Department of Health and Human Services

Centers for Medicare & Medicaid Services

2016

Annual Report to Congress on the Medicare and Medicaid Integrity Programs

- For Fiscal Year 2016
- October 1, 2015 through September 30, 2016

To comply with 45 CFR § 92.8 this report is available in languages other than English as shown below.

English

The Fiscal Year 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs is a summary of the fraud, waste, and abuse prevention and detection activities undertaken by the Centers for Medicare & Medicaid Services during the period from October 1, 2015 to September 30, 2016. The report is presented in the English language. If your primary language is not English you may request a copy of this report translated into the language you prefer. Please address your request to:

Centers for Medicare & Medicaid Services
Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Please make sure to reference the title of this report (The Fiscal Year 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) in your request.

Arabic العربية

السنة المالية التقرير السنوي إلى الكونغرس عن الرعاية الطبية وبرامج السلامة الطبية ملخص للغش والتبذير وإساءة 2016 استعمال لمنع وكشف الأنشطة التي تضطلع بها المراكز للخدمات الطبية آند الرعاية الطبية خلال الفترة من 1أكتوبر 2015إلى 30سبتمبر 2016. ويرد التقرير باللغة الإنكليزية. إذا لغتك الأولى ليست اللغة الإنجليزية فيمكنك طلب نسخة من هذا التقرير ترجمة إلى اللغة التي تفضلها. الرجاء معالجة الطلب الخاص بك إلى:

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إلى الكونغرس على الرعاية الطبية وبرامج 2016التقرير السنوي السنة المالية)الرجاء التأكد من يشير عنوان هذا التقرير في الطلب الخاص بك (السلامة الطبية.

Chinese 形容词

向国会提交有关医疗保险和医疗补助完整性计划 2016 财年年报是欺诈、 浪费和滥用预防和检测方面进行的活动中心医疗保险与医疗补助服务 2015 年 10 月 1 日至 2016 年 9 月 30 日期间的摘要。 在英语语言中提交报告。 如果您的主要语言不是英语可能请求翻译成你喜欢的语言这报告的副本。 有意者请有意者请将您的要求：

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请务必参考本报告书 （财政年度 2016年年度报告向国会提交有关医疗保险和医疗补助计划完整程序） 在您的请求标题。

French Français

Le rapport annuel de l'exercice 2016 au Congrès sur le Medicare et Medicaid intégrité des programmes est un résumé de la fraude, de gaspillage et activités de prévention et de détection de l'abus entreprises par les centres de Services Medicare & Medicaid durant la période du 1er octobre 2015 au 30 septembre 2016. Le rapport est présenté en langue anglaise. Si votre langage primaire n'est pas l'anglais, vous pouvez demander une copie de ce rapport traduit dans la langue que vous préférez. Veuillez adresser votre demande à :

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S'il vous plaît assurez-vous de référencer le titre de ce rapport (rapport annuel de l'exercice 2016 au Congrès sur le Medicare et Medicaid intégrité programmes) dans votre demande.

French Creole franse kreyòl

Ane Fiskal 2016 Anyèl Rapò a nan Kongrè a sou Pwogram Entegrite Medicare ak Medicaid se yon rezime nan fwod, fatra, ak prevansyon abi ak deteksyon aktivite yo eskize pa Sant pou Medicare & Medicaid Sèvis pandan peryòd la nan, 1 oktòb 2015 a 30 septanm , se 2016. rapò a prezante nan lang angle a. Si lang prensipal ou se pa angle ou ka mande yon kopi rapò sa a tradui nan lang lan ou prefere. Tanpri adrese demann ou a:

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Tanpri asire w ke w referans tit la nan rapò sa a (Ane Fiskal 2016 Anyèl Rapò a nan Kongrè a sou Medicare nan ak Medicaid Pwogram Entegrite) nan demann ou an.

German Deutsche

Das Geschäftsjahr 2016 jährlich einen Bericht Kongress über die Medicare und Medicaid-Integrität-Programme ist eine Zusammenfassung von dem Betrug, Verschwendung und Missbrauch Prävention und Aufdeckung Tätigkeiten durch die mitten für Medicare & Medicaid Services während der Zeit von 1. Oktober 2015 bis 30. September 2016. Der Bericht ist in englischer Sprache vorgestellt. Wenn Ihre Muttersprache nicht Englisch ist, können Sie verlangen, eine Kopie dieses Berichts übersetzt in die Sprache, die Sie bevorzugen. Bitte richten Sie Ihre Anfrage an:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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Bitte achten Sie auf den Titel dieses Berichts (The Fiscal Year 2016 Annual Report zum Kongress über die Medicare und Medicaid-Integrität-Programme) in Ihrer Anfrage zu verweisen.

Italian Italiano

Relazione annuale al Congresso della Medicare e Medicaid integrità programmi anno fiscale 2016 è un riepilogo delle frodi, rifiuti e attività di prevenzione e rilevamento di abuso intraprese dai centri per Medicare e Medicaid Services durante il periodo dal 1° ottobre 2015 al 30 settembre 2016. La relazione è presentata in lingua inglese. Se la vostra lingua non è l'inglese si può richiedere una copia della presente relazione tradotta nella lingua che preferisci. Si prega di rivolgersi a:

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Si prega di assicurarsi fare riferimento il titolo di questa relazione (relazione annuale l'anno fiscale 2016 al Congresso sul Medicare e Medicaid integrità programmi) nella vostra richiesta.

Japanese 日本語

メディケアとメディケイド整合性プログラムに関する議会 2016 年度年次報告書は、詐欺、廃棄物と虐待予防と発見活動 2015 年 10 月 1 日から 2016 年 9 月 30 日までの期間中のメディケア ・ メディケイド ・ サービス センターによって実施の概要です。 レポートは、英語で表示されます。 あなたの主言語が英語でない場合は、このレポートをご希望の言語に翻訳のコピーを要求可能性があります。 リクエストのご住所します。

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お客様のリクエストでこのレポート (の年度 2016 メディケアとメディケイド整合性プログラムの議会に年次報告書) のタイトルを参照してください。

Korean 한국인

메디케어 및 메디 케이드 무결성 프로그램에 의회에 연례 보고서는 회계 년도 2016은 사기, 낭비, 남용 예방 및 탐지 활동 2015 년 10 월 1 일 9 월 30 일, 전망 기간 동안 메디케어 및 메디 케이드 서비스 센터에 의해 시행 된의 요약 이다. 보고서는 영어로 제공 됩니다. 기본 언어를 영어 경우에 당신이 선호 하는 언어로 번역 하는이 보고서의 복사본을 요청할 수 있습니다. 하시기 바랍니다 귀하의 요청을 주소:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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확인 요청에서 (메디케어 및 메디 케이드 무결성 프로그램에 의회는 회계 연도 2016 연례 보고서)이이 보고서의 제목을 참조 하십시오.

Persian (Farsi) فارسی

یکپارچگی برنامه خلاصه تقلب اتلاف و سوء استفاده از پیشگیری به کنگره مدیکر و مدیکید 2016گزارش سالانه سال 30به 2015اکتبر سال 1پزشکی در طول دوره از & و تشخیص فعالیت های انجام شده توسط مراکز خدمات مدیکر 2016سپتامبر سال است. این گزارش در زبان انگلیسی ارائه شده است. اگر شما زبان اصلی انگلیسی شما درخواست یک کپی از این گزارش به زبان دلخواه شما ترجمه شده. لطفا درخواست خود را به آدرس:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
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یکپارچگی به کنگره مدیکر و مدیکید 2016گزارش سالانه سال)لطفا در صورت اطمینان به مرجع عنوان این گزارش در درخواست شما (برنامه.

Polish Polski

Sprawozdanie roczne 2016 roku obrachunkowego do Kongresu na Medicare i Medicaid integralności programów jest podsumowanie oszustwa, odpadów i nadużycia zapobiegania i wykrywania działań podejmowanych przez centrum dla Medicare & Medicaid Services w okresie od 1 października 2015 r. do 30 września 2016.

Sprawozdanie jest przedstawione w języku angielskim. Jeśli głównym językiem nie jest angielski może poprosić o kopię tego raportu, przetłumaczone na język, który wolisz. Należy zwrócić do:

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Upewnij się odwołać tytuł niniejszego sprawozdania (The 2016 roku obrachunkowego roczne sprawozdanie z Kongresu na Medicare i Medicaid integralności programów) w swoim zgłoszeniu.

Portuguese Português

O relatório anual do ano Fiscal de 2016 ao Congresso sobre o Medicare e o Medicaid programas de integridade é um resumo da fraude, desperdício e atividades de prevenção e deteção de abuso empreendidas pelos centros para Medicare e Medicaid Services durante o período compreendido entre 1 de outubro de 2015 e 30 de setembro de 2016. O relatório é apresentado no idioma inglês. Se sua língua materna não é o inglês, você pode solicitar uma cópia deste relatório, traduzido para o idioma que você prefere. Por favor, dirija o seu pedido para:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Por favor, certifique-se de referência o título deste relatório (o ano Fiscal de 2016 relatório anual ao Congresso sobre o Medicare e o Medicaid programas de integridade) em seu pedido.

Russian русский

2016 финансовый год ежегодный доклад Конгрессу по Medicare и Medicaid целостности программ является резюме мошенничества, расточительства и злоупотреблений предупреждения и выявления деятельности центры по Medicare

& Medicaid Services за период с 1 октября 2015 г. по 30 сентября 2016 года. Доклад представлен на английском языке. Если ваш основной язык не является английским, вы можете запросить копию настоящего доклада, переведены на язык, который вы предпочитаете. Обращайтесь, пожалуйста, ваш запрос:

Centers for Medicare & Medicaid Services
Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Пожалуйста, убедитесь, что ссылка на название настоящего доклада (2016 финансовый год ежегодный доклад Конгрессу по Medicare и Medicaid целостности программ) в запросе.

Spanish Español

El informe anual del año Fiscal 2016 al Congreso en los programas de integridad de Medicaid y Medicare es un resumen del fraude, desperdicio y abuso prevención y detección de las actividades realizadas por los centros para servicios de Medicare y Medicaid durante el periodo de 01 de octubre de 2015 a 30 de septiembre de 2016. El informe se presenta en el idioma inglés. Si tu lengua materna no sea el inglés puede solicitar una copia de este informe, traducido al idioma que prefiera. Por favor, dirija su solicitud a:

Centers for Medicare & Medicaid Services
Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
Attn: CMS Alternate Format Team

Por favor asegúrese de referencia el título de este informe (informe anual del año Fiscal 2016 al Congreso en los programas de integridad de Medicaid y Medicare) en su petición.

Tagalog Tagalog

ang tao ng panuusan 2016 taunang ulat na sa kongreso ng medicare at medicaid palatuntunang pagtatapat ay isang buod ng daya , ang , at ang labis ng at detection

undertaken gawain sa mga sentro ng medicare & amp ; medicaid paglilingkod sa mga tuldok sa oktubre 1 , 2015 sa septyembre 30 , 2016 . ang mga ulat ay iniharap sa wika ng ingles . kung ang pangunahing wika ay hindi maaaring hindi ko ang isang salin ng inilipat ito sa kanilang wika na mas gusto . ang tirahan mo na kahilingan :

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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gawing sigurado naman sa kaukulan ang titulo ng kanilang ito (ang tao ng panuusan 2016 taunang ulat na sa kongreso ng medicare at medicaid pagtatapat palatuntunang) sa inyong mga kahilingan .

Vietnamese Việt Nam

Báo cáo thường niên năm tài chính 2016 để đại hội về Medicare và Medicaid toàn vẹn chương trình là một bản tóm tắt của gian lận, lãng phí và lạm dụng phòng ngừa và phát hiện các hoạt động thực hiện bởi các trung tâm dịch vụ Medicare & Medicaid trong giai đoạn từ 1 tháng 10 năm 2015 đến ngày 30 tháng 9 năm 2016. Báo cáo được trình bày bằng tiếng Anh. Nếu ngôn ngữ chính của bạn không phải là tiếng Anh, bạn có thể yêu cầu một bản sao của báo cáo này được dịch sang ngôn ngữ bạn muốn. Xin địa chỉ yêu cầu của bạn:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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Baltimore, MD 21244-1850
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Hãy chắc chắn để tham khảo các tiêu đề của báo cáo này (The năm tài chính 2016 báo cáo thường niên để đại hội về Medicare và Medicaid tích hợp chương trình) trong yêu cầu của bạn.

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2. For all other CMS publications, you can:
   a. Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
   b. Send a fax to 1-844-530-3676.
   c. Send an email to AltFormatRequest@cms.hhs.gov.
   d. Send a letter to:

   Centers for Medicare & Medicaid Services
   Office of Equal Employment Opportunity & Civil Rights (OEOCR)
   7500 Security Boulevard, Room N2-22-16
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Note

Your request for CMS publications should include:

- Your name, phone number, and the mailing address where we should send the publications.
- The publication title and CMS Publication No., if available.
- The format you need, like Braille, large print, compact disc (CD), audio CD, or a qualified reader.

If you believe you have been subjected to discrimination in a CMS program or activity, there are three ways to file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

1. Online at the Office for Civil Rights of the U.S. Department of Health and Human Services
2. By phone: Call 1-800-368-1019. TDD users should call 1-800-537-7697.
3. In writing: Send information about your complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

For additional information, email AltFormatRequest@cms.hhs.gov.

Executive Summary

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2016 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.[1]

Medicare Program Integrity

CMS estimates that program integrity activities saved Medicare an estimated total of $17.9 billion in FY 2016, for an average return on investment of $12.4 to 1 for the three-year period of October 1, 2013 - September 30, 2016. (See the summary table on the next page). CMS's program integrity activities either prevent improper payments or recover overpayments.

CMS achieved significant savings in FY 2016 through activities designed to prevent improper payments. Improper payments prevention represented 85.9 percent ($15.3 billion) of the total Medicare FY 2016 savings, including:

- Systematic Edits ($999.5 million);
- Provider Enrollment Actions ($786.9 million);
- Prepayment Edits and Reviews ($13.5 billion); and
- Other Actions ($65.5 million).

Included in these amounts are savings from the Fraud Prevention System (FPS), which stopped, prevented, or identified $527.1 million in improper payments, and the National Correct Coding Initiative (NCCI) edits, which saved the Medicare program $815.2 million. In addition, CMS had 508 active payment suspensions during FY 2016.

Among other activities, Medicare Administrative Contractors (MACs) request medical documentation from providers and suppliers as part of prepayment and post-payment reviews. In FY 2016, MAC prepayment medical review prevented nearly $6.1 billion in improper payments. Prepayment medical review efforts avoid "pay and chase" by preventing improper payments from being made, as well as promote provider and supplier compliance.

[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.

Type of Medicare Savings[a]	Savings (in millions)		
	2014	2015	2016
Prevention Savings			
Systematic Edits	$ 1,129.3	$ 1,095.7	$ 999.5
Provider Enrollment	874.3	1,106.4	786.9
Prepayment Edits and Reviews	11,859.7	12,346.2	13,478.6
Other Actions	52.2	128.0	65.5
Total Prevention Savings	**$ 13,915.5**	**$ 14,676.3**	**$ 15,330.6**
Recovered Savings			
Overpayment Recoveries	$ 3,880.4	$ 2,481.4	$ 2,319.7
Cost Report Payment Accuracy	687.3	223.9	33.4
Plan Penalties	3.4	5.0	44.9
Other Actions	3.6	1.6	18.8
Law Enforcement Referrals	105.3	65.4	106.1
Total Recovered Savings	**$ 4,680.0**	**$ 2,777.3**	**$2,523.0**
Total Savings (Prevention and Recovered)	**$ 18,595.5**	**$ 17,453.6**	**$ 17,853.5**

[a] There were a number of changes to metrics and metric categories for FY 2016, and these changes are detailed in footnote b of Table 3. Appendix B also provides detailed methodologies for all savings metrics. Savings values for FY 2014 and FY 2015 will differ from the values published in the Annual Medicare and Medicaid Integrity Programs Reports to Congress for FY 2013/2014 and FY 2015 because of these metric changes.

Recovered savings represented the remaining estimated $2.5 billion of FY 2016 savings. Recovered savings activities included:

- Overpayment Recoveries ($2.3 billion);
- Cost Report Payment Accuracy ($33.4 million);
- Plan Penalties ($44.9 million);
- Other Actions ($18.8 million); and
- Law Enforcement Referrals ($106.1 million).

Program integrity activities saved Medicare an estimated total of $17.9 billion in FY 2016, which represents an increase of 2.3 percent from FY 2015 ($17.5 billion). Although recovered savings declined from $2.8 billion in FY 2015 to $2.5 billion in FY 2016, prepayment prevention savings increased from $14.7 billion to $15.3 billion, respectively. This increase in prevention savings emphasizes CMS's focus on a proactive prevention strategy, instead of a "pay and chase" approach.

A more detailed list of savings by program integrity activity is included in the full report in Table 3 and throughout section 1.3 of the report.

Medicaid Program Integrity

States are responsible for collecting overpayments identified by Audit Medicaid Integrity Contractors (MICs). Once identified, states generally have up to one year from the date of the final audit report to return the federal share.[2] In FY 2016, CMS Audit MICs identified $50.6 million in Medicaid overpayments (representing a federal share of $31.1 million).[3]

Through the Medicaid Recovery Audit Program, the states have recovered a total combined federal and state share amount of $82.3 million for FY 2016 and returned the federal share of $49.2 million to the Treasury.[4] CMS also supported state activities through the Medicaid Integrity Program that led to substantial recoveries – including $956.5 million in combined federal and state share recoveries reported by states for FY 2016.

Coordinated Activities in Program Integrity

CMS coordinated closely with a variety of partners during FY 2016, including federal law enforcement officials from the Department of Health and Human Services (HHS), the Department of Justice (DOJ), state law enforcement officials including those from state Medicaid Fraud Control Units, clinicians, and other federal agencies before, during, and after the development of fraud leads. For example, twenty-three state Medicaid Fraud Control Units participated in an unprecedented nationwide sweep on June 22, 2016 led by the Medicare Fraud Strike Force[5] that resulted in criminal and civil charges against 301 individuals, including doctors, nurses, and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $900 million in false billings.

Medicaid is a partnership between the federal government and states. CMS is committed to maintaining coordination and a strong relationship with states to improve Medicaid program integrity. State program integrity reviews provide federal oversight of the states' activities and serve as an opportunity to gain insight into current trends in fraud, waste, and abuse, and to share best practices. Data exchange, such as in provider enrollment and the Transformed-Medicaid Statistical Information System (T-MSIS), is another important area where CMS and states rely on each other to promote program integrity.

In FY 2012, HHS and the DOJ developed the Healthcare Fraud Prevention Partnership (HFPP), a voluntary, public-private partnership among the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector. At the

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[2] States are required to return the federal share of any collections during the calendar quarter in which they effect the collection. At the conclusion of one year, the states are required to refund the federal share of any identified overpayments, regardless whether they actually collected the amount overpaid. See 42 CFR § 433.316.

[3] The amounts identified, once collected, appear in the appropriate place on the Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (CMS 64).

[4] Medicaid RAC Program recoveries (both total and federal share) as reported by the states as of January 2017.

[5] The Medicare Fraud Strike Force is a partnership between the Department of Justice Criminal Division, U.S. Attorney's Offices, the FBI and HHS-OIG.

end of FY 2016, the HFPP consisted of 70 partner organizations. During FY 2016, the HFPP completed a number of studies using multiple partner data to address fraud, waste, and abuse. Those participating on active cases in the HFPP's information sharing sessions identified, on average, seven new fraud leads per partner.

Today, with the authorities and resources provided by Congress, CMS has more tools than ever before to continue implementing important strategies to prevent fraud, waste, and abuse.

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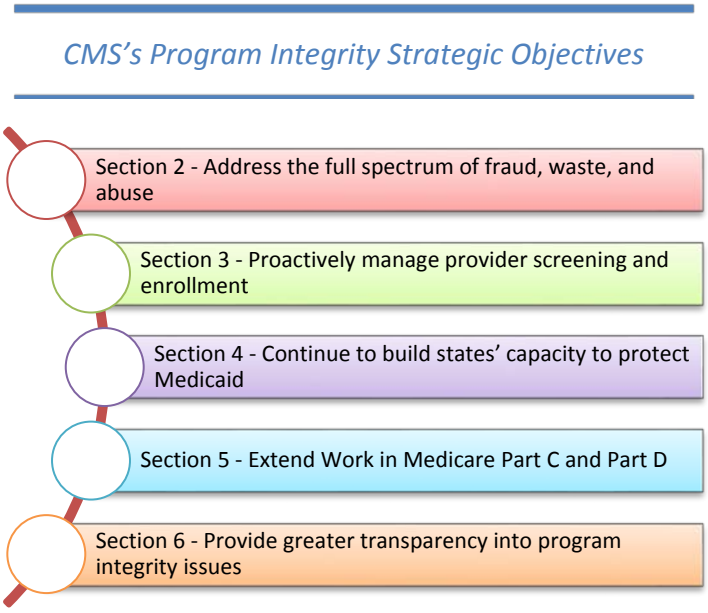
1. Introduction

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2016 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.



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.

In 2010, CMS created the Center for Program Integrity (CPI) to align the program integrity functions of the Medicare and Medicaid programs. A reorganization of CPI in September 2014 from a program-specific to a functional approach further emphasized this realignment. CPI is responsible for implementation of the Medicare Integrity Program and the Medicaid Integrity Program. This report focuses on the program integrity activities led by or including significant involvement of CPI. Program integrity in Medicare and Medicaid concentrates on reducing improper payments, by either preventing or recovering erroneous payments. It is important to note that while all payments made as a result of fraud constitute "improper payments," not all improper payments constitute fraud.

As part of the September 2014 reorganization, CPI developed five strategic objectives that guided our initiatives through FY 2016 to reduce improper payments:

1. Address the full spectrum of waste, abuse, and fraud
2. Proactively manage provider screening and enrollment
3. Continue to build states' capacity to protect Medicaid

4. Extend work in Medicare Part C and Part D, Medicaid managed care, and the Marketplace[6]
5. Provide greater transparency into program integrity issues

Importantly, CMS's comprehensive program integrity activities extend across the agency. In addition to CPI, the Office of Financial Management, the Center for Medicaid and CHIP Services, and the Center for Medicare also perform program integrity activities. For example, the Office of Financial Management oversees the Medicare Secondary Payer (MSP) program and certain improper payment measurement programs, while CPI leads the CMS-wide strategy to address the national opioid misuse epidemic.[7]

During FY 2016, CMS's program integrity efforts resulted in an estimated $17.9 billion in savings for the Medicare Trust Funds, demonstrating the effectiveness of CMS's comprehensive approach to program integrity in Medicare.[8] Since the introduction of the savings methodologies in the FY 2013/2014 Report to Congress, CMS has continued to improve its data and subsequently has updated certain savings methodologies. In most cases, these savings are conservative because they do not include measures of sentinel effect, or changes in provider and supplier behavior resulting from our focused program integrity work in certain areas. Section 1.3.2 of the report provides more detail on Medicare savings for FY 2016. Appendix B provides the program integrity savings methodology.

In Medicaid, CMS actions contributed to an increase in program integrity-related collections since the launch of the Medicaid Integrity Program in 2006. The amounts of collections increased threefold from FY 2006 to FY 2010 and have consistently remained high since that time. For FY 2016, states reported $956.5 million in total Medicaid program integrity collections, with $522.2 million attributable to the federal share.

Summary of Report Content

This report contains six sections, organized by CMS's strategic objectives for program integrity, detailing specific aspects of CMS's program integrity efforts. Five appendices at the end of this report provide additional information and references. Highlights for each section follow:

Section 1 - This section serves as the report introduction and provides background information regarding CMS's program integrity activities. It highlights CMS's statutory authority to establish and report on its program integrity

[6] While the strategic objective from 2014 includes Medicaid Managed Care and the Marketplace, the focus of this FY2016 report is on Medicare Part C and Part D programs.

[7] Additional information regarding HHS' actions to address opioid-drug related overdoses and deaths is available at this webpage.

[8] Although the $17.9 billion was not required to be subjected to OIG certification, the OIG did certify that the savings were grounded in methodologies used to develop the FPS adjustment factor. The FPS savings methodology represented the first time in federal health care programs that the OIG certified a cost avoidance calculation. This critical achievement lays the foundation and support for savings identified through prevention of improper payments in this report. Our comprehensive savings methodology is included as Appendix B to this report.

activities, identifies and defines the various program activities, and presents the methods of measuring these activities' success.

Section 2 - This section describes CMS's efforts to address the full spectrum of waste, abuse, and fraud. This includes initiatives that are foundational to protecting program integrity, such as enhancements to our data sharing and analytic capabilities, our prior authorization programs, and improved coordination of our compliance and investigation activities across the integrity continuum.

Section 3 - This section outlines CMS's approach to manage provider screening and enrollment. It includes information about activities such as provider screening, temporary provider enrollment moratoria, and our ongoing project to revalidate all existing Medicare providers.

Section 4 - This section defines CMS's role to continue to build states' capacity to protect Medicaid. This section also discusses collaborative audits through the National Medicaid Audit Program.

Section 5 - This section details CMS's efforts to extend program integrity work in Medicare Part C and Part D.

Section 6 - This final section discusses CMS's dedication to provide greater transparency into program integrity issues through education, outreach, partnership, strategic communications, and data releases. This section includes activities such as the Healthcare Fraud Prevention Partnership (HFPP), Open Payments, and improper payment rate measurement.

1.1. Reporting Requirements

This FY 2016 Report to Congress for Medicare & Medicaid describes CMS's program integrity activities during FY 2016. 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.[9]

Federal law also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare and Medicaid. This FY 2016 Report to Congress for Medicare & Medicaid fulfills the reporting requirements with respect to Medicare and Medicaid program integrity, Medicaid Recovery Auditors, and Medicare Part C and Part D Recovery Auditors.[10] Moreover, the Medicare Fee-For-Service (FFS) Recovery Audit Contractors (RACs) program is discussed in section 2.14 of this report, but a comprehensive report on the Recovery Auditing in Medicare Fee-For-Service is published separately.

Medicare Funding

The Health Insurance Portability and Accountability Act of 1996[11] (HIPAA) 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 amount specified in HIPAA increased between FY 1997 and FY 2003 and remained at $720 million through FY 2010, after which the Patient Protection and Affordable Care Act[12] (the Affordable Care Act) increased the base funding level and applied an annual inflation adjustment to the new base funding level. This funding supports program integrity functions performed across CMS including: Audits, MSP, Medical Review, Provider Outreach and Education, Benefits Integrity, and Provider Enrollment.

CMS received additional mandatory funding for the Medicare Integrity Program (specifically for the Medicare-Medicaid Data Match program or Medi-Medi) from the

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9 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' 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.

10 CMS is subject to other requirements to report to Congress on the use of Health Care Fraud and Abuse Control program funds, Recovery Audit Contractors (RACs), and the implementation of the predictive modeling requirements under the Small Business Jobs Act of 2010 (SBJA). This report details activities that may be subject to other reporting requirements, but have been included to provide a full description of CMS's program integrity activities.

11 Public Law 104-191.

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

Federal Hospital Insurance Trust Fund in FY 2006 under the DRA. The Affordable Care Act provided additional funding through 2020 and permanent indexing of the mandatory amounts. Beginning in FY 2009, the Medicare Integrity Program has also received discretionary Health Care Fraud and Abuse Control (HCFAC) program funding, subject to annual appropriation. CMS obligated a total of $1.4 billion in FY 2016 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.[13] The Medicaid Integrity Program represents the first comprehensive strategy at the federal level to combat fraud, waste, and abuse in the Medicaid program and is one component in the overall effort to safeguard Medicaid program integrity.

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 Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[14] CMS obligated a total of $157.0 million in FY 2016 for Medicaid Program Integrity activities. This included $79.7 million in funding from the Medicaid Integrity Program and $77.3 million in from the 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 Innovation Center models, the RAC programs, and Durable Medical Equipment (DME) Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity.

[13] CMS has been required to report on Medicaid program integrity activities since the enactment of the DRA, which added section 1936 to the Act. Section 6402(j) of the Affordable Care Act amended section 1893 of the Act and established the requirement that CMS report on Medicare program integrity activities.

[14] 42 U.S.C. 1396u-6(e)(1)(D).

1.2. Program Integrity in Medicare and Medicaid

CMS is accountable for the protection of the Medicare Trust Funds and other public resources from fraud, waste, and abuse, and for the reduction of improper payments in Medicare and Medicaid. These programs provide a significant amount of healthcare services to a vast number of individuals each day. In FY 2016, Medicare and Medicaid collectively covered an estimated 116.6 million people. During the course of FY 2016, the average monthly Medicare enrollment was 57.1 million,[15] while the average monthly enrollment for Medicaid was 70.9 million.[16] Furthermore, there were more than 11.4 million enrollees in both the Medicare and Medicaid programs.[17] CMS directly administers Medicare through contracts with private companies that processed 1.2 billion FFS claims in FY 2015.[18] This represents an average of 3.2 million claims every day. States administer Medicaid within the bounds of federal law and regulations, and CMS partners with each state Medicaid program to support program integrity efforts. The 56 separately state-run Medicaid programs process claims for services provided to Medicaid beneficiaries.[19] Total federal expenditures for Medicare, Medicaid, and program administration exceeded $874 billion dollars in FY 2015.[20] This does not include the states' share of expenditures for their participation in the Medicaid program.

As required by law, CMS procures 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.

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Zone Program Integrity Contractors[21] (ZPICs)	Medicare Fee-for-Service (FFS)	• 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 • Make recommendations to CMS for appropriate administrative actions (i.e., revocations and suspensions) to protect Medicare Trust Fund dollars

15 2016 CMS Statistics (CMS Pub. No. 03513), Table I.1, page 2.

16 2016 CMS Statistics, Table I.16, page 11.

17 This data comes from a brief on Medicare-Medicaid dual enrollment from 2006 through 2015 found at the Medicare-Medicaid Coordination Office FY 2016 Report to Congress.

18 2016 CMS Statistics, Table V.5, page 42. FY 2015 is the most current year for which this information is available.

19 In addition to the 50 states and the District of Columbia, the territories of American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands participate in the Medicaid program.

20 2016 CMS Statistics, Table III.1, page 28. FY 2015 is the most current year for which this information is available.

21 For the purposes of this report, references to the ZPICs include legacy Program Safeguard Contractors.

Contractor	Program	Program Integrity Responsibilities
		• Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits), in coordination with 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
Medicare Administrative Contractors (MACs)	Medicare FFS	• Perform provider and supplier screening and enrollment • Audit the Medicare cost reports upon which CMS bases Medicare payments to institutional providers, such as hospitals and skilled nursing facilities • Conduct prepayment and post-payment medical review • Analyze claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claim types • Develop and implement prepayment edits • Determine payment amounts for and make payments to providers, suppliers, and individuals • 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	• Conducts nationwide medical review as directed by CMS • Notifies CMS and the MACs of identified improper payments and noncompliance with documentation requests
Medicare FFS RACs	Medicare FFS	• Conduct post-payment audits to identify a wide range of improper payments • 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	• 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

Contractor	Program	Program Integrity Responsibilities
		• 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 Parts C and D	• Conducts data analyses of national Part C and Part D issues leading to potential identification of improper payments and regulatory compliance • Coordinates Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement • Supports CMS enforcement of Part C and Part D plan sponsors' compliance and fraud audits of providers
Outreach and Education (O&E) MEDIC	Medicare Parts C and D	• Develops educational resources and conducts training on fraud, waste, and abuse activities for Medicare Part C and Part D
Part D RAC	Medicare Part D	• Conducts post-payment reviews of reconciled Part D Prescription Drug Event (PDE) data to identify a wide range of improper payments
State Medicaid RACs	Medicaid FFS and Managed Care	• Contracted by State Medicaid Agencies (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers
Audit MICs	Medicaid FFS and Managed Care	• 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)
Education MICs	Medicaid FFS and Managed Care	• Develop educational resources and conduct training on fraud, waste, and abuse activities for Medicaid providers

1.3.Measuring Program Integrity Success

1.3.1. Improper Payment Rates

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 forms workgroups, and directs and tracks corrective actions to address identified high-priority vulnerabilities to resolution. One such corrective action workgroup established by the PI Board is the Improper Payment Action Plan workgroup.

The workgroup periodically collects data from improper payment reports and formulates action plans for review by the PI Board.

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, in FY 2016, the PI Board approved the Marketplace IPT and Documentation Improvement IPT. All of the approved IPTs work independently under the directive of the PI Board and provide regular updates.

Table 2 provides the gross improper payment rates (a calculation which includes both overpayments and underpayments) and summarizes trends in the improper payment rates since 2010 for Medicare FFS, Part C, and Part D; Medicaid; and CHIP.[22] Section 6.4 of this report provides specific information on how each program measures improper payment.

Table 2: Reported Improper Payment Rates for 2010 through 2016

Program	2010	2011	2012	2013	2014	2015	2016
Medicare FFS	10.5%	8.6%	8.5%	10.1%	12.7%	12.1%	11.0%
Part C	14.1%	11%	11.4%	9.5%	9.0%	9.5%	10.0%
Part D	N/A	3.2%	3.1%	3.7%	3.3%	3.6%	3.4%
Medicaid	9.4%	8.1%	7.1%	5.8%	6.7%	9.8%	10.5%
CHIP	N/A	N/A	8.2%	7.1%	6.5%	6.8%	8.0%

While this report discusses many of the ways that CMS reduces the improper payment rates for Medicare, Medicaid, and CHIP, please see the FY 2016 HHS Agency Financial Report (AFR) for a comprehensive overview of improper payment rates for CMS programs, as well as corrective actions implemented in FY 2016.

[22] Improper payment rates for Medicare Part D began in 2011. The improper payment rates for CHIP began in 2012. The first improper payment rate reported for CHIP after the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) was enacted was in 2012. It is important to note that the 2012 and 2013 CHIP rates do not include results of all states. The 2012 CHIP rate only represents 1 cycle since only 17 states had been sampled at that time. The 2013 CHIP rate represents 2 cycles since only 34 states had been sampled at the time. Beginning in and following 2014 the CHIP rate represents all 3 cycles of states.

1.3.2. Medicare Savings

CMS saved an estimated $17.9 billion in FY 2016 (see Table 3). This represents a return on investment of $12.4 to 1 for the three-year period of October 1, 2013 - September 30, 2016.[23] An estimated 85.9 percent of the savings in FY 2016 resulted from prevention actions, safeguarding Medicare dollars.

In FY 2016, CMS continued to develop new methodologies for administrative actions for savings that were not previously measured. By taking swift administrative action, when appropriate, to revoke or deactivate providers' and suppliers' billing privileges, CMS estimates it avoided paying $786.9 million in FY 2016. CMS also extended its NCCI methodology for Medically Unlikely Edits (MUEs) to include savings from DME MUEs. CMS estimates NCCI MUE edits saved $544.4 million in FY 2016.

The savings measures may not capture the full scope of savings achieved through program integrity activities. In addition, savings from sentinel effects are not measured. A sentinel effect occurs when providers and suppliers alter their billing behavior or come into compliance because of oversight actions. By taking administrative action, CMS deters and reduces fraudulent behavior across the provider and supplier population. CMS cannot assess a dollar value at this time to account for the sentinel effect savings because this type of behavior change is difficult to measure and attribute to CMS's specific administrative actions.

Table 3: Medicare Savings

Type of Medicare Savings [a, b] **(Table continues on the following page)**	**FY 2014 (in millions)**	**FY 2015 (in millions)**	**FY 2016 (in millions)**
Prevention Savings			
Systematic Edits			
National Correct Coding Initiative (NCCI) – Procedure-to-Procedure Edits	$ 295.4	$ 285.4	$ 270.8
NCCI – Medically Unlikely Edits	620.4	592.4	544.4
Ordering and Referring Edits	150.9	143.3	109.4
Fraud Prevention System Edits	2.3	11.3	20.4
Zone Program Integrity Contractor (ZPIC) Edits	60.5	63.4	54.5
Provider Enrollment			
Revocations	700.7	886.2	629.6
Deactivations	173.5	220.2	157.4
Prepayment Edits and Reviews			
Medicare Secondary Payer (MSP) Operations	7,088.7	7,316.9	7,353.7
Medicare Administrative Contractor (MAC) Medical Reviews	4,713.1	4,969.5	6,071.0

[23] The three-year return on investment for the Medicare Integrity Program for FY 2014, FY 2015, and FY 2016 is calculated by dividing the combined total Medicare savings from FY 2014, FY 2015, and FY 2016 by the combined total Medicare obligations from FY 2014, FY 2015, and FY 2016. The reader is cautioned that the above amounts include RAC findings that are also reported separately in a distinct Report to Congress pertaining to the Medicare FFS Recovery Audit program.

Type of Medicare Savings [a, b] **(Table continues on the following page)**	**FY 2014 (in millions)**	**FY 2015 (in millions)**	**FY 2016 (in millions)**
ZPIC Prepayment Reviews	57.9	59.8	54.0
Other Actions			
Payment Suspensions	52.2	128.0	46.7
Medicare Part D Reconciliation Data Reviews	--	--	18.8
Total Prevention Savings	**$13,915.5**	**$14,676.3**	**$ 15,330.6**
Recovered Savings			
Overpayment Recoveries			
MSP Operations	$ 1,111.3	$ 1,173.9	$ 1,202.4
MSP Commercial Repayment Center	59.3	149.6	104.7
MAC Medical Reviews	28.9	9.7	32.7
Medicare FFS RAC Reviews	2,064.3	237.7	274.0
Supplemental Medical Review Contractor (SMRC) Reviews	--	45.1	117.8
ZPIC Post-Payment Reviews	103.4	175.5	178.7
Retroactive Revocations	0.4	0.8	2.1
Overpayments Related to Risk Adjustment Data	456.3	660.4	326.4
National Benefit Integrity Medicare Drug Integrity Contractor (NBI MEDIC) Part D Data Analysis Projects	53.8	23.5	78.5
Medicare Part D RAC Reviews	2.7	5.2	2.3
Cost Report Payment Accuracy			
Provider Cost Report Reviews and Audits	639.7	133.2	23.5
Cost-Based Plan Audits	47.6	90.8	10.0
Plan Penalties			
Medicare Part C and Part D Program Audits	3.4	5.0	7.8
Medical Loss Ratio Requirement	--	--	37.1
Other Actions			
Party Status Appeals Initiative	3.6	1.6	18.8
Law Enforcement Referrals			
ZPIC Law Enforcement Referrals	49.3	6.7	2.5
NBI MEDIC Part C Law Enforcement Referrals	2.7	21.9	3.5
NBI MEDIC Part D Law Enforcement Referrals	53.4	36.8	100.1
Total Recovered Savings	**$4,680.0**	**$2,777.3**	**$2,523.0**
Total Savings (Prevention and Recovered)	**$18,595.5**	**$17,453.6**	**$17,853.5**

Type of Medicare Savings [a, b] (Table continues on the following page)	FY 2014 (in millions)	FY 2015 (in millions)	FY 2016 (in millions)

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

[b] Savings values for FY 2014 and FY 2015 differ from the values published in the Annual Medicare and Medicaid Integrity Programs Reports to Congress for FY 2013/2014 and FY 2015 based on a number of changes to Table 3 for FY 2016, including metric name changes, methodology updates, and new metrics. The following metrics underwent significant name changes: Part A/B RAC changed to Medicare FFS RAC Reviews, MEDICs changed to NBI MEDIC Part D Data Analysis Projects, Appeals Initiatives changed to Party Status Appeals Initiative, and Compliance Audits changed to Medicare Part C and Part D Program Audits. Risk Adjustment Data Validation was removed from the table because no recent recoveries have occurred. Savings methodologies for the following metrics were updated for FY 2016: NCCI PTP edits, NCCI MUEs, ZPIC Post-Payment Reviews, and Medicare Part C and Part D Program Audits. The savings values for the NCCI PTP edits and NCCI MUEs were also recalculated for FY 2014 and FY 2015. The following metrics are new in FY 2016: Ordering and Referring Edits, Medicare Part D Reconciliation Data Reviews, Overpayments Related to Risk Adjustment Data, and Medical Loss Ratio Requirement. Savings for Ordering and Referring Edits and Overpayments Related to Risk Adjustment Data were also calculated for FY 2014 and FY 2015 because the data were available to do so.

1.3.3. Medicaid Savings

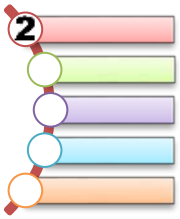
The creation of the Medicaid Integrity Program by, and the funding provided through, the DRA has had a significant impact on the effectiveness of states' efforts to protect the integrity of the Medicaid program against fraud, waste, and abuse. As a result of both federal and state efforts to focus more resources on strengthening states' capacities to protect the integrity of their Medicaid programs, states' collections of Medicaid overpayments increased significantly after the establishment of the Medicaid Integrity Program in 2006. From 1989 until 2006, total Medicaid collections from program integrity were below $300 million each year. Beginning in FY 2006, the amount collected started to rise until, in FY 2010, it exceeded one billion dollars. It has remained near that level each year thereafter. In FY 2016, total Medicaid collections from program integrity were approximately $956.5 million.[24]

1.4. OIG and GAO Recommendations Implemented

CMS acts on recommendations from the OIG and GAO on program vulnerabilities to improve current practices and develop new strategies and practices to deter and detect fraud, waste, and abuse. More details about these recommendations and CMS's responses are on the OIG and GAO websites.

[24] Amounts for Medicaid program integrity collections as reported by states.

2. Address the Full Spectrum of Fraud, Waste, and Abuse



CPI serves as the focal point within CMS for all efforts to address fraud, waste, and abuse in Medicare and Medicaid. This section describes the wide range of program integrity activities that CMS utilizes to comprehensively address fraud, waste, and abuse. These activities include many different approaches to program integrity, such as data analysis, prior authorization demonstrations and models, investigations and audits, and recovery actions.

- Fraud Prevention System
- National Correct Coding Initiative
- Medicare FFS Medical Review
- Demonstrations and Models
- Provider Cost Report Audits
- Zone Program Integrity Contractors
- Unified Program Integrity Contractors
- DMEPOS Competitive Bidding
- Appeals Initiatives
- Medicare Secondary Payer
- Medi-Medi Program
- Command Center
- Recovery Audit Programs
- Medicare Shared Savings Program
- Partnership with Law Enforcement

CMS uses a multi-faceted approach to target all causes of fraud, waste, and abuse that result in improper payments, with a focus on prevention activities. This includes concentrating efforts on initiatives that are foundational to protecting program integrity across the continuum of fraud, waste, and abuse, as well as improving payment accuracy.

The staff within CPI dedicated to investigations and audits work closely with, and serve as liaison to, the HHS-OIG, U.S. DOJ, and other federal and state law enforcement agencies in developing and/or referring cases against providers and suppliers or Part C and Part D plans that commit or participate in potentially fraudulent or other unlawful activities.

During FY 2016, CMS continued to integrate Medicare and Medicaid program integrity efforts, and provide technical guidance to states, providers and suppliers, and other stakeholders on program integrity activities. CMS continued to conduct Medicare and Medicaid boots-on-the-ground investigations, Medicaid provider audits, prepayment and post-payment Medicare FFS medical reviews, and State program integrity reviews. Our integrated and combined actions generate corrective action recommendations and drive program integrity improvements.

2.1. Fraud Prevention System

The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA).[25] Since June 30, 2011, the FPS has applied predictive algorithms and other sophisticated analytics nationwide on a continuous basis against all Medicare FFS claims prior to payment to identify, prevent, and stop potentially fraudulent claims. CMS uses FPS predictive models to identify egregious, suspect, or aberrant activity and automatically generate and prioritize leads for further review and investigation, primarily by ZPICs. By targeting investigative resources towards the most egregious providers and suppliers, the FPS indirectly reduces administrative and compliance burdens on compliant providers and suppliers, protecting and preserving the Trust Funds for quality health care for program beneficiaries.

The FPS helped identify or prevent $527.1 million in inappropriate payments during FY 2016, which resulted in a ROI of $6.3 to $1.[26] Since CMS implemented the original FPS technology in June 2011, the FPS has identified or prevented almost $2.0 billion in inappropriate payments by discovering new leads or contributing to existing investigations. To measure ROI from the FPS in FY 2016, CMS continued to use the same methodology described in the Second and Third Year FPS Reports to Congress, which HHS-OIG certified.[27]

During FY 2016, the FPS models generated 688 leads that were included in the ZPICs' workload, resulting in 476 new investigations and augmented information for 212 existing investigations. During this period, the ZPICs also continued to work leads opened during previous implementation years.

The SBJA requires CMS to evaluate the cost-effectiveness and feasibility of expanding the use of predictive analytic technologies to Medicaid and CHIP. The Secretary submitted HHS's recommendations for implementation of this requirement in the FPS, Third Implementation Year Report to Congress, issued in July 2015. After extensive analysis and discussion with states, it is not feasible at this time to systematically expand predictive analytics technology to all Medicaid and CHIP claims, and it may not be cost-effective for all states to adopt predictive analytics individually. However, CMS continues to believe there are opportunities to transfer the knowledge and lessons learned from our experience with the FPS and assist states with identifying program integrity risks using predictive analytics technologies to protect their Medicaid and CHIP programs from fraud, waste, and abuse.

Several data sources support the FPS, including the Integrated Data Repository (IDR), tips acquired from 1-800-MEDICARE, the Fraud Investigation Database (FID), and the

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[25] Public Law 111-240.

[26] During FY 2016, CMS operated the FPS (FPS 1.0) and simultaneously developed FPS 2.0, which is the next generation of the FPS. FPS 2.0 became operational in FY 2017, so there were no savings associated with it in FY 2016. The $6.3 to $1 ROI includes costs associated with both FPS 1.0 and the development of FPS 2.0. If the FPS 2.0 costs are excluded from the calculation, the ROI would be $8.2 to $1.

[27] Fraud Prevention System Return on Investment Fourth Implementation Year

Compromised Numbers Checklist. For example, to develop and test models that are more comprehensive more quickly, analysts use historical claims from the IDR to analyze patterns and develop models for the FPS.

2.2. Medicare and Medicaid National Correct Coding Initiative

Medicare National Correct Coding Initiative

Given the volume of claims processed by Medicare each day and the significant 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. The NCCI program consists of edits designed to reduce improper payments in Medicare Part B. CMS originally implemented the NCCI program in the Medicare program in January 1996 using Procedure-to-Procedure (PTP) edits to ensure accurate coding and reporting of services by physicians.[28]

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. The coding policies use coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, CMS national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. The NCCI Coding Policy Manual is a general reference tool that explains the rationale for NCCI edits.

In addition to PTP edits, CMS established the Medically Unlikely Edit (MUE) program in 2007 as part of the NCCI program to reduce the Medicare Part B paid claims improper payment rate. MUEs prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a Healthcare Common Procedural Coding System (HCPCS)/CPT code is the maximum number of units of service under most circumstances reportable by the same provider for the same beneficiary on the same date of service. The NCCI is continuously refined, with revised edit tables published quarterly. Generally, CMS provides a pre-implementation review and comment period to representative national organizations impacted by the edits. Each quarter CMS evaluates the input from all sources before adding, deleting, or modifying any edits.

Since October 2008, CMS has made public and posted all PTP edits and the majority of MUEs on the CMS NCCI Edits website. To prevent misuse or manipulation by fraudulent or abusive individuals and entities, CMS does not publish certain edits. The use of PTP edits developed through the NCCI program saved the Medicare program $270.8 million in FY 2016. In addition, MUEs saved the Medicare program $544.4 million in FY 2016.

[28] See Section 1.1 of Appendix B for further information regarding NCCI PTP edits.

Medicaid NCCI

Section 1903(r) of the Act required CMS to notify states by September 1, 2010 which NCCI methodologies are compatible with claims filed with Medicaid. It also required states to use these methodologies to process applicable Medicaid claims filed on or after October 1, 2010.[29] CMS has worked closely with state Medicaid agencies (SMAs) to implement the NCCI methodologies in their Medicaid programs. Complete and correct implementation of NCCI methodologies in state Medicaid programs will be a long-term undertaking by both CMS and the states.[30] However, CMS use of the Medicaid NCCI methodologies in states' adjudication of Medicaid claims produces significant savings in federal and state Medicaid program expenditures based on reductions in improper payments for Medicaid claims with improper coding, as has occurred in the Medicare program.

In FY 2013, CMS created a new major technical guidance document for states, the Medicaid National Correct Coding Initiative Technical Guidance Manual, which compiles, organizes, and integrates CMS requirements for state implementation for the Medicaid NCCI methodologies. Similar to that for Medicare, the Medicaid NCCI is continuously refined, with revised edit tables published quarterly. Normally, CMS provides a pre-implementation review and comment period to the state Medicaid programs and to representative national organizations impacted by the edits. Each quarter CMS evaluates the input from all sources before adding, deleting, or modifying any edits. The Medicaid NCCI edits include Medicare compatible edits and Medicaid specific NCCI edits. These resources are located on The National Correct Coding Initiative in Medicaid website.

2.3. 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 against inappropriate payments that pose the greatest risk to the Trust Funds and take corrective actions. To meet this requirement, CMS contracts with the MACs and the SMRC to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review.[31] Medical review is an example of such FFS claims data analysis.

Medical Review (Prepayment)

Medical review is the collection of information and the clinical review of medical records to ensure only items and services that meet all Medicare coverage, coding, and medical necessity requirements are paid. Medical review activities concentrate in areas where data analysis, Comprehensive Error Rate Testing (CERT) program results, OIG/GAO findings, and RAC findings indicate questionable billing patterns. In an effort to increase

[29] CMS reported on the implementation of this requirement in a March 2011 Report to Congress on Implementation of the National Correct Coding Initiative in the Medicaid Program.

[30] DHHS Office of the Inspector General Inconsistencies in State Implementation of NCCI Edits, et al.

[31] The ZPICs and Medicare FFS RACs also perform medical review, as discussed in sections 2.6 and 2.14, respectively.

proper billing, CMS continues to enhance medical review efforts and encourages MACs to incorporate increased provider feedback processes, such as one-on-one education and more detailed review results notification.

CMS continues to focus on prepayment review of claims that have historically resulted in high rates of improper payments. This will reduce the number of improper payments and similarly reduce the improper payment rate, by stopping improper payments before the claims are paid. In FY 2016, the MACs saved nearly $6.1 billion through prepayment medical review.

Supplemental Medical Review (Post-payment)

In FY 2016, CMS also conducted post-payment medical reviews through the SMRC. The SMRC operates at the direction of CMS and provides support for a variety of tasks aimed at reducing the improper payment rate by enhancing medical review efficiencies. One of the SMRC's primary tasks is evaluating medical records and related documents to determine whether claims billed complied with Medicare's coverage, coding, and payment rules, including those claims identified by the OIG and/or GAO. In FY 2016, the SMRC saved $117.8 million through post-payment review.

2.4. 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. Details and the status of demonstrations and models conducted in FY 2016 follow.[32]

Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967[33] authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of the investigation and prosecution of potential fraud in the provision of care or services provided under the Medicare program.

Prior Authorization of Power Mobility Devices

In FY 2012, CMS implemented the Prior Authorization of Power Mobility Devices Demonstration for Medicare beneficiaries who reside in seven states where historically there has been extensive evidence of fraud or improper payments (CA, FL, IL, MI, NY, NC, and TX). The demonstration implemented prior authorization, a tool used by private-sector health care payers, to prevent improper payments and deter fraud prior to a supplier's rendering the service and submitting the claim for payment. The

[32] While demonstrations and models help contribute to CMS program integrity objectives, these programs are not supported by program integrity funding. Both demonstrations and models are supported by other sources and authority as referenced herein.

[33] Public Law 90-248

demonstration began for orders written on or after September 1, 2012. In FY 2014, CMS announced the expansion of the demonstration to an additional 12 states (AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA) to begin on October 1, 2014. Based on initial data, spending per month on power mobility devices in the 19 demonstration states, as well as in the non-demonstration states, has decreased since September 2012. CMS also extended the demonstration to August 31, 2018 in FY 2015. The most current outcomes and status of this demonstration are on the CMS Prior Authorization of PMDs website.

Pre-Claim Review Demonstration for Home Health Services

In FY 2016, CMS began implementing a Pre-Claim Review Demonstration for Home Health Services to test whether pre-claim review improves methods for the identification, investigation, and prosecution of Medicare fraud occurring among Home Health Agencies (HHAs) providing services to people with Medicare benefits, as well as whether the demonstration helps reduce expenditures while maintaining or improving quality of care.

The Pre-Claim Review Demonstration for Home Health Services began in Illinois on August 3, 2016. Based on early information from Illinois, CMS believed additional education efforts would be helpful before expansion of the demonstration to other states. The education efforts focused on how to submit pre-claim review requests, documentation requirements, and common reasons for non-affirmation. As of April 1, 2017, the demonstration was paused while CMS considered a number of changes to improve the demonstration in response to feedback received on the demonstration.

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 to reduce program expenditures, while preserving or enhancing the quality of care furnished to beneficiaries.

Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport

The Medicare Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport Model began as a 3-year model in Pennsylvania, New Jersey, and South Carolina on December 1, 2014 for transports occurring on or after December 15, 2014.[34] CMS selected these states as the initial states for the model because of their high utilization and improper payment rates for these services. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care, using a model that establishes a prior authorization process for repetitive, scheduled non-emergent ambulance transport to reduce utilization of services that do not comply with Medicare policy.

CMS uses this prior authorization process to ensure that all relevant clinical or medical documentation requirements are met before services are rendered to beneficiaries and before claims are submitted for payment. Prior authorization does not create new clinical

[34] 79 FR 68271 (Nov. 14, 2014).

documentation requirements nor change any existing Medicare coverage policies. As required by section 515 of the Medicare Access and CHIP Reauthorization Act of 2015, beginning January 1, 2016 CMS included six additional states in the model: Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.[35] On December 4, 2017, CMS announced that the model is being extended in the current model states for one additional year to allow for additional evaluation of the model. The model is currently scheduled to end in all states on December 1, 2018.[36]

CMS believes using a prior authorization process will help make sure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered to the beneficiaries and before claims are submitted for payment. The 2016 outcomes and status of this demonstration are available on the Prior Authorization of Repetitive Scheduled Non-Emergent Ambulance Transport Model website. CMS has observed a decrease in expenditures for repetitive scheduled non-emergent ambulance transports in the model states since implementation. Prior to the model, spending on repetitive schedule non-emergent ambulance transports in the model states averaged $18.9 million per month. Based on data from the first year of the model, spending decreased to an average of $5.4 million per month.

In the first year of the model, 18,367 prior authorization requests were received and finalized. Of those 18,367 requests, 6,430 were affirmed. Repetitive scheduled non-emergent ambulance transports were approved for all beneficiaries who met all the requirements. Submitters have unlimited opportunities to resubmit requests to include all necessary and relevant documentation needed for an affirmed decision. Affirmation rates have increased in the recent months as ambulance suppliers and physicians better understand the prior authorization process and documentation requirements. In cases where the beneficiary's condition does not meet Medicare's coverage requirements, CMS provides the beneficiary with contact information for state and local agencies that may be able to assist with identifying alternative transportation arrangements.

Prior Authorization for Non-Emergent Hyperbaric Oxygen Therapy

In FY 2015, CMS implemented the Prior Authorization for Non-Emergent Hyperbaric Oxygen (HBO) Therapy model in the states of Michigan, Illinois, and New Jersey. CMS selected the initial states for the model because of their high utilization and improper payment rates for this service. CMS is testing whether prior authorization helps reduce expenditures, while maintaining or improving quality of care, using a model that establishes a prior authorization process for non-emergent hyperbaric oxygen therapy to reduce utilization of services that do not comply with Medicare policy. Providers in Michigan began submitting prior authorization requests on March 1, 2015 for treatments occurring on or after April 13, 2015, and providers in Illinois and New Jersey began submitting prior authorization requests on July 15, 2015 for treatments occurring on or after August 1, 2015.

The 2016 outcomes and status of this demonstration are available on the Prior Authorization for Non-Emergent Hyperbaric Oxygen Therapy website. There was a

[35] 80 FR 64418-19 (Oct. 23, 2015).

[36] 82 FR 58400 (Dec. 12, 2017).

temporary decrease in April and May of 2015 after prior authorization began in Michigan, and in August and September of 2015 after prior authorization began in Illinois and New Jersey. CMS believes that this was due to providers adapting to the new process, and that expenditures then increased as providers gained a deeper understanding of the prior authorization process and the documentation requirements for non-emergent HBO therapy.

Prior to the model, spending on non-emergent HBO therapy in the model states averaged $1.6 million per month. As of 2016, spending had decreased to an average of $1.2 million per month. This is a difference of $410,000. Multiplying $410,000 by the 13 months the model has been operational equals a total reduction of $5.3 million in non-emergent HBO therapy expenditures.

Since inception of the model through April 2016, CMS has received and processed 1,932 prior authorization requests. Of those 1,932 requests, 971 were provisionally affirmed and 961 were non-affirmed. Submitters have unlimited opportunities to resubmit requests to include all necessary and relevant documentation needed for a provisionally affirmed decision. Affirmation rates have increased in the recent months, as providers better understand the prior authorization process and documentation requirements.[37]

2.5. Medicare Provider Cost Report Audits

Auditing 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 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. This process determines that provider payments are proper and in accordance with CMS regulations and instructions.

The settlement process for cost reports includes:

1. timely receipt and acceptance of the cost report;
2. desk review of the submitted cost report;
3. audit (if warranted) of the cost report; and
4. final settlement of the cost report.

This cost report settlement process provides a method to detect improper payments and identify the reasons these improper payments have occurred. These reasons for improper payments provide insight into potential payment vulnerabilities that can strengthen and focus the program integrity response. The cost report includes calculations of the final payment amount for items such as:

[37] Medicare Prior Authorization of Non-Emergent Hyperbaric Oxygen (HBO) Therapy Status Updated (Posted 11/16/2016).

- direct graduate medical education and indirect medical education;
- disproportionate share hospital (DSH) payments; and
- Medicare bad debts.

During FY 2016, approximately 48,000 Medicare cost reports were received and accepted by the MACs. This includes initial cost report filings as well as amended filings. Tentative settlements were completed for approximately 20,000 cost reports. In addition, approximately 25,000 cost reports were desk reviewed and around 2,700 audits were completed. In FY 2016, cost report reviews and audits saved $23.5 million.

2.6. Zone Program Integrity Contractors

One way CMS investigates instances of suspected fraud, waste, and abuse is through the activities of the ZPICs. The ZPICs develop investigations and take actions to prevent inappropriate payments from the Medicare Trust Funds to Medicare providers and suppliers. They also identify improper payments that the MACs recover.

The ZPICs take a variety of actions to detect and deter fraud, waste, and abuse in the Medicare program, including conducting interviews and site visits, implementing appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and performing program integrity reviews of medical records and documentation. While the MACs and other contractors also perform medical review to make coverage or coding determinations, ZPICs perform program integrity-directed medical review with a focus specifically towards fraud detection and investigation. The ZPICs look for possible falsification of documents that may lead to identification of provider or supplier overpayments.

Zone Program Integrity Contractor Goals

Protect the Medicare Trust Fund by taking action to prevent payments for fraudulent billing and recover any inappropriate payments

Identify and develop cases of suspected fraud.

In FY 2016, the ZPICs saved an estimated $674.7 million in potentially improper payments by taking appropriate action to initiate collection, prevent improper payment to Medicare providers and suppliers, or refer cases to law enforcement. See Table 4 for more detail of the savings identified by the ZPICs.

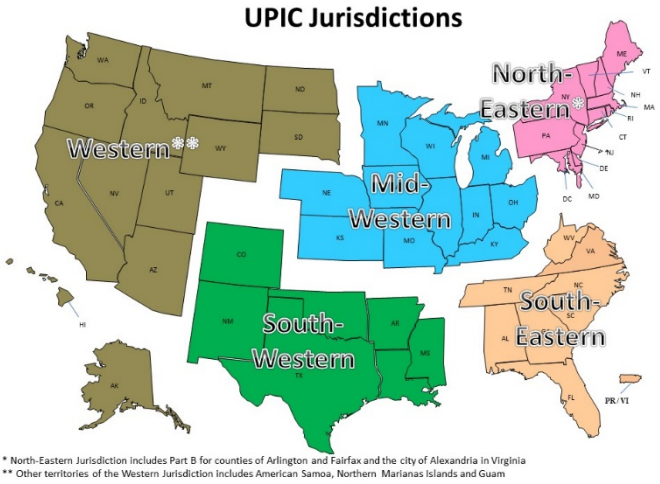
Table 4: Savings Identified by ZPICs

Type of Savings	Savings (in millions)
	2016
Prevention Savings	
Estimated Amount Avoided Due to Revocation of Billing Privileges	$ 338.3
Estimated Amount Prevented by Automatically Denying Claims	54.5
Estimated Amount Prevented by Denying Claims After Prepayment	54.0
Amount Held in Escrow During Payment Suspensions	46.7
Post-Payment Recovery Savings	
Estimated Amount Recovered after Identifying Overpayments	178.7
Estimated Amount Saved through Referrals to Law Enforcement	2.5
Total Savings	$ 674.7

2.7.Unified Program Integrity Contractors

The Unified Program Integrity Contractors (UPICs) consolidate the Medicare and Medicaid program integrity functions currently performed by the ZPICs, including the Medi-Medi program, and the Audit MICs. In FY 2016, CMS had contractors assigned to combat and prevent fraud, waste, and abuse in the Medicare program (i.e., ZPICs) or the Medicaid program (i.e., Audit MICs). The UPICs seek to merge these separate contracting functions into a single contractor, in a geographic area, with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations. The UPIC contracting structure provides CMS with a flexible vehicle to address the complex landscape of program integrity across both Medicare and Medicaid. In May 2016, seven vendors were included in the flexible contracting award:

- AdvanceMed Corporation
- Health Integrity LLC
- HMS Federal Solutions
- Noridian Healthcare Services LLC
- SafeGuard Services LLC
- Strategic Health Solutions
- TriCenturion, Inc.



The Midwestern Jurisdiction contract was awarded to AdvanceMed Corporation on June 1, 2016 and the Northeastern Jurisdiction contract was awarded to SafeGuard Services, LLC on October 26, 2016. The Western, Southwestern, and Southeastern Jurisdiction awards, anticipated in FY 2017, will conclude the UPIC contracting process.

2.8. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding[38]

Prior to the implementation of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Medicare paid for DMEPOS items using a fee schedule based on historic supplier charges from the 1980s. Numerous studies from the HHS OIG and the GAO have shown these fee schedule prices were excessive, and taxpayers and Medicare beneficiaries were bearing the burden of these excessive payments.

Under the DMEPOS Competitive Bidding Program,[39] DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. In the Round 1 Rebid of DMEPOS Competitive Bidding Program (January 1, 2011 – December 31, 2013) in nine areas, CMS has saved $220 million per year.[40] After the first two years of Round 2 of the DMEPOS Competitive Bidding Program in 91 areas[41] and the national diabetes testing supplies mail-order programs (July 1, 2013-June 30 2015), Medicare has saved approximately $3.6 billion.[42] . Health monitoring data indicate that the program implementation is going smoothly with few inquiries or complaints and no negative beneficiary health outcomes. The savings experienced predominantly came from lower payments and decreased unnecessary utilization. Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in all competitive bidding areas, while, at the same time, reducing overutilization of DMEPOS items and services. More details about the program are on the DMEPOS Competitive Bidding website.

2.9. Appeals Initiatives

CMS's party status appeals initiative occurs at Level 3 of the five-level Medicare FFS appeals process. Level 3 of the appeals process is a hearing before an Administrative Law Judge (ALJ) within the HHS Office of Medicare Hearings and Appeals (OMHA). CMS regulations allow for Qualified Independent Contractor (QIC) participation in ALJ

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38 The DMEPOS Competitive Bidding Program is a CMS administrative program and neither is it a specific program integrity activity nor is it funded from program integrity obligations. The program appears in this report because it represents CMS's proactive approach to preventing improper payments.

39 The DMEPOS Competitive Bidding Program was initially required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Public Law 108-173], modified by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) [Public Law 110-275], and expanded by the Affordable Care Act.

40 For more information, visit the DMEPOS Competitive Bidding webpage.

41 Metropolitan statistical areas (MSAs) are areas designated by the Office of Management and Budget (OMB) that include major cities and the suburban areas surrounding them. As a result of the OMB's updates to the original 91 Round 2 MSAs, there are now 90 MSAs for the Round 2 Re-compete. However, CMS is conducting the Round 2 Re-compete in the same geographic areas that were included in Round 2. See the Competitive Bidding Areas (CBAs) Fact Sheet webpage.

42 See the Competitive Bidding Program Continues fact sheet webpage.

hearings either as a party or as a "non-party" participant. Each type of participation affords the QIC different rights:

- Participation as a party allows the QIC additional opportunities to represent its position related to its decision-making. The QIC is afforded the right to call witnesses, provide testimony, and present evidence.
- "Non-party" participation limits the QIC to submitting written position papers and to appearing at the hearing to answer questions.
- Participation as a party provides a more robust opportunity to defend the QIC's decision-making on a particular claim.

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 interest for CMS. CMS funds QICs' participation as a party in ALJ hearings in accordance with 42 CFR § 405.1012. By invoking party status in an ALJ hearing, a QIC can better defend the preceding 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 other parties. The additional rights afforded to parties are extremely beneficial to the ALJ hearing and the QIC's ability to defend a claim denial successfully. 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. In FY 2016, the estimated amounts in controversy were $18.8 million for the party status appeals initiative. Data shows ALJ overturn rate is lower in cases in which the QIC participates as a party.

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.

2.10. Integrated Data Repository and the One Program Integrity Portal

CMS continues to augment the data available in the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and prescription drug information. CMS is using the IDR to provide broader and easier access to data and enhanced data integration, while strengthening and supporting CMS's analytical capabilities. The IDR contains Medicare Part A, Part B (including DME), Part C (encounter), and Part D paid claims beginning with January 2006, both before and after final payment.[43] This allows for prepayment analytics on historical data to develop models for use in the FPS. Claims data in the IDR are from both the National Claims History and Shared Systems data.

[43] Please note that Medicare Advantage organizations began submitting Part C encounter data claims documentation beginning in January 2012.

CMS continues to integrate new data sources into the IDR. CMS has added Shared Systems location data for pre-adjudicated claims, claims submitter, and medical review utilization data. CMS is also working to incorporate state Medicaid data into the IDR through standard T-MSIS data formats, while also working with states to improve the quality and consistency of the data from each state. An overview of the CMS IDR is on the IDR webpage.

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 (including Business Object, SAS, and STARS) and to facilitate data sharing with program integrity contractors and law enforcement.[44] One PI provides a single access point to the data within the IDR, as well as analytic tools to review the data. One PI improves CMS' ability to detect fraud, waste, and abuse with consistent, reliable, and timely analytics. CMS has also been working closely with its law enforcement colleagues to provide One PI training and support. The One PI team continues to enhance the overall training process by revising manuals and training content. Training now includes virtualized web-based training in combination with on-site instructor led training to reduce training costs and provide better access for law enforcement.

2.11. Medicare Secondary Payer

Medicare Secondary Payer (MSP) is an important program that protects both Medicare beneficiaries and the sustainability of the Medicare Trust Funds. The MSP program ensures that when Medicare is a secondary payer (the insurance that pays after another "primary" insurance), Medicare does not pay, or recovers Medicare funds paid conditionally, once another individual or entity is determined to be primarily responsible for payment.

Medicare, Medicaid and SCHIP Extension Act

The mandatory insurer reporting requirements of section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007[45] continues to be the primary source of new MSP information reported to CMS from group health plans and other insurers. The annual number of new MSP records posted to CMS's systems remains more than twice the number posted before implementation of section 111 of MMSEA. MSP operations saved $8.7 billion in FY 2016. This includes approximately $1.3 billion in direct recoveries that replenished the Medicare Trust Fund. *See Table 3 for savings from MSP operations.*

Commercial Repayment Center Recovery Auditor

The Commercial Repayment Center (CRC) Recovery Auditor performs the recovery of Part A and Part B payments mistakenly made by the Medicare program when another entity had primary payment responsibility. There are two broad situations where the

[44] The Department of Justice Health Care Fraud and Abuse Control Program Annual Report to Congress for Fiscal Year 2016.

[45] Public Law 110-173.

CRC makes recoveries. The first is when a beneficiary has or had coverage through an employer-sponsored Group Health Plan (GHP). The CRC generally recovers payments in this situation from employers. In FY 2016, CMS expanded the CRC's workload to include the second situation, which is the recovery of certain conditional payments where an applicable plan (a Non-Group Health Plan (NGHP) entity such as a liability insurer, no-fault insurer, or workers' compensation entity) has or had primary payment responsibility.

In FY 2016, the CRC identified $243.7 million in mistaken payments, and processed net collections of $104.7 million (excluding interest) on behalf of the Medicare program. Collections for the remaining identified debt will continue into future fiscal years as additional overpayments are simultaneously identified and collections initiated.

2.12. Medicare-Medicaid Data Match Program

The Medicare-Medicaid Data Match (Medi-Medi) program supports the integration of Medicare and Medicaid investigations and audits where possible. Medi-Medi functionality matches Medicare and Medicaid claims and other data to identify improper billing and utilization 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. During FY 2016, CMS collaborated with states that account for most of the expenditures in Medicaid. Participating states include Alabama, Arizona, Arkansas, California, Florida, Georgia, Iowa, Louisiana, Mississippi, Missouri, Nebraska, New York, New Jersey, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, West Virginia, and Wyoming.

The Medi-Medi program promotes collaboration among SMAs, CMS, and law enforcement by targeting resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse. CMS also collaborates with SMAs when conducting audits. Program participation is optional for the states; however, CMS works diligently to identify which states would benefit the most from participation in the program. Each state Medi-Medi program design accommodates the individual complexity of that state and its program integrity efforts.

For example, in collaboration with the Arkansas Office of Medicaid Inspector General (OMIG), CMS identified a program vulnerability where Arkansas Medicaid paid nearly 10 times more than any other state for Group Psychotherapy services. CMS initiated a study to assess the root causes of this vulnerability and make recommendations to Arkansas OMIG for improvement. The Medicaid Inspector General presented a report, which contained potential program policy changes related to Group Psychotherapy Services, to the Medicaid Task Force committee of the Arkansas Legislature, which ultimately approved the majority of the recommendations. As a result, Arkansas Medicaid expects to save nearly $70 million annually on Group Psychotherapy. Representatives from the Arkansas OMIG also presented the topic at the 2016 National

Association of Medicaid Program Integrity Conference (NAMPI) and emphasized the subsequent cost savings analyses.

As another example, through proactive data analysis study, CMS identified crossover claims paid by eight (8) state Medicaid programs for Medicare Part B and DME claims that had been fully voided by Medicare. Claims voided by Medicare should not be paid by Medicaid, and thus are considered potential overpayments for the Medicaid program. For this study, the claims were identified by matching the Medicare voided claims to paid Medicaid professional services and DME claims by the recipient SSN, date of service, HCPCS, and provider. The total dollars identified for the eight states totaled more than $2.6 million.

2.13. Command Center

The Command Center opened in July 2012 and provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from OIG and the DOJ, including the Federal Bureau of Investigation (FBI), state law enforcement officials, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads in real time. CMS first tested the value of the concept in a pilot Command Center and found that CMS can significantly reduce the time needed for making decisions on administrative actions, such as payment suspensions.

In FY 2016, the Command Center conducted 15 missions, which included participants from CMS and our partners, such as the HHS-OIG and FBI, that are designed to lead to improvements in the fraud prevention and detection process. Missions are facilitated collaboration sessions that bring together experts from various disciplines to improve the processes for fraud prevention in Medicare and Medicaid. CMS is also working with the FBI, HHS-OIG, and other federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud prevention.[46]

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

Medicare Fee-For-Service[47]

In FY 2016, the Medicare Fee-for-Service (FFS) Recovery Audit Program collectively identified and corrected 380,229 claims with improper payments that resulted in the correction of $473.9 million in improper payments. The total corrections identified include $404.5 million in overpayments collected and $69.5 million in underpayments repaid to providers. The Medicare FFS Recovery Audit Program achieved savings of

[46] See the Department of Justice Healthcare Fraud and Abuse Control Program Annual Report for Fiscal Year 2016.

[47] For more information on the Medicare FFS Recovery Audit Program, including the FY 2015 Medicare FFS RAC Report to Congress, the reader should consult https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/.

$274.0 million when accounting for overpayments collected, underpayments repaid to providers, and amounts overturned on appeal.

During FY 2016, the RACs focused their reviews on coding for hospital stays and claims for DME. These claim types have a history of improper payments. CMS continues to monitor and make continuous enhancements to the Recovery Audit Program. In addition to using the Medicare FFS RACs to correct improper payments, CMS also uses RAC findings to prevent future improper payments. For example, in FY 2016, CMS released four Quarterly Provider Compliance Newsletters that provided detailed information on 15 complex review findings identified by the RACs.[48]

Part C and Part D

Section 1893(h)(9) of the Act expanded the use of RACs to the Medicare Part C and Part D programs. CMS awarded a contract for a Medicare Part D RAC with national jurisdiction in January 2011. The primary function of the Part D RAC is to conduct post-payment reviews to identify improper payments made to Part D plan sponsors, which provide coverage of outpatient prescription drugs for Medicare beneficiaries. Results from the RAC reviews also help CMS identify vulnerabilities in the Part D program that can lead to implementing preventive actions by focusing resources more effectively on new fraud, waste, or abuse issues as they emerge.

The Part D RAC uses a CMS-approved audit methodology to identify potential improper payments based on Prescription Drug Event (PDE) records submitted by Part D plan sponsors. The RAC works with a data validation contractor to confirm the results, obtaining additional documentation from plan sponsors when needed. The RAC sends Notifications of Improper Payments to plan sponsors after finalizing the findings. Plan sponsors can then appeal the RAC's findings. CMS collects any overpayments from plan sponsors after all appeals are considered. Pursuant to statutory requirements, the RAC collects a contingency fee based on a percentage of improper payments corrected. During FY 2016, CMS recovered $2.3 million in overpayments.

Section 1893(h)(9) of the Act required the implementation of a Medicare Part C RAC program. CMS previously published a solicitation for comments and, in 2014, issued a request for proposals. However, no proposals were received. In 2015, CMS issued a request for information and reviewed comments received. Currently, CMS is exploring a Medicare Part C RAC program that will fit into the larger Medicare Part C program integrity efforts.

Medicaid

Section 1902(a)(42) of the Act also required states to establish Medicaid RAC programs by submitting state plan amendments (SPAs). As of the end of FY 2016, 47 states and the District of Columbia had implemented Medicaid RAC programs. Four states had HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration.

[48] For more information, see the Medicare Learning Network Downloads Archive webpage.

As a measure of effectiveness of the State Medicaid RAC Program for FY 2016, 26 states reported a total combined federal and state share amount of Medicaid RAC recoveries of $82.3 million, returning the federal share of $49.2 million to the Treasury.[49]

2.15. Medicare Shared Savings Program

Under the Medicare Shared Savings Program (Shared Savings Program), providers of services and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare fee-for-service (FFS) payments under Parts A and B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements.[50] CMS developed a streamlined provider and supplier screening process to enhance program integrity efforts for the Medicare Shared Savings Program. The Shared Savings Program incentivizes Accountable Care Organizations (ACOs) to continue broad-based program participation and improve program function and transparency. The process relies in part on safeguards associated with Medicare FFS enrollment.

Provider and supplier screening is conducted by CMS for organizations applying to the Medicare Shared Savings Program, and periodically thereafter for ACO participants. The electronic capture and exchange of provider information assists with provider and supplier screenings. Some of the information captured includes, but is not limited to, enrollment status, reassignment details, current/previous Medicare Exclusion Data 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.

2.16. Partnership with Law Enforcement

The first Medicare Fraud Strike Force (Strike Force) launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse in South Florida. The 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 potential fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. DOJ and HHS have expanded Strike Force operations to a total of nine areas in the United States—Brooklyn, New York; Chicago, Illinois; Dallas, Texas; Detroit, Michigan; Los Angeles, California; Miami, Florida; Tampa, Florida; Southern Louisiana; and Southern

[49] State Medicaid RAC recoveries include overpayments collected, adjusted, and refunded to CMS.

[50] 81 FR 37950 (June 10, 2016).

Texas.

On June 22, 2016, an unprecedented nationwide sweep led by the Medicare Fraud Strike Force in 36 federal districts resulted in criminal and civil charges against 301 individuals, including 61 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $900 million in false billings. Twenty-three state Medicaid Fraud Control Units (MFCUs) also participated in the arrests. In addition, CMS suspended payment to a number of providers. At the time, this coordinated takedown was the largest in history, both in terms of the number of defendants charged and loss amount. [51]

3. Proactively Manage Provider Screening and Enrollment

- Medicare Provider Screening and Site Visits
- Provider Revalidation
- PECOS and NPPES Improvements
- TBD
- Medicaid Provider Enrollment Oversight
- Provider Enrollment Moratoria

Provider enrollment is the gateway to the Medicare and Medicaid programs and is the key to preventing ineligible providers, or if applicable, suppliers from entering either program. CMS and state Medicaid programs pay providers and suppliers for furnishing covered services to eligible beneficiaries, either on a FFS basis or through risk-based managed care arrangements. Payments to fraudulent providers and suppliers, either directly 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 and suppliers, when applicable, that engaged in the fraud—is resource-intensive and can take several years. In contrast, keeping ineligible entities and individuals from enrolling as providers and suppliers in Medicare and as providers in state Medicaid programs allows the programs to avoid paying inappropriate claims to such parties and then later attempting to identify and recover those overpayments. Provider and supplier 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 is different in 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, fraud prevention programs, and the sharing of data through its Healthcare Fraud Prevention Partnership. States directly oversee the

[51] HEAT Strike Force June 2016 Press Release

provider screening and enrollment process for their own Medicaid programs and CMS provides regulatory guidance and technical assistance to states.

3.1. Medicare Provider Screening and Site Visits

CMS implemented additional screening provisions through a final rule published on February 2, 2011.[52] CMS's regulation establishes three levels of provider and supplier enrollment risk-based screening: "limited"; "moderate"; and "high"; and classification by entire provider and supplier-types.

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 all the requirements in the "limited" screening level, in addition to unannounced site visits. Providers and suppliers in the "high" risk category are subject to all of the requirements in the "limited" and "moderate" screening levels, in addition to fingerprint-based criminal background checks (FCBCs). For Medicare, CMS began phasing in the fingerprinting requirements on August 6, 2014. In FY 2016, CMS denied approximately 1,100 enrollments and revoked more than 475 enrollments because of the FCBCs.

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. In FY 2016, APS resulted in more than 3.3 million screenings. These screenings were composed of more than 18,500 actionable License Continuous Monitoring alerts, and more than 200 actionable Criminal Continuous Monitoring alerts, which resulted in approximately 148 revocations due to felony convictions and over 3,000 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 2016, the initiative resulted in 45,584 site visits conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 25,617 conducted by the

[52] 76 FR 5862 (Feb. 2, 2011).

National Supplier Clearinghouse, which conducts site visits for Medicare DME suppliers. This work resulted in 508 revocations due to non-operational site visit determinations for all providers and suppliers.

CMS's provider screening and enrollment initiatives in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2016, CMS deactivated 140,475 enrollments and revoked 8,339 enrollments.[53]. Site visits and the revalidation initiative[54] have contributed to the deactivation[55] and revocation[56] of more than 862,221 enrollment records since CMS started implementing these screening and enrollment requirements (Figure 1).

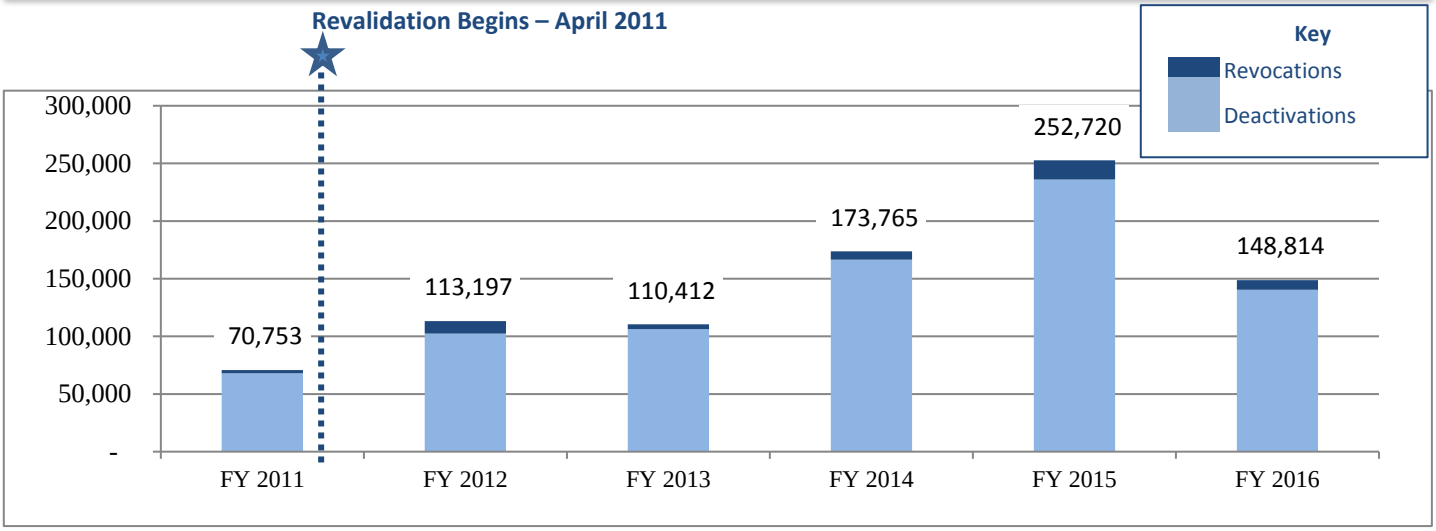
[53] We note that the first and second phase revalidation results are point-in-time results, as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

[54] The revalidation initiative 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. This initiative is discussed in detail in section 3.2.

[55] 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.

[56] Revocation means the provider's or supplier's billing privileges are terminated. See 42 CFR § 424.535.

Figure 1: Revocation and Deactivation Trend from FY 2011 though FY 2016



Notes: Revocation means the provider's or supplier's billing privileges are terminated. Deactivation means the provider's or supplier's billing privileges are stopped, and can be restored upon the submission of updated information. Deactivation also occurs when a provider is deceased or voluntarily withdraws from the Medicare program.

Provider Enrollment Regulatory Improvements

In December 2014, CMS finalized a rule, titled "Medicare Program; Requirements for the Medicare Incentive Reward Program and Provider Enrollment", that provided CMS with additional authority to remove providers and suppliers who pose a risk of fraud or abuse from the Medicare program.[57] The rule finalized the following:

- the denial of an enrollment application from a provider or supplier affiliated with a defunct provider or supplier with an outstanding Medicare debt;
- the revocation of a provider or supplier for a pattern or practice of submitting claims for services that fail to meet Medicare requirements; and
- the clarification of the list of felony convictions that may result in a denial of enrollment or revocation of Medicare billing privileges.

This rule became effective on February 3, 2015.

3.2. Provider Revalidation

In FY 2016, CMS continued its revalidation initiative, 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

[57] 79 FR 72500 (Dec. 5, 2014).

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.

In FY 2016, CMS revalidated the enrollment information for 165,328 providers and suppliers. CMS completed the revalidation mailings in 2015; however, revalidation processing continued through FY 2016. CMS has enrolled or revalidated enrollment information for more than 2.2 million Medicare providers and suppliers under the enhanced screening requirements of section 1866(j) of the Act.

3.3. Provider Enrollment, Chain and Ownership System and National Plan and Provider Enumeration System 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 2016, 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;
- attending provider outreach events;
- sponsoring quarterly calls with associations (e.g., Medical Group Management Association and American Medical Association);
- holding Open Door Forums with providers and suppliers; and
- conducting education and outreach through listservs, CMS.gov, PECOS homepage, Medicare Learning Network® (MLN) Matters Articles, change requests and national provider calls.

In FY 2016, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including the following changes:

- implemented a new address validation tool in PECOS to flag Commercial Mail Receiving Agencies (CMRA) and invalid or vacant addresses(this enhanced address verification software in the PECOS can better detect vacant or invalid addresses or CMRAs, which strengthens provider enrollment screening);
- implemented an enhancement that streamlines the application process, and enables providers and suppliers to make changes to their application even after submission; and
- implemented an enhancement that allows providers and suppliers to view their revalidation due date and other relevant information as part of the PECOS revalidation center.

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

In FY 2016, CMS released the beta version of the new NPPES system to modernize the interface and provide enhanced features for managing and enumerating NPIs, with a full rollout planned for FY 2017. This modernization includes:

- a completely streamlined and modernized user interface;
- the ability for surrogates to work on behalf of providers to create/update both Individual and Organizational NPI records;
- additional optional identifier fields: additional physical addresses and additional organization names; and
- bulk upload and bulk enumeration for large organizations.

3.4. 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.[58] Additionally, CMS has the discretionary authority to revoke Medicare billing privileges when a state has terminated for cause a provider's or supplier's Medicaid billing privileges. To meet this requirement, CMS has established a process for states to report and share information about Medicaid terminations. States must 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 to strengthen program integrity in FY 2016 with an organizational change to align oversight of Medicaid provider enrollment within the same area that oversees Medicare provider enrollment. Because the provider screening and enrollment requirements included in the Act are comparable between the Medicare and Medicaid programs, this organizational change increases alignment of policy and guidance between programs, reduces burden on the SMAs to comply with the requirements for provider

[58] 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 revocation of enrollment is governed by 42 CFR § 455.416.

screening and enrollment, and improves the enrollment experience for providers in these programs.

CMS continued its efforts to assist the states with their required screening by providing guidance through the Medicaid Provider Enrollment Compendium (MPEC), a policy manual that contains clarified guidance regarding how SMAs may, in certain circumstances, rely on Medicare provider screening activities in lieu of conducting their own. In FY 2016, CMS established a 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. In addition, CMS participated in enrollment conference calls with state providers and provided webinar trainings on states' use of various enrollment tools, including the process CMS established to provide revocation, termination, and enrollment data to the states, as well as PECOS. CMS also conducts provider enrollment and termination outreach and education at the Medicaid Integrity Institute (MII) twice a year. For FY 2016 MII courses, 49 states, the District of Columbia and Puerto Rico attended. Similar outreach and education opportunities are presented annually at the National Association for Medicaid Program Integrity (NAMPI). CMS also performs compliance assistance site visits to discuss enrollment operations and implementation of certain statutory requirements.

3.5. 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), and in and around Houston, Texas (Part B ground ambulance suppliers).[59] The moratoria also applied to Medicaid and CHIP. 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

[59] 78 FR 46339 (July 31, 2013).

Detroit, Michigan; and Part B ground ambulance suppliers in and around Philadelphia, Pennsylvania.[60] CMS continued to extend these moratoria in 6-month increments.[61]

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.[62]

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 moratoria-designated geographic locations. 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.

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 continuation of these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries.

3.6. 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 providers and suppliers. CMS uses the information obtained during site verifications to determine if provider enrollment requirements are met and to calculate a fraud level indicator.

60 79 FR 6475 (Feb. 4, 2014).

61 81 FR 5444 (Feb. 2, 2016).

62 81 FR 51120 (Aug. 3, 2016).

Since inception in July 2009, this project has produced significant 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.

From October 1, 2015 through September 30, 2016, the Medicare Administrative Contractor covering Florida (First Coast Service Operations) had conducted 7,790 site visits to verify providers' and suppliers' operational status, deactivated 385 practice locations, and revoked or denied 854 providers. CMS saved $9.6 million from prepayment medical record review via this initiative.

4. Continue to Build States' Capacity to Protect Medicaid

CMS assists states in building their internal capacity to conduct program integrity activities for Medicaid. Using funds provided in § 1936(e) of the Act, CMS promotes state Medicaid integrity efforts by providing state agencies with guidance and oversight, education and technical assistance, and federal resources for augmenting states' capacity for auditing providers. Funding also supports the preparation and dissemination of educational toolkits for states to use to enhance awareness of Medicaid fraud, waste, and abuse among providers, beneficiaries, managed care organizations, and others. Through reviews of state processes and procedures, CMS also identifies areas of improvement and works with the states to make sure they have robust and effective program integrity strategies.

- Medicaid Integrity Institute
- State Program Integrity Reviews
- Medicaid and CHIP Business Information Solutions
- Guidance and Technical Assistance
- Toolkits to Educate Providers and Beneficiaries
- National Medicaid Audit Program
- Annual Upper Payment Limit (UPL) Demonstrations
- Disproportionate Share Hospital (DSH) Audit and Reporting

In addition, CMS continues to use HCFAC program discretionary funds to develop and implement enterprise systems that support Medicaid, in particular the Medicaid and CHIP Business Information Solution (MACBIS) initiative, which will improve the ability of CMS and the states to gather and analyze data that will support program integrity activities.

4.1. Medicaid Integrity Institute

Established through an interagency agreement with the DOJ in 2007, the Medicaid Integrity Institute (MII) is located within the DOJ's National Advocacy Center in Columbia, South Carolina. MII's mission is to provide substantive, effective training tailored to the ongoing needs of State Medicaid program integrity employees, the goal of which is to raise performance standards and professionalism in Medicaid program integrity nationwide at no cost to the states. The MII environment provides a unique opportunity for state personnel to receive training and technical assistance, along with the opportunity to collaborate with colleagues from other states in a structured learning environment. CMS's funding of MII programs relieves states of some of the financial burden to train their program integrity staff and supports, in part, CMS's statutory obligation to provide support and assistance to help states combat Medicaid fraud and abuse. In addition to training in the fundamentals of program integrity activities, the MII regularly refreshes course offerings to focus on emerging program integrity issues in areas such as Medicaid managed care, home health and personal care services, provider screening and enrollment, and predictive analytics in Medicaid.

From the first course in FY 2008 through FY 2016, the MII has provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 7,035 enrollments in 152 courses and 10 workgroups. In addition, in FY 2013, the MII initiated its own professional accreditation program. The MII established the designation of Certified Program Integrity Professional (CPIP) 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, 2016, 288 state employees from 47 states have received the CPIP credential.[63]

State Attendees Apply Lessons
from MII Provider Auditing Fundamentals Program

"*The training was effective because there was variety in subjects presented and variety in the attendees. Speaking with colleagues from other states was helpful in getting a clear picture of how similar problems can be solved in a myriad of ways. The presenters also brought collectively a good breadth, and individually a good depth, of knowledge across many different areas of Medicaid audit.*

The face-to-face interaction with Investigators from other States and getting to hear the issues they are currently dealing with and suggestions and/or tips they volunteered to aid throughout the auditing/investigation process was extremely helpful."

In FY 2016, the MII provided onsite training with 773 participants enrolled in the following courses:

- Basic Skills and Techniques in Medicaid Fraud Detection – CPIP course (2 courses)
- Specialized Skills and Techniques in Medicaid Fraud Detection – CPIP course (2 courses)
- Program Integrity Fundamentals Seminar – CPIP course
- Managed Care Oversight Seminar (2 courses)
- Medicaid Provider Enrollment Seminar (2 courses)
- CPT Outpatient Coding Boot Camp (2 courses)
- Coding for Non-Coders
- CPT ICD-10CM & ICD-PCS Coding Boot Camp (formerly the Inpatient Coding Boot Camp)
- Evaluation & Management Boot Camp
- Interactions between Medicaid Fraud Control Units (MFCU) and Program Integrity (PI) Units
- Faculty Development Seminar

[63] Medicaid Integrity Institute (MII) Annual Report FY14-16

The distance learning sessions provided in FY 2016 included:

- Medicaid HITECH, EHR Incentive Program, and Meaningful Use Update – Part I
- Detecting Trafficking through Social Media
- Medicaid HITECH, EHR Incentive Program, and Meaningful Use Update – Part II
- DME, CPAP Supplies: Fraud, Waste, and Abuse

4.2. State Program Integrity Reviews

CMS undertakes a wide array of activities to oversee and support states' Medicaid program integrity efforts. 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 its compliance with Federal statutory and regulatory requirements. Onsite reviews during CY2014-CY2016 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 program integrity efforts in 54 states during CY2016. [64] 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 2016 included provider terminations, Medicaid RACs, and implementation status of Payment Error Rate Measurement (PERM) corrective action plans and state program integrity review corrective action plans.

4.3. 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 to ensure high performing Medicaid and CHIP programs. This initiative creates a more robust and comprehensive information management strategy — a "transformed data state" — to integrate Medicaid and CHIP program, 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 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 Medicare data, 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.

[64] Section 1101(a) of the Social Security Act defines the term "State", except where otherwise provided, to include the District of Columbia and the Commonwealth of Puerto Rico, and when used in titles IV, V, VII, XI, XIX, and XXI includes the Virgin Islands and Guam.

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 council's strategy includes:

- promoting consistent leadership on key challenges facing state health programs;
- improving the efficiency and effectiveness of the federal-state partnership;
- making data on Medicaid, CHIP, and state health programs more widely available to stakeholders; and
- reducing duplicative efforts within CMS and minimizing the burden on states.

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 performance data. Implementation of T-MSIS by states began on a rolling basis starting April 2016. As of December 2017, 49 states have begun submitting T-MSIS data, representing 97 percent of the Medicaid and CHIP population. CMS continues to work with the remaining states to help them submit data and expects all states to report T-MSIS data by 2018.

T-MSIS is an expansion of the existing CMS MSIS data and extract process. The new T-MSIS extract format should further CMS and states' goals for improved timeliness, reliability, and more robust data analysis process through monthly updates and an increased volume of data provided. The Medicaid and CHIP Program (MACPro) will collect program data to automate State Plan Amendments (SPA) review and approvals and assist enterprise-level considerations. The MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

During the last year, CMS has invested significant resources in the development, implementation, and integration of two primary systems: the T-MSIS and MACPro. Quality and performance data requirements are being identified and documented and will be collected through T-MSIS and MACPro.

CMS achieved the following milestones in 2016:

- maintained and expanded the cloud-hosting infrastructure to support business intelligence and data analysis of MACBIS data (T-MSIS and other legacy data as able);
- developed and documented new requirements for all MACBIS projects (MACPro, T-MSIS, Pharmacy, and MBES);
- initiated the creation of the draft Unified Medicaid and CHIP Data Model;
- implemented a data governance strategy for Medicaid and CHIP data to provide guidance regarding release of data;

- developed and deployed first phase of analytic dashboard containing Medicaid and CHIP eligibility and enrollment data; this tool will be used by internal stakeholders for ongoing program monitoring and oversight;
- developed user-friendly T-MSIS state data profiles that contain summary level data on eligibility, claims, provider and managed care plan information;
- provided data to downstream CMS systems that will consume T-MSIS data;
- managed legacy systems and migrated legacy functionality and data as identified in releases for both MACPro and T-MSIS;
- implemented the significantly enhanced release of the T-MSIS production application to production, including file and data validation, receipt and control and flexible operational reporting;
- operated and maintained the T-MSIS application;
- established and implemented a state testing strategy for independent state testing for new releases of T-MSIS;
- developed processes to evaluate T-MSIS test data from states, to prepare states for production;
- developed processes to compare T-MSIS test data from states with previous MSIS submissions, to evaluate completeness of data;
- continued to improve T-MSIS state data completeness and quality;
- provided SAS EBI and MicroStrategy access and analytic capabilities to Medicaid and CHIP data starting with T-MSIS and expanding as more data is added;
- significantly enhanced the foundational MACPro application with a flexible state of the art tool to allow for quicker implementation of authorities; and
- developed and promoted to MACPro production
  - Release 4.1 Health Home State Plan Module (HHSPA)
  - Release 4.1.1 HHSPA Health Home Content Analysis Report
  - Release 4.3 Quality Measures Modules which encompassed the 2014-2016 Adult, Child, and Maternal Infant and Health Quality Measures
  - Release 4.3.1 Quality Measures Reporting Module which encompassed Measure by Measure and Maternal Infant and Health
  - Release 6.0 User Management Module, which encompassed Role-based User Management

4.4. Guidance and Technical Assistance

CMS provides technical assistance on program integrity activities to states and stakeholders, including CMS contractors, state Medicaid Fraud Control Units (MFCUs), the HHS OIG, other HHS agencies, and the DOJ, including U.S. Attorneys' Offices and the FBI. Common topics include requests for assistance related to policy and regulatory requirements governing disclosures, provider exclusions and enrollment, the National Medicaid Audit Program, and specific fraud referrals.

CMS provided additional assistance to states through regular teleconferences with Medicaid program integrity directors, Medicaid Fraud, Waste, & Abuse Technical Advisory Group meetings, and outreach activities as described below:

- CMS staff host a monthly call in which the program integrity directors of the 19 smallest Medicaid programs participate.[65]

- CMS leadership and staff work with the CMS Medicaid Fraud & Abuse Technical Advisory Group on a variety of policies and issues in Medicaid program integrity.

- CMS's New York field office hosted its last regional meeting of program integrity stakeholders from Medicaid, Medicare, and law enforcement agencies to discuss current fraud issues and recent cases in December 2016. Stakeholders have the option to attend other workgroups hosted by the FBI beginning in FY 2017.

- In addition to distance learning provided to the states through the MII, CMS hosted webinars for Medicaid program integrity staff on topics such as:

    - Medicaid HITECH, EHR Incentive Program, and Meaningful Use Update (2 part series)
    - Detecting Trafficking through Social Media
    - DME, CPAP, Supplies: Fraud/Waste/Abuse

- CMS reporting on State Medicaid RAC performance.

In addition, in March 2016, CMS published the MPEC[66] to help states in implementing various enrollment requirements; including provider site visit and fingerprint-based criminal background check (FCBC) requirements. CMS also conducts state site visits to review and advise states' about implementation challenges in provider screening and enrollment. To date, CMS has completed 17 state site visits.

4.5. Toolkits to Educate Providers and Beneficiaries

The Education Medicaid Integrity Contractor (Education MIC) works with stakeholders to develop educational materials about Medicaid fraud, waste, and abuse for providers, beneficiaries, managed care organizations, and others. The Education MIC divided the education effort into two projects with one centered on a targeted provider education program and the other on developing materials for a broader audience (providers, beneficiaries, managed care organizations, and others). The education effort focused on priority areas that CMS, state Medicaid officials, and the Education MIC identified as lacking educational information related to improper payments resulting from fraud, waste, and abuse. Stakeholders identified these priority areas through feedback scans. The Education MIC developed the materials with the expertise of stakeholders from SMAs, law enforcement agencies, provider and advocacy organizations, and other relevant groups.

[65] Participating states' programs met the following criteria: (i) fewer than 14 staff, (ii) fewer than 18,000 providers, and (iii) annual Medicaid expenditures of $1.7 billion or less.

[66] For more information about MPEC, see section 3.3 of this report.

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. 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. The Education MIC conducted 24 train-the-trainer sessions for states using these online educational toolkits during FY 2016, instructing state program integrity staff how to use the materials to educate and inform providers and other relevant stakeholders.

4.6. National Medicaid Audit Program

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers, audit providers' claims, and to identify overpayments. CMS made the first audit assignments to Audit MICs in September 2008, and has continuously reviewed the results of the audit program to monitor its performance. Because of these reviews, CMS has focused on conducting collaborative projects with states since FY 2011, using states' up-to-date Medicaid claims data.

Collaborative audits are an effective way to augment a state's audit capacity by leveraging the resources of CMS and its Audit MICs, resulting in more timely and accurate audits. These audits combine the resources of CMS and the MICs to assist states in addressing suspicious payments, including algorithm development, data mining, auditors, and medical review staff. Through this process, the approach more effectively uses resources in support of states in their program integrity efforts. The collaborative process includes a discussion between the state and CMS regarding potential audit issues and the states' provision of Medicaid Management Information System (MMIS) data for data mining. The state, together with CMS, determines the audit processes the Audit MICs follow during the collaborative audit. In some instances, the Audit MICs conduct the entire audit. In other cases, the Audit MICs supplement state resources by providing medical review staff and other resources.

Collaborative audits have identified substantial amounts of potential overpayments to providers in recent years. Overpayments identified by collaborative audits increased from $2 million in FY 2012 to $36 million in FY 2015, with the cumulative total at more than $75.8 million. The increase in overpayments identified is due to improved data, improved engagement and collaboration with states, increased state participation in audits, and greater experience with targeting and conducting these audits.

During FY 2016, the Audit MICs identified $50.6 million in total Medicaid overpayments sent to states for collection. States are responsible for collecting overpayments identified by Audit MICs, and are permitted up to one year from the date of the final audit report to return the federal share (42 CFR § 433.312). For FY 2016, states reported a total combined federal and state share amount of MIC audit recoveries

of $13.1 million and returned the federal share of $7.9 million to the Treasury.[67] CMS obligated $26.2 million for Audit MIC activities in FY 2016.

To better coordinate Medicare and Medicaid program integrity audit and investigation work, CMS is currently shifting its Audit MIC workload to the UPICs. In addition to collaboration with states, CMS also assisted federal law enforcement agencies such as the HHS-OIG and the FBI through audit work.

4.7. Annual Upper Payment Limit Demonstrations

The Medicaid statute requires that states set provider payment rates that are consistent with efficiency, economy and quality of care. For certain services, federal regulations establish aggregate upper payment limits (UPL) to implement this state requirement. The UPL applies to facility services, including: inpatient and outpatient services, provided in hospitals, clinics, nursing facilities, and institutions for individuals with developmental disabilities. Certain facilities - such as Indian Health Service and tribal facilities, and Federally Qualified Health Centers - are exempt from the UPL requirements. The UPL is based on reasonable estimates of the amount that would be paid to the facilities under Medicare payment principles. For each of the three designated ownership categories: state government owned or operated, non-state government owned or operated, and privately owned and operated, states are required to annually demonstrate that payment for the above mentioned services do not exceed the applicable UPL. Payment for services provided in all other Medicaid inpatient and outpatient facilities may be based on the customary charges of the provider but must not be more than the prevailing charges in the locality for comparable services under comparable circumstances.[68] States are required to submit methodologies and data to CMS to demonstrate that Medicaid payments comply with the applicable limits.

CMS issued a State Medicaid Director's letter on March 18, 2013 (SMDL 13-003); requiring states to submit their UPL demonstrations on an annual basis for all facility benefits. Prior to the issuance of the letter, CMS generally reviewed UPL demonstrations only as part of the review procedures for state requests to change provider payment rates. The annual process provides CMS with information to verify that states are complying with UPL requirements each year, prior to the start of a state's fiscal year.

CMS uses the annual process to identify gaps or aberrances in the data the states submit to support UPL demonstrations and factors within states' demonstrations that do not adhere to Medicare principles. With this information, CMS will promote consistent national reviews of state UPL demonstrations, determine additional state needs for technical assistance and guidance, and reinforce our efforts of ensuring program accountability and regulatory oversight.

[67] MIC audit recoveries include overpayments collected, adjusted, or refunded to CMS.

[68] 42 CFR § 447.325

4.8. Disproportionate Share Hospital Audit and Reporting

On December 19, 2008, CMS promulgated CMS-2198-F: Medicaid Program: Disproportionate Share Hospital (DSH) Payments. The final rule implemented section 1001 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,[69] requiring state audits and reports to ensure the appropriate use of DSH payments. The statute requires that states submit the annual independent certified audit and report as a condition of receiving Federal Financial Participation (FFP) for DSH payments.

Audits and reports were required beginning with Medicaid State plan rate year (SPRY) 2005. The final rule established a December 31, 2009 submission deadline for the first two years of audits and reports. Subsequent audits and reports are due each year on December 31, three years after the completion of the SPRY. The final rule also required that audits and reports meet regulatory requirements as a condition of receiving FFP for DSH payments after the submission deadline. State-specific annual DSH reports are available in the "Annual DSH Reports" section of the CMS Medicaid.gov website.

This process ensures the fiscal integrity of the Medicaid program by making sure that payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs do not exceed that hospital's eligible uncompensated costs incurred in furnishing inpatient and outpatient hospital services to Medicaid-eligible patients and the uninsured.

[69] Public Law 108-173.

5. Extend Work in Medicare Part C and Part D[70]

CMS is committed to expanding its program integrity activities in capitated managed care programs in Medicare and Medicaid.

- Medicare Drug Integrity Contractor
- Medicare Parts C and D Marketing Oversight
- Audits of Medicare Advantage and Part D Plan Sponsors
- Compliance and Enforcement in Medicare Part C and Part D

Enrollment in Medicare Part C and Part D has experienced significant growth in recent years. CMS has conducted oversight of Medicare Part C and Part D plan sponsors through audits to determine whether plans deliver the appropriate healthcare services and medications as prescribed. Further information on Part C and Part D RAC activities is in section 2.14, Part C and Part D oversight in sections 5.4 and 5.5, and Risk Adjustment Data Validation (RADV) and improper payments in section 6.4.

5.1. Medicare Drug Integrity Contractor

National Benefit Integrity Medicare Drug Integrity Contractor

The National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) performs data analysis to fight fraud, waste, and abuse in Medicare Part C and Part D. The NBI MEDIC identifies improper payments through data analysis and notifies plan sponsors to recover the corresponding overpayments. Because of the NBI MEDIC's data analysis projects, HHS recovered $78.5 million in FY 2016 from Part D sponsors. The NBI MEDIC also refers some information to law enforcement organizations for additional investigation.

According to notifications received from law enforcement in FY 2016, NBI MEDIC referrals to law enforcement resulted in recoveries of $3.5 million for Part C and $100.1 million for Part D. The majority of these savings were from sentences ordering restitution.

The NBI MEDIC also conducts proactive data analysis to identify potential fraud, waste and abuse involving controlled substances. Data analyses include identifying trends, anomalies, and questionable physician and pharmacy practices involving prescription opioids in order to identify outliers, educate plan sponsors, and recover improper payments, as well as make referrals to law enforcement when appropriate. Examples include:

[70] Please see section 2.13 for activities regarding the Part C and Part D Recovery Audit Programs. Please also note that while CPI included Medicaid Managed Care and the Marketplace in its 2014 strategic objectives, the focus of this FY2016 report is on Medicare Part C and Part D programs.

- Quarterly Pharmacy Risk Assessment, which categorizes pharmacies as high, medium, or low risk;
- Prescriber Risk Assessment, which provides a peer comparison 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; and
- identification of improper payments for drugs inappropriately covered under the Part D program without a prior authorization for example, Transmucosal Immediate Release Fentanyl.[71]

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 NBI MEDIC assists law enforcement and Part D plans in addressing drug diversion through data analysis and the Pill Mill Doctor Project results. For example, in response to requests for information from law enforcement, the NBI MEDIC conducts invoice reconciliations, impact calculations, and reviews of medical records.

In April 2015, CMS and the NBI MEDIC launched PLATO, which is a voluntary, web-based tool designed to help plan sponsors combat potential fraud, waste, and abuse in the Medicare Advantage and Part D programs. PLATO was developed to assist plan sponsors in identifying and addressing potential fraud, waste, and abuse, as well as to encourage sharing information between plan sponsors and CMS. CMS's federal law enforcement partners are also users of PLATO.

PLATO can help plan sponsors identify suspicious pharmacies and providers. The tool provides users with national Part D summary information that is updated monthly so that an overall picture of provider activity can be obtained. This benefit will allow plan sponsors to overcome the constraint of being limited to only their drug claims processing information.

In addition, PLATO provides plan sponsors an 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 PLATO include: terminations, payment suspensions, post-payment reviews, and referrals to law enforcement.

Outreach and Education (O&E) MEDIC

The Outreach and Education (O&E) MEDIC provides Part C and Part D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups.

In FY 2016, CMS hosted three Medicare Parts C & D Fraud, Waste, and Abuse Trainings, one in-person event and two as virtual training webinars. Program integrity professionals from plan sponsors, pharmacy benefit managers, law enforcement, CMS,

[71] Centers for Medicare & Medicaid Services (CMS) Opioid Misuse Strategy 2016

and CMS contractors from across the nation attended these events. More than 150 individuals attended the in-person training, and more than 950 individuals attended each webinar. Through these events, CMS provided program integrity training to more than 2,150 program integrity professionals. These trainings provided valuable information about Medicare Advantage (MA) and Prescription Drug fraud schemes and anti-fraud, waste, and abuse activities and initiatives. Additionally, during in-person trainings, attendees shared data and leads on suspected potential fraud that they take back to their organizations for further investigation. CMS also provided outreach and educational materials to program integrity stakeholders through the CMS O&E MEDIC website, which had more than 5,000 vetted members at the close of FY 2016.

5.2. Part C and Part D Program Integrity Oversight

In FY 2016, CMS continued to invest HCFAC funding to strengthen Medicare Part C and Part D oversight. CMS enhanced its data analysis and improved coordination with law enforcement to provide a more comprehensive assessment of program integrity activities in the Part C and Part D programs. All MA and Part D plan sponsors are required to have a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse. This plan consists of written policies, procedures, and standards that articulate the organization's commitment to comply with all applicable federal and state standards related to fraud and abuse. Plan sponsors must have a properly trained, effective compliance officer and provisions for internal monitoring and auditing, as well as other requirements. These requirements help ensure plan sponsors track and identify potential beneficiary or provider abuse. As part of the program integrity oversight of Part C and Part D programs, CMS evaluates plan sponsors' operations for compliance with federal regulations and guidance.

Over the past few years, CMS has been working to strengthen federal regulations and procedures to ensure that Medicare pays only for covered prescriptions with valid prescriber identifiers (e.g., NPIs) on the prescription drug claim. Since 2011, CMS has been taking steps to verify that only valid prescriber identifiers accompany Part D claims and to recover funds paid for claims for which there is no valid prescriber identifier or for prescriptions written by unauthorized prescribers. In collaboration with the Drug Enforcement Administration (DEA), CMS directed Part D sponsors to submit only active and valid prescriber identifiers on a PDE record, and began validating the format of all prescriber identifiers coded as a NPI and excluding from payment reconciliation those PDEs with invalid NPIs.

In April 2012, CMS published a final rule requiring that Part D sponsors must submit to CMS only PDE records that contain active and valid individual prescriber NPIs beginning January 1, 2013.[72] CMS, through the annual Medicare "Dear Doctor" letter, explained the NPI requirement to prescribers. CMS began to deny any PDE without an active and valid individual NPI beginning on May 6, 2013 and continued to assess each sponsor's performance regarding NPI use and validity of submitted NPIs, notifying

[72] 77 FR 22072 (Apr. 12, 2012).

sponsors of their performance in preparation for this deadline. Based on this assessment, 99.6 percent of the 2013 PDEs received during the first quarter of the coverage year reported the prescriber's NPI, and all but 0.002 percent of the reported NPIs were valid and currently active (or active within a year of the date of service). CMS also examined the taxonomy codes, self-reported by the providers, to identify their specialty. Because a small percentage of these taxonomy codes would be unreasonable for specific prescribers, CMS initiated a review of the corresponding PDEs to determine what drugs were prescribed, if any were controlled substances, and if the prescribers had valid individual DEA numbers.

5.3. Medicare Part C and Part D Marketing Oversight

CMS takes compliance action against MA organizations, PDPs, Section 1976 Cost Plans, and Medicare-Medicaid Plans that fail to send timely and accurate Annual Notice of Change (ANOC)/Evidence of Coverage (EOC) documents to Medicare enrollees. The ANOC document provides the Medicare enrollee with a description of changes in the enrollee's existing coverage, costs, or service area that will become effective in January. The EOC document 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 and accuracy reviews of ANOC/EOC documents to ensure that Medicare enrollees receive correct ANOC/EOC documents within specified deadlines. CMS issues notices to Plans/Part D Sponsors for late and/or inaccurate ANOC/EOC documents, such as Notices of Non-Compliance, Warning letters, and Ad-Hoc Corrective Action Plans. CMS also has the option to refer a Plan/Part D sponsor for evaluation to determine if a Civil Money Penalty (CMP) should be imposed when a Plan/Part D Sponsor substantially fails to comply with program and/or contract requirements.

5.4. Part C and Part D Audits

CMS conducts program audits of Part C organizations and Part D plan sponsors to evaluate their delivery of healthcare services and medications to beneficiaries. Program audits in 2016, 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) and standalone PDP contracts owned and operated by the parent organization were included in the scope of the 2016 audits. The audits evaluated sponsor compliance in the following program areas:

- Compliance Program Effectiveness (CPE)
- Part D Formulary and Benefit Administration (FA)
- Part D Coverage Determinations, Appeals, and Grievances (CDAG)
- Part C Organization Determinations, Appeals, and Grievances (ODAG)

- Special Needs Plans Model of Care (SNP-MOC)

Plans have all program areas audited except in the case that a protocol was not applicable to their operation. For example, if a sponsor does not operate a SNP plan, then they would not have a SNP MOC audit performed. Likewise, a standalone PDP does not have the ODAG protocol applied, since it does not offer the MA benefit.

In 2016, audits cited an average of 18 conditions of noncompliance per sponsor audited which decreased from an average of 27 conditions per audited sponsor in 2015. Sponsors with cited conditions of noncompliance in their audit report must correct all deficiencies and undergo validation to ensure compliance before the program audit is closed.

In general, program audits give CMS reasonable assurance that sponsors deliver benefits in accordance with the terms of their contract and plan benefit package. However, CMS also has authority to take enforcement actions, up to and including termination, if warranted, for findings that involve direct beneficiary harm or the potential to result in such harm. Section 5.5 discusses CMS enforcement efforts in more detail.

CMS has greatly increased the level of transparency with respect to our audit materials, the performance of our audits and the results of those audits, including any enforcement actions that may result. Program audits, and the consequences of possible enforcement actions, continue to drive improvements in the industry and increase sponsor's compliance with core program functions in the MA and Part D program.

5.5. Compliance and Enforcement in Medicare Part C and Part D

CMS has the authority to take enforcement or contract actions when CMS determines that an MA 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 Medicare Part C and Part D program requirements; or
- no longer substantially meets the applicable conditions of the Medicare Part C and D program.

Enforcement and contract actions include:

- CMPs;
- Intermediate Sanctions (for example, suspension of marketing, enrollment, and payment); and
- Contract Terminations.

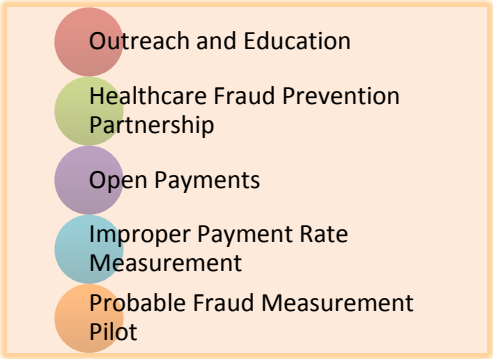
In FY 2016, CMS issued 16 CMPs placed two MA/Part D organizations under marketing and enrollment sanctions, and one Program of All-Inclusive Care for the Elderly (PACE) organization under an enrollment suspension. Overall, in FY 2016, CMS collected $7.8

million from CMPs. Medicare Part C and D enforcement notices are publicly available on the Part C and Part D Enforcement Actions webpage.

Starting with audits conducted in 2017 (based on contract year 2015), CMS will begin to evaluate the findings of noncompliance from financial audits for potential enforcement actions, in accordance with applicable regulations. These enforcement actions can also be found on the Part C and Part D Enforcement Actions webpage.

6. Provide Greater Transparency into Program Integrity Issues

CMS is dedicated to providing greater transparency into program integrity issues through education, outreach, partnership, strategic communications, and data releases. This enables CMS to work with its partners and stakeholders to share best practices and lessons learned in program integrity. Increased transparency and accountability enhances program efficiency and effectiveness.



6.1. Outreach and Education

Provider Outreach and Education

One of the goals of provider education and outreach is to reduce the Medicare improper payment rate by giving 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 Comprehensive Error Rate Testing (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 MLN educational products, information, and resources for the health care professional community. Specifically, Medicare contractors use MLN Matters articles[73] explaining 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.

Beneficiary Education

CMS and HHS launched the Fraud Prevention Campaign in January 2010 to increase public awareness about Medicare's fight against fraud. Each year, CMS informs Medicare beneficiaries on an ongoing basis about the importance of guarding their personal information against identity theft and how they can protect against and report

[73] MLN Matters articles are national education articles prepared in consultation with clinicians, billing experts, and CMS subject matter experts tailored by content and language to specific provider type(s).

suspected fraud. In FY 2016, this effort included the *Medicare & You* handbook and other beneficiary education materials, 1-800-MEDICARE, and the Medicare.gov website. A wide range of beneficiary materials, including the Medicare Summary Notice, the MyMedicare.gov Message Center, and response letters to beneficiary inquiries disseminate similar messages.

6.2. Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP)[74] is a voluntary, public-private partnership consisting of the Federal Government, state agencies, law enforcement, private health insurance plans, and healthcare anti-fraud associations. Established in July 2012 by the Secretary of HHS and the U.S. Attorney General, the HFPP provides visibility into the larger universe of healthcare claims and claimants beyond those encountered by any single partner. The ultimate goal of the HFPP is to exchange facts and information to identify trends and patterns that will uncover fraud, waste, and abuse that may not otherwise be identified. The purpose of the HFPP is to improve the detection and prevention of healthcare fraud, waste, and abuse by:

- Exchanging data and information between the public and private sectors;
- Leveraging various analytic tools against data sets provided by HFPP partner organizations; and
- Providing a forum for public and private leaders and subject matter experts to share successful practices and effective methodologies for detecting and preventing healthcare fraud, waste, and abuse.

In FY 2016, the HFPP reached a membership level of 70 partner organizations, representing over 65 percent of covered lives within the United States, and an increase of 30 percent since FY 2015. The amount of data collected in support of studies increased by 300 percent in FY 2016, leading to the performance of new studies, the replication of prior studies with new data, and the attainment of actionable leads.

In October 2016, the HFPP convened a special session of its membership to discuss what the HFPP can do in regards to the increasing problems of opioid misuse. During this session, HFPP members articulated approaches with respect to the management of prescription opioid fraud, waste, and abuse and identified feasible strategies representing best practices. Specifically, three core approaches reflecting their mission were identified. The approaches served as guiding principles for the HFPP's recommended actions for addressing prescription opioid misuse and OUD, all of which should be strongly considered by all payers and other relevant stakeholders in the U.S. This framework was developed, in part, on the U.S. Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) priority areas for addressing opioid use.[75]

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[74] The Healthcare Fraud Prevention Partnership (HFPP) is authorized under section 1128C(a)(2) of the Act.

[75] White Paper on proposed healthcare strategies payers can implement to reduce the harms of opioids.

6.3. Open Payments

Open Payments is a national program that promotes transparency by publishing data on the financial relationships between the health care industry (applicable manufacturers and group purchasing organizations, or GPOs) and health care providers (physicians and teaching hospitals). CMS publishes financial data for each program year[76] 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 annually after its initial publication to include data corrections submitted by applicable manufacturers and GPOs.

In FY 2016, CMS published 11.9 million payment records, transfers of value, or instances of ownership/investment interest reported during calendar year 2015. These financial transactions totaled $7.5 billion. CMS also re-published 2013 and 2014 data due to updates made by industry, such as additions/deletions of records, resolution of disputes, and release of delay in publication records, so that the public has access to nearly two and half years of Open Payments data.

CMS publishes information for each reporting year on its public website, and updates the website annually with an additional full year of data. This public website increases access to, and knowledge about, healthcare industry financial relationships and provides the public with information to enable them to make informed decisions about their healthcare. Disclosure of the financial relationships between the industry and health care providers 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. Manufacturers and GPOs self-report the data displayed on the Open Payments website.

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 2016. CMS hosted regular open forum discussions to share program updates and obtain feedback directly from stakeholders. In addition, CMS continued to improve the usability of the public website and Open Payments system.

The summary table below shows the number of records and value of payments published through FY 2016.

[76] The program year coincides with the calendar year. In this case, the program year is the calendar year ended December 31, 2015.

Table 5: Open Payments Summary

	Program Year			Total Published	Delay in Publication[3] Program Year		
	2013[1]	2014[1]	2015	(2013 - 2015)	2013	2014	2015
Number of Records[2] (in millions)	4.5	11.9	11.9	28.2	0.15	0.12	0.16
Value of payments (in billions)	$3.9	$7.5	$7.5	$16.8	$0.45	$1.3	$1.0

[1] This number varies from the previously published Report to Congress due to updates made by industry such as additions/deletions of records, resolution of disputes, and release of delay in publication.
[2] A record is a single row in a dataset reported by an applicable manufacturer or GPO.
[3] The Open Payments final rule (42 CFR § 403.910) provides applicable manufacturers and GPOs the opportunity to request a delay in publication pursuant to certain research payments or under a product research or development agreement. This delay is not to exceed four calendar years after the date of the payment or other transfer of value, or upon the approval, licensure or clearance of the covered drug, device, biological, or medical supply by the FDA.

6.4. 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)[77] 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; and
- report on actions the Agency is taking to reduce improper payments.

Comprehensive Error Rate Testing Program

The Medicare FFS program has been identified as being at high risk for improper payments. To comply with the IPIA, CMS established the 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 that was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment. 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 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 on an annual basis.

While all payments made as a result of fraud constitute "improper payments," not all improper payments constitute fraud. Many improper payments result from insufficient documentation to determine whether the service or item was medically necessary. In

[77] Public Law 107-300, Public Law 111-204, and Public Law 112-248, respectively.

order to reduce improper payments, CMS is working on multiple fronts to meet our improper payment reduction goals, including increased prepayment and post-payment medical review, enhanced analytics, and expanded education and outreach to the provider and supplier communities.

The Medicare FFS improper payment rate for FY 2016 was 11.0 percent, representing an estimated $41.1 billion in improper payments. Additional information on the Medicare FFS improper payment methodology and corrective actions is included in the FY 2016 HHS Agency Financial Report on pages 208 – 213.[78]

Payment Error Rate Measurement Program

The Medicaid program and CHIP have been identified as being 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 a 17-state rotation so that each state is reviewed once every three years.

The national Medicaid improper payment rate, based on measurements conducted in fiscal years 2014, 2015, and 2016, was calculated and reported in the HHS FY 2016 Agency Financial Report. The national Medicaid improper payment rate for FY 2016 was 10.5 percent; representing an estimated $61.2 billion in improper payments including both the federal and state share. This was an increase in the improper payment rate from FY 2015 due to state difficulties coming into compliance with new requirements that include:

- all referring or ordering providers must be enrolled in Medicaid and claims must contain the referring or ordering NPI,
- states must screen providers under a risk-based screening process prior to enrollment, and
- attending providers must include their NPI on all electronically filed institutional claims.

[78] Numbers taken from the FY 2016 HHS Agency Financial Report as referenced have been rounded to the first decimal in an effort to maintain consistency within this Medicare and Medicaid Integrity Program report.

While these requirements will ultimately strengthen Medicaid program integrity, they require systems changes that many states had not fully implemented. The national Medicaid component improper payment rates in FY 2016 were:

- Medicaid FFS, 12.4 percent;
- Medicaid managed care, 0.3 percent; and
- Medicaid eligibility, 3.1 percent.[79]

The FY 2016 national CHIP improper payment rate, based on measurements conducted in 2014, 2015, and 2016, was 8.0 percent or $1.1 billion in estimated improper payments, including both the federal and state share. The national CHIP component improper payment rates were:

- CHIP FFS, 10.2 percent;
- CHIP managed care, 1.0 percent; and
- CHIP eligibility, 4.2 percent.[80]

As with Medicaid, CHIP saw an increase in the improper payment rate from FY 2015 due to states having difficulties coming into compliance with the same new requirements.

Additional information on the Medicaid and CHIP improper payment methodology and corrective actions is included in the FY 2016 HHS Agency Financial Report on pages 216 – 224.

Improper Payment Rate Measurement in the Part C and Part D Programs

The Medicare MA and Part D programs have been identified as being at high risk for improper payments. In compliance with IPIA, CMS makes efforts to address improper payments[81] in MA and Part D. Unlike Medicare FFS, 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 (Parts A and 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.[82] In addition,

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[79] In light of changes to the way states adjudicate beneficiary eligibility for Medicaid under current law, for FYs 2015 through 2018, CMS will not conduct the eligibility measurement component of PERM. In place of these PERM eligibility reviews, all states are required to conduct eligibility review pilots. During this time, the Medicaid eligibility component improper payment rate is held constant at the FY 2014 national rate of 3.11 percent.

[80] In light of changes to the way states adjudicate beneficiary eligibility for CHIP under current law, for FYs 2015 through 2018, CMS will not conduct the eligibility measurement component of PERM. In place of these PERM eligibility reviews, all states are required to conduct eligibility review pilots. During this time, the CHIP eligibility component improper payment rate is held constant at the FY 2014 national rate of 4.22 percent.

[81] The improper payment rate noted in this section includes both overpayments and underpayments.

[82] Under Part C, CMS may also make payments of rebates to plans that bid below the benchmark for their services area(s).

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 Part C payment error estimate reported for FY 2016 was 10 percent, or $16.2 billion. The Part C payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by Part C 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 2016 methodology consisted of the following steps:

- Selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2014, 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; and
- Extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount.

The Part D payment error estimate reported for FY 2016 was 3.4 percent, or $2.4 billion. Beginning in FY 2016, the Part D error estimate measured only one component, the Payment Error Related to PDE Data Validation.[83]

Additional information on the Medicare Part C and Part D improper payment methodology and corrective actions is included in the FY 2016 HHS Agency Financial Report on pages 213 – 216.

6.5. Probable Fraud Measurement Pilot

While CMS is able to calculate improper payment rates in Medicare, Medicaid, and CHIP as described above, it is extremely difficult to attribute which portion of the improper payments are based upon fraudulent activity. Documenting the baseline amount of fraud in Medicare would be an important step to allowing CMS to more effectively evaluate the success of ongoing fraud prevention activities, however such metrics are very difficult to obtain. CMS is not aware of any other HHS healthcare systems which have an established baseline fraud measurement rate.

[83] The three other previously measured components – Payment Error Rated to Low Incoming Subsidy Status, Payment Error Related to Medicaid Status, and Payment Error Related to Direct and Indirect Remuneration - pose very little risk of payment error to the government. Over the years of measurement, the error estimates for these components as demonstrated in previous measurement cycles significantly decreased, such that the effort and resources required to measure them were no longer cost effective.

In collaboration with the HHS Office of the Assistant Secretary for Planning and Evaluation and with approval of the Office of Management and Budget, CMS designed the Probable Fraud Measurement (PFM) Pilot to test the methodologies, protocols, and instruments used to estimate probable fraud that were developed for possible use in a nationwide program. The PFM Pilot was conducted from December 2015 to March 2016 in the Miami-Dade County, Florida home health service area. The PFM Pilot consisted of extracting claims data; performing field interviews of beneficiaries, HHAs and attending providers; collecting medical documentation; evaluating the methodologies; revising and re-testing methodologies (when necessary); providing recommendations for improvement; and identifying best practices.

In the context of the PFM Pilot, a review panel of experienced health care analysts, clinicians, policy experts, and fraud investigators reviewed collected data to determine whether there was sufficient evidence to refer any of the cases to ZPICs for further investigation. At the conclusion of the pilot, twenty cases were identified for possible referrals to ZPICs. Although the PFM Pilot was not designed to generate actual referrals, the findings warranted that additional analysis be conducted to determine whether these cases should, in fact, be referred to the ZPICs for further investigation.[84]

[84] This analysis is ongoing. CMS will assess the value of expanding the pilot to a larger geographic area (e.g., national) and expanding the measurement to other areas of Medicare.

Appendix A - Table of Program Integrity Obligations

CMS Program Integrity Obligations (amounts in thousands)[85]	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual
Address the Full Spectrum of Waste, Abuse, and Fraud			
Program Integrity Staffing and Support	$95,147	$129,276	$154,165
Integrity Continuum	0	0	6,113
Fraud Prevention System	21,720	16,491	56,427
Program Integrity Modeling and Analytics	1,850	18,524	19,031
One PI Data Analysis	24,578	34,302	22,044
Benefits Integrity	141,812	150,932	145,025
Medical Review	179,001	191,178	184,793
Provider Audit	158,230	153,876	147,283
Medicare Secondary Payer	150,486	153,286	150,407
Medi-Medi	48,306	55,461	52,345
Appeals Initiatives	2,268	7,885	5,401
Administration for Community Living (ACL) Senior Medicare Patrols	0	0	17,428
Medicare Recovery Audit Program[86]	471,371	147,656	107,282
Address the Full Spectrum of Waste, Abuse, and Fraud Subtotal[87]	$1,294,769	$1,058,867	$1,067,744
Proactively Manage Provider Screening and Enrollment			
Advanced Provider Screening	$16,473	$21,037	$24,886
Provider Enrollment, Chain and Ownership System (PECOS)	17,618	28,836	29,273
Section 6401 Provider Screening/Other Enrollment[88]	38,382	29,684	12,058

[85] The chart represents total obligations for the CMS Center for Program Integrity, Medicare Integrity Program and Medicaid Integrity Program for FY 2016 (10/1/2015 through 9/30/2016, inclusive).

[86] 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.

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

[88] This amount includes funding from sources other than HCFAC or DRA.

Appendix A - Table of Program Integrity Obligations

CMS Program Integrity Obligations (amounts in thousands)[85]	FY 2014 Actual	FY 2015 Actual	FY 2016 Actual
National Supplier Clearinghouse	27,386	18,991	17,373
Proactively Manage Provider Screening and Enrollment Subtotal	$99,859	$98,548	$83,590
Continue to Build States' Capacity to Protect Medicaid			
State Medicaid Access to Data and Support	$84,036	$68,969	$90,565
Continue to Build States' Capacity to Protect Medicaid Subtotal	$84,036	$68,969	$90,565
Extend Work in Medicare Part C and Part D			
MEDIC	$22,873	$27,327	$22,299
Part C and D Contract/Plan Oversight	14,322	15,655	17,526
Monitoring, Performance Assessment, and Surveillance	44,366	49,774	54,871
Program Audit	33,068	34,843	37,686
Compliance and Enforcement	16,950	17,569	17,314
Extend Work in Medicare Part C and Part D Subtotal	$131,579	$145,168	$149,696
Provide Greater Transparency into Program Integrity Issues			
Outreach and Education	$35,977	$37,121	$46,330
Healthcare Fraud Prevention Partnership	14,324	19,407	10,603
Open Payments	0	22,512	16
Error Rate Measurement Activities	30,914	42,658	24,031
Probable Fraud Measurement Study	40,194	1,715	53,328
Provide Greater Transparency into Program Integrity Issues Subtotal	$121,409	$123,413	$134,308
Total CMS Program Integrity Obligations[89]	$1,731,652	$1,494,965	$1,525,903

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

Appendix A - Table of Program Integrity Obligations

Appendix B - Program Integrity Savings Methodology

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 Savings
- Appendix B-3 – Fraud Prevention System 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 activities supported by program integrity funding. 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 Annual Report to Congress on the Medicare and Medicaid Integrity Programs. Starting with fiscal years (FYs) 2013/2014, CMS has been continually improving its methodology for measuring savings to include savings metrics for more programs and ensure consistent, repeatable measurement to allow benchmarking and trending over time.

Savings for Medicare are achieved through both prevention and recovery of improper payments, including fraud, waste, and abuse. CMS takes a comprehensive approach to program integrity that includes support investments, such as analytics and information technology, as well as front-line investments where the final actions that result in savings occur (such as investigation and audit contractors). CMS measures savings against the total budget investment to achieve a comprehensive ROI of the full spectrum of activities that support final action.

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 providers[90] in the absence of these actions. CMS describes prevention activities in four categories: systematic edits, provider enrollment actions, prepayment edits and reviews, and other actions. The following sections describe the methodologies used to determine the prevention savings in the FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings*.

Type of Medicare Savings	Medicare Program
Prevention Savings	
Systematic Edits	
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
Zone Program Integrity Contractor (ZPIC) Edits	FFS

[90] 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.

Type of Medicare Savings	Medicare Program
Provider Enrollment	
Revocations	FFS
Deactivations	FFS
Prepayment Edits and Reviews	
Medicare Secondary Payer (MSP) Operations	FFS
Medicare Administrative Contractor (MAC) Medical Reviews	FFS
ZPIC Prepayment Reviews	FFS
Other Actions	
Payment Suspensions	FFS
Medicare Part D Reconciliation Data Reviews	Part D

1 Systematic Edits

A systematic edit is a set of instructions coded into the claims processing system to identify and automatically deny or reject all or part of a claim exhibiting specific errors or inconsistency with Medicare policy, thus preventing improper payment without the need for manual intervention. CMS calculates savings from the following systematic edits on 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
- Zone Program Integrity Contractor (ZPIC)[91] 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 systematic 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

[91] For the purposes of this document, references to ZPICs include legacy Program Safeguard Contractors (PSCs). CMS has begun transitioning contracts to Unified Program Integrity Contractors (UPICs), which perform the functions of ZPICs/PSCs and Medicaid Integrity Contractors. The first UPICs became operational in FY 2017; thus, there were no administrative actions taken by UPICs in FY 2016.

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.[92] NCCI edits apply to services rendered by the same provider for the same beneficiary on the same date of service (DOS), hereafter referred to as the same patient encounter.

First implemented in 1996, NCCI PTP edits prevent inappropriate payment for services that should not be billed together at the same patient encounter. Each PTP edit 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 patient encounter, 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 the Multi-Carrier System (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 patient encounter. Thus, it is possible that an NCCI PTP edit will be triggered when a payable code is billed after a non-payable code pair already received payment. 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, providers may append clinically descriptive 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

[92] When billing Medicare, healthcare providers use HCPCS/CPT codes to define medical services performed on patients.

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 PTP edit denials/cutbacks, and 3) accounting for subsequent payment of previously denied/cutback services.[93]

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.

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 and patient encounter. CMS only counts savings from the earliest, or unique, PTP edit denial/cutback of claim lines that share the same HCPCS code, rendering provider, beneficiary, and DOS.

Pricing PTP Edit Denials and Cutbacks

In MCS, most denied/cutback claim lines receive 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 the average allowed payment amount per unit using claim lines paid in the same calendar year for the same HCPCS code and other matching factors, including the claims processing contractor, locality, and place of service.[94] 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. 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.

[93] In FY 2016, CMS updated the methodology for determining savings attributable to NCCI PTP edits in MCS claims. The FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs provides the FY 2016 savings as well as the FY 2014 and 2015 savings recalculated with this updated methodology.

[94] 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.

Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/cutback services. Specifically, where there are one or more 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 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 claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals.[95]

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, Fiscal Intermediary Standard (or Shared) System (FISS), and Viable Information Processing Systems (VIPS) Medicare System (VMS) claims data in the IDR

First implemented in 2007, NCCI MUEs prevent payment for the billing of an inappropriate quantity of the same service[96] for a single patient encounter. 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, i.e., the same patient encounter. 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

[95] A provider has up to one year to submit a claim and, thereafter, a specified time frame 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 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.

[96] For the purposes of this document, the term "service" generally refers to an item or service.

implemented in MCS, DMEPOS MUEs are implemented in the Viable Information Processing Systems (VIPS) Medicare System (VMS), and hospital outpatient service MUEs are implemented in the Fiscal Intermediary Standard (or Shared) System (FISS).

If a HCPCS/CPT code has an MUE adjudicated as a claim line edit, providers may use clinically descriptive 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. 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 MUE denials, and 3) accounting for subsequent payment of previously denied services.[97]

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 and patient encounter. CMS only counts savings from the earliest, or unique, MUE denial of claim lines that share the same 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 receive a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated

[97] In FY 2016, CMS extended the methodology to include savings from hospital outpatient service MUEs in FISS. CMS's methodology now quantifies the savings from all of the claims processing systems in which it implements NCCI MUEs. The FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs provides the FY 2016 NCCI MUE savings as well as the FY 2014 and 2015 savings recalculated with this extended methodology.

price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates the average allowed payment amount per unit using claim lines paid in the same calendar year for the same HCPCS code and other matching factors, including the claims processing contractor, locality, and place of service.[98] 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 receive 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 the average allowed payment amount per unit using paid claim lines for the same HCPCS code and other matching factors, including the competitive bid or fee schedule region, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[99] 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.[100] 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) the fee schedule. For a Hospital OPPS or reasonable cost claim line, CMS 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. For a fee schedule claim line, CMS calculates the average of Medicare's provider payment amount per unit of service using claim lines paid in the same calendar quarter or year for the same HCPCS code and other matching factors, including the claims processing contractor, facility state, and attending provider specialty. The provider payment amount represents Medicare's payment responsibility after the beneficiary deductible and coinsurance.

Accounting for Subsequent Payment

98 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.

99 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 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.

100 CMS uses the provider billed amount to estimate the price in the following situations: 1) when pricing indicators or matching factors are unavailable, 2) for claim lines priced under the fee schedule where the calculated amount using CMS's pricing methodology is greater than the billed amount, or 3) for claim lines priced under the reasonable cost methodology where the reimbursement rate is greater than 1.2.

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 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 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.

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.[101] O&R edits prevent inappropriate payment for items or services when the ordering/referring provider 1) does not have a current

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

Medicare enrollment record, valid opt-out affidavit, or valid National Provider Identifier (NPI) or 2) is not eligible to order or refer items or services for Medicare beneficiaries.[102]

If a claim line does not pass the ordering/referring provider requirements, the O&R edit logic automatically denies or rejects the claim line.[103] 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 non-physician practitioners who have current 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 non-physician practitioners 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.

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 O&R edit 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 and patient encounter. CMS only counts

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[102] 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.

[103] 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.

savings from the earliest, or unique, O&R denial or rejection of claim lines that share the same 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 receive 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 the average allowed payment amount per unit using claim lines paid in the same calendar year for the same HCPCS code and other matching factors, including the claims processing contractor, locality, and place of service.[104] 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 receive 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 the average allowed payment amount per unit using paid claim lines for the same HCPCS code and other matching factors, including the competitive bid or fee schedule region, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[105] 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 one or more 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 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

[104] 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.

[105] 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 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.

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

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 systematic edits and analytical models (see Appendix B-3) 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 a FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as a FPS model 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 Medicare Administrative Contractor (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 and patient encounter. 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 Zone Program Integrity Contractor Edits

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied by ZPIC-initiated systematic edits, adjusted for historical appeals experience.
Data Source:	1) CMS Analysis, Reporting, and Tracking (CMS ART) fields D5c and E3c, 2) Paid amount adjustment factor, and 3) Appeals adjustment factor

The primary goal of ZPICs 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 Trust Fund monies are not inappropriately paid. ZPICs 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 zones[106] to cover the nation, and each ZPIC operates in a specific zone. ZPICs receive leads about potential fraud from several sources, including complaints, MACs, FPS, CMS, and the Department of Health and Human Services (HHS) Office of the Inspector General (OIG). ZPICs also conduct their own proactive data analysis to look for aberrant billing patterns.

During investigations, ZPICs 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 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.[107]

Systematic edits are among the administrative actions a ZPIC may initiate. A ZPIC may request that the MAC within its jurisdiction implement systematic edits[108] to address program integrity issues and prevent the loss of future Medicare funds. Depending on the issue, these ZPIC-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

[106] In FY 2016, CMS had seven program integrity zones. The FY 2017 transition to UPICs will consolidate the ZPIC/PSC zones into five UPIC jurisdictions.

[107] The administrative actions that may result from ZPIC investigations include systematic edits, provider enrollment revocations and deactivations (Section 2), prepayment reviews (Section 3.3), payment suspensions (Section 4.1), post-payment reviews (Section 5.6), and referrals to law enforcement (Section 9.1).

[108] Depending on the jurisdiction, either the MAC or the ZPIC installs DME systematic edits in VMS, the system that processes DME claims.

of services for beneficiaries identified as part of a fraud scheme. In most cases, MACs must comply with ZPICs' requests to install systematic edits in the relevant local claims processing system. Providers have the right to appeal systematic edit denials through the Medicare FFS appeals process.

ZPICs report savings due to their systematic edits through the CMS Analysis, Reporting, and Tracking (CMS ART) portal, based on summaries of denied claim lines received from the MACs. Savings reflect claim lines denied during the fiscal year, regardless of when the MAC installed the edit. CMS compiles the savings reports from all jurisdictions and estimates actual savings using HHS-OIG-certified adjustment factors, described as follows:

1. *Paid amount adjustment factor:*[109] ZPIC savings reports indicate either the provider billed amount or the Medicare allowed amount (e.g., the sum of Medicare's maximum payment to the provider and the beneficiary's cost share for the service) for the denied claims, depending on the MAC providing the claim lines summary. When a savings report includes provider billed amounts, CMS multiplies the billed amount by a service-type-specific adjustment factor to estimate what Medicare would have paid. This paid amount adjustment factor is a historical average of the rendering-provider-level ratios of Medicare paid amounts to billed amounts for paid claims by service type. CMS then estimates Medicare's avoided costs by summing the already-reported Medicare allowed amounts and the adjusted billed amounts for the denied claims.

2. *Appeals adjustment factor:*[110] Because payment denials may be overturned on appeal, CMS multiplies the sum of costs avoided by the appeals adjustment factor to remove the expected portion for providers' successful appeals. This factor averages the historical percentage of change in error rate due to claim payment denials overturned on appeal. CMS reports the appeals-adjusted avoided costs as the estimate of Medicare's actual savings.

2 Provider Enrollment

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 CMS-855 enrollment application and 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 based on regulatory-defined reasons, if they are found to be non-compliant with the enrollment eligibility requirements.

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

[109] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 8, p. 24.

[110] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 9, pp. 24–25.

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 currently 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.

2.1 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.
Data Source:	1) Provider Enrollment Chain and Ownership System (PECOS) and 2) Previous 18 months of claims data in the IDR for each revoked provider

CMS has 14 authorities upon which to revoke, or terminate, 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 other revocation reasons, a provider may appeal a revocation determination by first 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, defined as having at least one revoked enrollment that became effective during the fiscal year, no other approved enrollments, and no active Provider Transaction Access Numbers (PTANs) or CMS Certification Numbers (CCNs) (i.e., no active billing privileges). CMS verifies fully revoked providers in the Provider Enrollment Chain and Ownership System (PECOS) using NPIs and Employee Identification Numbers (EINs). 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 claims data from the Integrated Data Repository (IDR) 90 days after the end of the fiscal year to allow time for claims adjudication and appeals.

CMS estimates the amount that Medicare did not pay a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider's revocation date.[111] 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 total costs avoided for the revoked provider during the length of its re-enrollment bar. CMS reports the total projected savings for a given revoked provider in the fiscal year the provider became fully revoked.

2.2 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 projected amounts from providers that may reactivate their enrollment within 12 months.
Data Source:	1) PECOS, 2) Previous 12 months of claims data in the IDR for each deactivated provider, and 3) Reactivation correction factor

CMS has multiple authorities upon which to deactivate, or stop, a provider's billing privileges. Examples include 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), failure to respond to a revalidation request, voluntary withdrawal, and death of a provider. Unlike revocations, deactivations have no re-enrollment bars or appeal rights. In most cases, a provider can reactivate its enrollment in Medicare at any time by submitting updated enrollment information or recertifying the information on file.

In determining savings, CMS excludes deactivation reasons that do not represent active intervention to promote program integrity, such as a provider's death or voluntary withdrawal from Medicare. CMS calculates costs avoided for fully deactivated providers, defined as having at least one deactivated enrollment that became effective during the fiscal year, no other approved or revoked enrollments, and no active PTANs or CCNs. CMS verifies fully deactivated providers in PECOS using NPIs and EINs. CMS captures claims data from the IDR 90 days after the end of the fiscal year to allow time for claims adjudication and appeals.

CMS estimates the amount that Medicare did not pay a fully deactivated provider based on the 12 months of claims history preceding the provider's 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.

[111] 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.

CMS reports the projected savings for a given deactivated provider in the fiscal year the provider became fully deactivated. The sum of the projected savings for all fully deactivated providers is multiplied by a correction factor, specifically the proportion of the previous year's total deactivation savings attributed to providers who remained deactivated for 12 months or more. Since deactivated providers can reactivate their enrollments at any time, this correction factor more conservatively estimates savings by removing the expected portion of the savings projection for providers that may reactivate their enrollment within 12 months.

3 Prepayment Edits and Reviews

Prepayment edits and reviews involve automated and manual examination of claims before they are paid to ensure that providers complied with Medicare policy. CMS calculates savings from the following prepayment edit and review activities for Medicare FFS claims:

- Medicare Secondary Payer (MSP) Operations
- MAC Medical Reviews
- ZPIC Prepayment Reviews

3.1 Medicare Secondary Payer Operations

Savings:	The amount Medicare FFS would have paid as the primary payer, subtracted by 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)[112]
- Liability insurance (including self-insurance)[113]
- No-fault insurance[114]
- Workers' compensation (WC)[115]

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

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[112] 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.

[113] 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.

[114] 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.

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

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. MACs then attribute costs avoided to the associated MSP records.[116]

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 are reported in the fiscal year during which the dates of service or dates of discharge for the applicable claims occurred.[117] For Workers' Compensation Medicare Set-Aside Agreements (WCMSAs),[118] 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.

[116] 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.

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

[118] 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.

3.2 Medicare Administrative Contractor Medical Reviews

Savings:	The estimated amount Medicare FFS did not pay for claim lines denied by MAC prepayment medical review (e.g., automated edits, complex review, etc.). The calculation varies across different MACs and subtracts out reversals.
Data Source:	MAC reports

MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. A MAC is a contractor that CMS has awarded a geographic jurisdiction to process and pay Medicare Part A and Part B medical claims[119] or DME claims. 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,[120] the Government Accountability Office (GAO), HHS-OIG, the Medicare FFS Recovery Audit Contractors (RACs), and other sources. MACs conduct targeted claim reviews where there is risk for improper payments in order to determine provider compliance with Medicare coverage, coding, and billing rules. When providers are found to be non-compliant, MACs take appropriate educational and/or corrective action. MACs' medical review efforts focus on reducing payment errors; thus MACs refer cases of potential fraud to ZPICs.

MACs conduct most of their reviews on a prepayment basis, using both automated and manual methods (see Section 5.3 for post-payment reviews). MACs develop and implement automated edits in their local claims processing systems to automatically deny payment for non-covered, incorrectly coded, or inappropriately billed services. MACs also use prepayment review edits to suspend claim lines with targeted criteria for manual review. When conducting manual claim reviews, MACs may request additional documentation from providers. Specific time frames apply to providers' submission of documentation and MACs' completion of reviews. Each

[119] CMS contracts with four of the A/B MACs to also process home health and hospice claims across the nation. The four home health and hospice claims processing areas do not coincide with the jurisdictional areas covered by these four A/B MACs.

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

MAC has a medical review staff of licensed health care professionals and coders, who examine medical records in order to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, up- or down-coded for adjusted payment. If a provider does not submit the requested documentation in a timely manner, the MAC denies the claims in question.

Providers have the right to use the Medicare FFS appeals process to appeal denials and adjustments resulting from MAC medical reviews.

The MACs currently use different methods for calculating savings from prepayment medical review.[121] Because a prepayment review denial occurs before claims processing assigns the Medicare allowed amount for that claim line, the MACs must determine what Medicare would have paid for that claim line. The MACs' differing methods include using the provider's billed amount, manually checking the Medicare fee schedule, and calculating an average paid amount based on previous claims. For all MACs, savings reflect claim lines denied during the fiscal year, regardless of when the triggering automated or prepayment review edit was implemented, less amounts from denial decisions that were reversed.

If a provider is simultaneously under prepayment review and payment suspension, the dollars for any claim lines approved for payment after prepayment review are held in escrow until the payment suspension is lifted. To ensure unique attribution of savings, the prepayment review metric excludes approved amounts held in escrow (see Section 4.1) but still includes any amounts that are denied during prepayment review.

[121] In Table 3: Medicare Savings of the FY 2013/2014 and the FY 2015 Annual Reports to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled "Medical Review" in the Prevention Savings section.

3.3 Zone Program Integrity Contractor Prepayment Reviews

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied after ZPIC-initiated prepayment review edits, adjusted for historical appeals experience.
Data Source:	1) CMS ART fields C1f1 and E2c, 2) Paid amount adjustment factor, and 3) Appeals adjustment factor

In addition to systematic edits (see Section 1.5), a ZPIC may request that the MAC in their jurisdiction implement prepayment review edits in the local claims processing system[122] to identify and suspend claims for medical review prior to payment.

During prepayment review, the MAC sends an additional documentation request (ADR) to the provider under review. In that notice, the provider is instructed to provide the necessary medical record documentation to the ZPIC for further review. In accordance with CMS guidance, the provider must submit the necessary documentation to the ZPIC within 45 calendar days or the claims are denied.[123] Once the documentation is received, the ZPIC 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 denies or adjusts payment for the claims.

Providers have the right to use the Medicare FFS appeals process to appeal denials and adjustments resulting from ZPIC prepayment reviews.

ZPICs report savings due to prepayment review through the CMS ART portal, based on summaries of denied claim lines received from the MACs. Savings reflect claim lines denied during the fiscal year, regardless of when the MAC installed the prepayment review edit. CMS compiles the savings reports from all jurisdictions and estimates actual savings using HHS-OIG-certified adjustment factors, described as follows:

[122] Depending on the jurisdiction, either the MAC or the ZPIC installs DME prepayment review edits in VMS, the system which processes DME claims.

[123] 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.

1. *Paid amount adjustment factor:*[124] ZPIC savings reports indicate either the provider billed amount or the Medicare allowed amount (e.g., the sum of Medicare's maximum payment to the provider and the beneficiary's cost share for the service) for the denied claims, depending on the MAC providing the claim lines summary. When a savings report includes provider billed amounts, CMS multiplies the billed amount by a service-type-specific adjustment factor to estimate what Medicare would have paid. This paid amount adjustment factor is a historical average of the rendering-provider-level ratios of Medicare paid amounts to billed amounts for paid claims by service type. CMS then estimates Medicare's avoided costs by summing the already-reported Medicare allowed amounts and the adjusted billed amounts for the denied claims.

2. *Appeals adjustment factor:*[125] Because payment denials may be overturned on appeal, CMS multiplies the sum of costs avoided by the appeals adjustment factor to remove the expected portion for providers' successful appeals. This factor averages the historical percentage of change in error rate due to claim payment denials overturned on appeal. CMS reports the appeals-adjusted avoided costs as the estimate of Medicare's actual savings.

If a provider is simultaneously under prepayment review and payment suspension, the dollars for any claim lines approved for payment after prepayment review are held in escrow until the payment suspension is lifted. To ensure unique attribution of savings, the prepayment review metric excludes approved amounts held in escrow (see Section 4.1) but still includes any amounts that are denied during prepayment review.

4 Other Actions

CMS calculates savings from the following other actions:

- Payment Suspensions
- Medicare Part D Reconciliation Data Reviews

4.1 Payment Suspensions

Savings:	The amount from active payment suspensions held in escrow on the last day of the fiscal year, multiplied by the historical proportion that Medicare FFS is expected to retain as offsets to overpayments.
Data Source:	1) Fraud Investigation Database (FID) and 2) Payment suspension adjustment factor

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

[124] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 8, p. 24.

[125] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 9, pp. 24–25.

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 until the case or investigation is resolved. When CMS terminates the payment suspension, the funds held in escrow are first applied to any overpayments owed by the provider, and any remaining amount is paid to the provider.

ZPICs and law enforcement agencies may request a suspension based upon reliable information that an overpayment exists or credible allegations of fraud. A payment suspension based upon reliable information that an overpayment exists occurs when payments to be made may be incorrect, or a provider fails to provide requested documentation. A fraud suspension occurs when there is a credible allegation of fraud against a provider. Once CMS approves a payment suspension, the ZPIC coordinates with the MAC to install the suspension edit in the appropriate systems. Payment suspensions for Part A and most Part B claims are implemented in the Healthcare Integrated General Ledger Accounting System (HIGLAS). Payment suspensions for DME claims, which are covered under Part B, are implemented in VMS. The ZPIC also enters the suspension information into the Fraud Investigation Database (FID) for tracking purposes.

CMS approves a suspension for an initial period of 180 days. Payment suspensions based upon reliable information of an overpayment are granted extensions only in rare circumstances and are generally not allowed to continue beyond 360 days. Payment suspensions based upon credible allegations of fraud may continue beyond 360 days with a written request from law enforcement. Providers have the opportunity to rebut a payment suspension.

Depending on the circumstances, CMS terminates a payment suspension when the ZPIC determines the overpayment amount and/or correct payments to be made, the provider submits the requested records, and/or the law enforcement case has been resolved. The MAC then uses the funds held in escrow to recoup Medicare overpayments and any other obligation the provider owes to CMS or HHS. The provider is paid any amount held in excess of what is owed. If the provider owes more money than what was withheld during the payment suspension, the MAC initiates further recovery action.

CMS reports savings from payment suspensions as the total amount suspended during the fiscal year and still held in escrow on the last day of the fiscal year. This amount is multiplied by a payment suspension adjustment factor, which is the historical proportion of amounts held in escrow subsequently used to offset overpayments referred to the MACs for recovery.[126] This metric only estimates what will be retained by Medicare and does not consider dollars that may be used to offset other federal debt.

To ensure unique attribution of savings,[127] the metric excludes amounts that had been held in escrow during the year, but where the payment suspension was terminated before the end of the reporting period. These dollars will have already been released to the provider or used to offset an overpayment referred to the MAC for recovery. If a provider is simultaneously under

[126] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 10, pp. 25–26.

[127] CMS does not currently have a way to attribute overpayment amounts offset through payment suspensions; thus, there may be overlap between the payment suspension savings reported in a given fiscal year and overpayment recoveries reported in subsequent fiscal years.

prepayment review and payment suspension, the payment suspension metric only includes amounts held in escrow for claims approved as payable.

4.2 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 cost data, submitted through prescription drug event (PDE) records[128] and direct and indirect remuneration (DIR)[129] 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 2016 Annual 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.[130]

[128] 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.

[129] 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.

[130] FY 2016 is the first year that CMS has 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.

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)[131] and analyzes PDE records for outliers or potential errors in the following categories:

- Total gross drug cost
- Per-unit drug price
- Quantity/daily dosage
- Duplicate PDEs[132]
- 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.[133] The Part D data analysis

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

[132] 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 systematic edits immediately upon submission.

[133] 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.

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.[134] The calculation of data quality review savings typically uses benefit-year data captured in September following the benefit year.[135] 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

Part D plan sponsors submit benefit-year DIR reports through CMS's Health Plan Management System (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.[136] 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

[134] 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.

[135] 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.

[136] 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.

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.[137] CMS calculates savings from DIR review as the sum of these reinsurance and risk corridor differences across all plans.[138] 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.

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. CMS describes recovery activities in five categories: overpayment recoveries, cost report payment accuracy, plan penalties, other actions, and law enforcement referrals. The following sections describe the methodologies used to determine the recovered savings in the FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings*.

Type of Medicare Savings	Medicare Program
Recovered Savings	
Overpayment Recoveries	
MSP Operations	FFS
MSP Commercial Repayment Center (CRC)	FFS
MAC Medical Reviews	FFS
Medicare FFS Recovery Audit Contractor (RAC) Reviews	FFS
Supplemental Medical Review Contractor (SMRC) Reviews	FFS
ZPIC Post-Payment Reviews	FFS
Retroactive Revocations	FFS
Overpayments Related to Risk Adjustment Data	Part C and Part D
National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) Part D Data Analysis Projects	Part D

[137] 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.

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

Type of Medicare Savings	Medicare Program
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 Initiative	FFS
Law Enforcement Referrals	
ZPIC 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 authority to recover these amounts. CMS reports savings from the following overpayment[139] recovery activities:

- *Medicare FFS*
  - MSP Operations
  - MSP Commercial Repayment Center (CRC)
  - MAC Medical Reviews
  - Medicare FFS Recovery Audit Contractor (RAC) Reviews
  - Supplemental Medical Review Contractor (SMRC) Reviews
  - ZPIC Post-Payment Reviews
  - Retroactive Revocations

- *Medicare Part C and Part D*
  - Overpayments Related to Risk Adjustment Data
  - National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) Part D Data Analysis Projects

[139] For the purposes 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. These metrics include MSP Operations and the MSP Commercial Repayment Center.

- 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 entities, 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 recovery of mistaken and conditional payments made by Medicare, when Medicare should not be the primary payer (see Section 3.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.[140] 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 decisions in disputed cases. Once information about primary coverage becomes available, either through new reporting or settlement of a case, CMS initiates recovery actions.

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 send CMS a check for the owed amount payable to Medicare. Outstanding debts are referred to the Department of the Treasury for further collection action.

MACs conduct MSP-related recovery from providers.[141] 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. MACs conduct post-payment adjustments for claims that another insurer/entity

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

[141] 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.

should have paid in part or full. In cases of duplicate primary payment by Medicare and another insurer/entity, 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 entity has ongoing responsibility for medicals (ORM).
Data Source:	CROWD system

The CRC is CMS's RAC responsible for MSP cases when an insurer is the identified debtor (see sections 3.1 and 5.1 for additional information about MSP operations). The CRC recovers Medicare's mistaken and conditional payments related to primary GHPs as well as liability, no-fault, and WC cases when the insurer/WC entity has accepted ongoing responsibility for medicals (ORM). In cases when a GHP should have been the primary payer, the CRC recovers Medicare's mistaken primary payments from the employer, other plan sponsor, insurer, or claims processing third-party administrator, as appropriate. CMS pays the CRC on a contingency fee basis, i.e., a percentage of the amount the identified debtor returned to Medicare. CMS reports recovered Medicare payments in the fiscal year during which they are collected.[142]

The CRC follows the same general recovery process for all types of insurers/entities. The CRC first issues the insurer/entity a notice of the claims conditionally or erroneously 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, and the insurer/entity must send CMS a check payable to Medicare. A liability insurer, no-fault insurer, or WC entity has the right to appeal all or a portion of the demand amount. GHPs do not have formal appeal rights but may submit a valid documented defense for any portion of the demand amount. Outstanding debts are referred to the Department of the Treasury for further collection action.

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

5.3 Medicare Administrative Contractor Medical Reviews

Savings:	The estimated amount of overpayments identified by MACs for recovery, subtracted by overpayments identified that have been reversed.
Data Source:	MAC reports

While MACs primarily focus on preventing improper payments (see Section 3.2), 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 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. The MAC may also recover overpayments from payment suspension escrow accounts. 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, subtracted by overpayment amounts reversed. CMS reports the total estimated savings from all MACs each fiscal year.[143]

[143] In Table 3: Medicare Savings of the FY 2013/2014 and the FY 2015 Annual Reports to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled “Medical Review” in the Post-Payment Recovery Savings section.

5.4 Medicare Fee-for-Service Recovery Audit Contractor Reviews

Savings:	The amount of Medicare FFS RAC-identified overpayments that Medicare recovered, subtracted by 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.[144] The Medicare FFS RACs' reviews focus on service-specific issues related to national Medicare policy. CMS approves all new topics for potential audits before the Medicare FFS RACs begin reviews. The Medicare FFS RACs may submit proposed review topics to CMS on a rolling basis. At times, CMS will also send the Medicare FFS RACs issues of potential improper payments identified by the MACs, ZPICs, or external entities (e.g., HHS-OIG and GAO). Each Medicare FFS RAC has the option to accept or decline these referred issues as topics for review.[145]

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 in a specified time frame. CMS also sets an initial limit on the number of reviews the Medicare FFS RACs may conduct under each approved topic. Once a Medicare FFS RAC has reached this limit, CMS reassesses the approved topic before allowing the Medicare FFS RAC to conduct additional reviews on the topic. Medicare FFS RACs are not allowed to identify improper payments more than three years after a claim was paid.

When a Medicare FFS RAC identifies an improper payment, it sends the provider a review results letter. The provider has a specified time frame to request a discussion with the Medicare FFS RAC regarding the review results. The discussion period offers the provider the opportunity

[144] In FY 2016, Medicare FFS RACs operated in four geographic regions. In FY 2017, CMS awarded new contracts for one Medicare FFS RAC to review national DME and home health/hospice claims and four Medicare FFS RACs to review other types of claims in four geographic regions.

[145] Under the new RAC contracts awarded in FY 2017, CMS can require the RACs to conduct specific reviews.

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.[146]

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 that a Medicare FFS RAC identified in a prior fiscal year for which collections occur in the current fiscal year. 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, subtracted by 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.[147]

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[146] 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.

[147] In Table 3: Medicare Savings of the FY 2013/2014 and the FY 2015 Annual Reports to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled "Part A/B RA" and "Part A/B RAC," respectively.

5.5 Supplemental Medical Review Contractor Reviews

Savings:	The amount of SMRC-identified overpayments that Medicare FFS collected.
Data Source:	MAC reports submitted to CMS

CMS contracts with the SMRC to perform nationwide medical reviews of post-payment Medicare FFS claims in order to identify improperly-paid claims. CMS issues the SMRC technical direction for each medical review project. 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
- CMS initiatives, such as the CERT program, First-Look Analysis Tool for Hospital Outlier Monitoring (FATHOM) reports,[148] and Program for Evaluating Payment Patterns Electronic Report (PEPPER)[149]
- Professional organizations

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. CMS assigns projects to the SMRC on an as-needed basis.

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 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 MACs provide CMS with quarterly data reports on the SMRC project-specific amounts of collected overpayments. The MACs' reports are based on data from HIGLAS, VMS, or their

[148] The FATHOM application generates hospital-specific Medicare claims data statistics, which identify areas with high payment errors.

[149] PEPPER is a comparative data report that provides hospital-specific Medicare data statistics for discharges vulnerable to improper payments.

own 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 Post-Payment Reviews

Savings:	The amount of ZPIC-identified overpayments that Medicare FFS recovered, subtracted by the amount that had been collected on ZPIC-identified overpayments overturned on appeal in the fiscal year.
Data Source:	1) HIGLAS and 2) VMS

During the course of an investigation, a ZPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a ZPIC requests additional documentation from a provider. The provider must submit documentation within a specified time frame, though a ZPIC has the discretion to grant extensions.[150] If a provider does not submit the requested documentation in a timely manner, the ZPIC denies the claims.

The ZPIC'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 calculates an overpayment in accordance with the Program Integrity Manual.

Once a post-payment review is complete, the ZPIC provides the results of the medical review to the provider[151] 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. 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.[152] Therefore,

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[150] 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.

[151] Depending on the status of investigations, ZPICs have discretion regarding whether to send a provider a review results letter.

[152] In FY 2016, CMS received direct access to overpayment transaction data from HIGLAS and VMS that allows for the tracking of collections on individual Part A, Part B, or DME accounts receivables. Starting with the FY 2016 values, the savings metric methodology has been updated from that used in prior fiscal years' calculations.

there may be overpayments identified by a ZPIC 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-identified overpayment. The receivable is closed in HIGLAS or VMS, and CMS does not include these amounts in the savings metric. To ensure unique attribution of savings, this metric also excludes ZPIC-identified overpayments that are not referred to the MAC for recovery, per the request of law enforcement (see Section 9.1).

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, or the revocation can be put into place retroactively. For example, if an investigator determines that a provider's license has already expired, CMS sets the effective date of that provider's revocation as the date the license expired. 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 2.1), 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,[153] 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.[154]

2. *Adjust for historical recovery experience*: To estimate actual recoveries, CMS multiplies the amount of identified overpayments by a proxy adjustment factor based on the MACs' historical recovery rate for ZPIC-identified overpayments. Specifically, this adjustment

[153] See Section 2.1 for the definition of a fully-revoked provider.

[154] This metric excludes retroactive revocations submitted by ZPICs to prevent possible overlap with the ZPIC post-payment reviews metric, which quantifies recoveries of ZPIC-identified overpayments.

factor is the historical ratio of the total amount of overpayments recovered by the MAC to the total amount of overpayments referred by the ZPICs.

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, 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 health status and demographics.

CMS's risk adjustment models[155] generate a risk score for a given beneficiary based on the beneficiary's 1) demographic characteristics for the current payment year[156] and 2) relevant diagnosis codes[157] from services provided in the previous payment year.[158] 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, CMS pays plan sponsors more for enrollees with higher projected medical costs and less for those with lower projected medical costs.

[155] CMS Hierarchical Condition Category (CMS-HCC) Models are used to risk adjust payments to MA organizations (Part C portion), section 1876 cost contract plans, and demonstration plans, as appropriate. Either the CMS-HCC or the CMS Frailty Adjustment Model 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.

[156] 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.

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

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

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, PACE organizations, and demonstration plans submit diagnosis codes 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.

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.[159]

Within a six-year look-back period, CMS re-calculates risk scores for prior payment years for the purpose of overpayment recovery. Each calendar year, CMS expects to announce one or more prior payment years subject to re-calculation and payment adjustment.[160] 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.[161]

5.9 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 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.

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

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

[161] FY 2016 is the first year that CMS has included savings from overpayments related to risk adjustment data in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs. The FY 2016 report provides the FY 2016 savings as well as the FY 2014 and 2015 savings calculated with this described methodology.

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.

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

The Medicare Part D RAC[162] reviewed post-reconciliation PDE records to identify improper payments made under the Medicare Part D benefit. 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 providers[163] or unauthorized prescribers[164] 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.

[162] The Medicare Part D RAC contract ended on 12/31/2015. However, an administrative and appeals option period was exercised 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. The administrative period ends on 12/31/2017.

[163] Excluded providers are not allowed to receive payment from Medicare or other federal health care programs. 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.

[164] 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.

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 is filed. CMS recouped overpayments through offsets to Medicare's monthly prospective payments to plan sponsors and reported these amounts as savings in the fiscal year during which the offsets occurred.

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 sum of the net settlement amounts, specifically the initially-filed amount subtracted by the final settled amount, for each cost item submitted in Medicare FFS provider cost reports.
Data Source:	System for Tracking for Audit and Reimbursement Reports 104 and 105, 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)[165]
- 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 debts[166] 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 Reimbursement (PS&R)[167] reports are available, whichever date is later.[168] 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

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[165] 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, end stage renal disease, and organ acquisition.

[166] 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.

[167] 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 MACs during the audit and settlement process.

[168] 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.

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 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.[169]

CMS determines savings from the settlement of Medicare costs by summing the relevant net settlement amounts from Medicare FFS provider cost reports. For each Medicare cost item, the net settlement amount is the initially-filed amount subtracted by the final settled amount. CMS reports savings in the fiscal year during which an NPR is issued. If a successful appeal or other re-opening results in a revised NPR, CMS reports adjustments to savings in the fiscal year the revised NPR is issued. The adjustment amount is determined by subtracting the final reopened amount from the preceding settled amount.

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.[170] 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

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

[170] 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.

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 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.[171] 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 and Part D plan sponsors, 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 program audit covers all of a plan sponsor's MA, MA-Prescription Drug (MA-PD), and PDP contracts with CMS. CMS annually determines the plan

[171] 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.

sponsors to be audited. Selection of plan sponsors for audit is primarily 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 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

If audits or other monitoring activities determine compliance violations that adversely affected enrollees,[172] CMS has the authority to impose civil money penalties (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.

Since 2014, CMS has used a pilot methodology to calculate CMPs using standard penalty amounts multiplied either by the number of affected enrollees (per-enrollee basis) or the number of affected contracts (per-determination basis). A CMP could also be increased or decreased due to aggravating or mitigating factors.[173] CMPs are limited to maximum amounts per violation. On December 15, 2016, CMS published a final methodology for calculating CMPs beginning in contract year 2017.

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[172] 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.

[173] A history of prior offense is an example of an aggravating factor. A same-day correction of a violation is an example of a mitigating factor. In the final methodology effective in contract year 2017, CMS will consider mitigating factors to determine if a CMP should be imposed, rather than as factors to reduce a penalty amount. Aggravating factors will continue to be used in the CMP calculation.

Plan sponsors have the option to pay CMPs by sending CMS a check payable to Medicare, wiring funds for Medicare 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.[174] Thus, there may be CMPs issued in a previous fiscal year for which collections occur in the current fiscal year.

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 is 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.[175] 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*

[174] In FY 2016, CMS updated the methodology for determining savings attributable to Medicare Part C and Part D program audits. In the FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, CMS provides the FY 2016 program audits savings calculated with the updated methodology as well as the FY 2014 and 2015 savings calculated according to the previous methodology. The previous methodology involved reporting savings in the fiscal year during which CMPs were issued, rather than the fiscal year in which they were collected. In Table 3: Medicare Savings of the FY 2013/2014 and the FY 2015 Annual Reports to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled "Compliance Audits."

[175] 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.

**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.

If an 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.[176]

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 enrollments below a specified level, MLR sanctions would not apply.

[176] MLR remittances are transferred to the General Fund of the Treasury.

8 Other Actions

8.1 Party Status Appeals Initiative

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

A provider, supplier, beneficiary, or state Medicaid agency dissatisfied with an initial determination may request an appeal. The Medicare FFS appeals process includes five levels:[177]

- 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 Qualified Independent Contractor (QIC)[178] 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).[179] The amount remaining in controversy must meet the threshold requirement.
- Level 4: Review by the Medicare Appeals Council within the HHS DAB.[180] 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.

[177] 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.

[178] CMS currently contracts with two Part A QICs, two Part B QICs, and one DME QIC.

[179] OMHA is independent of CMS.

[180] The Medicare Appeals Council within the DAB is independent of CMS.

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.

CMS's party status appeals activities support Medicare program integrity initiatives. In addition to QICs' performance of Level 2 appeals, CMS funds QICs' participation as a party in ALJ hearings in accordance with 42 CFR § 405.1012.[181] The QIC can participate in an ALJ hearing as a participant or as a party. As a participant, the QIC may file position papers and/or provide testimony to clarify factual or policy issues in a case.[182] By invoking party status in 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 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 will participate as a party. Within ten days of receiving a hearing notice, a QIC must notify the ALJ, the appellant, and all other parties that it intends to participate as a party. Generally, the QICs invoke party status when there are significant amounts in controversy, national policy implications, or 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,[183] CMS considers the estimated amount in controversy as savings.[184] Savings are based on the "item original amount" field from the Medicare Appeals System (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.[185] 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 (see sections 1.5, 3.3, 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,

[181] CMS or its contractor may choose to participate as a party in ALJ appeals, except when an unrepresented beneficiary files the hearing request.

[182] The QICs may join ALJ hearings as non-party participants 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.

[183] 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.

[184] 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.

[185] In Table 3: Medicare Savings of the FY 2013/2014 and the FY 2015 Annual Reports to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled "Appeals Initiatives."

respectively. ZPICs' and the NBI MEDIC's investigations may involve providers, beneficiaries, and/or other entities. Once a ZPIC 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 and the NBI MEDIC must make an immediate referral to HHS-OIG without first conducting an investigation. For example, a ZPIC 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-OIG of fraud allegations made by current or former employees of provider organizations, MA organizations, or Part D plan sponsors.

If HHS-OIG does not accept the case, the ZPIC or the NBI MEDIC has the option to refer the case to other law enforcement agencies, such as the Federal Bureau of Investigation (FBI) or state and local law enforcement.

When a ZPIC 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 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' and the NBI MEDIC's law enforcement referrals.

9.1 Zone Program Integrity Contractor Law Enforcement Referrals

Savings:	The estimated amount Medicare expects to recover from cases referred to law enforcement by the ZPICs, adjusted for historical recovery experience.
Data Source:	1) CMS ART fields B6 and B2b and 2) Law enforcement adjustment factor

CMS reports the value of ZPICs' law enforcement referrals made 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.[186] This factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to the original amount referred by ZPICs.

[186] CMS. Report to Congress Fraud Prevention System Second Implementation Year, June 2014. Table 12, pp. 27–28.

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.[187] CMS reports 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.[188] CMS reports these amounts in the fiscal year during which a court issues a final judgment or commitment order.

[187] The court may order funds be returned to Medicare and/or plan sponsor(s).

[188] The court may order funds be returned to Medicare and/or plan sponsor(s).

Appendix B-2 – Medicaid Savings

Introduction

State Medicaid programs and CMS share accountability for Medicaid program integrity and ensuring proper use of both federal and state dollars. CMS and the states collaborate to combat improper payments through prevention and post-payment recovery strategies. In the Annual Report to Congress on the Medicare and Medicaid Integrity Programs, CMS currently quantifies Medicaid program integrity savings related to overpayment recoveries made through collaborative federal-state programs as well as state-level initiatives. States report recoveries in three categories: 1) general fraud, waste, and abuse; 2) false claims; and 3) state Medicaid RACs. CMS sums the amounts from these categories to report total Medicaid program integrity recoveries.

The federal share of a Medicaid overpayment is determined by the federal medical assistance percentage (FMAP). States generally have one year from the date of identification to return the full federal share of an identified overpayment, regardless of the amount the state succeeds in collecting from the associated provider(s).[189] 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.[190] Given that states generally have one year to return the federal share, some of the recovered amounts reported in the current fiscal year may be related to amounts identified in the previous fiscal year.

The following sections describe the three categories of Medicaid program integrity recoveries currently quantified in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

1 General Fraud, Waste, and Abuse Recoveries

Savings:	The total recovered amount, including federal and state shares, of Medicaid overpayments identified by Audit Medicaid Integrity Contractors (MICs) or through state-level program integrity activities.
Data Source:	State Medicaid program integrity quarterly reports (Form CMS-64 Summary, Item 9C1)

The Deficit Reduction Act of 2005 established the Medicaid Integrity Program to provide federal support in addressing improper payments in Medicaid. CMS's operations include the use of Audit Medicaid Integrity Contractors (MICs) as part of the National Medicaid Audit Program and providing states with technical assistance and training to build their internal capacity to conduct Medicaid program integrity activities. CMS's guidance and

[189] 42 CFR § 433.300-316

[190] 42 CFR § 433.318

support, such as educational toolkits and the CMS-DOJ Medicaid Integrity Institute, are intended to have positive downstream effects on state's program integrity efforts.

1.1 Audit Medicaid Integrity Contractors

In collaboration with states, CMS's Audit MICs conduct post-payment 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 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.

The category of general fraud, waste, and abuse recoveries includes the recovered amount (federal and state shares) of Medicaid overpayments identified by Audit MICs. The recovered federal share includes amounts collected from providers as well as amounts refunded by the state, if a state is not able to collect the full amount of an identified overpayment after one year.

As a separate metric related to Audit MICs, the Annual Report to Congress on the Medicare and Medicaid Integrity Programs also describes the amount, including federal and state shares, of overpayments newly identified during the reporting year by Audit MICs and sent to the states for collection.

1.2 Other State Program Integrity Activities

The states undertake a variety of program integrity activities, and specific efforts depend on each state's care delivery systems and areas at high risk for improper payments. The category of general fraud, waste, and abuse includes collections from state-level efforts, such as the following:

- Provider audits
- Medicaid Fraud Control Unit (MFCU) investigations[191]
- Data mining activities[192] conducted by state Medicaid agencies as well as MFCUs
- Settlements

[191] MFCUs investigate and prosecute Medicaid provider fraud and patient abuse or neglect under state law. The Social Security Act requires each state to operate a MFCU, unless HHS grants an exception. A state's MFCU must be separate and distinct from the state Medicaid agency and is usually part of the state Attorney General's office. MFCUs pursue criminal convictions, civil settlements, and both criminal and civil recoveries of funds. The HHS-OIG, in exercising oversight for the MFCUs, annually recertifies each MFCU, assesses each MFCU's performance and compliance with federal requirements, and administers a federal grant award to fund a portion of each MFCU's operational costs.

[192] Data mining is the process of identifying fraud through the screening and analysis of data.

- Civil monetary penalties

2 Office of Inspector General-Compliant False Claims Act Recoveries

Savings:	The total recovered amount, including federal and state shares, of Medicaid false or fraudulent payments in states with HHS-OIG-compliant false claims acts.
Data Source:	State Medicaid program integrity quarterly reports (Form CMS-64 Summary, Item 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 requirements. The 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.

In order to qualify for the financial incentive, a state's false claims act must meet the following requirements:

- Establish liability to the state for false or fraudulent Medicaid claims, as described in the Federal False Claims Act (FCA)[193]
- Qui tam provisions that are at least as effective as those described in the FCA[194]
- Filing under seal for 60 days with review by the state's attorney general
- Civil penalty at least equal to the amount authorized under the FCA

[193] Under the FCA, individuals or entities that knowingly submit false or fraudulent claims under state Medicaid programs are liable to the federal government for three times the amount of damages plus civil penalties for each claim.

[194] Under the qui tam provisions of the FCA, whistleblowers may file lawsuits in federal court against individuals and entities submitting false or fraudulent Medicaid claims. A whistleblower receives a share of any recovered amounts.

3 State Medicaid Recovery Audit Contractors

Savings:	The total amount, including federal and state shares, of Medicaid overpayments collected by states in coordination with their Medicaid RACs, after subtracting contingency fees.
Data Source:	State Medicaid program integrity quarterly reports (Form CMS-64 Summary, Items 9E and 10E)

Under Section 1902 of the Social Security Act, states must contract with one or more Medicaid RACs to identify and recover overpayments as well as identify underpayments made to Medicaid providers. Within CMS's general guidelines, states have flexibility regarding the design and operation their Medicaid RAC program. While CMS requires state Medicaid RAC programs to review FFS claims, states may decide whether managed care claims are subject to Medicaid RAC review. States determine the focus areas for Medicaid RAC audits as well as the limits on the number and frequency of medical records subject to Medicaid RAC review. States must also coordinate Medicaid RAC efforts with other Medicaid auditing entities, including state and federal law enforcement. CMS requires states to have an appeals process for providers seeking review of Medicaid RAC findings.

States establish the compensation structure for their Medicaid RAC programs, including the fee paid for identifying underpayments and the contingency fee rate based on overpayments recovered. If an overpayment determination is reversed due to an appeal, the Medicaid RAC must return the contingency fees associated with that payment within a reasonable time frame. CMS reimburses states 50 percent of Medicaid RAC program administrative costs and shares in Medicaid RAC fees in the same proportion as the FMAP, up to the highest contingency fee rate of Medicare RACs (unless the state has been granted a waiver).

The total Medicaid program integrity recoveries includes the amount of Medicaid RAC-related collections from providers or other entities. As a separate metric related to Medicaid RACs, the Annual Report to Congress on the Medicare and Medicaid Integrity Programs also describes the total recoveries of Medicaid RAC-identified overpayments, which combines collections and state refunds of uncollected federal shares after any adjustments to the overpayment amounts. Thus, from this amount, the reported federal share returned to the Treasury includes both collections and refunds after adjustments.

Appendix B-3 – Fraud Prevention System Methodology

Introduction

The FPS examines Medicare FFS claims nationwide by applying predictive modeling and other sophisticated analytics technology to identify and prevent improper payments. FPS is fully integrated with the Medicare FFS claims processing system and also uses other data sources, including compromised Medicare beneficiary identification numbers, PECOS, the FID,[195] and complaints received by Medicare's call center. This integration allows the FPS to analyze provider networks, billing patterns, and beneficiary utilization patterns in order to detect potential fraud, waste, and abuse. CMS implements both analytical models and systematic edits in the FPS to address specific vulnerabilities.

FPS models look for aberrant billing patterns in post-payment claims data. Models use four types of detection logic: filtering fraudulent claims based on specific rules or criteria, identifying individual and aggregate anomalies, predicting fraud based on known characteristics, and discovering fraud networks through associative analysis. Alerts, or leads, are created as each model identifies claims and other data that suggest aberrant billing.

FPS edits screen claims prior to payment and automatically deny or reject claims exhibiting noncompliance with Medicare coverage criteria or other improper billing characteristics (see Appendix B-1, Section 1.4 for additional background information).

In the Annual Report to Congress on the Medicare and Medicaid Integrity Programs, CMS quantifies the total amount, both costs avoided and amounts for recovery, identified through FPS leads and edits.

1 Leads for Zone Program Integrity Contractors

CMS uses the FPS to focus investigative resources on suspect claims and providers and swiftly impose administrative action when warranted. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation by ZPICs. The ZPICs investigate leads through boots-on-the-ground activities, such as site visits to the provider, interviews with beneficiaries, and review of medical documentation. Based on the results of all information collected, the ZPICs coordinate with CMS and the MACs in taking appropriate administrative action to recover improper payments and prevent future loss of funds. ZPICs also refer some cases to law enforcement. ZPICs track FPS attribution by each type of ensuing preventive or recovery administrative action, including the following:

- ZPIC-Initiated Prevention Actions

[195] In FY 2017, CMS launched the Unified Case Management system for use by the UPICs. The FID will be retired once all of the UPICs are operational.

    - Systematic Edits*
    - Prepayment Review Edits*
    - Payment Suspensions
    - Provider Revocations
    - Provider Deactivations

**Implemented in the claims processing systems*

- ZPIC-Identified Recovery Actions
    - Overpayments
    - Law Enforcement Referrals

A FPS lead may initiate an investigation or contribute to an ongoing investigation. ZPICs use three CMS-defined attribution categories to document the manner in which information from the FPS impacted an investigation or case:[196]

- *Initiated:* The FPS played a role in opening or reopening the investigation/case.
- *Augmented/Expedited:* The FPS made a meaningful contribution by either augmenting or increasing the priority of an ongoing investigation.
- *Corroborated:* The FPS provided information that confirmed or validated information already collected during the course of an investigation.

ZPICs provide CMS with annual reports categorized by administrative action and FPS attribution category. CMS validates the data by checking it against PECOS, the FPS, and the FID, and asks the ZPICs to verify discrepancies. CMS makes the final decision of excluding any ZPIC-reported data found to be inconsistent across data systems.

The total FPS identified amount includes improper payments stopped, prevented, or referred for recovery through ZPICs' administrative actions across FPS attribution categories. Identified amounts quantify the success of the FPS in helping ZPICs detect fraudulent and other improper claims. The following sections describe the amounts identified by each type of ZPIC administrative action impacted by a FPS lead.

[196] ZPICs were required to report by FPS attribution category for administrative actions that occurred after April 14, 2016.

1.1 Zone Program Integrity Contractor-Initiated Systematic Edits

Identified Amount:	The estimated value of all claim lines denied by the systematic edits that ZPICs initiated after receiving leads or information from the FPS.
Data Source:	ZPICs' annual reports submitted to CMS

A FPS lead may contribute to a ZPIC initiating systematic edits in the affected claims processing systems to prevent the loss of future funds. CMS reports the identified amount as the estimated value of all claim lines denied by FPS-attributed systematic edits during the fiscal year.[197] Appendix B-1, Section 1.5 provides further information about ZPICs' FPS-attributed and other systematic edits.

1.2 Zone Program Integrity Contractor-Initiated Prepayment Review Edits

Identified Amount:	The estimated value of all claim lines denied due to prepayment review edits that ZPICs initiated after receiving leads or information from the FPS.
Data Source:	ZPICs' annual reports submitted to CMS

A FPS lead may contribute to a ZPIC initiating prepayment review edits in the affected claims processing systems to identify and suspend claims for medical review prior to payment. CMS reports the identified amount as the estimated value of all claim lines denied during the fiscal year due to ZPICs' FPS-attributed prepayment review edits.[198] Appendix B-1, Section 3.3 provides further information about ZPICs' FPS-attributed and other prepayment review edits.

1.3 Zone Program Integrity Contractor-Initiated Payment Suspensions

Identified Amount:	The amount from active payment suspensions held in escrow on the last day of the fiscal year, due to payment suspensions requested by ZPICs after receiving leads or information from the FPS.
Data Source:	1) ZPICs' annual reports submitted to CMS and 2) FID

A FPS lead may contribute to a ZPIC requesting a payment suspension to hold all or a portion of payments to a provider. CMS reports the identified amount as the amount held in escrow on the last day of the fiscal year, due to FPS-attributed payment suspensions.

[197] Depending on the ZPIC, the provider's billed amount or Medicare's allowed provider payment amount may be used to determine the value of a denied claim line in the identified amount.

[198] Depending on the ZPIC, the provider's billed amount or Medicare's allowed provider payment amount may be used to determine the value of a denied claim line in the identified amount.

Appendix B-1, Section 4.1 provides further information about FPS-attributed and other payment suspensions.

1.4 Zone Program Integrity Contractor-Initiated Provider Revocations

Identified Amount:	The projected costs avoided due to fully revoked providers that ZPICs identified for revocation after receiving leads or information from the FPS.
Data Source:	1) ZPICs' annual reports submitted to CMS, 2) PECOS, and 3) Claims data in the IDR for each revoked provider

A FPS lead may contribute to a ZPIC requesting revocation of a provider. For a given FPS-attributed revocation, CMS reports the identified amount in the fiscal year during which the provider's full revocation becomes effective. Appendix B-1, Section 2.1 provides further information about FPS-attributed and other revocations, including the methodology used to project costs avoided.

1.5 Zone Program Integrity Contractor-Initiated Provider Deactivations

Identified Amount:	The projected costs avoided due to fully deactivated providers that ZPICs identified for deactivation after receiving leads or information from the FPS.
Data Source:	1) ZPICs' annual reports submitted to CMS, 2) PECOS, and 3) Claims data in the IDR for each deactivated provider

A FPS lead may contribute to a ZPIC requesting deactivation of a provider. For a given FPS-attributed deactivation, CMS reports the identified amount in the fiscal year during which the provider's full deactivation becomes effective. Appendix B-1, Section 2.2 provides further information about FPS-attributed and other deactivations, including the methodology used to project costs avoided.

1.6 Zone Program Integrity Contractor-Identified Overpayments

Identified Amount:	The amount of overpayments identified by ZPICs during post-payment reviews conducted after receiving leads or information from the FPS.
Data Source:	ZPICs' annual reports submitted to CMS

A FPS lead may contribute to a ZPIC conducting a post-payment review of questionable claims and identifying an overpayment. The ZPIC then refers the overpayment to the MAC in its jurisdiction for recovery. CMS reports a given FPS-attributed overpayment amount as an identified amount in the fiscal year during which the ZPIC refers the amount to the MAC. As the post-payment review and recovery process is the same for

ZPIC-identified overpayments from both FPS-attributable and other investigations, see Appendix B-1, Section 5.6 for more details.

1.7 Zone Program Integrity Contractor Law Enforcement Referrals

Identified Amount:	The value of FPS-attributed cases referred to law enforcement by ZPICs after receiving leads or information from the FPS.
Data Source:	ZPICs' annual reports submitted to CMS

ZPICs may refer FPS-attributed cases to law enforcement for potential prosecution. CMS reports the value of a given referral as an identified amount in the fiscal year during which the ZPIC refers the case to law enforcement. As the law enforcement referral process is the same for both FPS-attributable and other investigations, see Appendix B-1, Section 9.1 for more details.

2 Fraud Prevention System Edits

Identified Amount:	The estimated value of all unique claim lines denied or rejected due to FPS edits.
Data Source:	1) FPS and 2) CWF claims data

FPS edits automatically reject or deny claim lines for non-covered, incorrectly-coded, or inappropriately-billed services not payable under Medicare policy. CMS estimates the identified amount as the value of all unique claim lines denied or rejected by FPS edits. For a given denied or rejected claim line, CMS reports an identified amount in the fiscal year during which the claim line was processed. Appendix B-1, Section 1.4 provides further information about FPS edits.

Report	Issued
CMS Financial Report for Fiscal Year 2016	November 2016
Medicare Fee-for-Service 2016 Improper Payments Report	FY 2016
Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2014-2018	2014
Comprehensive State Program Integrity Review Reports	FY 2016
FY 2016 CMS Budget Justification	FY 2016
FY 2016 HHS Agency Financial Report	November 2016
Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2016	February 2016
Medicaid and CHIP 2015 Improper Payments Report	FY 2015
Medicare FFS Recovery Audit Program	FY 2015
Program Year 2015 Open Payments	April 2017

Acronym	Description
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADR	Additional Documentation Request
ALJ	Administrative Law Judge
ANOC	Annual Notice of Change
APS	Advanced Provider Screening
BCRC	Benefits Coordination & Recovery Center
CAP	Corrective Action Plan
CCN	CMS Certification Number
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
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
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
DDPS	Drug Data Processing System
D/E	Discussion/Education
DEA	Drug Enforcement Administration
DIR	Direct and Indirect Remuneration
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOJ	Department of Justice

Acronym	Description
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 Standard (or Shared) System
FMAP	Federal Medical Assistance Percentage
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
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
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

Acronym	Description
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
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
MA-PD	Medicare Advantage Prescription Drug
MCS	Multi-Carrier System
MEDIC	Medicare Drug Integrity Contractor
Medi-Medi	Medicare-Medicaid Data Match Program
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MII	Medicaid Integrity Institute
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
MSIS	Medicaid Statistical Information System
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NAMPI	National Association for Medicaid Program Integrity
NBI	National Benefit Integrity
NCCI	National Correct Coding Initiative
NPI	National Provider Identifier
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

Acronym	Description
OMIG	Arkansas Office of Medicaid Inspector General
One PI	One Program Integrity
OPPS	Outpatient Prospective Payment System
O&R	Ordering and Referring [Edit]
PACE	Program of All-Inclusive Care for the Elderly
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	Program Integrity
PI Board	Program Integrity Board
PPS	Prospective Payment System
PS&R	Provider Statistical and Reimbursement [System or Report]
PSC	Program Safeguard Contractor
PTAN	Provider Transaction Access Number
PTP	Procedure-to-Procedure [Edit]
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
SMRC	Supplemental Medical Review Contractor
SPA	State Plan Amendment
SPRY	[Medicaid] State Plan Rate Year
SSN	Social Security Number
TDD	Telecommunication Device for the Deaf
T-MSIS	Transformed-Medicaid Statistical Information System
TTY	Text Telephone

Acronym	Description
UOS	Unit of Service
UPIC	Unified Program Integrity Contractor
UPL	Upper Payment Limit
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement
ZPIC	Zone Program Integrity Contractor

Public Law	Title	Short Title
74-271	The Social Security Act	SSA, 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	Affordable Care Act
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
112-248	Improper Payments Elimination and Recovery Improvement Act of 2012	IPERIA
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA