors due to state non-compliance with provider screening, enrollment, and National Provider Identifier (NPI) requirements have driven the Medicaid improper

⁹⁴ <https://www.cms.gov/blog/2018-medicare-fee-service-improper-payment-rate-lowest-2010>

payment estimate. The majority of improper payments have been cited on claims where a newly enrolled provider had not been appropriately screened by the state, a provider did not have the required NPI on the claim, or a provider was not enrolled. Although these errors remain a driver of the Medicaid rate, state compliance has improved, as the Medicaid FFS improper payment rate for these errors decreased from 9.27 in FY 2017 to 7.21 in FY 2018.⁹⁵

For FYs 2015 through 2018, CMS did not conduct the eligibility measurement component of PERM. During this time, for the purpose of computing the overall national improper payment rate, the Medicaid and CHIP eligibility component improper payment rates were held constant at the FY 2014 national rate of 3.1 percent and 4.2 percent, respectively. In place of these PERM eligibility reviews, all states were required to conduct Eligibility Review Pilots to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors. Based on the pilots, CMS updated the eligibility component measurement methodology and published a final rule to update the methodology for the PERM eligibility component.⁹⁶ Since FY 2018, CMS resumed the eligibility component measurement under this final rule and will report an updated national eligibility improper payment estimate in FY 2019.

Improper Payment Rate Measurement in the MA and Part D Programs

In the MA and Part D programs, CMS makes prospective, monthly per-capita payments to MA organizations and Part D plan sponsors. Each per-person payment is based in part on a bid amount, approved by CMS, that reflects the plan's estimate of average revenue required to provide coverage of original Medicare (Part A and Part B) benefits to an enrollee with an average risk profile. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on the individual enrollee's health status and demographic factors.⁹⁷ 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 MA payment error estimate reported for FY 2018 was 8.10 percent, representing \$15.55 billion in improper payments. The MA payment error rate was driven by errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS for payment purposes. Specifically, the estimate reflects the extent to which diagnoses that plans report to CMS lack supporting medical record documentation. The FY 2018 methodology consisted of the following steps:

⁹⁵ [The 2018 HHS Agency Financial Report](#) at 212.

⁹⁶ 82 FR 31158 (July 5, 2017).

⁹⁷ Under MA, CMS may also make payments of rebates to plans that bid below the benchmark for their services area(s).

- Selection of a stratified random sample of beneficiaries for whom a risk-adjusted payment was made in calendar year 2016, where the strata are high, medium, and low risk scores
- Medical record review of the diagnoses submitted by plans for the sampled beneficiaries
- Calculation of beneficiary-level payment error for the sample
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in an MA gross payment error amount

The Part D payment error estimate reported for FY 2018 was 1.66 percent, representing \$1.32 billion in improper payments. CMS measures the inconsistencies between the information reported on PDEs and the supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication orders, as appropriate), and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error, which is simulated onto a representative sample of beneficiaries to determine the Part D improper payment estimate.⁹⁸

5.2. Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership consisting of the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations. The overall mission of the HFPP is to be a leading coordinating body for the health care industry to reduce fraud, waste, and abuse by:

- Providing an unparalleled cross-payer data source, representing the full spectrum of the health care industry, to enable the performance of sophisticated data analytics and information-sharing for the benefit of all Partners
- Achieving meaningful participation by Partners and establishing strategic collaborations with diverse stakeholders
- Leveraging Partnership resources and relationships to generate real-time, comprehensive approaches that materially impact efforts to reduce health care fraud, waste, and abuse

In FY 2018, the HFPP reached a membership level of 112 Partner organizations, an increase of 33 percent since FY 2016. Membership is comprised of 9 federal agencies, 12 associations, 61 private payers, and 30 state and local partners.

To achieve its objectives, the HFPP uses a “Trusted Third Party” (TTP), a CMS contractor, to act as a “common data aggregator” under the HIPAA Privacy Rules. Under this model, the TTP is able to conduct cross-payer data aggregation and analysis services

⁹⁸ Additional information on the Medicare Part C and Part D improper payment methodology and corrective actions can be found in the HHS FY 2018 AFR on pages 207-210.

to identify potential fraud across payers, while ensuring that each Partner only has access to its own claims data.

In FY 2017, the HFPP expanded its study methodology to collect frequently updated data, including personally identifiable information and protected health information. In FY 2018, Partners submitted over 10.3 billion professional claim lines (submitted on a CMS-1500 claim form) for conducting cross-payer analyses. By the end of FY 2018, the HFPP had commenced or completed 157 individual partner studies since its inception. These cross-payer studies enable the HFPP to proactively identify vulnerabilities in real time, significantly increasing the value of membership to all Partner organizations. The HFPP is currently using professional claims but is planning to expand to collect institutional, pharmacy, and dental claims in the future.

The HFPP uses a diverse variety of approaches to identify vulnerabilities in Partner data. These methods include:

- Standard searches to detect anomalies that may indicate the existence of fraud, waste, and abuse
- Scanning of incoming claims information against existing data sets, such as lists of deactivated providers
- Creation of reference files that list providers that may be suspect based on known risks
- Creation of informational content to support stakeholders in addressing vulnerabilities (e.g., white papers)

Some studies initiated in FY 2017 and continued into FY 2018 include the identification of:

- Services billed under an “impossible day” scenario (including evaluation and management services, psychotherapy services, and physical and occupational therapy services)
- Referring providers with no prior relationship treating that patient
- Excessive holiday and weekend billing
- Deactivated providers that continue to submit claims for payment

The HFPP held quarterly Regional Information Sharing Sessions throughout FY 2018. These sessions allow Partners to participate in case sharing sessions, listen to panel discussions, receive updates from law enforcement, and have the opportunity to collaborate with members from across the Partnership

In May 2018, the HFPP released a white paper entitled “Examining Clinical Laboratory Services: A Review by the Healthcare Fraud Prevention Partnership.”⁹⁹ Clinical laboratory services generated an estimated \$87.3 billion in revenue in 2017, totaling 2.6%

⁹⁹ The Healthcare Fraud Prevention Partnership white paper (May 2018), <https://hfpp.cms.gov/hfpp-white-papers/hfpp-clinical-lab-services-white-paper.pdf>

of annual healthcare spending in North America. This represents a large target for potential fraud and abuse. While the typical laboratory claim is relatively low in cost (less than \$200), the sheer volume of laboratory services performed provides an opportunity for potential losses related to fraud and abuse in these services to reach the hundreds of millions of dollars. In addition, because claims for potentially fraudulent or abusive services either can be made by individuals or disseminated networks of providers and laboratories, fraud in this area can be particularly challenging for private and public payers, law enforcement, and other responsible entities to identify and investigate.¹⁰⁰ The HFPP seeks to use this paper to provide foundational information and to set the stage for additional discussions and interventions to address fraud and abuse in this area.

5.3. Outreach and Education

Medicare Provider Outreach and Education

One of the goals of provider outreach and education is to reduce the Medicare improper payment rate by providing Medicare FFS providers the timely and accurate information they need to bill correctly the first time. The MACs educate Medicare providers, suppliers, and their staff about Medicare policies and procedures, including local coverage policies, significant changes to the Medicare program, and issues identified through review of provider inquiries, claim submission errors, medical review data, and CERT program data. Medicare contractors use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program, including CMS-developed materials and contractor-developed materials.

CMS-developed materials include Medicare Learning Network® (MLN) educational products, information, and resources for the health care professional community. For example, MLN Matters articles are one such product in which clinicians, billing experts, and CMS subject matter experts create content that explains Medicare policies, as well as the latest changes to CMS programs. Medicare contractors also use other MLN products, such as webinars and fact sheets, in their education and outreach programs, and disseminate CMS-developed listserv messages. Contractor-developed materials include education on local coverage policies and listserv messages tailored to the contractor's jurisdiction. CMS receives significant positive feedback from providers on the value of these educational materials.

Medicare Beneficiary Education

CMS undertakes various activities to inform Medicare beneficiaries about the importance of guarding their personal information against identity theft and how they can protect against and report suspected fraud. In FY 2018, this effort included the *Medicare & You* handbook and other beneficiary education materials, the 1-800-MEDICARE hotline, and via [Medicare.gov](https://www.medicare.gov). CMS disseminated similar messages through a wide range of

¹⁰⁰ [*Id.* at 2.](#)

beneficiary touch points, including the Medicare Summary Notice, the MyMedicare.gov Message Center, and response letters to beneficiary inquiries.

Beginning in September 2018, CMS conducted a national “Guard Your Card” advertising campaign to alert beneficiaries about scams to obtain their Medicare number and the importance of protecting their number to prevent identity theft and Medicare fraud. The campaign reminded beneficiaries that while new Medicare cards include more secure Medicare numbers, it is still important that they guard their number to prevent Medicare fraud. Earned, paid, and social media outreach and other promotional efforts continued into late 2018 to remind beneficiaries to protect their Medicare number and warning them about the types of scams that occur during the Medicare open enrollment period.¹⁰¹

The Senior Medicare Patrol (SMP) program, administered by the Administration for Community Living (ACL), is another important way to reach Medicare beneficiaries. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In FY 2018, discretionary HCFAC funds from CMS were allocated to the Administration for Community Living to support the SMP program.

Medicaid Educational Toolkits

CMS uses an online resource for Medicaid program integrity education, which provides public access to educational toolkits covering a variety of topics, such as dental compliance and beneficiary card sharing.¹⁰² These toolkits include print and electronic media, train-the-trainer guides, webinars, videos, and other innovative strategies for promoting successful practices and enhancing awareness of Medicaid fraud, waste, and abuse.

State Medicaid Program Integrity units also have access to the Regional Information Sharing System (RISS). The MII supports this Medicaid program integrity workspace, which is a secure, web-based system for collaboration, and dissemination where all states can exchange documents, tips, and best practices about Medicaid program integrity under the auspices of the DOJ Office of Legal Education. Educational material, including course material from the MII, is maintained on RISS.

Outreach and Education of Medicare Advantage and Part D Plans

In FY 2018, CMS continued the sharing of educational training tools for MA and Part D plans on the Health Plan Management System (HPMS). MA and Part D plans are able to

¹⁰¹ In FY 2019, the period in which the new Medicare cards were being mailed to and first used by beneficiaries, CMS undertook an enhanced address validation process and other measures to reduce the risk of the cards being stolen and subsequently used fraudulently. Details of this effort, as well as estimates of the fraudulent claim payments prevented, will be included in the FY 2019 Medicare & Medicaid Program Integrity Report to Congress.

¹⁰² Medicaid Program Integrity online toolkits are available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html>.

access educational presentations, fact sheets, and booklets on the same platform where CMS makes available other pertinent information such as CMS communications, operational information, and policy materials – all within a single system used daily by MA organizations and Part D plan stakeholders.

Medicare Parts C and Part D Fraud, Waste, and Abuse (FWA) Education and Outreach

In FY 2018, CPI led the development of multiple training events about current Medicare Parts C and Part D fraud schemes, fraud prevention techniques, and anti-fraud, waste, and abuse activities. The training events consisted of the following:

- (1) Two smaller 35-person events at the CPI Command Center where groups were educated about the latest trends in Medicare Part C and Part D fraud, waste and abuse. Attendees included participants from Medicare Parts C and Part D plans, law enforcement and the MEDIC. Attendees had an overwhelmingly positive experience, with 96% of respondents saying they would recommend the training to others and 94% mentioning that the training met their expectations. Attendees also provided feedback about topics for future training events that were considered for the larger offsite training event.
- (2) A larger offsite training event was held with 144 attendees that included Medicare Part C and Part D plan sponsors, law enforcement, MEDIC and CMS staff. The event included lively group discussions, highly interactive information-sharing exercises, and presentations and panel discussions that featured active question-and-answer segments. The audience reacted positively to the overall event, with 100% of respondents saying they would be interested in attending other CPI-sponsored training events and 98% of respondents recommending this training to others.

5.4. Open Payments

The Open Payments program is a statutorily required, national disclosure program that promotes transparency and accountability by making information about the financial relationships between the health care industry (reporting entities)¹⁰³ and providers (covered recipients)¹⁰⁴ available to the public.

The Open Payments data includes payments and other transfers of value made by reporting entities to covered recipients, along with ownership and investment interests

¹⁰³ Reporting entities refers to applicable manufacturers and group purchasing organizations (GPOs) required to report payments or transfers of value to covered recipients under the Physician Payment Sunshine Act (42 USC §1320a-7h).

¹⁰⁴ Covered recipients are any physicians (excluding medical residents) who are not employees of the applicable manufacturer that is reporting the payment; or teaching hospitals that receive payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which such information is available.

held by physicians or their immediate family members in the reporting entities. Payments are reported across three main categories:

- 1) General Payments: Payments or other transfers of value that are not in connection with a research agreement or research protocol. General payments may include, but are not limited to honoraria, gifts, meals, consulting fees, and travel compensation.
- 2) Research Payments: Payments or other transfers of value made in connection with a formal research agreement or research protocol.
- 3) Physician Ownership Information: Information about the ownership or investment interests those physicians or their immediate family members have in the reporting entities.

CMS publishes financial data for each program year¹⁰⁵ by June 30 of the following year, as well as updates from previous program periods. In addition, CMS updates, or “refreshes,” the Open Payments data at least once each year after its initial publication. These updates include data corrections made since the initial publication of data that were submitted by applicable manufacturers and GPOs.

In FY 2018, CMS published 11.54 million payment records, transfers of value, or instances of ownership/investment interest reported during calendar year 2017. These financial transactions totaled \$8.40 billion.

Disclosure of the financial relationships between the reporting entities and covered recipients does not signify an inappropriate relationship, and Open Payments does not prohibit such transactions. The public can search, download, and evaluate the reported data found on the Open Payments website (<https://openpaymentsdata.cms.gov/>). Manufacturers and GPOs self-report the data displayed on the Open Payments website.

The Open Payments search tool is a crucial piece of the program, as this is the vehicle that provides the public access to the Open Payments data. CMS continues to maintain the search tool and make updates for optimal user experience and accessibility. The following are the notable enhancements to the search tool throughout FY 2018.

- The **Payments by State** page allows the user to view national averages, total dollar amount received in payments per state and a summary of the natures of payments received by each state. These enhancements are presented by a map and a pie chart, respectively. The pie chart is sortable by both national and individual state views.
- **Homepage redesign** – the homepage was reformatted with a new look and layout, featuring an updates search bar that allows users to search by physician name as well as teaching hospital and reporting entity. The new layout is designed to better

¹⁰⁵ The program year coincides with the calendar year. In this case, the program year is the calendar year ended December 31, 2017.

organize existing site contents as well as highlight new pages and additions to site content.

- **“Facts About Open Payments” page redesign** – the Facts About Open Payments page was redesigned to be more user friendly and include detailed information about the various types of payments included in the data. The different payment types now feature iconography, which is carried throughout the full site.
- **Mobile Responsiveness** – the site was redesigned to be fully mobile responsive for optimal use on a smartphone or tablet. All pages and content like tables, charts, maps, and other graphics were redesigned enabling users to view the site in full on smartphones and tablets.

Partner engagement and outreach efforts are a priority for CMS. Open Payments stakeholders, including medical college faculty, teaching hospital employees, industry professional groups, physicians, attorneys, and compliance professionals, received Open Payments outreach throughout FY 2018.

Appendix A – Table of Program Integrity Actual Obligations

CMS Program Integrity Obligations (amounts in thousands) ¹⁰⁶	FY 2018 Actual Amounts (in thousands)
Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden	
Program Integrity Staffing and Support	\$197,896
Integrity Continuum	\$25,822
Fraud Prevention System	\$27,357
Program Integrity Modeling and Analytics	\$32,962
One PI Data Analysis	\$22,224
Benefits Integrity	\$102,396
Medical Review	\$210,813
Provider Audit	\$178,166
Medicare Secondary Payer	\$143,522
Medi-Medi	\$29,616
Medicare Part C and Part D	\$193,823
Appeals Initiatives	\$4,070
Administration for Community Living (ACL) Senior Medicare Patrols	\$18,142
Medicare Recovery Audit Program ¹⁰⁷	\$82,790
Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden Subtotal ¹⁰⁸	\$1,269,599
Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden	
Advanced Provider Screening	\$31,650
Provider Enrollment, Chain and Ownership System (PECOS)	\$36,982
Section 6401 Provider Screening/Other Enrollment ¹⁰⁹	\$10,507
National Supplier Clearinghouse	\$20,546
Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden Subtotal	\$99,685

¹⁰⁶ The chart represents total obligations for the CMS Center for Program Integrity, Medicare Integrity Program, and Medicaid Integrity Program for FY 2017 (10/1/2016 through 9/30/2017, inclusive).

¹⁰⁷ The Medicare Recovery Audit Program is not a budget appropriation. RACs receive payment through contingency fees based on the amounts recovered from their audit activity. In addition, RACs receive payment for identifying underpayments.

¹⁰⁸ This total includes amounts for the Medicare Recovery Audit Program, which are not obligations under the budget authority. See previous footnote.

¹⁰⁹ This amount includes funding from sources other than HCFAC or DRA.

Appendix A – Table of Program Integrity Actual Obligations

CMS Program Integrity Obligations (amounts in thousands) ¹⁰⁶	FY 2018 Actual Amounts (in thousands)
Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs	
State Medicaid Access to Data and Support	\$66,839
Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs Subtotal	\$66,839
Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education	
Outreach and Education	\$68,401
Healthcare Fraud Prevention Partnership	\$20,966
Open Payments	\$32,200
Improper Payment Rate Measurement Activities	\$63,030
Probable Fraud Measurement Study	\$68,401
Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education Subtotal	\$184,597
Total CMS Program Integrity Obligations ¹¹⁰	\$1,620,720

¹¹⁰ This total includes amounts for the Medicare Recovery Audit Program, which are not obligations under the budget authority.

Appendix B - Program Integrity Savings Methodology Document

The Program Integrity Savings Methodology Appendix documents CMS’s approach to measuring savings attributable to its program integrity activities during the fiscal year. This appendix includes the following sub-appendices:

- Appendix B-1 – Medicare Savings Methodology
- Appendix B-2 – Medicaid and Children’s Health Insurance Program Savings Methodology

CMS continues to refine and enhance its data and methodologies, and this appendix will be updated as needed each fiscal year.

Appendix B-1 – Medicare Savings Methodology

Introduction

The Centers for Medicare & Medicaid Services (CMS) measures its program integrity return on investment (ROI) based on Medicare savings achieved through program-integrity-funded activities that prevent or recover improper payments. Savings represent the numerator of the ROI, while the Medicare program integrity obligations represent the denominator. This appendix provides the methodologies used to determine the Medicare savings amounts presented in the FY 2018 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings*.

Prevention Savings

CMS calculates prevention savings attributable to prepayment administrative actions in the Medicare fee-for-service (FFS) program (also known as Medicare Part A and Part B) and the Medicare prescription drug benefit program (Part D). Prevention savings are the estimated amounts Medicare would have paid providers¹¹¹ or plan sponsors in the absence of these actions. The following table lists CMS’s prevention activities.

Prevention Activities	Medicare Program
Automated Actions	
National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits	Fee-for-Service (FFS)
NCCI Medically Unlikely Edits (MUEs)	FFS
Ordering and Referring (O&R) Edits	FFS
Fraud Prevention System (FPS) Edits	FFS
Medicare Administrative Contractor (MAC) Automated Medical Review Edits	FFS
Zone Program Integrity Contractor (ZPIC)/Unified Program Integrity Contractor (UPIC) Automated Edits	FFS
Prepayment Review Actions	
Medicare Secondary Payer (MSP) Operations	FFS
MAC Non-Automated Medical Reviews	FFS
ZPIC/UPIC Non-Automated Reviews	FFS
Provider Enrollment Actions	
Revocations	FFS
Deactivations	FFS
Other Actions	
Medicare Part D Reconciliation Data Reviews	Part D

¹¹¹ For the purpose of this document, the term “provider” may refer to a provider, supplier, physician, or non-physician practitioner, and the term may represent an individual or an organization.

1 Automated Actions

Automated actions prevent improper payments without the need for manual intervention. Automated actions occur as the result of edits, or sets of instructions, that are coded into a claims processing system to identify and automatically deny or reject all or part of a claim exhibiting specific errors or inconsistency with Medicare policy. CMS calculates automated action savings from the following edits of Medicare FFS claims:

- National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits
- NCCI Medically Unlikely Edits (MUEs)
- Ordering and Referring (O&R) Edits
- Fraud Prevention System (FPS) Edits
- Medicare Administrative Contractor (MAC) Automated Medical Review Edits
- Zone Program Integrity Contractor (ZPIC)/Unified Program Integrity Contractor (UPIC)¹¹² Automated Edits

1.1 National Correct Coding Initiative Procedure-to-Procedure Edits

Savings:	The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or reduced in payment due to a PTP edit, accounting for any subsequently paid claim lines.
Data Source:	Multi-Carrier System (MCS) claims data in the CMS Integrated Data Repository (IDR)

CMS developed the NCCI edits to promote national correct coding practices and reduce inappropriate payments from improper coding in Medicare Part B claims. The coding decisions for these edits are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, Medicare policies, coding guidelines developed by national societies, and standards of medical and surgical practice. NCCI edit tables are refined and updated quarterly to address changes in coding guidelines and additions, deletions, and modifications of Healthcare Common Procedural Coding System (HCPCS)/CPT codes.¹¹³ NCCI edits apply to services rendered by the same provider for the same beneficiary on the same date of service (DOS).

First implemented in 1996, NCCI PTP edits prevent inappropriate payment for services that should not be billed together for the same provider, beneficiary, and DOS. Each PTP edit

¹¹² During FY 2018, CMS completed the contract transitions to UPICs, which perform the functions of ZPICs and Medicaid Integrity Contractors. The Midwestern and Northeastern UPIC jurisdictions became operational in FY 2017. The Southeastern, Southwestern, and Western UPIC jurisdictions became operational in FY 2018.

¹¹³ When billing Medicare, health care providers use HCPCS/CPT codes to define medical services performed on patients.

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applies to a specific pair of HCPCS/CPT codes. CMS uses PTP edits for pairs of codes where one code should not be reported with another code for a variety of reasons. For example: a) one code may represent a component of a more comprehensive code, or b) the codes may be mutually exclusive due to anatomic, gender, or temporal reasons. One code in each edit pair is defined as eligible for payment. If the two codes of an edit pair are billed for the same provider, beneficiary, and DOS, the edit automatically allows payment for the claim line containing the eligible code and denies payment for the claim line containing the other code.

NCCI PTP edits are used to adjudicate claims for practitioner, ambulatory surgical center, outpatient hospital, and outpatient therapy services. CMS currently calculates savings due to PTP edits for practitioner and ambulatory surgical claims. Practitioner and ambulatory surgical PTP edits occur in MCS before claims are sent to the Common Working File (CWF).

For every incoming claim line, PTP edits test for edit code pairs between the reported HCPCS/CPT code and all other codes submitted at the same time or in the claims history for the same provider, beneficiary, and DOS. Thus, it is possible to trigger an NCCI PTP edit by billing a code after payment of a different code from a PTP edit for the same provider, beneficiary, and DOS. If the code on the current claim line is the non-payable code in the edit pair, it is automatically denied. If the code on the current claim line is the payable code in the edit pair, in most cases, MCS automatically reduces the allowed payment for the payable code by the amount previously allowed for its non-payable code pair. The PTP edits savings metric includes the cutback amounts from such claim lines.

When justified by clinical circumstances and documented in the medical record, providers may append NCCI-associated modifiers to some codes in order to bypass PTP edits. If there are no clinical circumstances under which a pair of services should be paid at the same encounter, the PTP edit for that pair cannot be bypassed with any modifiers. After a PTP edit denial/cutback, a provider could resubmit the service with corrected information that makes the claim payable. Providers also have the right to appeal PTP edit denials/cutbacks through the Medicare FFS appeals process.

CMS calculates savings attributable to PTP edits in three steps: 1) identifying PTP edit denials/cutbacks, 2) pricing these denials/cutbacks, and 3) accounting for subsequent payment of previously denied/cutback services.

Identifying PTP Edit Denials and Cutbacks

System logic in MCS automatically appends a specific reduction code to claim lines that fail one of the PTP edits. During processing, claim lines may be denied for multiple errors. CMS attributes savings to PTP edits only when a PTP edit code is the system's highest priority reason for denying or reducing payment for a claim line.

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When a claim line is denied/cutback, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, PTP edit denial/cutback of claim lines that share the same claim type code, HCPCS code, rendering provider, beneficiary, and DOS.

Pricing PTP Edit Denials and Cutbacks

In MCS, most denied/cutback claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been fully payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.¹¹⁴ For each unique denial, CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.¹¹⁵ For each unique cutback, CMS first determines the cutback amount by subtracting the allowed payment amount from the system-generated or average price. CMS then multiplies the cutback amount by 80% to estimate what Medicare did not have to pay.

Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/cutback services. Specifically, where there are any subsequently paid claim lines for a previously denied/cutback service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from a) the priced amount of the earliest denial, up to that priced amount, or b) the cutback amount of the earliest cutback, up to that cutback amount. Subsequently paid claim lines include those that were processed after the earliest denial/cutback and that share the same claim type code, HCPCS code, rendering provider, beneficiary, and DOS. All amounts used in these steps have the estimated beneficiary coinsurance removed.

For a given PTP denied/cutback claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of PTP edits savings uses

¹¹⁴ For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹¹⁵ In the methodology for this and other edits involving Part B services, CMS uses 80% as a conservative estimate of what Medicare did not have to pay a provider. There may be denied services for which Medicare would have paid 100% or the beneficiary would have paid 100% as part of his/her deductible.

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claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.¹¹⁶

1.2 National Correct Coding Initiative Medically Unlikely Edits

Savings:	The estimated amount Medicare FFS did not have to pay for all unique claim lines denied due to an MUE, accounting for any subsequently paid units of service.
Data Source:	MCS, Viable Information Processing Systems (VIPS) Medicare System (VMS), and Fiscal Intermediary Shared System (FISS) claims data in the IDR

First implemented in 2007, NCCI MUEs prevent payment for the billing of an inappropriate quantity of the same service¹¹⁷ rendered by the same provider for the same beneficiary on the same DOS. An MUE for a given service defines the maximum units of that service that a provider would report under most circumstances for the same beneficiary on the same DOS. MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS edit, the MUE value is compared to the sum of all UOS for the same HCPCS/CPT code, provider, beneficiary, and DOS on claim lines of the current claim and paid claim lines of previously submitted claims. If the sum of all UOS exceeds the MUE value, all UOS for that HCPCS/CPT code and DOS are denied on the current claim.

NCCI MUEs apply to claims for hospital outpatient services; practitioner services; ambulatory surgery center services; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Before claims are sent to CWF, practitioner and ambulatory surgical MUEs are implemented in MCS, DMEPOS MUEs are implemented in VMS, and hospital outpatient service MUEs are implemented in FISS.

If a HCPCS/CPT code has an MUE adjudicated as a claim line edit, and when justified by clinical circumstances documented in the medical record, providers may use NCCI-associated modifiers to report the same HCPCS/CPT code on separate claim lines in order to receive payment for medically necessary services in excess of the MUE value.

¹¹⁶ A provider has up to one year to submit a claim and, thereafter, a specified period to file an appeal if the claim is denied. There may be a small percentage of claim line denials and appeals for a given fiscal year that are not included in the savings calculation. This is due to claims submission, adjudication, and appeal decisions after the data capture. This applies to all metrics that use claims data captured 90 days after the end of the fiscal year.

¹¹⁷ For the purpose of this document, the term “service” generally refers to an item or service.

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After an MUE denial, a provider could resubmit the service with corrected information that makes the claim payable. Providers also have the right to use the Medicare FFS appeals process to appeal denials due to either claim line or DOS MUEs.

CMS calculates savings attributable to MUEs in three steps: 1) identifying MUE denials, 2) pricing these denials, and 3) accounting for subsequent payment of previously denied services.

Identifying MUE Denials

System logic in MCS, VMS, and FISS automatically appends a specific reduction, action, or reason code, respectively, to claim lines that fail an MUE. During processing, claim lines may be denied for multiple errors. CMS attributes savings to MUEs only when an MUE code is the system's highest priority reason for denying a claim line.

When a claim line is denied, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, MUE denial of claim lines that share the same claim type code, HCPCS code, provider, beneficiary, and DOS.

Pricing MUE Denials

In order to quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.¹¹⁸ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS:* In VMS, most MUE denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and

¹¹⁸ For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

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other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹¹⁹ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each MUE denial based on the applicable pricing mechanism.¹²⁰ CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) the Hospital Outpatient Prospective Payment System (OPPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from MUE denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. First, CMS removes any savings from denied claim lines where the provider was subsequently paid for UOS above the MUE value, which may be due to medical necessity. Specifically, CMS does not count an MUE denial toward savings if the total paid UOS for claim lines with the same claim type code, HCPCS code, provider, beneficiary, and DOS as that denial exceed the MUE value. Second, CMS subtracts out subsequently paid UOS below the MUE value. Specifically, for claim lines with the same claim type code, HCPCS code, provider, beneficiary, and DOS and total paid UOS below the MUE value, CMS 1) subtracts the subsequently paid UOS from the earliest denied UOS and 2) multiplies the difference by the non-coinsurance price to obtain the remaining savings. Subsequently paid UOS include those claims lines that were processed after the earliest denial.

For a given MUE denied claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of MUE savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

¹¹⁹ For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

¹²⁰ CMS uses the provider-billed amount to estimate the price in the following situations: 1) when pricing indicators are unavailable and 2) for claim lines priced under the fee schedule where the calculated amount using CMS's pricing methodology is greater than the billed amount.

1.3 Ordering and Referring Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or rejected due to an O&R edit, accounting for any subsequently paid units of service.

Data Source: MCS and VMS claims data in the IDR

Physicians or other eligible professionals must be enrolled in or validly opted out of the Medicare program to order or refer certain items or services for Medicare beneficiaries. In addition, only physicians and certain types of non-physician practitioners are eligible to order or refer such items or services for Medicare beneficiaries. CMS implemented O&R edits to validate Part B clinical laboratory and imaging, DME, and Part A home health agency claims that require identification of the ordering/referring provider.¹²¹ O&R edits prevent inappropriate payment for items or services when the ordering/referring provider: 1) does not have an approved Medicare enrollment record or a valid opt-out affidavit and a valid National Provider Identifier (NPI) or 2) is not eligible to order or refer items or services for Medicare beneficiaries.¹²²

If a claim line does not pass the ordering/referring provider requirements, the O&R edit logic automatically denies or rejects the claim line.¹²³ This prevents payment to the billing provider, i.e., the provider who furnished the item or service based on the order or referral. CMS regularly updates a public ordering/referring data file containing the NPIs and names of physicians and eligible professionals who have approved Medicare enrollment records or valid opt-out affidavits on file and are of a type/specialty that is eligible to order and refer. Billing providers may reference this information to ensure that the physicians and eligible professionals from whom they accept orders and referrals meet Medicare's criteria.

After an O&R edit denial/rejection, a provider could resubmit the service with corrected information that makes the claim payable. Providers may also have the right to appeal O&R edit denials through the Medicare FFS appeals process.

¹²¹ The term ordering/referring provider denotes the person who ordered, referred, or certified an item or service reported in a claim.

¹²² CMS calculates savings from Phase 2 O&R edits, which were fully implemented in January 2014. See MLN Matters® article #SE1305 “Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A Home Health Agency (HHA) Claims” for additional information. CMS also includes savings from a previously-implemented edit that identifies claims missing the required matching NPI for the ordering/referring provider.

¹²³ Claims are rejected when the required matching NPI is missing. Claims are denied when 1) the ordering/referring provider is not allowed to order/refer or 2) there is a mismatch in the ordering/referring provider information.

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CMS currently calculates savings due to O&R edits for Part B clinical laboratory and imaging claims and DME claims, which are implemented in MCS and VMS, respectively, before claims are sent to CWF. CMS calculates savings attributable to O&R edits in three steps: 1) identifying O&R edit denials/rejections, 2) pricing these denials/rejections, and 3) accounting for subsequent payment of previously denied/rejected services.

Identifying O&R Edit Denials and Rejections

System logic in MCS and VMS automatically appends a specific reduction or action code, respectively, to claim lines that fail an O&R edit. During processing, claim lines may be denied for multiple errors. CMS attributes savings to O&R edits only when an O&R edit code is the system's highest priority reason for denying or rejecting a claim line.

When a claim line is denied or rejected, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials/rejections for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, O&R denial or rejection of claim lines that share the same claim type code, HCPCS code, rendering provider, beneficiary, and DOS.

Pricing O&R Edit Denials and Rejections

In order to quantify what Medicare did not have to pay for each denial/rejection, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.¹²⁴ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS:* In VMS, few O&R edit denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average

¹²⁴ For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

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allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹²⁵ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/rejected services. Specifically, where there are any subsequently paid claim lines for a previously denied/rejected service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from the priced amount of the earliest denial/rejection, up to that priced amount. Subsequently paid claim lines include those that were processed after the earliest denial/rejection and that share the same claim type code, HCPCS code, rendering provider, beneficiary, and DOS. All amounts used in these steps have the estimated beneficiary coinsurance removed.

For a given O&R denied or rejected claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of O&R edits savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

1.4 Fraud Prevention System Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or rejected due to an FPS edit, accounting for any subsequently paid claim lines.

Data Source: 1) FPS and 2) CWF claims data

The FPS is capable of evaluating claims for episodes of care that span different service types or providers (e.g., inpatient care, outpatient and practitioner services, and DME) as well as those that span multiple visits over a period of time. Because of its integrated potential fraud identification capabilities, CMS implements both edits and analytical models in the FPS to address vulnerabilities for fraud, waste, and abuse on a national level. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if an FPS edit is an appropriate and effective action against that vulnerability,

¹²⁵ For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

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or if other approaches, such as an FPS model¹²⁶ or provider education, are better suited for the issue. CMS continuously develops new FPS edits and updates existing edits.

FPS edits screen Medicare FFS claims prior to payment. FPS edits automatically reject or deny claim lines for non-covered, incorrectly coded, or inappropriately billed services not payable under Medicare policy. FPS edits occur after NCCI, prepayment, and local MAC edits but prior to some CWF edits. Providers have the right to appeal FPS edit denials through the Medicare FFS appeals process. Unlike for denials, providers may not appeal FPS rejections, but they are allowed to resubmit their claims with additional or corrected information.

When a claim line is denied or rejected, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, FPS denial or rejection of claim lines that share the same HCPCS code, provider, beneficiary, and DOS. For most denied or rejected claim lines, FPS automatically generates the price, i.e., the amount Medicare would have paid for that claim line. The pricing data fields are the Medicare payment amount for Part A claims and the provider reimbursement amount for Part B claims. Both amounts exclude the beneficiary cost share. A small number of claim lines do not have a priced amount and are not included in savings.

To estimate actual costs avoided, CMS subtracts any subsequently paid resubmissions from the priced amount of the earliest denial or rejection, up to that priced amount. Paid resubmissions include paid claim lines that were processed after the earliest denial or rejection and that share the same HCPCS code, provider, beneficiary, and DOS.

For a given FPS denied or rejected claim line, CMS reports savings in the fiscal year during which the claim line was processed. The calculation of FPS edits savings uses claims data captured 90 days after the end of the fiscal year to allow time for appeals.

1.5 Medicare Administrative Contractor Automated Medical Review Edits

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by MAC automated medical review edits, accounting for subsequently paid claims or claim lines.

Data Source: MCS, VMS, and FISS claims data in the IDR

The MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. CMS awards a geographic

¹²⁶ FPS models look for aberrant billing patterns in post-payment claims data. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation by ZPICs/UPICs.

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jurisdiction to each MAC to process and pay Medicare Part A and Part B medical claims¹²⁷ or DME claims. The MACs perform a variety of operational functions, but this document focuses on MAC activities in support of program integrity.

CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program,¹²⁸ the Government Accountability Office (GAO), the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Medicare FFS Recovery Audit Contractors (RACs), and other sources. The MACs' medical review efforts focus on reducing payment errors; thus, the MACs refer cases of potential fraud to ZPICs/UPICs. The MACs conduct most of their medical review activities prior to payment using both automated and non-automated, or manual, methods (see Section 2.2 for non-automated medical reviews that occur prior to payment and Section 5.3 for post-payment medical reviews).

CMS generally considers medical review as automated when a payment decision is made at the system level with no manual intervention. The MACs develop and implement automated medical review edits in MCS, VMS, and FISS to automatically deny payment for non-covered, incorrectly coded, or inappropriately billed services. The MACs must base these automated denials on clear policy, such as a local coverage determination. Another type of automated medical review edit automatically denies claims or claim lines that had been suspended for non-automated review but the provider did not respond in a timely manner to an additional documentation request (ADR).

Providers have the right to appeal MAC automated medical review edit denials through the Medicare FFS appeals process.

CMS calculates savings attributable to MAC automated medical review edit denials in three steps: 1) identifying MAC automated medical review edit denials, 2) pricing these denials, and 3) accounting for subsequent payment of previously denied services.¹²⁹

1. Identifying MAC Automated Medical Review Edit Denials

¹²⁷ CMS contracts with four of the A/B MACs to also process home health and hospice claims across the nation.

¹²⁸ Through the CERT program, CMS annually calculates the Medicare FFS improper payment rate by determining if claims in a statistically-valid random sample were properly paid under Medicare coverage, coding, and billing rules.

¹²⁹ In FY 2018, CMS implemented a standardized savings calculation for MAC medical review denials in FISS, which aligns with CMS's standardized calculations for MCS and VMS and replaces the use of MAC-reported savings.

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System logic in MCS and VMS automatically appends a specific Program Integrity Management Reporting (PIMR) activity code¹³⁰ to claim lines that fail an automated medical review edit. In MCS, CMS identifies automated medical review denials as those denied claim lines tagged with the MAC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies automated medical review denials as those denied claim lines with a combination of the MAC-specific automated PIMR activity code and a medical review edit code in the automated range provided by each MAC.¹³¹

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of automated review.¹³² For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim¹³³ or claim line level.¹³⁴

When a claim or claim line is denied, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest processed medical review edit denial among matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines as those that share the same HCPCS code, rendering provider, beneficiary, and DOS. In FISS, CMS considers matching claims as those that share the same claim type code,

¹³⁰ CMS previously maintained a PIMR system, which interfaced with the claims processing systems and provided system-generated reports of cost, savings, and workload data related to each MAC's medical review unit. Although CMS retired the PIMR system in 2012, it retained the PIMR data fields in the claims processing systems for the MACs' continued use.

¹³¹ CMS does not currently have a comprehensive way to determine if a MAC medical review denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over MAC medical review denials.

¹³² The MACs annually provide CMS with lists of edit and denial reason codes used for medical review. CMS also includes the cross-contractor reason code 56900 (failure to comply with an ADR) as a MAC-specific code, when other claim attributes indicate a MAC reviewed the applicable claim/claim line. In some cases, MAC-denied claims/claim lines do not have an edit reason code or PIMR code to indicate automated or non-automated medical review. CMS counts these cases as automated medical review savings because MAC denials without an edit reason code most frequently have an automated PIMR code.

¹³³ For services reimbursed at the claim line level, if CMS identifies a MAC denial at the claim level, CMS excludes from savings any claim lines with non-MAC-specific denial reason codes.

¹³⁴ CMS considers MAC-denied claim lines in MAC medical review savings *only if* the claim-level denial reason code is 1) a MAC or ZPIC/UPIC-specific medical review code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

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beneficiary, provider, and DOS or admission date, and it considers matching claim lines as those that share the same claim type code, beneficiary, provider, HCPCS code, and DOS.¹³⁵

2. Pricing MAC Automated Medical Review Edit Denials

In order to quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS*: In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.¹³⁶ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS*: In VMS, the majority of MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹³⁷ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated

¹³⁵ In FISS, CMS also may match claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

¹³⁶ For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹³⁷ For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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medical review denial based on the applicable pricing mechanism.¹³⁸ CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a prospective payment system (PPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claims or claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claims or claim lines include those that were processed after the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial. In FISS, claim-level attributes are the same claim type code, beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial.¹³⁹ Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

For a given denied claim or claim line, CMS reports savings in the fiscal year during which the DOS or admission date for that claim or claim line occurred. The calculation of MAC automated medical review edit savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

1.6 Zone Program Integrity Contractor/Unified Program Integrity Contractor Automated Edits

Savings:	The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by ZPIC/UPIC-initiated automated edits, accounting for subsequently paid claims or claim lines.
Data Source:	MCS, VMS, and FISS claims data in the IDR

¹³⁸ CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

¹³⁹ In FISS, CMS also may identify subsequently paid claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

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The primary goal of ZPICs/UPICs is to identify cases of suspected fraud, waste, and abuse; develop cases thoroughly and in a timely manner; and take immediate action to ensure that Medicare funds are not inappropriately paid. ZPICs/UPICs have teams of investigators, data analysts, and medical reviewers to perform program integrity functions for the Medicare FFS program and the Medicare-Medicaid Data Match Program. CMS has established geographic program integrity jurisdictions¹⁴⁰ to cover the nation, and each ZPIC/UPIC operates in a specific jurisdiction. ZPICs/UPICs receive leads about potential fraud from several sources, including complaints, MACs, FPS, CMS, and HHS-OIG. ZPICs/UPICs also conduct their own proactive data analysis to look for aberrant billing patterns.

During investigations, ZPICs/UPICs may request and review medical records from providers; analyze data; conduct interviews with beneficiaries, providers, or other medical personnel; and conduct onsite visits to provider locations. Based on the findings and sometimes CMS's approval, ZPICs/UPICs initiate appropriate administrative actions, such as denying or suspending payment that should not be made to a provider due to reliable evidence of fraud or abuse.¹⁴¹

Automated edits are among the administrative actions a ZPIC/UPIC may initiate. A ZPIC/UPIC may request that the MAC within its jurisdiction implement automated edits¹⁴² to address program integrity issues and prevent the loss of future Medicare funds. In most cases, the MACs must comply with ZPICs'/UPICs' requests to install automated edits in the relevant local claims processing system. Depending on the issue, these ZPIC/UPIC-initiated edits may automatically deny payment for 1) non-covered, incorrectly coded, or inappropriately billed services, 2) services submitted by suspicious providers, or 3) certain types of services for beneficiaries identified as part of a fraud scheme. Another type of ZPIC/UPIC automated edit denies claim lines that had been suspended for non-automated review but the provider did not respond in a timely manner to an ADR.

Providers have the right to appeal ZPIC/UPIC automated edit denials through the Medicare FFS appeals process.

¹⁴⁰ The Midwestern and Northeastern UPIC jurisdictions were operational throughout FY 2018. Five ZPIC zones remained active until the Southeastern, Southwestern, and Western UPIC jurisdictions became operational in the third quarter of FY 2018.

¹⁴¹ The administrative actions that may result from ZPIC/UPIC investigations include automated edits, non-automated reviews (Section 2.3) provider enrollment revocations and deactivations (Section 3), payment suspensions, post-payment reviews (Section 5.6), and referrals to law enforcement (Section 9.1).

¹⁴² Depending on the jurisdiction, a UPIC may install DME automated edits in VMS, the system that processes DME claims.

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CMS calculates savings attributable to ZPIC/UPIC automated edits in three steps: 1) identifying ZPIC/UPIC automated edit denials, 2) pricing these denials, and 3) accounting for subsequent payment of previously denied services.¹⁴³

1. Identifying ZPIC/UPIC Automated Edit Denials

System logic in MCS and VMS automatically appends a specific PIMR activity code to claim lines that fail an automated edit. In MCS, CMS identifies ZPIC/UPIC automated edit denials as those denied claim lines tagged with the ZPIC/UPIC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies automated edit denials as those denied claim lines with the ZPIC/UPIC-specific automated PIMR activity code and a medical review edit code in the ranges allocated by each MAC for ZPIC/UPIC use.¹⁴⁴

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies ZPIC/UPIC automated denials as those denied claims or claim lines with a ZPIC/UPIC-specific code as the denial reason and a ZPIC/UPIC-specific edit reason code or PIMR code indicative of automated review.¹⁴⁵ For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim¹⁴⁶ or claim line level.¹⁴⁷

When a claim or claim line is denied, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest processed automated edit denial among

¹⁴³ In FY 2018, CMS implemented standardized savings calculations for ZPIC/UPIC denials in MCS, VMS, and FISS, which replaces the use of ZPIC/UPIC-reported savings.

¹⁴⁴ CMS does not currently have a comprehensive way to determine if a ZPIC/UPIC denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over ZPIC/UPIC automated denials.

¹⁴⁵ The MACs annually provide CMS with lists of edit and denial reason codes used for ZPICs/UPICs. CMS also includes the cross-contractor reason code 56900 (failure to comply with an ADR) as a ZPIC/UPIC-specific code, when other claim attributes indicate a ZPIC/UPIC reviewed the applicable claim/claim line. In some cases, ZPIC/UPIC-denied claims/claim lines do not have an edit reason code or PIMR code to indicate automated or non-automated review. CMS counts these cases as automated review savings.

¹⁴⁶ For services reimbursed at the claim line level, if CMS identifies a ZPIC/UPIC denial at the claim level, CMS excludes from savings any claim lines with non-ZPIC/UPIC-specific denial reason codes.

¹⁴⁷ CMS considers ZPIC/UPIC-denied claim lines in ZPIC/UPIC savings *only if* the claim-level denial reason code is 1) a ZPIC/UPIC-specific code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

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matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines as those that share the same HCPCS code, rendering provider, beneficiary, and DOS. In FISS, CMS considers matching claims as those that share the same claim type code, beneficiary, provider, and DOS or admission date, and it considers matching claim lines as those that share the same claim type code, beneficiary, provider, HCPCS code, and DOS.¹⁴⁸

2. Pricing ZPIC/UPIC Automated Edit Denials

In order to quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most ZPIC/UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.¹⁴⁹ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS:* In VMS, some of the ZPIC/UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹⁵⁰ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated

¹⁴⁸ In FISS, CMS also may match claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

¹⁴⁹ For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹⁵⁰ For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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denial based on the applicable pricing mechanism.¹⁵¹ CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a prospective payment system (PPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claims or claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claims or claim lines include those that were processed after the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial. In FISS, claim-level attributes are the same claim type code, beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial.¹⁵² Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

For a given denied claim or claim line, CMS reports savings in the fiscal year during which the DOS or admission date for that claim or claim line occurred. The calculation of ZPIC/UPIC automated edit savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

2 Prepayment Review Actions

Some claims may require manual examination before they are paid to ensure that providers complied with Medicare policy. This document uses the broad category of prepayment review actions to describe program integrity activities involving manual processing prior to an initial claim determination. CMS calculates prepayment review action savings from the following activities for Medicare FFS claims:

¹⁵¹ CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

¹⁵² In FISS, CMS also may identify subsequently paid claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

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- Medicare Secondary Payer (MSP) Operations¹⁵³
- MAC Non-Automated Medical Reviews
- ZPIC/UPIC Non-Automated Reviews

2.1 Medicare Secondary Payer Operations

Savings:	The amount Medicare FFS would have paid as the primary payer, minus Medicare's secondary payment (as applicable), for all instances of MSP records available during prepayment claims processing.
Data Source:	1) Contractor Reporting of Operational and Workload Data (CROWD) system and 2) CMS records of Workers' Compensation Medicare Set-Aside Agreements (WCMSAs)

MSP is the term used to describe the set of provisions governing primary payment responsibility when a beneficiary has other health insurance or coverage in addition to Medicare. Over the years, Congress has passed legislation that made Medicare the secondary payer to certain primary plans in an effort to shift costs from Medicare to the appropriate private sources of payment. If a beneficiary has Medicare and other health insurance or coverage that may be expected to pay for medical expenses, coordination of benefits rules determine which entity pays first, second, and so forth.

The types of other health insurance or coverage that may have primary payment responsibility for a beneficiary's claim include the following:

- Group health plan (GHP)¹⁵⁴
- Liability insurance (including self-insurance)¹⁵⁵
- No-fault insurance¹⁵⁶

¹⁵³ MSP operations involve the collection and identification of MSP occurrences and the application through automated edits and manual examination of claims.

¹⁵⁴ A GHP is a health insurance plan offered by an employer or other plan sponsor (e.g., union or employee health and welfare fund). A Medicare beneficiary may be eligible for GHP employee/family coverage if he/she or a spouse is currently working, or for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Specific situations, including employer size and the beneficiary's status (e.g., age 65 or older, disabled, and/or end-stage renal disease), determine whether Medicare or the GHP has primary payment responsibility. Some Medicare beneficiaries have retiree GHP coverage through a former employer. For these beneficiaries, Medicare is always the primary payer, and the retiree GHP is the secondary payer.

¹⁵⁵ Liability insurance may pay for medical expenses resulting from negligence, such as inappropriate action or inaction that causes injury. Examples of liability insurance types include automobile, uninsured/underinsured motorist, homeowners', product, and malpractice.

¹⁵⁶ No-fault insurance may pay for medical expenses resulting from injury in an accident, regardless of who is at fault for causing the accident. Examples of no-fault insurance types include automobile, homeowners', and commercial.

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- Workers' compensation (WC)¹⁵⁷

In situations when Medicare is not the primary payer, providers must bill the primary payer(s) before billing Medicare. If services are not covered in full by the primary payer(s), Medicare may make secondary payments for the services, as Medicare coverage allows. When a beneficiary does not have other health insurance or coverage for a claim, Medicare remains the primary payer.

CMS's MSP operations involve prevention of erroneous primary payments as well as recovery of mistaken or conditional payments made by Medicare (see sections 5.1 and 5.2 for additional information about recovery efforts). CMS collects information about Medicare beneficiaries' other health insurance or coverage through a variety of methods. These methods include mandatory reporting by other insurers regarding covered Medicare beneficiaries, beneficiary self-reporting of other coverage, and claims investigations. In addition, Medicare providers are obligated to ask Medicare beneficiaries about other coverage and submit that information with Medicare claims.

In order to prevent erroneous primary payments, CMS records MSP information for beneficiaries in the CWF, which is the system that maintains beneficiary claims history and entitlement information. Incoming claims are automatically checked against MSP records. System logic built into the CWF 1) allows Medicare to pay correctly when incoming claims are correctly billed to Medicare as a secondary payer and 2) enables the CWF to automatically deny or reject a claim that is erroneously billed to Medicare as the primary payer.

Some MSP-related claims may require manual intervention by the MACs. A claims examiner reviews the claim and information about other coverage. Depending on the findings regarding payment responsibility, the claim may be adjusted such that Medicare only makes a secondary payment, or the claim may be rejected or denied. The MACs then attribute costs avoided to the associated MSP records.¹⁵⁸

Providers may appeal or resubmit a denied/rejected claim and provide additional information to support receiving payment. If the primary payer is not expected to promptly pay the claim, a provider may receive a conditional payment from Medicare (see Section 5.1). If the primary payer denies the claim or makes an exhausted benefits determination, a provider may bill Medicare and include documentation of the primary payer's denial or determination. Medicare may make a payment, as Medicare coverage allows.

To determine savings, the amount Medicare would have paid as the primary payer is based on the Medicare fee schedule and Medicare coverage of items and services. What Medicare pays as the secondary payer is subtracted from this amount. In general, savings

¹⁵⁷ WC refers to a law or plan requiring employers to cover employees who get sick or injured on the job.

¹⁵⁸ The MACs' MSP-related claims processing efforts are not currently included in the MSP program obligations in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

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are reported in the fiscal year during which the dates of service or dates of discharge for the applicable claims occurred.¹⁵⁹ For WCMSAs,¹⁶⁰ the full amount set aside is reported in the fiscal year during which the agreement is set up. Since Medicare does not receive ongoing WC claims, yearly savings due to WCMSAs cannot be determined.

2.2 Medicare Administrative Contractor Non-Automated Medical Reviews

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied prior to payment by MAC non-automated medical reviews, accounting for subsequently paid claims or claim lines.

Data Source: MCS, VMS, and FISS claims data in the IDR

In addition to automated medical review edits (see Section 1.5), the MACs conduct non-automated, or manual, medical reviews where there is risk for improper payment. In MCS, VMS, and FISS, the MACs implement non-automated medical review edits, which suspend all or part of a claim possessing the targeted criteria for review. The MACs may request additional documentation from providers (i.e., through an ADR), and specific time frames apply to providers' submission of documentation and the MACs' completion of reviews. Each MAC has a medical review staff of trained clinicians and claims analysts, who review claims and associated documentation in order to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, are up- or down-coded for adjusted payment. The MACs also offer providers education to resolve errors and improve future accuracy.¹⁶¹

Providers have the right to appeal MAC non-automated medical review denials through the Medicare FFS appeals process.

¹⁵⁹ For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

¹⁶⁰ A workers' compensation settlement may provide for funds to be set aside to pay for future medical and/or prescription drug expenses related to an injury, illness, or disease. A WCMSA may be set up for using these funds. Medicare will not pay for any medical expenses related to the injury, illness, or disease until all of the set-aside funds are used appropriately.

¹⁶¹ Effective FY 2018, CMS implemented Targeted Probe and Educate (TPE), a national medical review strategy that focuses on providers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. TPE involves up to three rounds of prepayment or post-payment claim review combined with individualized provider education. See Section 5.3 for information about MAC post-payment medical reviews.

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CMS calculates savings attributable to MAC non-automated medical review denials in three steps: 1) identifying MAC non-automated medical review denials, 2) pricing these denials, and 3) accounting for subsequent payment of previously denied services.¹⁶²

1. Identifying MAC Non-Automated Medical Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit (i.e., manual routine review, complex probe review, prepayment complex provider-specific review, and prepayment complex manual review) that fired on a given claim line. In MCS, CMS identifies non-automated medical review denials as those denied claim lines tagged with a MAC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies non-automated medical review denials as those denied claim lines with a combination of a MAC-specific non-automated review PIMR activity code and a medical review edit code in the non-automated ranges provided by each MAC.¹⁶³

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC non-automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of non-automated medical review.¹⁶⁴ For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim¹⁶⁵ or claim line level.¹⁶⁶

CMS only counts savings from the earliest processed medical review edit denial among matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines

¹⁶² In FY 2018, CMS implemented a standardized savings calculation for MAC medical review denials in FISS, which aligns with CMS's standardized calculations for MCS and VMS and replaces the use of MAC-reported savings.

¹⁶³ For VMS, CMS notes two methodological items related to attribution. First, for the rare cases where a claim line has a category mismatch between the PIMR activity code and the medical review edit code (e.g., an automated PIMR activity code and a medical review edit code in the non-automated range), CMS categorizes the denial based on the medical review edit code. Second, CMS does not currently have a comprehensive way to determine if a MAC medical review denial is the system's highest priority reason for denying the claim line. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over MAC medical review denials.

¹⁶⁴ The MACs annually provide CMS with lists of edit and denial reason codes used for medical review.

¹⁶⁵ For services reimbursed at the claim line level, if CMS identifies a MAC denial at the claim level, CMS excludes from savings any claim lines with non-MAC-specific denial reason codes.

¹⁶⁶ CMS considers MAC-denied claim lines in MAC medical review savings *only if* the claim-level denial reason code is 1) a MAC or ZPIC/UPIC-specific medical review code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

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as those that share the same HCPCS code, rendering provider, beneficiary, and DOS. In FISS, CMS considers matching claims as those that share the same claim type code, beneficiary, provider, and DOS or admission date, and it considers matching claim lines as those that share the same claim type code, beneficiary, provider, HCPCS code, and DOS.¹⁶⁷

2. Pricing MAC Non-Automated Medical Review Denials

In order to quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS*: In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.¹⁶⁸ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS*: In VMS, the majority of MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹⁶⁹ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated

¹⁶⁷ In FISS, CMS also may match claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

¹⁶⁸ For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹⁶⁹ For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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medical review denial based on the applicable pricing mechanism.¹⁷⁰ CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a prospective payment system (PPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claims or claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claims or claim lines include those that were processed after the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial. In FISS, claim-level attributes are the same claim type code, beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial.¹⁷¹ Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

For a given denied claim or claim line, CMS reports savings in the fiscal year during which the DOS or admission date for that claim or claim line occurred. The calculation of MAC non-automated medical review savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

2.3 Zone Program Integrity Contractor/Unified Program Integrity Contractor Non-Automated Reviews

Savings:	The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by ZPIC/UPIC non-automated reviews, accounting for subsequently paid claims or claim lines.
Data Source:	MCS, VMS, and FISS claims data in the IDR

¹⁷⁰ CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

¹⁷¹ In FISS, CMS also may identify subsequently paid claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

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In addition to automated edits (see Section 1.6), a ZPIC/UPIC may request that the MAC in their jurisdiction implement non-automated prepayment review edits in the local claims processing system¹⁷² to identify and suspend claims for medical review prior to payment.

To initiate non-automated review, the MAC sends an ADR to the provider under review. In that notice, the provider is instructed to provide the necessary medical record documentation to the ZPIC/UPIC for further review. In accordance with CMS guidance, the provider must submit the necessary documentation to the ZPIC/UPIC within 45 calendar days or the claims are denied.¹⁷³ Once the documentation is received, the ZPIC/UPIC examines the medical records for compliance with Medicare policy while determining if there is evidence of fraud, waste, or abuse. When the medical documentation does not support the services billed by the provider, the ZPIC/UPIC denies or adjusts payment for the claims.

Providers have the right to appeal ZPIC/UPIC non-automated review denials through the Medicare FFS appeals process.

CMS calculates savings attributable to ZPIC/UPIC non-automated review denials in three steps: 1) identifying ZPIC/UPIC non-automated review denials, 2) pricing these denials, and 3) accounting for subsequent payment of previously denied services.¹⁷⁴

1. Identifying ZPIC/UPIC Non-Automated Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit (i.e., manual routine review, complex probe review, prepayment complex provider-specific review, and prepayment complex manual review) that fired on a given claim line. In MCS, CMS identifies ZPIC/UPIC non-automated review denials as those denied claim lines tagged with a ZPIC/UPIC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies non-automated review denials as those denied claim

¹⁷² Depending on the jurisdiction, a ZPIC/UPIC may install DME prepayment review edits in VMS, the system that processes DME claims.

¹⁷³ CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

¹⁷⁴ In FY 2018, CMS changed the title of this metric from “ZPIC/UPIC Prepayment Reviews” to “ZPIC/UPIC Non-Automated Reviews.” CMS also implemented standardized savings calculations for ZPIC/UPIC non-automated review denials in MCS, VMS, and FISS, which replaces the use of ZPIC/UPIC-reported savings.

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lines with a ZPIC/UPIC-specific non-automated review PIMR activity code and a medical review edit code in the ranges allocated by each MAC for ZPIC/UPIC use.¹⁷⁵

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies ZPIC/UPIC non-automated review denials as those denied claims or claim lines with a ZPIC/UPIC-specific code as the denial reason and a ZPIC/UPIC-specific edit reason code or PIMR code indicative of non-automated review.¹⁷⁶ For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim¹⁷⁷ or claim line level.¹⁷⁸

CMS only counts savings from the earliest processed non-automated review denial among matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines as those that share the same HCPCS code, rendering provider, beneficiary, and DOS. In FISS, CMS considers matching claims as those that share the same claim type code, beneficiary, provider, and DOS or admission date, and it considers matching claim lines as those that share the same claim type code, beneficiary, provider, HCPCS code, and DOS.¹⁷⁹

2. Pricing ZPIC/UPIC Non-Automated Review Denials

In order to quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most ZPIC/UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality,

¹⁷⁵ CMS does not currently have a comprehensive way to determine if a ZPIC/UPIC non-automated review denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over ZPIC/UPIC review denials.

¹⁷⁶ The MACs annually provide CMS with lists of edit and denial reason codes used for ZPICs/UPICs.

¹⁷⁷ For services reimbursed at the claim-line level, if CMS identifies a ZPIC/UPIC denial at the claim level, CMS excludes from savings any claim lines with non- ZPIC/UPIC-specific denial reason codes.

¹⁷⁸ CMS considers ZPIC/UPIC-denied claim lines in ZPIC/UPIC savings *only if* the claim-level denial reason code is 1) a ZPIC/UPIC-specific code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

¹⁷⁹ In FISS, CMS also may match claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

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place of service, and pricing modifier.¹⁸⁰ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS*: In VMS, the majority of ZPIC/UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).¹⁸¹ CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated review denial based on the applicable pricing mechanism.¹⁸² CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a prospective payment system (PPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claims or claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claims or claim lines include those that were processed after the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary,

¹⁸⁰ For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹⁸¹ For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

¹⁸² CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70% to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

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and DOS as the denial. In FISS, claim-level attributes are the same claim type code, beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial.¹⁸³ Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

For a given denied claim or claim line, CMS reports savings in the fiscal year during which the DOS or admission date for that claim or claim line occurred. The calculation of ZPIC/UPIC non-automated review edit savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

3 Provider Enrollment Actions

Providers must enroll in the Medicare FFS program to be paid for covered services they furnish to Medicare beneficiaries. In order to enroll, providers must submit a paper CMS-855 enrollment application or a corresponding online application through the Provider Enrollment Chain and Ownership System (PECOS) and then undergo risk-based screening. If a prospective provider does not meet eligibility requirements, CMS denies enrollment. Once enrolled, providers are responsible for keeping their enrollment information (e.g., address, practice location, adverse legal actions, etc.) up-to-date. CMS may revoke or deactivate a currently enrolled provider's Medicare billing privileges if the provider's behavior triggers one or more of the 14 revocation reasons or three deactivation reasons.

A provider may have multiple enrollments (e.g., enrollments per state or specialty), and CMS's administrative actions occur at the individual enrollment level. Depending on the circumstances, CMS may deny, revoke, or deactivate one or more of a provider's enrollments. If CMS applies an administrative action to all of a provider's enrollments, the provider cannot bill Medicare. If CMS applies an administrative action to only a subset of a provider's enrollments, the provider can continue to bill Medicare through its remaining active enrollments, as appropriate.

CMS estimates savings in Medicare FFS due to provider revocations and deactivations. The methodology uses each revoked or deactivated provider's claims history to project avoided costs assuming a revoked or deactivated provider would have continued the same billing patterns.

¹⁸³ In FISS, CMS also may identify subsequently paid claims or claim lines as those with the same original claim control number or the same original claim control and line number, respectively.

3.1 Revocations

Savings:	The projected amount Medicare FFS did not pay fully revoked providers during each provider's re-enrollment bar, based on a weighted moving average of each provider's historically paid claims and adjusted to exclude estimated amounts from expected billing by active providers for like services as previously billed by revoked providers for the same beneficiaries.
Data Source:	1) PECOS, 2) Previous 18 months of CWF claims data for each revoked provider, and 3) Cost avoidance adjustment factor

CMS has 14 regulatory reasons upon which to revoke a provider's Medicare FFS billing privileges. Examples include non-compliance with Medicare enrollment requirements, certain felony convictions, submission of false or misleading application information, determination that the provider is non-operational, abuse of billing privileges, failure to comply with enrollment reporting requirements, and termination of Medicaid billing privileges. Depending on the revocation reason, CMS bars a provider from re-enrolling in Medicare for one to three years.

If the revocation reason is non-compliance with Medicare enrollment requirements, a provider may submit a corrective action plan (CAP) for CMS's consideration. If CMS approves the CAP, the provider's revocation is rescinded. If CMS denies the CAP, the provider cannot appeal that decision but may continue through the appeals process for the revocation determination.

For all revocation reasons, a provider may appeal a revocation determination by requesting reconsideration before a CMS hearing officer. The reconsideration is an independent review conducted by an officer not involved in the initial determination. If the provider is dissatisfied with the reconsideration decision, the provider may request a hearing before an HHS Administrative Law Judge (ALJ) within the Departmental Appeals Board (DAB). Thereafter, a provider may seek DAB review and then judicial review.

CMS calculates costs avoided for fully revoked providers at the professional identifier and provider type level. As the professional identifier, CMS uses the NPI for individual providers and the Employer Identification Number (EIN) for provider organizations. CMS defines a full revocation as an NPI or EIN by provider type with at least one revoked enrollment and no other approved enrollments.¹⁸⁴ CMS verifies fully revoked

¹⁸⁴ In FY 2018, CMS updated the methodology to define a full revocation at the professional identifier and provider type level, instead of only at the professional identifier level. CMS also updated the methodology to include revocation savings from all Part A provider types. Previously, CMS counted revocation savings from the following provider types: Part B organization, Part B individual practitioner, home health agency, hospice, and DME supplier.

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providers in PECOS. Because providers have appeal rights, the savings metric only includes revocations in place for at least 90 days that have not been overturned on appeal. CMS captures CWF claims data 90 days after the midpoint and end of the fiscal year to allow time for claims adjudication and appeals.

CMS estimates the amount that Medicare did not pay fully revoked providers in two steps: 1) projecting costs avoided and 2) accounting for billing picked up by active providers. CMS includes a given revoked provider in the savings calculation for the fiscal year in which the provider became fully revoked.

Projecting Costs Avoided

CMS projects what Medicare would have paid a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider's full revocation date.¹⁸⁵ Using the paid claims in this 12-month period, CMS calculates the weighted moving average for each month of the revoked provider's re-enrollment bar to project the Medicare payments that provider would have received. The sum of the payment projections for each month represents the costs avoided for the revoked provider during the length of its re-enrollment bar.

Accounting for Billing Picked Up by Active Providers

CMS multiplies the sum of the projected costs avoided for all fully revoked providers by a standard, provider-type-specific proportion of Medicare's payments representing services not expected to be shifted to other active providers. This cost avoidance adjustment factor is derived from a historical sample of revoked providers and their beneficiaries. CMS calculates each provider-type-specific cost avoidance adjustment factor as the following ratio:¹⁸⁶

- Numerator: Pre-revocation billing minus post-revocation billing for the same beneficiaries and services, defined as:
 - Pre-revocation billing: The costs paid to any provider for the same services furnished to the same beneficiaries as appear in revoked providers' billing during the 180 days preceding each revoked provider's revocation

¹⁸⁵ CMS uses the earliest 12 months in the 18 months preceding the provider's revocation date because a provider may change its billing practices closer to the revocation date, especially if the provider becomes aware of CMS conducting a review or investigation of its claims.

¹⁸⁶ CMS's calculation of cost avoidance adjustment factors is based on FPS methodology certified by HHS-OIG. In FY 2018, CMS calculated an updated set of cost avoidance adjustment factors specific to the following provider types: Part B individual practitioner, Part B organization, DME supplier, home health agency, hospice, skilled nursing facility, other Part A provider – inpatient, and other Part A provider – outpatient.

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- Post-revocation billing: The costs paid to any provider for those same services furnished to those same beneficiaries during the 180 days following each revoked provider's revocation
- Denominator: The total cost of services paid to revoked providers for the same beneficiaries represented in the numerator during the 180 days preceding each provider's revocation

Since other providers may subsequently bill for the beneficiaries of revoked providers, this factor more conservatively estimates savings by removing the expected portion of the costs avoided projection for those services previously billed by revoked providers and subsequently expected to be picked up by active providers.

3.2 Deactivations

Savings:	The projected amount Medicare FFS did not pay fully deactivated providers during a 12-month period, based on a weighted moving average of each provider's historically paid claims and adjusted to exclude 1) estimated amounts from providers that may reactivate their enrollment within 12 months and 2) estimated amounts from expected billing by active providers for like services as previously billed by deactivated providers for the same beneficiaries.
Data Source:	1) PECOS, 2) Previous 12 months of CWF claims data for each deactivated provider, 3) Reactivation correction factor, and 4) Cost avoidance adjustment factor

CMS has three regulatory reasons upon which to deactivate, or stop, a provider's billing privileges. These reasons are no submission of Medicare claims for 12 consecutive calendar months, failure to report a change in information (e.g., practice location, billing services, or ownership), and failure to respond to a CMS notice to submit or certify enrollment information.¹⁸⁷ Unlike revocations, deactivations have no re-enrollment bars. In most cases, a provider can reactivate its enrollment in Medicare at any time by submitting a new enrollment application or recertifying the information on file.

CMS calculates costs avoided for fully deactivated providers at the professional identifier and provider type level. As the professional identifier, CMS uses the NPI for individual providers and the EIN for provider organizations. CMS defines a full deactivation as an NPI or EIN by provider type with at least one deactivated enrollment and no other

¹⁸⁷ In addition to the three regulatory reasons, CMS may also deactivate providers for other reasons, e.g., due to death or voluntary withdrawal from Medicare. In determining savings, CMS excludes deactivation reasons that do not represent active intervention to promote program integrity.

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approved or revoked enrollments.¹⁸⁸ CMS verifies fully deactivated providers in PECOS. CMS captures CWF claims data 90 days after the midpoint and end of the fiscal year to allow time for claims adjudication and appeals.

CMS estimates the amount that Medicare did not pay fully deactivated providers in three steps: 1) projecting costs avoided, 2) accounting for reactivations within 12 months, and 2) accounting for billing picked up by active providers. CMS includes a given deactivated provider in the savings calculation for the fiscal year in which the provider became fully deactivated.

Projecting Costs Avoided

CMS projects what Medicare would have paid a fully deactivated provider based on the 12 months of claims history preceding the provider's full deactivation date. Using the paid claims in this period, CMS calculates the weighted moving average for each month in a future 12-month period to project the Medicare payments that provider would have received. The sum of the payment projections for each month represents the costs avoided for the deactivated provider during a 12-month period.

Accounting for Reactivations within 12 Months

CMS multiplies the sum of the projected costs avoided for all fully deactivated providers by a reactivation correction factor, specifically the proportion of the previous year's total deactivation savings attributed to providers who remained deactivated for 12 months or more. CMS calculates a reactivation correction factor for each type of deactivation reason. Since deactivated providers can reactivate their enrollments at any time, this correction factor more conservatively estimates savings by removing the expected portion of the costs avoided projection for providers that may reactivate their enrollment within 12 months.

Accounting for Billing Picked Up by Active Providers

After accounting for reactivations within 12 months, CMS multiplies the costs avoided projection by a standard, provider-type-specific proportion of Medicare's payments representing services not expected to be shifted to other active providers. This cost avoidance adjustment factor is derived from a historical sample of deactivated providers

¹⁸⁸ In FY 2018, CMS updated the methodology to define a full deactivation at the professional identifier and provider type level, instead of only at the professional identifier level. CMS also updated the methodology to include deactivation savings from all Part A provider types. Previously, CMS counted deactivation savings from the following provider types: Part B organization, Part B individual practitioner, home health agency, hospice, and DME supplier.

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and their beneficiaries. CMS calculates each provider-type-specific cost avoidance adjustment factor as the following ratio:¹⁸⁹

- Numerator: Pre-deactivation billing minus post-deactivation billing for the same beneficiaries and services, defined as:
 - Pre-deactivation billing: The costs paid to any provider for the same services furnished to the same beneficiaries as appear in deactivated providers' billing during the 180 days preceding each deactivated provider's deactivation
 - Post-deactivation billing: The costs paid to any provider for those same services furnished to those same beneficiaries during the 180 days following each deactivated provider's deactivation
- Denominator: The total cost of services paid to deactivated providers for the same beneficiaries represented in the numerator during the 180 days preceding each provider's deactivation

Since other providers may subsequently bill for the beneficiaries of deactivated providers, this factor more conservatively estimates savings by removing the expected portion of the costs avoided projection for those services previously billed by deactivated providers and subsequently expected to be picked up by active providers.

4 Other Actions

4.1 Medicare Part D Reconciliation Data Reviews

CMS contracts with private health insurance companies and organizations to offer prescription drug benefits for Medicare beneficiaries who choose to enroll in Part D. Beneficiaries may join a stand-alone prescription drug plan (PDP) or a Medicare Advantage (MA) plan with prescription drug coverage. All Part D plans are required to provide a minimum set of prescription drug benefits, and Medicare subsidizes these basic benefits using four legislated payment mechanisms: direct subsidy, low-income subsidies, reinsurance subsidy, and risk corridors.

A plan receives monthly prospective payments from CMS for the direct subsidy, the low-income cost-sharing subsidy, and the reinsurance subsidy. During benefit-year-end reconciliation, CMS compares its prospective payments to a plan with the plan's actual

¹⁸⁹ CMS's calculation of cost avoidance adjustment factors is based on FPS methodology certified by HHS-OIG. In FY 2018, CMS calculated provider-type-specific cost avoidance adjustment factors based on deactivated providers' data, rather than using the cost avoidance adjustment factors based on revoked providers' data. These adjustment factors are specific to the following provider types: Part B individual practitioner, Part B organization, DME supplier, home health agency, hospice, skilled nursing facility, other Part A provider – inpatient, and other Part A provider – outpatient.

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cost data, submitted through prescription drug event (PDE) records¹⁹⁰ and direct and indirect remuneration (DIR)¹⁹¹ reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payment.

CMS validates both PDE and DIR data in advance of reconciliation and quantifies savings for each initiative, described in the following sections. In the FY 2018 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings* provides the sum of savings from both the PDE data quality review and DIR data review initiatives.¹⁹²

Prescription Drug Event Data Quality Review

Savings:	The sum of the differences in gross covered drug costs between the initial and corrected versions of PDEs flagged during pre-reconciliation data quality review and subsequently adjusted or deleted by Part D plan sponsors.
Data Source:	PDE records from the IDR, which are flagged and tracked by the data analysis contractor

During the benefit year, CMS conducts data analysis and validation of PDE records to flag data quality issues for Part D sponsors' review and action. This pre-reconciliation data quality review initiative promotes accuracy in the plan-reported financial data used in the Part D year-end payment reconciliation process. CMS's Part D data analysis contractor receives a weekly data stream from the Drug Data Processing System (DDPS)¹⁹³ and analyzes PDE records for outliers or potential errors in the following categories:

- Total gross drug cost
- Per-unit drug price
- Quantity/daily dosage

¹⁹⁰ Every time a beneficiary fills a prescription under a Part D plan, the plan sponsor must submit a PDE summary record to CMS. A PDE record contains information about the beneficiary, prescriber, pharmacy, dispensed drug, drug cost, and payment.

¹⁹¹ DIR is any price concession or arrangement that serves to decrease the costs incurred by a Part D sponsor for a drug. Examples of DIR include discounts, rebates, coupons, and free goods contingent on a purchase agreement offered to some or all purchasers, such as manufacturers, pharmacies, and enrollees. Some DIR, namely POS price concession, is already reflected in the drug price reported on the PDE. Plans must report other types of DIR annually to CMS.

¹⁹² FY 2016 was the first year that CMS included savings from Medicare Part D reconciliation data reviews in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. Part D payment reconciliation is an established process, and CMS has conducted the data review activities for several years.

¹⁹³ Before CMS conducts data quality reviews, PDE records are subject to edits in both the Prescription Drug Front-End System and the DDPS.

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- Duplicate PDEs¹⁹⁴
- MSP issues
- Covered plan-paid and low income cost-sharing amounts in the catastrophic coverage phase of the benefit

The Part D data analysis contractor posts reports of flagged PDEs to a PDE analysis website shared with Part D plan sponsors. Sponsors have specified time frames to review, investigate, and act on the reports by a) providing a written response explaining the validity of a PDE or b) adjusting or deleting a PDE accordingly if the PDE is invalid.¹⁹⁵ The Part D data analysis contractor stops reviewing and flagging PDEs for a given benefit year when CMS finalizes payment reconciliation, typically in September following the benefit year.

Among the PDEs flagged during pre-reconciliation data quality review, CMS quantifies savings by summing the differences in gross covered drug costs between the initial and corrected versions of PDEs adjusted or deleted by plan sponsors. This metric represents the reduction in drug costs included in the payment reconciliation process.¹⁹⁶ The calculation of data quality review savings typically uses benefit-year data captured in September following the benefit year.¹⁹⁷ For a given benefit year, CMS reports savings in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

Direct and Indirect Remuneration Data Review

Savings:	The sum of the differences in Medicare's reinsurance and risk corridor shares, comparing a reconciliation simulation using the initially-submitted DIR with the actual reconciliation using the reviewed and finalized DIR for each plan.
Data Source:	1) DIR data reported by Part D plan sponsors in the Health Plan Management System (HPMS) and 2) Part D Payment Reconciliation System

¹⁹⁴ CMS's data analysis contractor looks for potential duplicate PDEs for the same beneficiary, DOS, and drug, where the PDEs have different values in one or more of other key claim identifiers and thus were not rejected by edits immediately upon submission.

¹⁹⁵ A PDE adjustment is made to the original PDE record, and the record is marked with an "adjustment" indicator. When a PDE record is deleted, the record is marked with a "deletion" indicator. Deleted PDEs are retained as records in the data system but are excluded from the reconciliation process.

¹⁹⁶ The impact of pre-reconciliation data quality review is not currently assessed through a comparative reconciliation simulation; thus, this metric represents aggregate savings potentially realized by Medicare, plans, and beneficiaries, depending on the circumstances.

¹⁹⁷ For PDE adjustments/deletions that occur between plan sponsors' data submission deadline for payment reconciliation (typically the end of June) and September, associated savings are realized in CMS's global reconciliation re-opening, which usually occurs four years after a given payment year.

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Part D plan sponsors submit benefit-year DIR reports through CMS's HPMS. The summary DIR report contains data at the plan benefit package level. If a sponsor received DIR at the sponsor or contract level, it must apply one of CMS's reasonable allocation methodologies to allocate DIR to the plan benefit package level.¹⁹⁸ Sponsors must also include good faith estimates for DIR that is expected for the applicable contract year but has not yet been received.

As part of the year-end reconciliation process, CMS reviews the submitted DIR data for potential errors and discrepancies. If CMS identifies a possible issue, it prepares a review results package for the plan sponsor to access in HPMS. The sponsor is responsible for investigating the issue and making any necessary changes to its DIR report. The sponsor must provide an explanation with any resubmission of its DIR data.

CMS uses the reviewed and finalized DIR data in the year-end Part D payment reconciliation process for each plan, specifically to determine the reconciliation amounts for Medicare's reinsurance subsidy and risk corridor payment/recoupment. Holding all other data constant, CMS also runs a reconciliation simulation for each plan using the initially submitted DIR data to calculate what the reinsurance and risk corridor amounts would have been. For each type of payment, CMS subtracts the actual amount from the simulated amount.¹⁹⁹ CMS calculates savings from DIR review as the sum of these reinsurance and risk corridor differences across all plans.²⁰⁰ For a given benefit year, CMS reports savings in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

¹⁹⁸ Part D plan sponsors must also report DIR at the 11-digit National Drug Code level, so that CMS can provide annual sales of branded prescription drugs to the Secretary of the Treasury to determine the fee amount to be paid by each manufacturer.

¹⁹⁹ For the reinsurance subsidy, CMS compares Medicare's simulated and actual amounts owed, i.e., 80% of the allowable reinsurance costs; thus, the comparison does not involve CMS's monthly prospective reinsurance payments.

²⁰⁰ Program of All-Inclusive Care for the Elderly (PACE) plans are excluded from this analysis, since PACE plans typically do not receive rebates.

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Recovered Savings

CMS calculates recovered savings attributable to program integrity activities in Medicare FFS, Medicare Advantage (Part C), and Medicare Part D. Recovered savings represent amounts that CMS took back or retained from providers, plan sponsors, or other insurers/entities due to Medicare payment policy and requirements. The following table lists CMS's recovery activities.

Recovery Activities	Medicare Program
Overpayment Recoveries	
MSP Operations	FFS
MSP Commercial Repayment Center (CRC)	FFS
MAC Post-Payment Medical Reviews	FFS
Medicare FFS Recovery Audit Contractor (RAC) Reviews	FFS
Supplemental Medical Review Contractor (SMRC) Reviews	FFS
ZPIC/UPIC Post-Payment Reviews	FFS
Retroactive Revocations	FFS
Overpayments Related to Risk Adjustment Data	Part C and Part D
Medicare Part D Plan Sponsor Audits	Part D
Medicare Part D RAC Reviews	Part D
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	FFS
Cost-Based Plan Audits	Cost-Based Plans
Plan Penalties	
Medicare Part C and Part D Program Audits	Part C and Part D
Medical Loss Ratio (MLR) Requirement	Part C and Part D
Other Actions	
Party Status Appeals	FFS
Law Enforcement Referrals	
ZPIC/UPIC Law Enforcement Referrals	FFS
NBI MEDIC Part C Law Enforcement Referrals	Part C
NBI MEDIC Part D Law Enforcement Referrals	Part D

5 Overpayment Recoveries

Given the volume of claims submitted to Medicare, CMS cannot review every claim prior to payment. Thus, CMS conducts a wide range of post-payment activities to identify improper payments and recover overpayments. An overpayment is any amount a provider or plan receives in excess of amounts properly payable under Medicare statutes and regulations. Overpayments are considered debts owed to the federal government, and CMS has the

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authority to recover these amounts. CMS reports savings from the following overpayment²⁰¹ recovery activities:

- *Medicare FFS*
 - MSP Operations
 - MSP Commercial Repayment Center (CRC)
 - MAC Post-Payment Medical Reviews
 - Medicare FFS Recovery Audit Contractor (RAC) Reviews
 - Supplemental Medical Review Contractor (SMRC) Reviews
 - ZPIC/UPIC Post-Payment Reviews
 - Retroactive Revocations
- *Medicare Part C and Part D*
 - Overpayments Related to Risk Adjustment Data
 - Medicare Part D Plan Sponsor Audits
 - Medicare Part D RAC Reviews

5.1 Medicare Secondary Payer Operations

Savings:	The amount of conditional and mistaken payments Medicare FFS recovered from 1) providers, 2) beneficiaries who received settlements from other insurers/WC carriers, and 3) global settlements with liability insurers.
Data Source:	1) CROWD system and 2) CMS records of global settlements with liability insurers

CMS's MSP operations include the recovery of mistaken and conditional payments made by Medicare, when another payer has primary payment responsibility (see Section 2.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.²⁰² Mistaken payments may occur if information about other coverage is unavailable or inaccurate at the time a claim is received. Medicare makes conditional payments for covered services on behalf of beneficiaries, when the primary payer is not expected to pay promptly for a claim. For example, Medicare may make a conditional payment in a contested compensation case, when there is a delay between the beneficiary's injury and the primary payer's determination or settlement. The purpose of conditional payments is to ensure continuity of care for Medicare beneficiaries and to avoid financial hardship on providers while awaiting

²⁰¹ For the purpose of this document, the overpayment recoveries category includes CMS's recovery of mistaken and conditional Medicare payments, when Medicare should not be the primary payer. This occurs through MSP operations and the MSP Commercial Repayment Center.

²⁰² For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

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decisions in disputed cases. CMS initiates recovery actions once information about primary coverage becomes available, either through new reporting or settlement of a case.

The Benefits Coordination & Recovery Center (BCRC) recovers Medicare payments from beneficiaries who have received a settlement, judgment, award, or other payment related to a liability, no-fault, or WC case. The BCRC sends the beneficiary and authorized representative (if applicable) a notice of the claims conditionally paid by Medicare. The beneficiary has the opportunity to provide proof disputing any of the claims and documentation of his/her reasonable procurement costs (e.g., attorney fees and expenses), which the BCRC takes into account when determining the repayment amount. The BCRC then issues a demand letter with the amount owed to Medicare. A beneficiary may appeal a demand letter and may also request a partial or full waiver of recovery. Otherwise, the beneficiary must reimburse CMS for the conditional payments. Outstanding debts are referred to the Department of the Treasury for further collection action.

The MACs conduct MSP-related recovery from providers.²⁰³ Activities include identifying claims to be recovered, requesting and receiving repayment, and referring unresolved debts to the Department of the Treasury. Most of the MACs' recovery efforts occur through claims processing. The MACs conduct post-payment adjustments for claims that another insurer/entity should have paid in part or full. In cases of duplicate primary payment by Medicare and another insurer/entity—i.e., the provider received a primary payment from both Medicare and another insurer/entity for a given episode of care—the MACs recover Medicare's portion from the provider.

CMS also pursues global settlement of liability cases involving many Medicare beneficiaries. Examples of such cases include mass tort and class action lawsuits. The full amount of a global settlement is reported in the fiscal year during which it is awarded.

5.2 Medicare Secondary Payer Commercial Repayment Center

Savings: The amount of mistaken and conditional payments Medicare FFS recovered in cases when GHPs had primary payment responsibility as well as in liability, no-fault, and WC cases when the insurer/WC carrier has ongoing responsibility for medicals (ORM).

Data Source: CROWD system

²⁰³ The MACs' MSP-related recovery efforts are not currently included in the MSP program obligations in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

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The CRC is CMS’s RAC responsible for MSP cases when an entity such as an insurer, employer, or WC carrier is the identified debtor (see sections 2.1 and 5.1 for additional information about MSP operations). The CRC recovers Medicare’s mistaken primary payments from GHPs (typically from the employer, insurer, claims processing third-party administrator, or other plan sponsor) as well as conditional payments from applicable plans (liability insurers, no-fault insurers, or WC carriers) when the insurer/WC carrier has accepted ORM. CMS pays the CRC on a contingency fee basis, i.e., a percentage of the amount the identified debtor returned to Medicare.

For recovery of conditional payments from applicable plans, the CRC first issues the insurer/entity a notice of the claims conditionally paid by Medicare. The insurer/entity has the opportunity to dispute the claims with supporting documentation. After making a determination about any disputes, the CRC issues a demand letter with the amount owed to Medicare. Applicable plans have the right to appeal all or a portion of the demand amount. For the recovery of mistaken payments from GHPs, the recovery process begins with the demand letter. The identified debtor must reimburse CMS for the identified claims listed in the demand letter. GHPs do not have formal appeal rights but may use the defense process to dispute the amount of the debt. Outstanding debts are referred to the Department of the Treasury for further collection action.

CMS reports recovered Medicare payments in the fiscal year during which they are collected.²⁰⁴ CMS calculates the CRC savings as the sum of direct payments from debtors and delinquent debt collections from the Department of the Treasury, minus excess collections that were refunded.²⁰⁵

5.3 Medicare Administrative Contractor Post-Payment Medical Reviews

Savings: The estimated amount of overpayments identified by the MACs for recovery, minus overpayments identified that have been reversed.

Data Source: MAC reports

While the MACs primarily focus on preventing improper payments (see sections 1.5 and 2.2), they may also conduct some post-payment review of claims when there is the likelihood of a sustained or high level of payment error. When conducting a post-payment review, a MAC may request additional documentation from a provider. The provider must submit documentation within a specified time frame, though the MAC has

²⁰⁴ For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

²⁰⁵ Excess collections may occur if the Department of the Treasury offsets against a payment due to the debtor by another federal program at the same time that a debtor makes a direct payment to the CRC.

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the discretion to grant extensions. If a provider does not submit the requested documentation in a timely manner, the MAC denies the claims.

The MAC applies Medicare coverage and coding requirements to determine if the provider received improper payments and sends the provider a review results letter. The MAC then adjusts the associated claims in the appropriate shared claims processing systems in order to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Delinquent debts may be referred to the Department of the Treasury for further collection action.

Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

The MACs provide CMS with reports of the estimated overpayment amounts identified for recovery and the overpayment amounts reversed on appeal. The MACs may use different methods to estimate overpayment amounts, such as using the provider-billed amount or the Medicare allowed amount of denied claims. The MACs compile reports based on data from the claims processing systems and internal records. Each MAC calculates post-payment medical review savings as the estimated amount of overpayments identified for recovery, minus overpayment amounts reversed. CMS reports the total estimated savings from all MACs each fiscal year.

5.4 Medicare Fee-for-Service Recovery Audit Contractor Reviews

Savings: The amount of Medicare FFS RAC-identified overpayments that Medicare recovered, minus 1) the amount of Medicare FFS RAC-identified underpayments reimbursed to providers and 2) the amount that had been collected on Medicare FFS RAC-identified overpayments overturned on appeal in the fiscal year.

Data Source: RAC Data Warehouse

CMS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.²⁰⁶ The Medicare FFS RACs' reviews focus on service-specific issues related to national and local Medicare policy. CMS approves all new issues for potential audits before the Medicare FFS RACs begin reviews. The Medicare FFS RACs may submit proposed review issues to CMS on a rolling basis. At times, CMS will also send the Medicare FFS RACs issues of potential improper payments identified by the

²⁰⁶ One Medicare FFS RAC reviews national DME, home health, and hospice claims, and four Medicare FFS RACs review other types of claims in four geographic regions.

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MACs, ZPICs/UPICs, or external entities (e.g., HHS-OIG and GAO). Each Medicare FFS RAC has the option to accept or decline these issues for review. CMS can also require the RACs to conduct specific reviews.

The Medicare FFS RACs identify overpayments and underpayments through claims data analysis and review of medical records, which they can request through ADR letters. If a provider does not submit the requested documentation in a timely manner, the Medicare FFS RAC denies the claims. CMS imposes limits on the number of ADRs Medicare FFS RACs may send within in a specified time frame as well as for each provider based on each provider's improper payment rate for past claims. CMS also sets an initial limit on the number of reviews the Medicare FFS RACs may conduct under each approved issue. Once a Medicare FFS RAC has reached this limit, CMS reassesses the approved issue before allowing the Medicare FFS RAC to conduct additional reviews on the issue. In addition, the Medicare FFS RACs must assess each approved issue every six months to check for and report any necessary updates to CMS. Medicare FFS RACs are not allowed to identify improper payments more than three years after a claim was paid.

After conducting a review, the Medicare FFS RAC sends the provider a review results letter. The provider has a specified time frame to request a discussion with the Medicare FFS RAC regarding any identified improper payments. The discussion period offers the provider the opportunity to submit additional documentation to substantiate the claims and allows the Medicare FFS RAC to review the additional information without the provider having to file an appeal. If warranted, the Medicare FFS RAC can reverse an improper payment finding during the discussion period and not proceed with administrative action.

After the discussion period, the Medicare FFS RAC refers an identified improper payment to the MAC in the appropriate claims processing jurisdiction. The MAC then adjusts the associated claim(s) in order to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Providers who disagree with a Medicare FFS RAC's improper payment determination have the right to use the Medicare FFS appeals process.²⁰⁷

Both the Medicare FFS RACs and the MACs record information in the RAC Data Warehouse, as related to the claims review and transactional status of RAC-identified improper payments. The Medicare FFS RACs provide CMS with monthly reports of all amounts identified and demanded. The MACs provide CMS with data on all overpayments collected, and all underpayments reimbursed. There may be overpayments

²⁰⁷ As required by Section 1893(h) of the Social Security Act, CMS pays Medicare FFS RACs on a contingency fee basis. A Medicare FFS RAC must return its contingency fee if an improper payment determination is overturned on appeal. CMS subtracts the amount of returned contingency fees from its program integrity obligations in the fiscal year during which a RAC returns the funds.

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that a Medicare FFS RAC identified in a prior fiscal year for which collections occur in the current fiscal year.²⁰⁸ The MACs also record appeal outcome information in the RAC Data Warehouse. If an overpayment is fully or partially overturned on appeal, any offsets or recoupments that had been made are removed from savings in the fiscal year of the appeal decision. Thus, CMS calculates savings attributed to Medicare FFS RACs as the sum of Medicare FFS RAC-identified overpayment collections received from providers, minus 1) the sum of Medicare FFS RAC-identified underpayments reimbursed to providers and 2) the sum of collections that had been made on Medicare FFS RAC-identified overpayments overturned on appeal during the fiscal year.

5.5 Supplemental Medical Review Contractor Reviews

Savings: The amount of SMRC-identified overpayments that Medicare FFS collected.

Data Source: SMRC reports

CMS contracts with the SMRC to perform nationwide medical reviews of post-payment Medicare FFS claims in order to identify improperly paid claims. CMS assigns medical review projects to the SMRC on an as-needed basis. The projects focus on issues identified by various sources, including but not limited to the following:

- Other federal agencies, such as HHS-OIG and GAO
- CERT program
- Professional organizations
- CMS internal data analysis

The SMRC conducts medical review based on the analysis of national claims data, as compared to medical review performed by each MAC, which is limited to claims data in a specific jurisdiction.

The SMRC identifies overpayments by evaluating claims data and the associated medical records for compliance with Medicare's coverage, coding, and billing requirements, as related to the assigned project. The SMRC can request the necessary documentation through ADR letters sent to providers. The SMRC cannot perform a duplicate review for any claim previously reviewed by another contractor.

The SMRC communicates its medical review findings to a provider in a final review results letter. Providers have the option to request a discussion/education (D/E) period with the SMRC. The D/E period provides an opportunity for a provider to review

²⁰⁸ The original Medicare FFS RACs remain under contract with CMS until 2018 for administrative purposes. The FY 2018 savings for Medicare FFS RAC reviews include amounts from both the original and the new Medicare FFS RAC contracts.

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nonpayment findings with the SMRC and for the SMRC to educate the provider in improving future billing practices. During this period, a provider may also submit additional information and/or documentation to support payment of the claim(s) initially identified for denial. The provider receives a D/E findings letter detailing the outcome of each D/E session.

After the D/E period, the SMRC refers any identified overpayments to the MACs for collection purposes. Providers who disagree with the SMRC's improper payment determinations have the right to use the Medicare FFS appeals process. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS.

The SMRC provides CMS with quarterly data reports on project-specific amounts of collected overpayments. The MACs generate these reports for the SMRC based on data from HIGLAS, VMS, or the MACs' internal reporting systems. CMS reports savings from SMRC reviews in the fiscal year during which overpayment amounts are collected. Therefore, there may be overpayments identified by the SMRC in a prior fiscal year for which collections occur in a later fiscal year. CMS does not currently report adjustments for collected overpayment amounts that may be later overturned on appeal.

5.6 Zone Program Integrity Contractor/Unified Program Integrity Contractor Post-Payment Reviews

Savings: The amount of ZPIC/UPIC-identified overpayments that Medicare FFS recovered, minus the amount that had been collected on ZPIC/UPIC-identified overpayments overturned on appeal in the fiscal year.

Data Source: 1) HIGLAS and 2) VMS

During the course of an investigation, a ZPIC/UPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a ZPIC/UPIC requests additional documentation from a provider. The provider must submit documentation within a specified time frame, though a ZPIC/UPIC has the discretion to grant extensions.²⁰⁹ If a provider does not submit the requested documentation in a timely manner, the ZPIC/UPIC denies the claims.

The ZPIC's/UPIC's clinical team reviews the provider's submitted documentation to determine if the claims billed to Medicare were appropriate. If claims are denied or adjusted during the post-payment review, the ZPIC/UPIC calculates an overpayment in accordance with the Program Integrity Manual.

²⁰⁹ CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

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Once a post-payment review is complete, the ZPIC/UPIC provides the results of the medical review to the provider²¹⁰ and refers the overpayment to the MAC in its jurisdiction for recovery. The MAC then adjusts the Part A, Part B, or DME claims associated with the overpayment in the respective shared claims processing system, and the provider is issued a demand letter requesting repayment of the overpayment. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. The MAC may also recover overpayments from an escrow account when CMS terminates a payment suspension.²¹¹ Delinquent debts may be referred to the Department of the Treasury for further collection action.

Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

Overpayment recoveries are tracked in HIGLAS for Part A and Part B receivables and in VMS for DME receivables. CMS calculates savings as the sum of collections received for Part A, Part B, and DME receivables in the fiscal year during which the collection occurred. Therefore, there may be overpayments identified by a ZPIC/UPIC in a prior fiscal year for which collections accrued in the current fiscal year. Offsets or recoupments made on overpayments that are fully or partially overturned on appeal are removed from savings in the fiscal year during which the appeal is processed.

There may be instances when the MAC cannot collect on a ZPIC/UPIC-identified overpayment. In those instances, the receivable is closed in HIGLAS or VMS, and CMS does not include the amounts in the savings metric. To ensure unique attribution of savings, this metric also excludes ZPIC/UPIC-identified overpayments that are not referred to the MAC for recovery, per the request of law enforcement (see Section 9.1).

²¹⁰ Depending on the status of investigations, ZPICs/UPICs have discretion regarding whether to send a provider a review results letter.

²¹¹ A Medicare payment suspension is an administrative action that temporarily holds all or a portion of payments to a provider. During a payment suspension, incoming claims from the provider continue to be adjudicated as denied, rejected, or payable in the claims processing system, but any amounts for payable claims are held in an escrow account. ZPICs/UPICs and law enforcement agencies may request a suspension based upon reliable information that an overpayment exists or credible allegations of fraud. Once CMS approves a payment suspension, the ZPIC/UPIC coordinates with the MAC to install the suspension edit in the appropriate systems. When CMS terminates a payment suspension, the funds held in escrow are used to recoup Medicare overpayments and any other obligation the provider owes to CMS or HHS. CMS no longer separately counts payment suspension escrow amounts in the total Medicare savings, since CMS captures those amounts Medicare retains as overpayment recoveries.

5.7 Retroactive Revocations

Savings: The amount of overpayments identified due to full, retroactive revocations, multiplied by a historical proportion that Medicare FFS expects to recover.

Data Source: 1) PECOS, 2) CMS revocations log, and 3) IDR claims data

When a provider is revoked from Medicare, the effective date is 30 days from the mailing of the letter notifying the provider of the revocation, except for those revocation reasons applied retroactively as specified in regulation. For example, if an investigator determines that a provider's license is suspended, CMS sets the effective date of that provider's revocation as the date the license was suspended. CMS has the authority to recover payments made to an ineligible provider. As part of their standard operating procedures, the MACs attempt to recover overpayments when a provider is retroactively revoked.

Providers are afforded the same CAP and appeal opportunities (see Section 3.1), whether the revocation effective date is retroactive or not.

The MACs do not currently track overpayment recoveries specifically related to retroactive revocations; thus, CMS estimates savings as follows:

1. *Identify overpayments associated with full, retroactive revocations:* CMS sums the amounts paid to fully,²¹² retroactively revoked providers for dates of service between the effective date and implementation date of the revocation. For a given full, retroactive revocation, CMS attributes estimated savings to the fiscal year in which the revocation was implemented.²¹³
2. *Adjust for historical recovery experience:* To estimate actual recoveries, CMS multiplies the amount of identified overpayments by a proxy, provider-type-specific adjustment factor based on the MACs' historical recovery rate for ZPIC-identified overpayments. Based on a historical sample, each provider-type-specific adjustment factor is the ratio of the total amount of overpayments recovered by the MAC to the total amount of overpayments referred by the ZPICs.

²¹² CMS defines a full, retroactive revocation at the professional identifier level where there is at least one revoked enrollment, no other approved enrollments, and no active billing privileges.

²¹³ This metric excludes retroactive revocations submitted by ZPICs/UPICs to prevent possible overlap with the ZPIC/UPIC post-payment reviews metric, which quantifies recoveries of ZPIC/UPIC-identified overpayments.

5.8 Overpayments Related to Risk Adjustment Data

Savings: The amount of overpayments that Medicare recovered from plan sponsors, due to the retrospective elimination of invalid diagnosis codes in risk-adjusted payments.

Data Source: Medicare Advantage and Prescription Drug System

CMS risk adjusts per capita payments to MA organizations, Part D plan sponsors, 1833 health care prepayment plans, Section 1876 cost contract plans, Program of All-Inclusive Care for the Elderly (PACE) organizations, and some demonstration plans, hereafter collectively referred to as plan sponsors. Risk-adjusted plan payments allow CMS to more accurately pay for enrollees with different expected costs based on their health status and demographics.

CMS's risk adjustment models²¹⁴ generate a risk score for a given beneficiary based on the beneficiary's 1) demographic characteristics for the current payment year²¹⁵ and 2) relevant diagnosis codes²¹⁶ from services provided in the previous year (i.e., the base year).²¹⁷ Each beneficiary's risk score is multiplied by the appropriate per capita payment rate, which is determined during an annual bidding process and represents the expected costs for a Medicare beneficiary of average health. Thus, payments are higher for enrollees with higher projected medical costs and lower for those with lower projected medical costs.

All diagnosis codes used for risk-adjusted payments must be documented in the medical record as a result of a face-to-face visit with an acceptable provider type, namely hospital inpatient facilities, hospital outpatient facilities, or physicians. MA organizations, Section 1876 cost contract plans, Section 1833 health care prepayment plans, PACE organizations, and demonstration plans submit diagnosis codes for risk adjustment through CMS's Risk Adjustment Processing System (RAPS) and the Encounter Data Processing System (EDPS). CMS uses Medicare FFS claims to risk adjust payments to stand-alone PDPs.

²¹⁴ CMS Hierarchical Condition Category (CMS-HCC) Models are used to risk adjust payments to MA organizations (Part C portion), Section 1876 cost contract plans, Section 1833 health care prepayment plans, and demonstration plans, as appropriate. The PACE CMS-HCC model and a frailty adjuster is used to risk adjust payments to PACE organizations. The Prescription Drug HCC (RxHCC) Model is used to risk adjust payments to MA organizations (Part D portion) and stand-alone PDPs.

²¹⁵ In this document, the terms "payment year," "benefit year," and "contract year" may be used interchangeably for Medicare Part C and Part D. Since most plans operate on a calendar-year basis, these terms usually reference the calendar year.

²¹⁶ CMS uses clinically-significant, cost-predictive medical conditions in the risk adjustment process. Examples include diabetes, congestive heart failure, and cancer.

²¹⁷ CMS assigns a new enrollee factor to any beneficiary who does not have 12 months of diagnoses to support a risk score.

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Plan sponsors are responsible for the accuracy of diagnosis codes submitted to CMS. After a given payment year, plan sponsors may identify unsupported or invalid diagnosis codes through internal audits and quality assurance activities or because of provider-reported issues. Plan sponsors must delete invalid diagnosis codes in RAPS and EDPS, as appropriate. Plan sponsors are not allowed to add diagnosis codes after the final risk adjustment data submission deadline for a given payment year.²¹⁸

CMS re-calculates risk scores for prior payment years for the purpose of recovering plan-identified overpayments. Each calendar year, CMS expects to announce one or more prior payment years subject to re-calculation and payment adjustment.²¹⁹ Plan sponsors return overpayments by deleting erroneous diagnoses. CMS incorporates deletions to re-calculate risk scores and determine what it should have paid plan sponsors. The overpayment is the difference between CMS's previous payment to the plan sponsor and the re-calculated payments for the payment year. CMS generally recoups overpayments by offsetting future payments to plan sponsors and notifies plan sponsors when payment adjustments will be applied. CMS reports the recoupment of overpayments as savings in the fiscal year during which the offsets occur.

5.9 Medicare Part D Plan Sponsor Audits

Medicare Part D Plan Sponsor Audits include the following activities:

- National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) Part D Data Analysis Projects
- Medicare Part D Plan Sponsor Self-Audits

In the FY 2018 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings* provides the sum of savings from both initiatives.

National Benefit Integrity Medicare Drug Integrity Contractor Part D Data Analysis Projects

Savings: The amount of overpayments that Medicare recovered from Part D plan sponsors, as related to NBI MEDIC data analysis projects.

Data Source: NBI MEDIC data analysis report for each project

CMS contracts with the NBI MEDIC, a program integrity contractor that is responsible for detecting and preventing fraud, waste, and abuse in the Medicare Part C and Part D programs nationwide. The NBI MEDIC's responsibilities include identification of vulnerabilities through its own proactive data analysis and external leads, developing

²¹⁸ The risk adjustment data submission deadline is no earlier than January 31 following the payment year.

²¹⁹ CMS may re-run risk score data and make payment adjustments multiple times for a given payment year.

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cases for referral to law enforcement agencies, and fulfilling requests for information from law enforcement agencies (see Section 9). Sources of leads for the NBI MEDIC's investigations include MA organizations, Part D plan sponsors, consumer groups, beneficiary complaints, law enforcement agencies, and CMS.

As part of its scope of work, the NBI MEDIC conducts data analysis projects related to specific Part D vulnerabilities in order to identify inappropriate payments. Data sources used to conduct data analysis include, but are not limited to, PDEs, Medicare FFS claims, plan formularies, and drug prior authorization information.

The NBI MEDIC submits its findings of improper payments to CMS, and once approved, it sends letters to the associated Part D plan sponsors. Each letter contains a summary of the analysis methodology and the PDE records identified as inappropriately paid. Part D plan sponsors are required to delete the inappropriately-paid PDE records, and the NBI MEDIC confirms that plan sponsors delete the relevant PDE records.

CMS reports data analysis project savings in the fiscal year during which plan sponsors delete the inappropriate PDE records.

Medicare Part D Plan Sponsor Self-Audits

Savings: The amount of overpayments that Medicare recovered from Part D plan sponsors due to self-audits.

Data Source: Self-audit attestations and close-out letters

CMS uses Medicare Part D plan sponsor self-audits to evaluate the appropriateness of questionable payments for Part D covered drugs identified through data analysis. CMS conducts data analysis to identify high-risk areas for inappropriate Medicare Part D payments and plan sponsors with potential overpayments for recovery. CMS provides notification to Part D plan sponsors to conduct a self-audit. Upon completion of the plan sponsor self-audit review, CMS validates whether plan sponsors have deleted the identified inappropriate PDE records. CMS reports self-audit savings in the fiscal year during which the PDE records are deleted.

5.10 Medicare Part D Recovery Audit Contractor Reviews

Savings: The amount of Medicare Part D RAC-identified overpayments that Medicare recovered from Part D plan sponsors.

Data Source: Plan payment adjustment forms

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The Medicare Part D RAC²²⁰ reviewed post-reconciliation PDE records to identify improper payments made under the Medicare Part D benefit.²²¹ CMS authorized the RAC to conduct audits of specific topics during particular plan years of interest. The Medicare Part D RAC could also propose new audit issues, which were subject to CMS's review and approval. Example audit topics included improper payments made to excluded providers²²² or unauthorized prescribers²²³ and inappropriate refills of certain drugs regulated by the Drug Enforcement Administration under the Controlled Substances Act. The Medicare Part D RAC could only identify improper payments on PDE records within the four years prior to a plan sponsor's current plan year.

The Medicare Part D RAC conducted automated, algorithm-based reviews as well as complex reviews using additional documentation requested from the plan sponsor. In addition to PDE records, the Medicare Part D RAC could also use other data sources, such as CMS's Medicare Exclusion Database, HHS-OIG's List of Excluded Individuals and Entities, or the General Services Administration's System of Award Management. The RAC referred cases of suspected fraud directly to the NBI MEDIC.

The Medicare Part D RAC's improper payment findings underwent an independent quality check by CMS's Data Validation Contractor and then had to receive approval from CMS. If the Medicare Part D RAC's findings were approved, the plan sponsor received a Notification of Improper Payment, which was determined by an improper payment calculation. Medicare Part D plan sponsors were given the opportunity to appeal improper payment determinations.

Inappropriately-paid PDE records had to be deleted by the Part D plan sponsor after the final appeal decision or within a specified time period if no appeal was filed. CMS recoups overpayments through offsets to Medicare's monthly prospective payments to plan sponsors and reports these amounts as savings in the fiscal year during which the offsets occur.

²²⁰ The Medicare Part D RAC contract ended on December 31, 2015. However, an administrative and appeals option period was exercised through December 2017 to allow the Medicare Part D RAC to complete outstanding audit issues that were initiated prior to the end of the contract period and receive payment.

²²¹ During FY 2018, Medicare Part D RAC activities included the appeals and recoupment process. The audits, validations, and Notification of Improper Payments issuance were all completed during FY 2016.

²²² Excluded providers are not allowed to receive payment from Medicare or other federal health care programs. HHS-OIG has multiple authorities under which to exclude providers, such as a convictions related to patient abuse, health care fraud, or the misuse of controlled substances.

²²³ An unauthorized prescriber is a provider who orders drugs for Medicare beneficiaries despite not being allowed to do so. The provider types with prescribing authority may vary by state, but some provider types do not have the authority to prescribe in any state.

6 Cost Report Payment Accuracy

Institutional providers and cost-based plans must submit cost reports, which CMS reviews or audits to ensure accurate payments in accordance with Medicare regulations. CMS reports savings from the following cost report activities:

- Provider Cost Report Reviews and Audits
- Cost-Based Plan Audits

6.1 Provider Cost Report Reviews and Audits

Savings: The difference between as-submitted or revised reimbursable cost requests submitted by providers and the settlement amounts, as determined through audits or desk reviews, for each cost item submitted in Medicare FFS provider cost reports.

Data Source: System for Tracking for Audit and Reimbursement Reports 104 and 106, as entered by the MACs

CMS determines final payment to the majority of institutional providers through a cost report reconciliation process performed by the MACs. CMS quantifies savings from the settlement of the following Medicare costs:

- Pass-through costs for hospitals paid under a prospective payment system (PPS)²²⁴
- All costs for critical access hospitals reimbursed on a cost-basis
- All costs for cancer hospitals reimbursed under the Tax Equity and Fiscal Responsibility Act
- Bad debts²²⁵ claimed by all provider types

A provider must file its annual cost report with its respective MAC either five months after the end of the provider's fiscal year or 30 days after the Provider Statistical and

²²⁴ Pass-through costs refer to amounts paid outside of the PPS. Examples of Medicare's pass-through payments to hospitals include amounts for disproportionate share hospital (DSH) qualification, graduate medical education, indirect medical education, nursing and allied health, bad debt, and organ acquisition.

²²⁵ Bad debt refers to Medicare deductibles and coinsurance amounts that are uncollectible from beneficiaries. In calculating reimbursement, CMS considers a provider's bad debt if it meets specific criteria.

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Reimbursement (PS&R)²²⁶ reports are available, whichever date is later.²²⁷ The annual cost report contains provider information, such as facility characteristics, utilization data, costs, charges by cost center (in total and for Medicare), accumulation of Medicare claims data (e.g., days, discharges, charges, deductible and coinsurance amounts, etc.), and financial statement data.

Each MAC conducts desk reviews of the cost reports submitted by providers in its jurisdiction to assess the data for completeness, accuracy, and reasonableness. The scope of a desk review depends on the provider type and whether the submitted cost report exceeds any thresholds set by CMS for specific review topics. If needed, the MAC may request additional documentation from a provider to resolve issues.

The MAC determines whether the cost report can be settled based on the desk review or whether an audit is necessary. A cost report audit involves examining the provider's financial transactions, accounts, and reports to assess compliance with Medicare laws and regulations. The audit may be conducted at the MAC's location (in-house audit) or at the provider's site (field audit). The MAC may limit the scope of an audit to selected parts of a provider's cost report and related financial records.

During the desk review or audit process, the MAC proposes adjustments made to the provider's submitted costs, so that the cost report complies with Medicare's regulations. The MAC notifies the provider of any adjustments, and the provider has a specified time frame to respond with any concerns.

Final settlement of a cost report involves the MAC issuing a Notice of Program Reimbursement (NPR) to the provider and submitting settled cost report data to CMS. The NPR explains any underpayments owed to the provider or overpayments owed to Medicare. In the case of an overpayment, the provider is required to send a check payable to Medicare, or the MAC recoups amounts by offsetting future payments to the provider. In the case of an underpayment, CMS issues a check to the provider or reduces any outstanding overpayment.

A provider may appeal disputed adjustments if the Medicare reimbursement amount in controversy is at least \$1,000. An appeal request must be filed within 180 days of receiving the NPR. Appeals disputing amounts of at least \$1,000 but less than \$10,000 are filed with the MAC and the CMS Appeals Support Contractor. Appeals disputing amounts of \$10,000 or more are filed with the Provider Reimbursement Review Board.

In addition, a final settled cost report may be reopened to correct errors, comply with updated policies, or reflect the settlement of a contested liability. A provider may submit

²²⁶ CMS's PS&R system accumulates statistical and reimbursement data for processed and finalized Medicare Part A paid claims. The system generates various summary reports used by providers to prepare Medicare cost reports and by the MACs during the audit and settlement process.

²²⁷ Provider Reimbursement Manual, Part II (PRM-II), § 104. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, § 110.A.

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a request for reopening, or the MAC may reopen a cost report based on its own motion or at the request of CMS. A reopening is allowed within three years of an original NPR or a revised NPR concerning the same issue for reopening.²²⁸

CMS determines savings from the settlement of provider cost reports by calculating the difference between reimbursable costs per the providers' initial or revised cost reports and the settlement amounts resulting from audits or desk reviews. CMS reports savings in the fiscal year during which an NPR is issued. If a successful appeal results in a revised NPR, CMS reports adjustments to savings in the fiscal year the revised NPR is issued.

6.2 Cost-Based Plan Audits

Savings: The difference between Medicare reimbursable costs claimed by cost-based plans on originally-filed cost reports and CMS-determined reimbursable amounts, accounting for settlement refunds determined through audit and amounts overturned on appeal.

Data Source: CMS tracking of audit reports and originally-filed cost reports

CMS reimburses Medicare cost-based plans based on the reasonable costs incurred for delivering Medicare-covered services to enrollees.²²⁹ Medicare cost-based plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans operated under Section 1876 of the Social Security Act and Health Care Prepayment Plans (HCPPs) established under Section 1833 of the Social Security Act.

CMS pays cost-based plans in advance each month based on an interim per capita rate for each Medicare enrollee. At the end of the cost-reporting period, each plan must submit a final cost report, claiming certain Medicare reimbursement for that plan. Upon receipt of the cost report, CMS may conduct an independent audit to determine if the costs are reasonable and reimbursable in accordance with CMS regulations, guidelines, and Medicare managed care manual provisions. CMS documents adjustments made to the plan's submitted costs, so that the cost report complies with Medicare's principles of payment and determines Medicare reimbursable amounts.

Based on the reconciliation of the CMS-determined Medicare reimbursable amounts and interim payments to the plan, CMS issues the plan an NPR indicating a balance due to the plan or to CMS. If the plan owes money to CMS, the plan has 30 days to provide

²²⁸ In the case of fraud, the MAC can reopen a cost report at any time.

²²⁹ Some Medicare cost plans provide Part A and Part B coverage, while others provide only Part B coverage. Some cost plans also provide Part D coverage. An HCPP operates like a Medicare cost plan but exclusively enrolls Part B only beneficiaries and provides only Part B coverage.

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payment, otherwise, interest is due. If CMS owes money to the plan, reimbursement is provided in a subsequent monthly payment to the plan.

Plans may appeal cost report adjustments that are greater than \$1,000. Plans have 180 days to submit a formal written appeal.

CMS determines savings from cost-based plan audits by calculating the difference between Medicare reimbursable amounts determined through cost report audits and reimbursable amounts claimed by cost-based plans.²³⁰ CMS attributes savings to the fiscal year in which NPRs are processed. If a plan receives a settlement refund or favorable appeal decision, CMS subtracts the refund or amount overturned on appeal from savings in the fiscal year during which the settlement refund or appeal is processed.

7 Plan Penalties

CMS has the authority to take enforcement actions when MA organizations or Part D sponsors fail to comply with program requirements. CMS reports financial penalties collected from plan sponsors, due to the following:

- Medicare Part C and Part D Program Audits
- Medical Loss Ratio (MLR) Requirement

7.1 Medicare Part C and Part D Program Audits

Savings: The sum of civil money penalty (CMP) amounts collected from MA organizations and Part D plan sponsors, due to compliance violations determined during program audits.

Data Source: CMS enforcement action records

CMS conducts program audits of MA organizations, Part D plan sponsors, and organizations offering Medicare-Medicaid plans (MMPs), hereafter collectively referred to as plan sponsors. Program audits evaluate plan sponsors' compliance with core program requirements and ability to provide enrollees with access to health care services and prescription drugs. A routine program audit covers all of a plan sponsor's MA, MA-Prescription Drug (MA-PD), PDP, and MMP contracts with CMS. CMS annually determines the plan sponsors to be audited. Selection of plan sponsors for audit may be based on annual risk assessments, which take into account past performance data, plan-reported data, and other operational information (e.g., changes in enrollment, formulary, or pharmacy benefit management). Other factors that affect plan sponsor selection

²³⁰ The cost-based plan audits metric quantifies savings as the truing-up of plan payments. Year-over-year savings may fluctuate depending on the number of audited plans, membership size, and contract years of plans subject to audit, plan adherence to payment regulations, settlement decisions, and other factors.

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include audit referrals from CMS central and/or regional offices and time since last audit. CMS initiates audits of plan sponsors throughout the year.

A program audit evaluates plan sponsor compliance in the following program areas, as applicable to the plan sponsor's operations:

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans Model of Care
- MMP Service Authorization Requests, Appeals, and Grievances
- MMP Care Coordination and Quality Improvement Program Effectiveness

If audits or other monitoring activities determine compliance violations that adversely affected or have the substantial likelihood of adversely affecting enrollees,²³¹ CMS has the authority to impose CMPs against plan sponsors. Other enforcement actions include intermediate sanctions (e.g., suspension of marketing, enrollment, or payment) and terminations. The number of violations and history of noncompliance are factored into the enforcement action taken. All enforcement actions may be appealed. CMP appeal requests must be filed no later than 60 days after receiving a CMP notice.

CMS calculates a CMP using standard penalty amounts multiplied by either the number of affected enrollees (per-enrollee basis) or the number of affected contracts (per-determination basis). After CMS calculates the standard penalty amount, it adds any aggravating factor penalty amounts, which are also calculated on a per-enrollee or per-determination basis. An example of an aggravating factor is a history of prior offense. CMPs are limited to maximum amounts per violation based on the enrollment size of the organization.

Plan sponsors have the option to pay CMPs by sending a check payable to CMS, wiring funds to the Department of the Treasury, or deducting from CMS's regular monthly payments to the plan sponsor. CMS reports program audits savings in the fiscal year during which CMP amounts are collected from plan sponsors. Thus, there may be CMPs issued in a previous fiscal year for which collections occur in the current fiscal year.

²³¹ Examples of compliance violations that result in enforcement actions include the following: 1) inappropriate delay or denial of beneficiary access to health services or medications, 2) incorrect premiums charged to or unnecessary costs incurred by beneficiaries, and 3) inaccurate or untimely information provided to beneficiaries about health and drug benefits.

7.2 Medical Loss Ratio Requirement

Savings:	The sum of remittances recovered from MA organizations and Part D sponsors, where each remittance equals the revenue of the MA organization or Part D sponsor contract for the contract year (subject to certain deductions for taxes/fees) multiplied by the difference between 0.85 and the credibility-adjusted (if applicable) MLR for the contract year.
Data Source:	MA organizations' and Part D sponsors' annual reports provided to CMS

An MLR represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, rather than for overhead expenses. MA organizations and Part D sponsors must report the MLR for each contract they have with CMS. A contract must have a minimum MLR of at least 85% to avoid financial and other penalties. Contracts beginning in 2014 or later are subject to this statutory requirement.²³² The minimum MLR requirement is intended to create incentives for MA organizations and Part D sponsors to reduce overhead expenses, such as marketing, profits, salaries, administrative expenses, and agent commissions, in order to help ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans.

An MLR is calculated as the percentage of Medicare contract revenue spent on the following:

- Incurred claims for clinical services*
- Incurred claims for prescription drugs
- Quality improving activities
- Direct benefits to beneficiaries in the form of reduced Part B premiums*

**Not applicable to Part D stand-alone contracts.*

Revenue includes enrollee premiums and CMS payments to the MA organization or Part D sponsor for enrollees. Certain taxes, fees, and community benefit expenditures may be deducted from the revenue portion of the MLR calculation.

²³² MLR requirements apply to all MA organizations and Part D sponsors offering Part C and/or D coverage, including the following: 1) MA organizations with contract(s) including MA-PD plans (all MA contracts must include at least one MA-PD plan; some contracts may also include MA-only plans); 2) Part D stand-alone contracts; 3) Employer Group Waiver Plans with contracts offering MA and/or Part D; 4) Part D portion of the benefits offered by Cost HMOs/Competitive Medical Plans and employers/unions offering HCPPs; and 5) Dual Eligible Special Needs Plans. MA organizations report one MLR for each contract with MA-PD plans, instead of one MLR for nondrug benefits and another for prescription drug benefits. CMS waives the MLR requirement for PACE organizations.

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If a MA organization or Part D sponsor has an MLR for a contract year that is less than 85%, the MA organization or Part D sponsor owes a remittance to CMS. CMS deducts the remittance from the regular monthly plan payments to the MA organization or Part D sponsor. Further MLR-related sanctions on MA organizations and Part D sponsors include a prohibition on enrolling new members after three consecutive years and contract termination after five consecutive years of failing to meet the minimum MLR requirement.

In general, MA organizations and Part D sponsors are required to report a contract's MLR in December following the contract year, and any payment adjustments are implemented the following July. The reporting deadline is earlier in the year for contracts that fail to meet the MLR threshold for two or more consecutive years, so that CMS has time to implement, prior to the open enrollment period, an enrollment sanction for any contract that fails to meet the MLR threshold for three or more consecutive years and contract termination for any contract that fails to meet the MLR threshold for five consecutive years. Once reported and attested by an insurer and reviewed by CMS, an MLR is considered final and may not be appealed. Savings are reported in the fiscal year during which remittances are recovered.²³³

CMS applies credibility adjustments to the MLR to address the impact of claims variability on the MLR for contracts with low enrollment. CMS defines the enrollment levels for credibility adjustments separately for MA and Part D stand-alone contracts. A contract with contract-year enrollment at or between specified levels (i.e., a partially credible contract) may add a scaled credibility adjustment (between 1.0% and 8.4%) to its MLR. This adjusted MLR is used both to determine whether the 85% requirement has been met and to calculate the amount of the remittance owed to CMS, if any. Contracts with enrollment levels above the full-credibility threshold do not receive a credibility adjustment. For contracts with enrollment below a specified level, MLR sanctions do not apply.

8 Other Actions

8.1 Party Status Appeals

Savings:	The sum of the estimated amounts in controversy related to Medicare FFS appeals, where a Qualified Independent Contractor (QIC) participated as a party in the Level 3 appeal, ALJ hearing, and the ALJ ruled to uphold the Level 2 decision or dismissed the case.
Data Source:	QIC party status reports supported by Medicare Appeals System (MAS) data

²³³ MLR remittances are transferred to the General Fund of the Treasury.

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The Medicare FFS appeals process includes five levels.²³⁴

- Level 1: Redetermination by a MAC is a second look at the claim and supporting documentation by an employee who did not take part in the initial determination.
- Level 2: Reconsideration by a QIC²³⁵ is an independent review of the MAC's redetermination. For decisions made as to whether an item or service is reasonable and necessary, a panel of physicians or other health care professionals conducts the review.
- Level 3: Hearing before an ALJ within the HHS Office of Medicare Hearings and Appeals (OMHA).²³⁶ The amount remaining in controversy must meet the threshold requirement.
- Level 4: Review by the Medicare Appeals Council within the HHS DAB.²³⁷ There are no requirements regarding the amount of money in controversy.
- Level 5: Judicial review in U.S. District Court. The amount remaining in controversy must meet the threshold requirement.

If a party disagrees with the decision made at one level of the process, the party can file an appeal to the next level. Each level of appeal has statutory time frames for filing an appeal and issuing a decision. The entities adjudicating the respective appeal conduct a new, independent review of the case at each level, and are not bound by the prior levels' findings and decision. The same appeal rights apply for claims denied on either a prepayment or post-payment basis.

In support of Medicare program integrity efforts, CMS funds QICs' participation as a party in ALJ hearings in accordance with party status appeals regulatory provisions in 42 CFR § 405.1012.²³⁸ In addition to QICs' performance of Level 2 appeals, a QIC may elect to participate in Level 3 appeals, either as a non-party participant in the proceedings on a request for an ALJ hearing or as a party to an ALJ hearing. As a non-party participant, a QIC may file position papers and/or provide testimony to clarify factual or policy issues in a case.²³⁹ As a party to an ALJ hearing, a QIC can better defend the Level 2 decision by filing position papers, submitting evidence, providing testimony to clarify factual or policy issues, calling witnesses, or cross-examining the witnesses of

²³⁴ Pursuant to statutory requirements, CMS begins recouping overpayment amounts after Level 2. If the appellant receives a favorable decision in a subsequent level of appeal, CMS reimburses the amount collected with interest.

²³⁵ CMS currently contracts with two Part A QICs, two Part B QICs, and one DME QIC.

²³⁶ OMHA is independent of CMS.

²³⁷ The Medicare Appeals Council within the DAB is independent of CMS.

²³⁸ CMS or one of its contractors (e.g., a MAC, QIC, RAC, ZPIC, UPIC, etc.) may elect to participate as a party in ALJ appeals, except when an unrepresented beneficiary files the hearing request.

²³⁹ The QICs may elect non-party participation in accordance with 42 CFR § 405.1010. Non-party participation is incorporated into the QICs' operational activities and is not part of this savings metric.

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other parties. The additional rights afforded to parties are extremely beneficial to the ALJ hearing and the QIC's ability to successfully defend a claim denial.

Each fiscal year, CMS determines the funding for and number of hearings in which the QICs are able to participate as a party. The QICs receive the ALJ Notices of Hearing and identify hearings in which they elect to participate as a party. Within ten days of a QIC receiving a hearing notice, a QIC must notify the ALJ, the appellant, and all other parties that it intends to participate as a party.²⁴⁰ Generally, the QICs elect party status when there are significant amounts in controversy, national policy implications, or particular areas of interest for CMS.

When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully upholds the prior decision or dismisses the case,²⁴¹ CMS considers the estimated amount in controversy as savings.²⁴² Savings are based on the "item original amount" field from the MAS. For both prepayment denials and overpayment determinations, this field represents the billed amount submitted by the provider for claims or claim lines under appeal. CMS reports savings in the fiscal year during which the QIC receives notice of the ALJ's ruling to uphold the prior decision or dismiss the case. CMS does not currently adjust reported savings if the appellant pursues further appeal rights and receives a favorable decision at Level 4 or Level 5.

9 Law Enforcement Referrals

ZPICs/UPICs (see sections 1.6, 2.3, and 5.6) and the NBI MEDIC (see Section 5.9) identify and investigate cases of suspected fraud related to Medicare FFS and Medicare Part C and Part D, respectively. ZPICs'/UPICs' and the NBI MEDIC's investigations may involve providers, beneficiaries, and/or other entities. Once a ZPIC/UPIC or the NBI MEDIC has gathered evidence to substantiate allegations of suspected fraud, CMS requires the contractor to refer such cases to the HHS-OIG Office of Investigations for consideration of civil or criminal prosecution.

In certain types of cases, ZPICs/UPICs and the NBI MEDIC must make an immediate referral to HHS-OIG without first conducting an investigation. For example, a ZPIC/UPIC or the NBI MEDIC must immediately advise HHS-OIG upon receiving allegations of kickbacks or bribes. As another example, the NBI MEDIC must immediately advise HHS-

²⁴⁰ If multiple entities, i.e., CMS and/or contractors, file an election to be a party to a hearing, the first entity to file its election is made a party to the hearing. The other entities are made participants in the proceedings under 42 CFR § 405.1010 and may file position papers and/or written testimony. The ALJ has discretion to allow additional parties if necessary for a full examination of the matters at issue.

²⁴¹ A case is dismissed when the appellant withdraws the appeals request or the appeals body determines that the appellant or appeal did not meet certain procedural requirements.

²⁴² Due to data system limitations, there may be overlap across fiscal years with other Medicare FFS savings metrics that quantify savings from prepayment denials and overpayment recoveries.

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OIG of fraud allegations made by current or former employees of provider organizations, MA organizations, or Part D plan sponsors.

When a ZPIC/UPIC or the NBI MEDIC refers a case to law enforcement for criminal or civil investigation, it reports the estimated value of the case to CMS, typically based on total paid amounts for the alleged fraudulent activities. If law enforcement accepts the referral, the ZPIC/UPIC or the NBI MEDIC remains available to assist and provide information at the request of law enforcement. When cases result in restitution, judgments, fines, and/or settlements, the Department of Justice (DOJ) routes Medicare recoveries to CMS or the plan sponsor. The following sections describe how CMS reports savings attributable to ZPICs'/UPICs' and the NBI MEDIC's law enforcement referrals.

9.1 Zone Program Integrity Contractor/Unified Program Integrity Contractor Law Enforcement Referrals

Savings: The estimated amount Medicare expects to recover from ZPIC/UPIC-referred cases accepted by law enforcement, adjusted for historical recovery experience.

Data Source: 1) ZPIC/UPIC reports and 2) Law enforcement adjustment factor

CMS reports the value of ZPICs'/UPICs' referrals accepted by law enforcement during the fiscal year, regardless of when the case concludes. Because the timeline of case resolution varies, CMS estimates the amount Medicare expects to recover by multiplying the value of the referrals by a law enforcement adjustment factor.²⁴³ This factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to amounts referred by ZPICs.

9.2 National Benefit Integrity Medicare Drug Integrity Contractor Part C Law Enforcement Referrals

Savings: The amount of court-ordered restitution, fines, forfeitures, and settlements from Part C cases referred to law enforcement by the NBI MEDIC.

Data Source: NBI MEDIC referral log

Regarding the NBI MEDIC's Part C cases referred to law enforcement, CMS reports the amount of court-ordered restitution, fines, forfeitures, and settlements.²⁴⁴ CMS reports

²⁴³ In FY 2018, CMS implemented an updated law enforcement adjustment factor.

²⁴⁴ The court may order funds be returned to Medicare and/or plan sponsor(s).

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these amounts in the fiscal year during which a court issues a final judgment or commitment order.

9.3 National Benefit Integrity Medicare Drug Integrity Contractor Part D Law Enforcement Referrals

Savings: The amount of court-ordered restitution, fines, forfeitures, and settlements from Part D cases referred to law enforcement by the NBI MEDIC.

Data Source: NBI MEDIC referral log

Regarding the NBI MEDIC's Part D cases referred to law enforcement, CMS reports the amount of court-ordered restitution, fines, forfeitures, and settlements.²⁴⁵ CMS reports these amounts in the fiscal year during which a court issues a final judgment or commitment order.

²⁴⁵ The court may order funds be returned to Medicare and/or plan sponsor(s).

Appendix B-2 – Medicaid and Children's Health Insurance Program Savings Methodology

Introduction

Medicaid and Children's Health Insurance Program (CHIP) costs are shared between states and the federal government. To receive federal Medicaid and CHIP funds, states provide an estimated budget of their prospective costs, and the federal government contributes a specific percentage of these costs as a grant to the state. CMS determines the federal contribution amount using the Federal Medical Assistance Percentage (FMAP).²⁴⁶ States then submit actual expenditure reports,²⁴⁷ which CMS uses to reconcile grant amounts. States are required to report their expenditures to CMS within 30 days of the end of each quarter and may adjust their past reporting for up to two years after an expenditure was made.²⁴⁸

States and CMS share accountability for Medicaid and CHIP program integrity and ensuring proper use of both federal and state dollars. As such, CMS and the states collaborate to combat improper payments through multiple strategies. In *Table 4: Medicaid and CHIP Savings* of the FY 2018 Report to Congress on the Medicare and Medicaid Integrity Programs, CMS quantifies the federal share²⁴⁹ of Medicaid and CHIP program integrity savings stemming from the Medicaid and CHIP financial management project²⁵⁰ and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. The following sections describe the methodologies used to determine these savings.

1 Medicaid and CHIP Financial Management Project

Under the financial management project, the CMS financial management staff²⁵¹ engages in financial oversight to ensure that state expenditures claimed for federal matching under Medicaid and CHIP are programmatically reasonable, allowable, and allocable in accordance with federal laws, regulations, and policy guidance. Federal funds paid to the

²⁴⁶ Congressional Research Service Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell

²⁴⁷ States submit quarterly expenditure reports on forms CMS-64 and CMS-21 for Medicaid and CHIP, respectively. The CMS-64 and CMS-21 are records of actual costs of running Medicaid and CHIP. States are responsible for maintaining supporting documentation for all reported expenditures.

²⁴⁸ 42 CFR § 430.30

²⁴⁹ As of FY 2018, CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

²⁵⁰ FY 2018 is the first year that CMS includes savings from the Medicaid and CHIP financial management project in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. In previous years, CMS reported on the project in the Health Care Fraud and Abuse Control Program Annual Report.

²⁵¹ CMS stations financial management staff, including accountants and financial analysts, at CMS regional offices, in states, and in the CMS central office.

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state are referred to as the Federal Financial Participation (FFP). When states submit budget and expenditure reports for Medicaid and CHIP, CMS applies the appropriate FMAP to each expenditure to determine the FFP. CMS reports Medicaid and CHIP financial management project savings as improper FFP that was either 1) averted due to financial management staff intervention or 2) recovered following financial management staff review or assistance in response to and resolution of financial issues.

1.1 Averted Medicaid and CHIP Federal Financial Participation

Savings: The total amount of FFP for which states agree to voluntarily 1) enter a credit adjustment on their expenditure report, 2) retract from their expenditure report, or 3) make a prior period credit adjustment on the current or a future expenditure report.

Data Source: CMS's Medicaid regional office averted FFP at-risk form

The CMS financial management staff works to ensure that states submit Medicaid and CHIP claims only for allowable expenditures. CMS uses the following activities to identify potentially improper, i.e., “at-risk,” FFP:

- Review of quarterly expenditure reports
- Technical assistance to states on financial management issues

If at-risk FFP is identified prior to finalizing the quarterly expenditure report, the state may make a credit adjustment on their expenditure report for the amount in question or retract the claim associated with the at-risk FFP. If identified after finalizing the expenditure report, the state makes a prior period credit adjustment,²⁵² which retroactively adjusts the claim in question and offsets the at-risk FFP for which the state already received reimbursement. Averted Medicaid and CHIP FFP represents the total dollar amount of at-risk FFP that was prevented or offset due to CMS financial management staff intervention and oversight during the fiscal year.

The CMS financial management staff submits the averted FFP at-risk form to the CMS central office for validation. CMS only reports approved amounts in the total averted Medicaid and CHIP FFP.

²⁵² As noted in GAO-18-564, states may adjust claims from prior quarters by either increasing or decreasing the amount of the claim, and therefore increasing or decreasing the FFP. These adjustments often reflect resolved disputes between CMS and the state or reclassifications of expenditures.

1.2 Recovered Medicaid and CHIP Federal Financial Participation

Savings: The total amount of at-risk FFP that the states returned to CMS as a result of CMS financial oversight activities.

Data Source: CMS's financial performance spreadsheet

The CMS financial management staff identifies potential improperly paid FFP through:

- Quarterly expenditure report reviews
- Annual financial management reviews
- Department of Health and Human Services Office of Inspector General (HHS-OIG) audits

If CMS and the state cannot resolve the issue and the state does not agree to return the improperly paid FFP, CMS initiates a disallowance action requiring the state to return the FFP.²⁵³

States have the right to request administrative reconsideration and/or Departmental Appeals Board (DAB) review to appeal a disallowance action within 60 days of receiving a disallowance letter. CMS may recover the disallowance amount if, following the DAB appeal, a decision has been rendered in CMS's favor or if the state did not appeal the disallowance and the 60-day filing period for an appeal has lapsed. CMS counts a disallowance as recovered once the state returns the associated FFP to CMS.

The total recovered Medicaid and CHIP FFP includes all at-risk FFP that has been recouped or returned to CMS within the fiscal year; thus, some amounts may be associated with financial issues identified in prior fiscal years. The total recovered Medicaid and CHIP FFP does not include any amounts actively under appeal.²⁵⁴

2 State-Reported Medicaid Overpayment Recoveries

States report Medicaid overpayment recoveries made through collaborative federal-state programs and state-level initiatives, including 1) Audit Medicaid Integrity Contractors (MICs)/Unified Program Integrity Contractors (UPICs), 2) state Medicaid Recovery Audit Contractors (RACs), 3) HHS-OIG-compliant false claims acts, and 4) other state program integrity activities.

As states and the federal government share in the cost of Medicaid, so too do the states and federal government share in overpayment recoveries. States have one year to return the

²⁵³ 42 CFR § 430.42

²⁵⁴ If FFP is appealed beyond the HHS DAB, CMS does not include these amounts in the total recovered Medicaid and CHIP FFP, even when the ultimate ruling is in CMS's favor.

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federal share of an identified overpayment;²⁵⁵ thus, some of the recovered amounts reported in the current fiscal year may be related to amounts identified in the previous fiscal year.

2.1 Audit Medicaid Integrity Contractor/Unified Program Integrity Contractor Recoveries

Savings: The total recovered federal share of Medicaid overpayments identified by Audit MICs/UPICs.

Data Source: State Medicaid program integrity quarterly reports, specifically:

- Form CMS 64.9C1, Line 5
- Form CMS 64.90FWA, Line 5

In collaboration with states, CMS's Audit MICs/UPICs²⁵⁶ conduct post-payment investigations and audits of Medicaid providers throughout the country and report identified overpayments to the states for recovery. CMS and the states collaborate to select issues and providers for audits. Any Medicaid provider, including FFS providers, managed care entities, and managed care network providers, may be subject to audit. After the associated states and providers have the opportunity to comment on any identified overpayments, CMS sends the states the final audit reports/final findings reports documenting total overpayments for recovery. States are responsible for sending demand letters to the appropriate providers, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their state's administrative process.

CMS reports the recovered federal share of Medicaid overpayments identified by Audit MICs/UPICs in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit.²⁵⁷

²⁵⁵ States have one year from the date of discovery to return the full federal share of an identified overpayment, regardless of the amount the state succeeds in collecting from the associated provider(s) (42 CFR § 433.300-316). If a state is unable to collect an overpayment because the provider is bankrupt or out of business, the state is not required to refund the federal share (42 CFR § 433.318).

²⁵⁶ Audit MICs operated for part of FY 2018, until CMS completed the transition from Audit MICs to UPICs.

²⁵⁷ In FY 2018, CMS began including in savings the amounts refunded by states due to the expiration of the one-year time limit.

2.2 State Medicaid Recovery Audit Contractor Recoveries

Savings:	The total recovered federal share of Medicaid overpayments identified by state Medicaid RACs, after subtracting contingency fees.
Data Source:	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Lines 9E and 10E

Unless CMS grants an exception, states must contract with one or more Medicaid RACs to identify and recover overpayments as well as identify underpayments made to Medicaid providers. States determine the operations and focus areas for Medicaid RAC audits. CMS requires states to have an appeals process for providers seeking review of Medicaid RAC findings.

CMS reports the recovered federal share of Medicaid overpayments identified by Medicaid RACs in the fiscal year during which the recovery occurred. The calculation of the recovered federal share includes 1) the federal share of amounts collected by states within the one-year time limit, plus 2) the federal share of amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit, less 3) the federal share of Medicaid RAC fees.²⁵⁸ The recovered federal share includes any necessary adjustments to previously-reported federal share amounts. For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

2.3 Office of Inspector General Compliant False Claims Act Recoveries

Savings:	The net federal share of Medicaid false or fraudulent payments recovered as a result of state action under an HHS-OIG-compliant false claims act, after subtracting the state financial incentive.
Data Source:	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Line 9C2

Many states have false claims acts that establish civil liability to the state for individuals and entities that knowingly submit false or fraudulent claims under the state Medicaid program. If a state obtains a recovery related to false or fraudulent Medicaid claims, the federal government is entitled to a share of the recovery, in the same proportion as the FMAP. To encourage states to pursue civil Medicaid fraud, Section 1909 of the Social Security Act includes a financial incentive for states if their false claims acts meet certain

²⁵⁸ CMS contributes the federal share of Medicaid RAC fees in the same proportion as the FMAP, up to the highest contingency fee rate of Medicare RACs.

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requirements.²⁵⁹ HHS-OIG, in consultation with the U.S. Attorney General, determines if a state’s false claims act qualifies for the incentive, which is a 10-percentage-point increase in a state’s share of recovered amounts.

CMS reports the net federal share of Medicaid false or fraudulent payments recovered under states’ HHS-OIG-compliant false claims acts in the fiscal year during which the recoveries occurred. A state’s compliance is subject to review before CMS awards a state the financial incentive; thus, the financial incentive does not appear in Form CMS 64 Summary, Line 9C2. Instead, CMS gives states the financial incentive on a finalization grant award. To report savings, CMS conservatively estimates the net federal share of recovered Medicaid false or fraudulent payments by subtracting out the state financial incentive for all states that report in Form CMS 64 Summary, Line 9C2.

2.4 Other State Program Integrity Recoveries

Savings:	The total recovered federal share of Medicaid overpayments identified through other state-level program integrity activities.
Data Source:	State Medicaid program integrity quarterly reports, specifically: <ul style="list-style-type: none"> • Form CMS 64.9C1, Lines 1A, 1B, 1C, 2, 3, 4, 6, and 8 • Form CMS 64.90FWA, Lines 1A, 1B, 1C, 2, 3, 4, 6, 8, and 9

The states undertake a variety of program integrity activities to identify and recover improper payments, including the following:

- Provider audits
- Medicaid Fraud Control Unit (MFCU) investigations²⁶⁰
- Data mining activities conducted by state Medicaid agencies as well as MFCUs
- Settlements and judgments
- Civil monetary penalties

CMS reports the recovered federal share of Medicaid overpayments identified through state-level program integrity activities in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit.²⁶¹ The recovered federal share includes any necessary adjustments to previously-reported federal

²⁵⁹ Refer to <https://oig.hhs.gov/fraud/state-false-claims-act-reviews> for more information on HHS-OIG’s requirements for states to receive the financial incentive.

²⁶⁰ Refer to <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu> for more information on MFCUs.

²⁶¹ In FY 2018, CMS began including in savings the amounts refunded by states due to the expiration of the one-year time limit.

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share amounts.²⁶² For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

²⁶² States report total adjustments, which could be related to Audit MIC/UPIC and/or other state program integrity activities.

Appendix C – Acronyms and Abbreviations

Acronym	Description
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADR	Additional Documentation Request
AFR	[HHS] Agency Financial Report
ALJ	Administrative Law Judge
ANOC	Annual Notice of Change
APS	Advanced Provider Screening [system]
BCRC	Benefits Coordination & Recovery Center
CAP	Corrective Action Plan
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CHIPRA	Children’s Health Insurance Program Reauthorization Act of 2009
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CMS ART	CMS Analysis, Reporting, and Tracking
COB&R	Coordination of Benefits & Recovery
CPI	[CMS] Center for Program Integrity
CPIP	Certified Program Integrity Professional
CPT	Common Procedural Terminology
CRC	Commercial Repayment Center [Recovery Auditor]
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
DAB	Departmental Appeals Board
DDPS	Drug Data Processing System
D/E	Discussion/Education
DEA	Drug Enforcement Administration
DIR	Direct and Indirect Remuneration

Appendix C – Acronyms and Abbreviations

Acronym	Description
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOJ	Department of Justice
DOS	Date of Service
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EDPS	Encounter Data Processing System
EIN	Employee Identification Number
EOC	Evidence of Coverage
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FCBC	Fingerprint-based Criminal Background Check
FFP	Federal Financial Participation
FFS	Fee-for-Service
FID	Fraud Investigation Database
FISS	Fiscal Intermediary Shared System
FMAP	Federal Medical Assistance Percentage
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
GPO	Group Purchasing Organization
HASP	Hospital Appeals Settlement Process
HCFAC	Health Care Fraud and Abuse Control Program
HCPCS	Healthcare Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HEAT	Healthcare Enforcement and Action Team
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency

Appendix C – Acronyms and Abbreviations

Acronym	Description
HHH	Hubert H Humphrey Building
HHS	Department of Health & Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
IDR	Integrated Data Repository
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPIA	Improper Payments Information Act of 2002
IPT	Integrated Project Team
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug
MAS	Medicare Appeals System
MCS	Multi-Carrier System
MEDIC	Medicare Drug Integrity Contractor
Medi-Medi	Medicare-Medicaid Data Match
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MII	Medicaid Integrity Institute
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MLN	Medicare Learning Network®
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MPEC	Medicaid Provider Enrollment Compendium

Appendix C – Acronyms and Abbreviations

Acronym	Description
MSIS	Medicaid Statistical Information System
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NBI	National Benefit Integrity
NCCI	National Correct Coding Initiative
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
OEOCR	Office of Equal Employment Opportunity & Civil Rights
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
One PI	One Program Integrity
OPPS	Outpatient Prospective Payment System
ORM	Ongoing Responsibility for Medicals
O&R	Ordering and Referring [Edit]
PACE	Program of All-Inclusive Care for the Elderly
Part C	Medicare Advantage Part C Program
Part D	Medicare Prescription Drug Program
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PERM	Payment Error Rate Measurement
PI Board	Program Integrity Board
PLATO™	Predictive Learning Analytics Tracking Outcome
PMD	Power Mobility Device
PPS	Prospective Payment System
PS&R	Provider Statistical and Reimbursement [System or Report]
PSC	Program Safeguard Contractor
PTP	Procedure-to-Procedure [Edit]

Appendix C – Acronyms and Abbreviations

Acronym	Description
QIC	Qualified Independent Contractor
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
RAPS	Risk Adjustment Processing System
ROI	Return on Investment
SBJA	Small Business Jobs Act of 2010
SMA	State Medicaid Agency
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
SMRC	Supplemental Medical Review Contractor
SOW	Statement of Work
SPRY	[Medicaid] State Plan Rate Year
TAF	T-MSIS Analytic Files
TDD	Telecommunication Device for the Deaf
T-MSIS	Transformed-Medicaid Statistical Information System
TTY	Text Telephone
UCM	Unified Case Management [system]
UOS	Unit of Service
UPIC	Unified Program Integrity Contractor
UPL	Upper Payment Limit
USC	United States Code
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement
ZPIC	Zone Program Integrity Contractor

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Appendix D - Statutes Referenced in this Report

Public Law	Title	Short Title
74-271	The Social Security Act	The Act
90-248	Social Security Amendments of 1967	
104-191	Health Insurance Portability and Accountability Act of 1996	HIPAA
107-300	Improper Payments Information Act of 2002	IPIA
108-173	Medicare Prescription Drug, Improvement, and Modernization Act of 2003	MMA
109-171	Deficit Reduction Act of 2005	DRA
110-173	Medicare, Medicaid and SCHIP Extension Act of 2007	MMSEA
110-275	Medicare Improvements for Patients and Providers Act of 2008	MIPPA
111-148	Patient Protection and Affordable Care Act	
111-152	Health Care and Education Reconciliation Act of 2010	
111-204	Improper Payments Elimination and Recovery Act of 2010	IPERA
111-240	Small Business Jobs Act of 2010	SBJA
111-3	Children’s Health Insurance Program Reauthorization Act of 2009	CHIPRA
111-309	Medicare and Medicaid Extenders Act of 2010	
112-242	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012	SMART Act
112-248	Improper Payments Elimination and Recovery Improvement Act of 2012	IPERIA
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA