Medicare and
Medicaid Integrity
Programs

FY 2017 ANNUAL REPORT

Oct. 1, 2016 – Sept. 30, 2017

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

English

The Fiscal Year 2017 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, 2016 to September 30, 2017. 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 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) in your request.

Arabic العربية

التقرير السنوي للسنة المالية 2017 إلى الكونغرس حول برامج نزاهة برنامجيّ الرعاية الصحية Medicare و Medicaid هو ملخص لأنشطة منع أعمال الاحتيال والهدر وإساءة الاستخدام وكشفها، والتي تم تنفيذها من قِبل مراكز خدمات برنامجيّ Medicare و Medicaid خلال الفترة من 1 أكتوبر 2016 إلى 30 سبتمبر 2017. ويتم تقديم هذا التقرير باللغة الإنجليزية. فإذا لم تكن لغتك الأساسية هي اللغة الإنجليزية، يمكنك طلب نسخة مترجمة إلى اللغة التي تفضلها من هذا التقرير. يُرجى توجيه طلبك إلى:

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يُرجى التأكد من ذكر عنوان هذا الخطاب (التقرير السنوي للسنة المالية 2017 إلى الكونغرس حول برامج نزاهة برنامجيّ الرعاية الصحية Medicare و Medicaid) في طلبك.

Chinese 形容词

《提交給國會的 2017 財年醫療保險和醫療輔助誠信計畫年度報告》概述了聯邦醫療保險和聯邦醫療輔助服務中心於 2016 年 10 月 1 日至 2017 年 9 月 30 日期間針對欺詐、浪費和濫用行為採取的預防和檢測措施。此報告內容以英文撰寫。若您的第一語言為非英語，您可請求獲取您所需語言的此報告譯本。請將您的請求發送至：

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
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Attn: CMS Alternate Format Team

請務必在您的請求中說明此報告的名稱（《提交給國會的 2017 財年醫療保險和醫療輔助誠信計畫年度報告》）。

French Français

Le rapport annuel de l'année financière de 2017 présenté au congrès pour les programmes Medicair et Medicaid reflète les activités frauduleuses, le gaspillage, et la prévention et la détection d'abus entrepris par les Centres pour Services Medicare & Medicaid pour la période allant du 1er octobre 2016 au 30 septembre 2017. Le rapport est présenté en anglais. Si vous ne maîtrisez pas l'anglais, vous pouvez demander un exemplaire de la traduction de ce rapport dans votre langue de prédilection. Veuillez faire parvenir votre demande à:

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Veuillez prendre soin d'indiquer le titre de ce rapport (Rapport annuel de l'année financière de 2017 présenté au congrès pour les programmes Medicair et Medicaid) dans votre demande.

French Creole franse kreyòl

Rapò Anyèl pou Ane Fiskal 2017 la yo soumèt Kongrè a sou Pwogram Entegrite Medicare ak Medicaid yo se yon rezime sou aktivite prevansyon ak deteksyon fwòd,

gaspiyaj ak abi ke Sant pou Sèvis Medicare & Medicaid (Centers for Medicare & Medicaid Services) mennen pandan peryòd apati 1ye oktòb 2016 jouk rive 30 septanm 2017. Rapò a fèt nan lang Angle. Si lang matènèl ou se pa lang Angle, ou ka mande yon kopi rapò sa a tradwi nan lang ou pi pito a. Tanpri voye demann ou an nan:

Centers for Medicare & Medicaid Services
Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
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Silvouplè asire w ke nan demann ou fè a, ou make tit rapò sa a kòm referans (Rapò Anyèl pou Ane Fiskal 2017 la yo soumèt bay Kongrè a sou Pwogram Entegrite Medicare ak Medicaid [The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs].

German Deutsche

Der Jahresbericht an den Kongress zu den Integritätsprogrammen von Medicare und Medicaid (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) für das Geschäftsjahr 2017 ist eine Zusammenfassung der Aktivitäten zur Verhinderung und Erkennung von Betrug, Verschwendung und Missbrauch, die von den Zentren für Medicare & Medicaid-Dienstleistungen (Centers for Medicare & Medicaid Services) im Zeitraum vom 1. Oktober 2016 bis zum 30. September 2017 unternommen wurden. Dieser Bericht ist auf Englisch verfasst. Falls Ihre Erstsprache nicht Englisch ist, können Sie eine Kopie dieses Berichts übersetzt in die Sprache anfordern, die Sie bevorzugen. Bitte richten Sie diese Anforderung an:

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

Bitten stellen Sie sicher, dass der Titel dieses Berichts (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) referenziert wird.

Italian Italiano

Il Rapporto al Congresso sui Programmi Integrità Medicare & Medicaid per l'anno fiscale 2017 (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) è un sommario delle attività di rilevazione e prevenzione di frode, sprechi e abusi intraprese dai Centers for Medicare & Medicaid Services nel periodo compreso fra il primo ottobre 2016 e il 30 settembre 2017. Questo rapporto è in inglese. È possibile richiedere una copia di questo rapporto tradotta in un'altra lingua. Rivolgere la richiesta 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

Fare riferimento al titolo di questo rapporto (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) nella richiesta.

Japanese 日本語

」（メディケア・メディケイド・インテグリティ・プログラムに関する２０１７年度年次報告書）は、2016 年10 月1 日から2017 年9 月30 日までの間、Centers for Medicare & Medicaid Services によって行われた防止検出活動（詐欺、浪費、虐待）の概要です。報告書は英語で発表されています。貴殿の主要言語が英語でない場合は、お望みの言語に翻訳されたかかるレポートのコピーを要求することができます。以下の宛先までご応募ください。

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

ご要望において、この報告書（The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs）の件名を必ず含めてください。

Korean 한국인

메디케어 및 메디케이드 무결성 프로그램(Medicare and Medicaid Integrity Programs)에 대한 2017 회계연도 대 의회 보고서는 2016년 10월 1일부터 2017년 9월 30일까지의 기간 동안 메디케어 및 메디케이드 서비스 (Medicare & Medicaid Services) 센터들이 수행한 사기, 낭비, 남용 예방 및 탐지 활동을 요약한 것입니다 . 이 보고서는 영어로 작성되어 있습니다. 귀하의 주언어가 영어가 아닐 경우, 귀하가 원하는 언어로 번역된 판본을 요청하실 수 있습니다. 아래의 주소지로 요청하십시오.

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

요청 시에 이 보고서의 제목 (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs)을 반드시 인용하십시오.

Persian (Farsi) فارسی

گزارش سالانه سال مالی 2017 در مورد برنامه‌های یکپارچه بیمه‌های درمانی Medicare و Medicaid برای کنگره، خلاصه‌ای از اقدامات کشف و پیشگیری از کلاهبرداری، اسراف و سوء استفاده است که توسط مراکز خدماتی Medicare و Medicaid از تاریخ 1 اکتبر 2016 تا تاریخ 30 سپتامبر 2017 انجام شده است. این گزارش به زبان انگلیسی ارائه می‌شود. اگر زبان مادری شما انگلیسی نیست، می‌توانید نسخه ترجمه شده این گزارش به زبان مورد نظرتان را درخواست کنید. لطفا درخواست خود را به آدرس زیر ارسال کنید:

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

لطفا عنوان این گزارش (گزارش سالانه سال مالی 2017 در مورد برنامه‌های یکپارچه بیمه‌های درمانی Medicare و Medicaid برای کنگره) را حتما در درخواست¬نامه خود قید فرمایید.

Polish Polski

Raport roczny za rok obrotowy 2017 do Kongresu w sprawie programów integracyjnych Medicare i Medicaid to podsumowanie działań związanych z zapobieganiem oszustwom, marnotrawstwu i nadużyciom oraz wykrywaniem ich, podjętych przez Centers for Medicare & Medicaid Services (Centra Usług Medicare i Medicaid) w okresie od 1 października 2016 r. do 30 września 2017 r. Raport został przedstawiony w języku angielskim. Jeśli Twoim ojczystym językiem nie jest język angielski, możesz

poprosić o przetłumaczenie tego raportu na język, który preferujesz. Podanie należy wysłać do:

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

W podaniu należy przywołać tytuł tego raportu (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) (Raport roczny do Kongresu za rok obrotowy 2017 w sprawie programów Medicare i Medicaid Integrity).

Portuguese Português

O relatório anual do ano Fiscal de 2017 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 2016 e 30 de setembro de 2017. 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:

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, certifique-se de referência o título deste relatório (o ano Fiscal de 2017 relatório anual ao Congresso sobre o Medicare e o Medicaid programas de integridade) em seu pedido.

Russian русский

Ежегодный отчет Конгрессу по 2017 фискальному году о программах целостности Медикэр и Медикейд подводит итоги действий по борьбе с мошенничеством, растратами и превышением полномочий, проводимых Центрами услуг Медикэр и Медикейд в период с 1 октября 2016 года по 30 сентября 2017 года. Отчет

составлен на английском языке. Если английский не является для вас родным языком, вы можете запросить перевод отчета на нужном вам языке. Отправьте запрос в Центры услуг Медикэр и Медикейд:

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

Просьба указать в запросе название настоящего отчета (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs).

Spanish Español

El informe anual del año Fiscal 2017 al Congreso en los programas de integridad de Medicaid y Medicare es un resumen del fraude, desperdicio y prevención de abuso y detección de las actividades realizadas por los Centros de Servicios de Medicare y Medicaid durante el periodo del 1 de octubre de 2016 a 30 de septiembre de 2017. El informe se presenta en el idioma inglés. Si su lengua materna no es inglés puede solicitar una copia de este informe, traducido al idioma que prefiera. Por favor, envie 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 2017 al Congreso en los programas de integridad de Medicaid y Medicare) en su petición.

Tagalog Tagalog

Ang Taunang Ulat sa Kongreso sa Fiscal na Taong 2017 sa Mga Programa ng Integridad ng Medicare at Medicaid ay isang buod ng panloloko, basura at prebensiyon ng pang-aabuso at deteksiyong aktibidad na isinagawa ng Centers for Medicare & Medicaid Services sa panahon mula Oktubre 1, 2016 hanggang Setyembre 30, 2017.

Itatanghal ang ulat sa wikang Ingles. Kung ang pangunahin mong wika ay hindi Ingles, maaari kang humiling ng kopya ng ulat na ito na nakasalin sa wikang gusto mo. Pakipadala ang kahilingan mo sa:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
Baltimore, MD 21244-1850
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Pakisiguro na itukoy ang pamagat ng ulat na ito (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) sa hiling mo.

Vietnamese Việt Nam

Báo Cáo Tài Chính Thường Niên cho Năm 2017 gửi lên cho Quốc Hội về các Chương Trình Liêm Chính của Medicare và Medicaid (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) là một bản tóm tắt các hoạt động phòng chống và phát hiện gian lận, lãng phí và lạm dụng được thực hiện bởi Trung tâm Dịch vụ Medicare & Medicaid (Centers for Medicare & Medicaid Services) trong khoảng thời gian từ ngày 1 tháng 10 năm 2016 đến ngày 30 tháng 9, 2017. Bản báo cáo này được trình bày bằng tiếng Anh. Nếu ngôn ngữ chính của quý vị không phải là tiếng Anh, quý vị có thể yêu cầu một bản sao của báo cáo này được dịch sang ngôn ngữ quý vị mong muốn. Vui lòng gửi yêu cầu của quý vị đến:

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Office of Equal Employment Opportunity & Civil Rights (OEOCR)
7500 Security Boulevard, Room N2-22-16
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Vui lòng đảm bảo là quý vị tham chiếu tiêu đề của báo cáo này (The Fiscal Year 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs) trong yêu cầu của mình.

CMS Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services and Language Assistance Services

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To request an auxiliary aid or service:

1. For Medicare publications, call 1-800-MEDICARE.
   TTY users should call 1-877-486-2048.
2. For all other CMS publications, you can:
   - Call 1-844-ALT-FORM (1-844-258-3676). TTY users should call 1-844-716-3676.
   - Send a fax to 1-844-530-3676.
   - Send an email to AltFormatRequest@cms.hhs.gov.
   - Send a letter 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
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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:

- Online at the Office for Civil Rights of the U.S. Department of Health and Human Services
- By phone: Call 1-800-368-1019. TDD users should call 1-800-537-7697.
- 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, DC 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) 2017 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report the use of appropriated funds and the effectiveness of the use of such funds for Medicare and Medicaid program integrity activities.[1]

CMS aims to ensure that correct payments are made to legitimate providers[2] for covered appropriate and reasonable services for eligible beneficiaries of the Medicare and Medicaid programs.

Medicare Program Integrity

CMS is committed to putting patients first in all of our activities and programs. To better empower patients and doctors, CMS must balance program integrity initiatives aimed at protecting beneficiaries and the Medicare Trust Funds with minimizing provider burden. In FY 2017, CMS continued to implement tools and work with law enforcement partners and other key stakeholders to help focus on prevention, early detection, and data sharing to prevent and reduce improper payments and promote program integrity.

Program integrity activities saved Medicare an estimated total of $15.5 billion in FY 2017, for an annual return on investment of $10.8 to 1.[3] (See the summary table on the next page.) These activities help strengthen the integrity and sustainability of the Medicare program, while promoting quality and the efficient delivery and financing of health care.

CMS achieved significant savings in FY 2017 through activities designed to prevent improper payments. Improper payments prevention represented 85.6 percent ($13.2 billion) of the total Medicare FY 2017 savings, including:

- Automated Actions ($4.0 billion);
- Prepayment Review Actions ($8.3 billion);
- Provider Enrollment Actions ($701.1 million); and
- Other Actions ($262.8 million).

Included in these amounts are savings from the National Correct Coding Initiative (NCCI) edits ($698.1 million), Medicare Secondary Payer Operations prepayment review edits ($7.4 billion),

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[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.

[2] For the purposes of this report, the term "provider" may refer to a provider, supplier, physician, or non-physician practitioner, and the term may represent an individual or an organization.

[3] In FY 2017, CMS updated the methodologies for certain Medicare savings metrics; thus, due to differing methodologies, some FY 2017 Medicare savings amounts are not directly comparable to amounts in earlier reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

and revocations ($588.5 million). In addition, CMS had 576 active payment suspensions during FY 2017. These activities emphasize CMS's focus on a proactive prevention strategy, instead of a "pay and chase" approach to our program integrity efforts.

Recovered savings represented the remaining estimated $2.2 billion of FY 2017 savings. The recovered savings included actual and estimated recoveries as follows:

- Overpayment Recoveries ($1.6 billion);
- Cost Report Payment Accuracy ($499.5 million);
- Plan Penalties ($27.4 million);
- Other Actions ($28.3 million); and
- Law Enforcement Referrals ($79.5 million).

Overall, program integrity activities saved Medicare an estimated $15.5 billion in FY 2017.

Type of Medicare Savings[a]	Savings (in millions)
Prevention Savings	
Automated Actions	$4,003.2
Prepayment Review Actions	$8,280.3
Provider Enrollment Actions	$701.1
Other Actions	$262.8
Total Prevention Savings[b]	$13,247.3
Recovered Savings	
Overpayment Recoveries	$1,588.2
Cost Report Payment Accuracy	$499.5
Plan Penalties	$27.4
Other Actions	$28.3
Law Enforcement Referrals	$79.5
Total Recovered Savings[b]	$2,222.9
Total Savings (Prevention and Recovered)[b]	$15,470.3

[a] Appendix B provides detailed methodologies for all savings metrics. CMS revised the category titles "Systematic Edits" and "Prepayment Edits and Reviews" to "Automated Actions" and "Prepayment Review Actions," respectively.

[b] Savings values may not add to totals due to rounding.

These savings allow CMS to better serve patients and provide high quality care.

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 and the federal government share mutual obligations and accountability for the integrity of the Medicaid program and the development, application, and improvement of program safeguards necessary to ensure proper and appropriate use of both federal and state dollars. By making sure taxpayer dollars are used responsibly, Medicaid program integrity plays an

important role in our overall efforts to refocus Medicaid on the nation's most vulnerable populations in order to provide a more robust level of care and a strengthened program overall.

CMS believes that states understand best the unique needs of their residents and has committed to restoring balance to the federal and state partnership. This commitment to flexibility is being fulfilled through efforts that include relieving burdensome regulatory requirements, speeding the processing of waivers and State Plan Amendments, and opening new avenues to state-led reforms through demonstrations. But this new flexibility must be balanced by a system that holds states accountable for producing improvements in program outcomes, as well as appropriate federal oversight of program integrity to protect the American taxpayers.

States are responsible for collecting overpayments identified by either Audit Medicaid Integrity Contractors (MICs) or, where operational, Unified Program Integrity Contractors (UPICs). Once identified, states generally have up to one year from the date of the final audit report or final findings report to return the federal share.[4] In FY 2017, CMS Audit MICs and UPICs identified $33.9 million in Medicaid overpayments (representing a federal share of $21.5 million).[5]

Through the efforts of Medicaid Recovery Audit Contractors under the Medicaid Recovery Audit Program, the states have recovered a total combined federal and state share amount of $64.0 million for FY 2017 and returned the federal share of $36.9 million to the Treasury.

This Administration takes the integrity of the Medicaid program very seriously. CMS supports state activities through the Medicaid Integrity Program by providing education and training opportunities through the Medicaid Integrity Institute and engaging in collaborative audits, among other efforts. For FY 2017, Medicaid Integrity Program activities led to substantial recoveries – including $785.1 million in combined federal and state share recoveries reported by states.

Coordinated Activities in Program Integrity

In addition to working with states, CMS coordinated closely with a variety of other partners during FY 2017, 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 (MFCUs), clinicians, and other federal agencies before, during, and after the development of fraud leads. For example, on July 13, 2017, the Attorney General and HHS Secretary announced the largest ever health care fraud enforcement action by the Medicare Fraud Strike Force, which included the participation of a number of federal agencies, including CMS.

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public/private partnership between the federal government, state agencies, law enforcement, private health insurance

[4] 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, states generally are required to refund the federal share of any identified overpayments, regardless whether they actually collected the amount overpaid. See 42 CFR § 433.316.

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

plans, employer organizations, and health care anti-fraud associations. The purpose of the HFPP is to foster a proactive approach to detect and prevent health care fraud through the voluntary sharing of data and information between the public and private sectors. Since its inception in 2012, the number of participants increased to 85 public, private and state partner organizations by the end of FY 2017. During FY 2017, the HFPP completed a number of studies using multiple partner data to address fraud, waste, and abuse. In FY 2017, the Partnership also hosted its annual Executive Board meeting. The meeting focused on strategies to streamline, strengthen, and grow the Partnership, including a call to action to broaden the HFPP's impact.

Recently, Congress has increased funding available to CMS to conduct Medicare and Medicaid program integrity. Additionally, new authorities have been added to CMS's toolkit, such as enhancements to provider screening and sophisticated data analytics that continue to help CMS to better address fraud and abuse in Medicare and Medicaid. Today, with these authorities and resources, 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) 2017 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.

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.

In 2010, CMS created the Center for Program Integrity (CPI) to align the program integrity functions of the Medicare and Medicaid programs. 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 by CPI.

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.

CMS is committed to putting patients first in all of our activities and programs. To better empower patients and doctors, CMS must balance program integrity initiatives aimed at protecting beneficiaries and the Medicare Trust Funds with minimizing provider burden. In FY 2017, CMS continued to implement tools and work with law enforcement partners and other key stakeholders to help focus on data-sharing, prevention, and early detection to prevent and reduce improper payments and promote program integrity.

During FY 2017, CMS's program integrity efforts resulted in an estimated $15.5 billion in savings for the Medicare Trust Funds, demonstrating the effectiveness of CMS's

comprehensive approach to program integrity in Medicare.[6] These savings demonstrate CMS's commitment to fiscal integrity and allows CMS to focus on efforts to better serve patients and provide high quality care. Since the introduction of the savings methodologies in the FY 2013/2014 Report to Congress, CMS has continued to improve the data included in the savings estimates 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 2017. 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 2017, states reported $785.1 million in total Medicaid program integrity collections, with $431.8 million attributable to the federal share.

CMS Strategic Goals

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

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

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

   To better empower patients and doctors, CMS must **balance program integrity initiatives aimed at protecting beneficiaries and the Medicare Trust Funds while minimizing provider burden**.

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

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

[6] Although the $15.5 billion was not required to be subjected to the Department of Health and Human Services Office of then Inspector General (HHS-OIG) certification, HHS-OIG did certify that the savings were grounded in methodologies used to develop the Fraud Prevention System (FPS) adjustment factor. The FPS savings methodology represented the first time in federal health care programs that HHS-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.

CMS can support states by **sharing best practices with them and increasing flexibility in program integrity approaches while improving accountability in Medicaid programs**.

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

   By using data-driven insights, CMS must always search for new ways to provide cost-effective care that improves patients' outcomes. There are countless opportunities at CMS to support and drive innovation and enhance our technology to prevent fraud, waste, and abuse of taxpayer dollars. CMS supports the development of innovative payment models, ensures the new models have appropriate oversight and monitoring to ensure the integrity and success of the models themselves, and supports the enrollment and screening of new provider types.

   To support its program integrity efforts, CMS must **integrate, analyze, and share data to inform decision making**.

4. Improve the CMS customer experience.

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

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

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

1.1. Reporting Requirements

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.[7] Section 1893(h)(8) of the Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare and Medicaid, including information on the performance of such contractors on identifying underpayments and

[7] 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.

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

This report fulfills the reporting requirements with respect to the Medicare and Medicaid Integrity Programs, the Medicare Fee-for-Service (FFS) Recovery Auditors, the Medicare Advantage (MA or Part C) and Medicare Prescription Drug Part D (Part D) Recovery Auditors, and the Medicaid Recovery Auditors.[8]

Medicare Funding

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[9] 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. Then the amount was capped at $720 million from FY 2003 through FY 2010, after which the Patient Protection and Affordable Care Act[10] increased the base funding level and also applied an annual inflationary adjustment to that base funding level. This funding supports the following program integrity functions performed across CMS, including: Audits, MSP, Medical Review, Provider Outreach and Education, Benefit Integrity, and Provider Enrollment.

CMS received additional mandatory funding for the Medicare Integrity Program (specifically for Medicare-Medicaid Data Match activities, or Medi-Medi) from the Federal Hospital Insurance Trust Fund in FY 2006 under the Deficit Reduction Act of 2005 (DRA).[11] The Patient Protection and Affordable Care Act provided additional funding through 2020 and permanent indexing of the mandatory amounts. Since 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 $1.3 billion in FY 2017 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. 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

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

9 Public Law 104-191.

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

11 Public Law 109-171.

expended. Beginning in FY 2011, the Patient Protection and Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[12] CMS obligated a total of $92.0 million in FY 2017 for the Medicaid Integrity Program. In addition, CMS obligated a total of $72.3 million in FY 2017 for Medicaid program integrity activities using discretionary HCFAC funds.

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

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 health care services to a vast number of individuals each day. During the course of calendar year 2017, the average monthly Medicare enrollment was 58.0 million, while the average monthly Medicaid enrollment was 72.3 million.[13] In FY 2016, there were more than 11.7 million enrollees in both the Medicare and Medicaid programs, a status frequently referred to as "dual eligibles."[14]

CMS directly administers Medicare through contracts with private companies that process more than one billion claims per year.[15] Medicaid is administered by states 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.[16] CMS had outlays of approximately $993.9 billion in FY 2017 (net of offsetting receipts and Payments of the Health Care Trust Funds).[17] As required by law, CMS procures

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[12] 42 U.S.C. 1396u-6(e)(1)(D).

[13] FY 2017 HHS Agency Financial Report (AFR), page 40, available at https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf.

[14] Medicare-Medicaid Coordination Office FY 2017 Report to Congress, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/RTC_MMCO_FY2017_06072018.pdf. FY 2016 is the most recent year for which this information is available.

[15] FY 2017 CMS Financial Report, page i, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2017_CMS_Financial_Report.pdf.

[16] 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.

[17] FY 2017 CMS Financial Report, page i, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2017_CMS_Financial_Report.pdf.

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 (ZPICs)[18]	Medicare 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 • Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the MACs • Conduct medical review for program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exists within their respective jurisdictions • Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the FPS • Identify improper payments to be recovered
Unified Program Integrity Contractors (UPICs)[19]	Medicare FFS and Medicaid	• Investigate leads generated by the Unified Case Management System (UCM) and complaints from beneficiaries and a variety of other sources • Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid • Make recommendations to CMS for appropriate administrative actions (i.e., revocations and suspensions) to protect Medicare Trust Fund dollars • Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the MACs • Conduct medical review for Medicare and Medicaid program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exists in Medicare and Medicaid

[18] For the purposes of this report, references to the ZPICs include legacy Program Safeguard Contractors (PSCs).

[19] CMS has begun transitioning contracts to UPICs, which will perform the functions of ZPICs/PSCs and Medicaid Integrity Contractors (MICs).

Contractor	Program	Program Integrity Responsibilities
		• Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the UCM • Identify improper payments to be recovered within Medicare and Medicaid
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 claims 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 Recovery Audit Contractors (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 • Provide system development and data center support for all coordination of benefits and recovery information systems
National Benefit Integrity (NBI) Medicare Drug Integrity	Medicare Part C and Part D	• Conducts data analyses of national Part C and Part D issues leading to potential identification of improper payments and regulatory compliance

Contractor	Program	Program Integrity Responsibilities
Contractor (MEDIC)		• 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
Part D RAC	Medicare Part D	• Conducts post-payment reviews of reconciled Part D Prescription Drug Events (PDEs) 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)

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 directs and tracks corrective actions to address identified high-priority vulnerabilities to resolution.

The PI Board also establishes smaller working groups—referred to as Integrated Project Teams (IPTs)—to focus on specific projects to address the identified vulnerabilities. For example, an Improper Payments Workgroup periodically collects data from improper payment reports and formulates action plans for review by the PI Board. Further, in FY 2017, the PI Board approved the Documentation Requirements Simplification 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 (including both overpayments and underpayments) and summarizes trends in the improper payment rates since 2011 for Medicare FFS, Part C, and Part D; Medicaid; and CHIP.[20] The methodologies for some of the improper payments have changed over the years represented in the table to include

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

additional measures, so some year-to-year increases in improper payment rates may indicate improved measurement rather than indicating increases in the incidence of improper payments. Section 5.1 of this report provides specific information on how each program measures improper payment.

Table 2: Reported Improper Payment Rates Trend for Reporting Years 2011-2017

Program	2011	2012	2013	2014	2015	2016	2017
Medicare FFS	8.6%	8.5%	10.1%	12.7%	12.1%	11.0%	9.5%
Part C	11.0%	11.4%	9.5%	9.0%	9.5%	10.0%	8.3%
Part D	3.2%	3.1%	3.7%	3.3%	3.6%	3.4%	1.7%
Medicaid	8.1%	7.1%	5.8%	6.7%	9.8%	10.5%	10.1%
CHIP	N/A	8.2%	7.1%	6.5%	6.8%	8.0%	8.6%

While this report discusses many of the ways that CMS reduces the improper payment rates for Medicare, Medicaid, and CHIP, please see the HHS FY 2017 AFR for a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2017.[21]

1.3.2. Medicare Savings

CMS saved an estimated $15.5 billion in FY 2017 (see Table 3).[22] This represents an annual return on investment of $10.8 to 1.[23] Overall, 85.6 percent of the savings in FY 2017 resulted from prevention actions, safeguarding Medicare dollars.

The savings measures may not capture the full scope of savings achieved through program integrity activities. For example, 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.

[21] The HHS FY 2017 AFR is available at https://www.hhs.gov/sites/default/files/fy-2017-hhs-agency-financial-report.pdf.

[22] In FY 2017, CMS updated the methodologies for certain Medicare savings metrics; thus, due to differing methodologies, some FY 2017 Medicare savings amounts are not directly comparable to amounts in earlier reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

[23] The annual return on investment for the Medicare Integrity Program for FY 2017 is calculated by dividing the total Medicare savings by the total Medicare obligations.

Table 3: Medicare Savings

Type of Medicare Savings[a] (Table continues on the following page)	FY 2017 (in millions)
Prevention Savings	
Automated Actions	
National Correct Coding Initiative (NCCI) – Procedure-to-Procedure Edits	$240.3
NCCI – Medically Unlikely Edits	$457.8
Ordering and Referring Edits	$95.8
Fraud Prevention System Edits	$32.1
MAC Automated Medical Review Edits	$3,110.6
ZPIC/UPIC Automated Edits	$66.6
Prepayment Review Actions	
Medicare Secondary Payer (MSP) Operations	$7,372.0
MAC Non-Automated Medical Reviews	$835.9
ZPIC/UPIC Prepayment Reviews	$72.4
Provider Enrollment Actions	
Revocations	$588.5
Deactivations	$112.6
Other Actions	
Payment Suspensions	$71.6
Medicare Part D Reconciliation Data Reviews	$191.2
Total Prevention Savings[b]	**$13,247.3**
Recovered Savings	
Overpayment Recoveries	
MSP Operations	$987.7
MSP Commercial Repayment Center	$157.4
MAC Post-Payment Medical Reviews	$53.9
Medicare FFS RAC Reviews	-$1.9
SMRC Reviews	$108.7
ZPIC/UPIC Post-Payment Reviews	$195.0
Retroactive Revocations	$0.6
Overpayments Related to Risk Adjustment Data	$81.5
Medicare Part D Plan Sponsor Audits	$5.0
Medicare Part D RAC Reviews	$0.3
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	$491.6
Cost-Based Plan Audits	$7.9
Plan Penalties	
Medicare Part C and Part D Program Audits	$5.3
Medical Loss Ratio Requirement	$22.1
Other Actions	
Party Status Appeals Initiative	$28.3
Law Enforcement Referrals	
ZPIC/UPIC Law Enforcement Referrals	$26.6

Type of Medicare Savings[a] (Table continues on the following page)	FY 2017 (in millions)
NBI MEDIC Part C Law Enforcement Referrals	$3.1
NBI MEDIC Part D Law Enforcement Referrals	$49.8
Total Recovered Savings[b]	**$2,222.9**
Total Savings (Prevention and Recovered)[b]	**$15,470.3**

[a] Appendix B provides detailed methodologies for all metrics listed in this table. CMS revised the category titles "Systematic Edits" and "Prepayment Edits and Reviews" to "Automated Actions" and "Prepayment Review Actions," respectively.
[b] Savings values may not add to totals due to rounding.

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. Since then, annual Medicaid program integrity collections have been higher, and, in FY 2017, total federal and state share Medicaid program integrity collections were approximately $785.1 million.

1.4. HHS-OIG and GAO Recommendations Implemented

CMS acts on recommendations from the Department of Health and Human Services' Office of Inspector General (HHS-OIG) and the Government Accountability Office (GAO) regarding 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 HHS-OIG (https://oig.hhs.gov/) and the GAO (http://www.gao.gov/) websites.

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

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

2.1. Medicare Fee-for-Service Medical Review

Consistent with sections 1815(a), 1833(e), and 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.[24] Medical reviews are an example of such FFS claims data analysis.

Medical Review (Prevention Edits)

Medical review involves both automated and manual processes to ensure that 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) results, HHS-OIG/GAO findings, and RAC findings indicate questionable billing patterns. In an effort to increase proper billing, CMS continues to enhance medical review efforts and has encouraged the MACs to incorporate increased provider feedback processes, such as one-on-one education and review results notifications with more detail.

CMS continues to focus on prepayment review of claims that have historically been found to have high rates of improper payments. This will reduce the number of improper payments and similarly the improper payment rate, by stopping improper payments before the claims are paid. In FY 2017, CMS revised the methodology for Part B outpatient and Durable Medical Equipment (DME) MAC medical review automated and non-automated reviews to be consistent with similar methodologies certified by HHS-OIG.[25] CMS estimates that MAC automated medical review edits saved $3.1 billion, and MAC non-automated medical review edits saved $835.9 million.

Supplemental Medical Review (Post-payment)

In FY 2017, CMS contracted with the SMRC to perform medical reviews focused on vulnerabilities identified by CMS data analysis, the CERT program, professional organizations, and federal oversight entities. One of the SMRC's primary tasks is evaluating medical records and related documents to determine whether claims were billed in compliance with Medicare's coverage, coding, and payment rules, including

[24] The ZPICs/UPICs also perform medical review, as discussed in section 2.3.

[25] This methodology revision was recommended by the GAO in its report available at https://www.gao.gov/products/GAO-16-394.

those claims identified by HHS-OIG and/or GAO. In FY 2017, the SMRC saved $108.7 million through post-payment review.

2.2. 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 costs reports includes:

- timely receipt and acceptance of the cost report;
- desk review of the submitted cost report;
- audit (if warranted) of the cost report; and
- 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, the recognition of which can be used to strengthen and focus the program integrity response. The cost report includes calculations of the final payment amount for items such as:

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

The audit process includes the timely receipt and acceptance of provider cost reports, desk review, and audit of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines that providers are paid properly, in accordance with CMS regulations and instructions. During FY 2017, the MACs received and accepted approximately 50,000 Medicare cost reports. This includes initial cost report filings as well as amended filings. Approximately 21,000 cost reports were desk reviewed and tentatively settled. In addition, the MACs completed approximately 650 audits. In FY 2017, cost report reviews and audits saved $491.6 million.

2.3. Unified Program Integrity Contractors

In FY 2016, CMS began consolidating the Medicare and Medicaid program integrity functions performed by the ZPICs, including Medicare-Medicaid Data Match (Medi-Medi) activities, and the Audit Medicaid Integrity Contractors (MICs) into the Unified

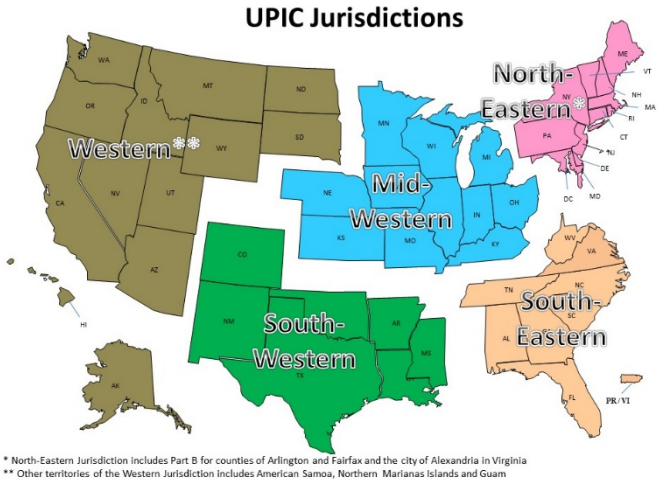
Program Integrity Contractors (UPICs). The UPICs merge these separate contracting functions into a single contractor, in a geographic area, with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations. The UPIC structure provides CMS with a flexible contracting vehicle to address the complex landscape of program integrity.

In FY 2017, the first UPICs became fully operational and began carrying out program integrity activities. In addition, CMS continued to work towards finalizing the awards for the remaining UPIC jurisdictions. ZPICs and Audit MICs remained fully operational in the geographic areas not covered by fully operational UPICs.

UPIC Transition

CMS began awarding UPIC contracts in FY 2016, and contracting activities continued through FY 2017. In May 2016, seven vendors were included in the award:

- AdvanceMed Corporation
- Health Integrity LLC (now Qlarant Integrity Solutions)
- 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 was fully operational on October 20, 2017. The Northeastern Jurisdiction contract was awarded to SafeGuard Services, LLC on November 1, 2016 and became fully operational on February 1, 2017. The Western Jurisdiction was awarded to Health Integrity LLC (Qlarant) on February 16, 2017, the Southeastern Jurisdiction was awarded to Safeguard Services, LLC on August 4, 2017, and the Southwestern Jurisdiction was awarded to Health Integrity LLC (Qlarant) on September 15, 2017; however, CMS received bid protests for these awards, delaying implementation. CMS anticipates completing the transition from ZPICs and Audit MICs to UPICs in FY 2018.

Medicare

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

The ZPICs/UPICs 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 review of medical records and documentation. The medical review function is not unique to ZPICs/UPICs, but the focus of those reviews is. The MACs and other contractors perform medical review to make coverage or coding determinations, while the ZPICs/UPICs perform program integrity-directed medical review oriented towards fraud detection and investigation. The ZPICs/UPICs look for possible falsification of documents that may lead to identification of provider or supplier overpayments.

In FY 2017, the ZPICs/UPICs saved an estimated $535.6 million in potentially improper payments by taking appropriate action to initiate collection, preventing payment to Medicare providers and suppliers, or referring cases to law enforcement. See Table 4 for more detail of the savings identified by the ZPICs/UPICs.

Table 4: Savings Identified by ZPICs/UPICs

Type of ZPIC/UPIC Savings	**Savings (in millions)**
	2017
Prevention Savings	
Automated Edits	$66.6
Prepayment Reviews	$72.4
Revocations	$103.2
Deactivations	$0.2
Payment Suspensions	$71.6
Recovered Savings	
Post-Payment Reviews	$195.0
Law Enforcement Referrals	$26.6
Total Savings [a]	**$535.6**

[a]Savings values may not add to totals due to rounding.

The Fraud Prevention System (FPS) is one source of leads for ZPICs/UPICs. The FPS is a predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA).[26] Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics against Medicare FFS claims nationwide to identify, prevent, and stop potentially fraudulent claims. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation by ZPICs/UPICs. Based on the results of all information collected, the ZPICs/UPICs either coordinate with CMS and the MACs in taking appropriate administrative action to recover improper payments and prevent future loss of funds, or the ZPICs/UPICs refer the case to law enforcement. Overall ZPIC/UPIC savings include amounts attributable to FPS leads.

[26] Public Law 111-240.

Medicaid

To better coordinate Medicare and Medicaid program integrity audit and investigation work, CMS is currently shifting its Audit MIC workload to the UPICs.

During FY 2017, the Audit MICs/UPICs identified $33.9 million in total Medicaid overpayments sent to states for collection. States are responsible for collecting overpayments identified by Audit MICs/UPICs, and are permitted up to one year from the date of the final audit report to return the federal share.[27] For FY 2017, states reported a total federal and state share combined amount of Audit MIC/UPIC audit recoveries of $22.8 million and returned the federal share of $14.6 million to the Treasury.

More information on the National Medicaid Audit Program can be found in section 3.4.

2.4. 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 (State Children's Health Insurance Program) Extension Act of 2007 (MMSEA)[28] continue 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 the implementation of section 111 of MMSEA. MSP operations saved $8.5 billion in FY 2017. This includes approximately $987.7 million in direct recoveries that replenished the Medicare Trust Fund. See Table 3 for savings from MSP operations.

Commercial Repayment Center (CRC) Recovery Auditors

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

[27] 42 CFR § 433.312.

[28] Public Law 110-173.

primary payment responsibility. In this situation, the CRC recovers Medicare payments from the applicable plan.

In FY 2017, the CRC identified $560.1 million in mistaken payments, and processed net collections of $157.4 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.

2.5. Part C and Part D Program Integrity

2.5.1. Medicare Drug Integrity Contractor

The National Benefit Integrity Medicare Drug Integrity Contract (MEDIC) supports CMS through a variety of functions that includes conducting investigations and referral of potential cases to law enforcement, performing proactive data and investigative analysis, identifying and reporting potential program vulnerabilities, and conducting health plan audits. Data analyses include identifying trends, anomalies, and questionable physician and pharmacy practices, including in areas such as aberrant opioid prescriptions, as well as tasks including educating plan sponsors, recovering improper payments, and making referrals to law enforcement when appropriate. Examples include:

- Quarterly Pharmacy Risk Assessment, which categorizes pharmacies as high, medium, or low risk;
- Outlier Prescriber Assessment, which provides a peer comparison of the prescribing of Schedule II controlled substances;
- Pill Mill Doctor Project, which identifies prescribers with a high risk of fraud, waste and abuse in prescribing Schedules II-IV controlled substances; and
- Improper payments for drugs inappropriately covered under the Part D program without a medically accepted indication (e.g., Transmucosal Immediate Release Fentanyl[29]).

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

In April 2015, CMS and the MEDIC launched the Predictive Learning Analytics Tracking Outcome (PLATO™). PLATO™ is a voluntary, web-based tool designed to assist Medicare Advantage (MA) and Part D plan sponsors in identifying and addressing

[29] CMS Opioid Misuse Strategy 2016, available at https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf.

potential fraud, waste, and abuse, as well as to encourage information sharing between plan sponsors and CMS. CMS's federal law enforcement partners also use PLATO™.

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

As a result of Part D plan sponsor audits, HHS recovered $5.0 million in FY 2017 from Part D sponsors.

According to notifications received from law enforcement in FY 2017, MEDIC referrals to law enforcement resulted in recoveries of $3.1 million for MA and $49.8 million for Part D. The majority of these savings were from sentences ordering restitution.

2.5.2. Part C and Part D Program Oversight

In FY 2017, CMS continued to invest HCFAC funding to strengthen MA 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 MA and Part D programs. All MA and Part D plan sponsors are required to have an effective program to prevent, detect, and correct MA and Part D non-compliance and fraud, waste, and abuse. This compliance program consists of written policies, procedures, and standards that articulate the organization's commitment to comply with all applicable federal and state standards, and fraud and abuse related to the Medicare program. Plan sponsors must have a properly trained, effective compliance officer, provisions for internal monitoring and auditing, and oversight of their first-tier downstream and related entities, 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 MA 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, CMS directed Part D sponsors to submit only active and valid prescriber identifiers on a Prescription Drug Event (PDE) record. CMS began rejecting from CMS's system PDEs with NPIs that were not active on the date of service on the PDE. In addition, CMS began validating the format of prescriber identifiers coded

as an NPI and rejected from CMS's system PDEs with NPIs that did not meet the format check.

In April 2012, CMS published a final rule requiring that beginning January 1, 2013, Part D sponsors must submit to CMS only PDE records that contain active and valid individual prescriber NPIs.[30] CMS began to deny any PDE without an active and valid individual NPI beginning on January 1, 2013. We continued to assess each sponsor's performance regarding NPI use and validity of submitted NPIs and notified sponsors of their performance in preparation for this deadline. Based on this assessment, we found that 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 (or 1 in 50,000) of the reported NPIs were valid and currently active, or active within a year of the date of service. We also examined the taxonomy codes, which are self-reported by the providers to identify their specialty. Because we found that a small percentage of these taxonomy codes would be unreasonable for a prescriber, we have initiated a review of the corresponding PDEs to determine what drugs were prescribed, if any are controlled substances, and if the prescribers have valid individual DEA numbers.

2.5.3. Medicare Part C and Part D Marketing Oversight

CMS takes compliance action against MA organizations, prescription drug plans (PDPs), Section 1876 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 MA organizations and 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 may determine a civil money penalty (CMP) should be imposed when an MA organization or Part D plan sponsor substantially fails to comply with program and/or contract requirements involving ANOC/EOC documents.

2.5.4. Part C and Part D Audits

CMS conducts program audits of MA organizations and Part D plan sponsors to evaluate their delivery of health care services and medications to beneficiaries. Program audits in 2017, 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.

[30] 77 FR 22072 (April 12, 2012).

Therefore, all MA, MA Prescription Drug (MA-PD), Medicare-Medicaid Plan, and standalone PDP contracts owned and operated by the parent organization were included in the scope of the 2017 audits. The audits evaluated sponsor compliance in the following program areas:

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans Model of Care

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 special needs plan, then they would not have a Model of Care audit performed. Likewise, a stand-alone PDP does not have the Part C Organization Determinations, Appeals, and Grievances protocol applied, since it does not offer the Part C benefit.

In 2017, an average of 12 conditions of noncompliance were cited per sponsor audited, which decreased from an average of 18 conditions per audited sponsor in 2016. Sponsors with cited conditions in their audit report are required to 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.

CMS is committed to 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 are increasing sponsors' compliance with core program functions in the MA and Part D programs.

2.5.5. 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 organization or Part D plan sponsor:

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

Enforcement and contract actions include:

- CMPs;

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

In FY 2017, CMS issued 22 CMPs and placed one MA/Part D organization under marketing and enrollment sanctions. Overall, in FY 2017, CMS collected $5.3 million from MA/Part D organization CMPs.[31]

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

2.6. Medicare and Medicaid National Correct Coding Initiative

Medicare NCCI

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. NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment for billing code pairs that should not be reported together by the same provider for the same beneficiary for the same date of service. NCCI Medically Unlikely Edits (MUEs) prevent payment for an inappropriate quantity of the same service rendered by the same provider for the same beneficiary on the same date of service. NCCI edit tables are refined and updated quarterly.[32]

In FY 2017, the use of NCCI PTP edits and MUEs saved the Medicare program $240.3 million and $457.8 million, respectively.

Medicaid NCCI

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

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[31] Medicare Part C and Part D enforcement notices are available at https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html.

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

2.7. 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 uses 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), MA (encounter), and Part D paid claims back to January 2006, both before and after final payment has been made.[33] This allows for 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.

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

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

2.8. 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 billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. For FY 2017, DOJ and HHS had expanded Strike Force operations in 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 Texas.

On July 13, 2017, the Strike Force led the largest national health care fraud takedown to date at that time[34] in 41 federal districts, resulting in criminal and civil charges against

[33] Medicare Part C organizations began submitting encounter data in January 2012.

[34] DOJ Press Release (July 13, 2017), available at https://www.justice.gov/opa/pr/national-health-care-fraud-takedown-results-charges-against-over-412-individuals-responsible.

412 individuals, including 115 doctors, nurses and other licensed medical professionals, for their alleged participation in health care fraud schemes involving approximately $1.3 billion in false billings. Thirty state MFCUs also participated in the arrests. CMS initiated payment suspensions against 295 providers and suppliers.

2.9. Command Center

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

In FY 2017, 25 missions, that included participants from CMS and CMS partners such as the FBI, were conducted in the Command Center. The Command Center's advanced technologies and collaborative environment allow multi-disciplinary teams of experts and decision makers to more efficiently coordinate policies and case actions, reduce duplication of efforts, and streamline fraud investigations for more immediate administrative action. These collaborative activities enable CMS to take administrative actions, such as revocations of Medicare billing privileges and payment suspensions, more quickly and efficiently.

2.10. Medicare-Medicaid Data Match

The Medicare-Medicaid Data Match (Medi-Medi) activities support the integration of Medicaid and Medicare investigations and audits where possible. Medi-Medi functionality matches Medicaid and Medicare claims and other data to identify improper billing and utilization patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the Medi-Medi program an important tool in identifying and preventing aberrant billing practices and other schemes across both programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. Participation in these activities is optional for the states; however, CMS works diligently to identify which states would benefit the most. Each state's participation in Medi-Medi activities is designed to accommodate the individual complexity of that state and its program integrity efforts. During FY 2017, CMS collaborated with states that account for most of the expenditures in Medicaid. Participating states included Alabama, Arizona, Arkansas, California, Florida, Georgia, Louisiana, Mississippi, Missouri, Nebraska, New York, North Carolina, Ohio, Pennsylvania, Tennessee, Texas, West Virginia, and Wyoming. For example:

- CMS has identified two examples where the ZPICs have successfully matched Medicare and Medicaid claims data for investigative purposes, collaborated with their state Medicaid partners, and successfully implemented administrative actions that ultimately resulted in successful law enforcement actions. In one zone, the ZPIC determined that an unlicensed individual was potentially

performing podiatry services and billing Medicare and Medicaid for these services using a licensed podiatrist's billing information. CMS implemented a 100 percent payment suspension on the provider group and ultimately revoked the provider's billing privileges. Through collaboration with state and federal partners, guilty pleas were successfully secured from the unlicensed individual as well as the licensed doctor who billed for the services. In another zone, the Program Safeguard Contractor identified a podiatrist that was potentially up-coding routine foot care services, billing for services not rendered/misrepresenting services, and billing for non-medically necessary services. Through collaborative efforts with state and federal partners, the provider ultimately pled guilty to health care fraud for perpetrating a $5 million scheme to defraud Medicare, Medicaid, and four private victim insurance companies. The provider was revoked from Medicare, sentenced to eight years in federal prison, and ordered to pay $4.9 million in restitution.

- In North Carolina, CMS assisted the State with on-site reviews which addressed potential patient harm and quality of care issues. In two separate cases, those on-site reviews and collaborative work identified the potential for prescription drug "Pill Mills" and patient harm. Referrals were made to the North Carolina Licensure Board and Quality Improvement Organization.

- A New York provider was identified for review; allegations identified services provided by unqualified staff, services not medically necessary and/or services not rendered as billed. The CMS UPIC and the State Inspector General conducted a joint onsite review. Findings from the onsite audit resulted in an immediate exclusion from the Medicaid program.

2.11. Medicare Shared Savings Program

Under the Medicare Shared Savings Program, providers of services and suppliers that participate in an Accountable Care Organization (ACO) continue to receive traditional Medicare FFS payments under Part A and Part B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements. The Shared Savings Program incentivizes ACOs to continue broad-based program participation and improve program function and transparency. CMS developed a streamlined provider and supplier screening process to enhance program integrity efforts for the Shared Savings Program. 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. These provider screenings are facilitated by the electronic capture and exchange of provider information including, but not limited to, enrollment status, reassignment details, current/previous Medicare Exclusion Database sanctions, payment suspensions, and FPS alerts. CMS may deny an application or impose additional safeguards on ACO participants whose screening reveals a history of program integrity issues or affiliation with individuals or entities that have a history of program integrity issues.

2.12. Federally-facilitated Exchange[35]

In FY 2017, the Exchange Integrated Project Team (IPT) conducted a fraud risk assessment of the Federally-facilitated Exchange (FFE), consistent with best practices developed by the GAO.[36] The assessment provides controls to prevent, detect, and respond to fraud in the FFE. In its oversight role, the PI Board was briefed on the fraud risk profile and initial implementation activities. To date, the IPT has taken a number of steps to prevent fraud during the enrollment process, including clarifying requirements and implementing system improvements to strengthen enrollment controls and manage fraud risk related to data matching issues.

An outgrowth of the risk assessment and PI Board is the continuation of several efforts to ensure program integrity in the FFE, including a complaints review process, agent broker license verification, high risk region analysis, investigations, and law enforcement referrals. Complaints are reviewed for potential fraud and unauthorized enrollment of consumers, and CMS works with issuers to cancel fraudulent policies. To date, over 20,000 complaints have been reviewed. The license verification project ensures that agents and brokers have an active state license, valid line of authority, and are registered with CMS to sell on the FFE, at the time of enrollment. Finally, CMS works to screen, prioritize, and investigate potential fraud and abuse leads that come from data analysis, as well as tips from external parties. Investigations may be conducted on the highest priority leads, such as those indicating consumer harm.

2.13. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding[37]

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 that is generally based on historic supplier charges from the 1980s. Numerous studies from HHS-OIG and GAO showed these fee schedule prices were excessive, and taxpayers and Medicare beneficiaries were bearing the burden of these excessive payments.

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

[36] More information on the PI Board and IPTs can be found in section 1.3.1.

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

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

Since adding the Round 2 and national mail-order for diabetic testing supplies competitive bidding programs on July 1, 2013, the Medicare DMEPOS Competitive Bidding Program, combined with other CMS fraud, waste, abuse initiatives, has saved over $2 billion per year. The Round 2 Recompete and the national mail-order recompete contract period began on July 1, 2016 and will end on December 31, 2018. The Round 1 2017 contract period began on January 31, 2017 and will end on December 31, 2018.[38]

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.

2.14. Party Status Appeals Initiative

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 hearings either as a party or 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 particular 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

[38] More details about the program are on the DMEPOS Competitive Bidding website, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/.

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 2017, the estimated amounts in controversy were $28.3 million for the party status appeals initiative. Data shows ALJ overturn rate is lower in cases in which the QIC participates as a party.[39]

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

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

2.15.1. Medicare FFS

The mission of the Medicare FFS Recovery Audit Program is to identify and correct overpayments made on claims for health care services provided to beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement corrective actions that will prevent future improper payments.

Section 1893(h) of the Act required that the FFS Recovery Audit Program expand nationwide by January 2010. The national FFS Recovery Audit Program was established in early 2009 after conducting a full and open competition.

As required by section 1893(h) of the Act, RACs are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to, providers. The RACs negotiate their contingency fees at the time of the contract award. The base contingency fees range from 10.4 – 14.4 percent for all claim types except DME, where it ranges from 15.4 – 18.9 percent. The RAC must return the contingency fee if an improper payment determination is overturned at any level of appeal.

CMS implemented a Hospital Appeals Settlement process (HASP) in 2014, and a similar process again in 2016, to help reduce the number of claims in the appeal backlog. These initiatives had a particularly large impact on the total amount of money that the RACs

[39] In FY 2018, the overall adjudicated reversal rate by the ALJ was 47.90 percent. However, in that same period, in cases in which the QIC participated as a Party, the adjudicated reversal rated was 25.60 percent. In sum, when the QIC participated as a Party in an ALJ hearing, the overturn rate was 22.30 percent lower.

were able to return to the Trust Funds in FY 2017, as collections for these claims were being returned during this time.

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

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

Results

In FY 2017, Medicare FFS RACs collectively identified and corrected 79,186 claims. Overall, the program experienced a loss of $1.9 million when accounting for overpayments collected, underpayments restored, and amounts overturned on appeal.

Table 5 breaks out overpayments collected, underpayments restored, and amounts overturned on appeal by FFS RAC region, including both old and new.

Table 5: RAC Performance

FFS RAC Region/Name	Collected Overpayments (in millions)	Restored Underpayments (in millions)	Overturned on Appeal[a] (in millions)
A / Performant	*($1.1)*	$0.0	$0.9
B / CGI	$13.5	$0.5	$0.9
C / Cotiviti	$3.3	$2.2	$16.0
D / HDI	$2.7	$0.1	$1.6
Unknown	*($3.4)*	*$2.1*	*$0.0*
1/ Performant	$1.9	$0.5	$0.0
2/ Cotiviti	$1.9	$0.6	$0.0
3/ Cotiviti	$3.2	$0.7	$0.0
4/ HDI/HMS	$1.3	$0.1	$0.0
5/ Performant	$1.1	$0.0	$0.0
Totals[b]	**$24.3**	**$6.8**	**$19.4**

Note: Payments made to providers under the Hospital Appeal Settlement process resulted in reduced collected overpayments. Because these reductions could not always be offset by other collected amounts, some resulted in an overall negative amount being reported.
[a] Overturned amounts include collected overpayments from previous FYs.
[b] Savings values may not add to totals due to rounding.

Additional results and analysis of Recovery Audit Program data are available for download on the Recovery Audit Program website at https://www.cms.gov/Research-

Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program.

Appeals

Providers who disagree with a RAC's improper payment determination may utilize the multilevel administrative appeals process under section 1869 of the Act. Recovery Audit Program appeals follow the same appeal process as other Medicare claim determinations. Throughout the four levels of the administrative appeals process, in FY 2017, there were 77,306 appeal decisions rendered for claims with overpayments identified by the RACs. Claims may have had initial overpayment determinations made prior to FY 2017. Appealed claims may be counted multiple times if the claim had appeal decisions rendered at multiple levels during FY 2017. For example, if a claim was appealed to the first level and received a decision in FY 2017, then appealed to the second level and received a decision in FY 2017, both decisions are counted. Of the 77,306 total appeals decided in FY 2017, 40,610 decisions, or 52.5 percent were overturned with decisions in the provider's favor (see Table 6).

Table 6: RAC Appeals

Appeal Level	Total Decisions in FY 2017	Favorable/ Partially Favorable Decision	Percent Overturned
1 (MAC)	37,158	30,406	81.8%
2 (QIC)	17,358	2,150	12.4%
3 (ALJ)	22,771	8,054	35.4%
4 (Departmental Appeals Board (DAB))	19	0	0.0%
Totals	***77,306***	***40,610***	***52.5%***

Oversight

CMS regularly evaluates the RACs' performance and adherence to the requirements in their SOWs. Staff members go on location to observe medical reviewers, information technology systems, and customer service areas. When onsite visits are not possible, CMS conducts desk audits on claims to confirm that all aspects of the review process were completed correctly and accounted for in the Data Warehouse. Regular meetings with the MACs, provider groups, and other stakeholders are also monitored for additional contractor oversight. If there are any findings in these evaluations, CMS notifies the RAC and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Reporting System for an overall performance rating for the year. These results are available to all federal agencies. CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

2.15.2. Part C and Part D

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

The primary corrective action on Part C payment error has been the contract-level Risk Adjustment Data Validation (RADV) audits. RADV verifies that diagnoses submitted by Part C organizations for risk adjusted payment are supported by medical record documentation. The RADV program is currently operational with the support of contractors. HHS previously published a solicitation for comments and, in 2014, issued a request for proposals; however, no proposals were received. In 2015, HHS issued a request for information and reviewed comments received. In the responses, the Part C industry expressed concerns of burden related to the high overturn rate in the early experience of the FFS RAC program. Additionally, potential RAC vendors expressed concerns with the unlimited delay in the contingency payment due to time frames not being established for appeal decisions in the Part C appeal process.[40] In FY 2017, CMS explored how to fit the Medicare Part C RAC program into the larger Medicare Part C program integrity efforts, and examined refinements that could be made to the operations of RACs such that their activities do not excessively burden plans.

The Part D RAC program became fully operational in FY 2012. Since its launch, the Part D RAC has recouped overpayments made as a result of prescriptions written by excluded or unauthorized providers and improper refills of Drug Enforcement Agency scheduled drugs. The Medicare Part D RAC contract ended in December 2015, but an administrative and appeals option period allows the RAC to complete work on outstanding audit issues until the end of December 2018. Because the option period does not permit new audit work, no new improper payments were identified by the Part D RAC during FY 2018. HHS is committed to ensuring program integrity for the Part D program and is exploring options for the Part D RAC. The Part D RAC recouped approximately $0.3 million in overpayments in FY 2017 that were identified in previous years.[41]

2.15.3. Medicaid

Section 1902(a)(42) of the Act requires states to establish Medicaid RAC programs. Each state has the flexibility to tailor its RAC program, where appropriate, with guidance from HHS. Although 47 states and the District of Columbia had implemented Medicaid RAC programs at various times through FY 2017, presently 12 states have HHS-approved exceptions to Medicaid RAC implementation due to high managed care penetration so a total of 38 states and the District of Columbia currently have operational RAC programs.

As a measure of effectiveness of the State Medicaid RAC Program for FY 2017, 28 states reported through the CMS-64 a total combined federal and state share amount of Medicaid RAC recoveries of $64.0 million, returning the federal share of $36.9 million to the Treasury.

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[40] 42 C.F.R. § 423.2600.

[41] More information can be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/index.html.

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

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

3.1. Medicaid 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 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 2017, the MII has provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 8,020 enrollments in 170 courses and 14 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, 2017, 359 state employees from 47 states have received the CPIP credential.

State Attendees Apply Lessons
from MII Medicaid Provider Enrollment Seminar – April 2017

"*I will take back information I learned from the sessions to share with my team. Clarification around the TIBCO reporting as well as the MPEC highlights are good examples. Conversations with representatives from other states and CMS helped me to identify potential areas of opportunity for enhanced training in my state. Additionally, we will be reviewing best practices shared from the other state representatives to determine if it would be beneficial to incorporate these practices in our state.*"

In FY 2017, the MII provided onsite training with 986 state employees enrolled in the following courses and meetings:

- 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
- Program Integrity Partnership in Managed Care Symposium
- Medicaid Provider Enrollment Seminar
- CPT Outpatient Coding Boot Camp
- Coding for Non-Coders
- CPT Inpatient Coding Boot Camp
- Evaluation & Management Boot Camp
- Program Integrity Directors' Symposium
- Interviewing and Interrogation Techniques Program
- Data Experts Symposium
- Emerging Trends in Home and Community-Based Services (HCBS) and Personal Care Services (PCS)
- Provider Auditing Fundamentals Program
- Medical Record Auditing
- Collaboration Opportunity in Medicaid Managed Care: CMS and State Auditing Community Meeting
- Healthcare Fraud Prevention Partnership Meeting
- CPIP Working Group Meeting
- MII Advisory Group Meeting

3.2. 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 CY 2015-2017 focused on specific areas of program integrity concern, including oversight of managed care organizations, provider screening and enrollment, personal care services, and non-emergency medical transportation.

To supplement the focused onsite reviews, CMS also initiated desk reviews of state program integrity efforts in 45 states and the District of Columbia during CY 2017. 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 2017 included provider terminations, Medicaid RACs, and implementation status of Payment Error Rate Measurement

(PERM) corrective action plans as well as states' program integrity corrective action plans.

3.3. Guidance and Technical Assistance

CMS provides technical assistance on program integrity via monthly calls to states and stakeholders, including CMS contractors, state MFCUs, HHS-OIG, other HHS agencies, and the DOJ including U.S. Attorneys' Offices and the FBI. These calls cover announcements regarding events of interest to the PI community, policy and operations-related group discussion, and the exchange of information regarding best practices and fraud trends.

In FY 2017, CMS held monthly Medicaid Fraud & Abuse Technical Advisory Group meetings. The Beneficiary Fraud Technical Advisory Group and the Small States Technical Advisory Groups also met monthly. In FY 2017, CMS convened a new monthly Data Analytics Technical Advisory Subgroup call.

In December 2016, CMS's New York field office hosted a regional meeting of program integrity stakeholders from Medicaid, Medicare, and law enforcement agencies to discuss current fraud issues and recent cases. CPI staff from New York also attended quarterly FBI Health Care Fraud Task Force meetings in New York City, providing updates on CPI activities and offering technical assistance to attendees as needed following these meetings.

In addition, in March 2016, CMS published the Medicaid Provider Enrollment Compendium (MPEC) to help states in implementing various enrollment requirements including provider site visit and fingerprint-based criminal background check requirements. In January 2017, CMS updated the MPEC to clarify existing guidance and provide additional guidance. CMS also provides education and outreach via numerous webinars and training calls, as well as presentations at the MII. In addition, CMS conducts state site visits to review and advise states about implementation challenges in provider screening and enrollment. To date, CMS has completed 17 state site visits with a minimum of another 15 state site visits planned in 2017.

3.4. National Medicaid Audit Program

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers and to audit providers' claims to identify overpayments. Under the auspices of the then-new Medicaid Integrity Program, CMS made the first audit assignments to Audit MICs in September 2008. To better coordinate Medicare and Medicaid program integrity audit and investigation work, CMS is currently shifting its Audit MIC workload to the UPICs.

CMS 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/UPICs, resulting in more timely and accurate audits. These audits combine the resources of CMS and the Audit MICs/UPICs, including algorithm development, data mining, auditors, and medical review staff, to assist states in addressing suspicious payments. The collaborative process includes a discussion between the state and CMS regarding potential audit issues and the state's provision of Medicaid Management Information System (MMIS) data for data mining. Because the process is collaborative, not prescriptive, the individual states, along with CMS, determine the audit processes the Audit MICs/UPICs follow during the collaborative audit. In some instances, the Audit MICs/UPICs conduct the entire audit. In other cases, the Audit MICs/UPICs supplement state resources by providing medical review staff and other resources.

In FY 2017, CMS increased state participation in collaborative audits to a total of 43 states, the District of Columbia, Guam, and the Northern Mariana Islands, which represented an overwhelming majority of Medicaid program expenditures. The most common collaborative audits have been conducted in the areas of hospice services, Medicaid credit balances, and emergency services to non-citizens.

During FY 2017, the Audit MICs/UPICs identified $33.9 million in total Medicaid overpayments sent to states for collection. States are responsible for collecting overpayments identified by Audit MICs/UPICs, and generally are permitted up to one year from the date of the final audit report to return the federal share.[42] For FY 2017, states reported a total federal and state share combined amount of Audit MIC/UPIC audit recoveries of $22.8 million and returned the federal share of $14.6 million to the Treasury.

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

3.5. 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 to conduct comparative analytics across state lines and between the Medicare and Medicaid programs. States will be able to analyze their own program data along with other information in the CMS data repositories, including Medicare data, in order to identify potential anomalies for further investigation. As appropriate, CMS will take action to

[42] 42 CFR § 433.312.

incorporate data from T-MSIS, as it is received from states, into both Medicaid-specific and multi-program analytics.

The Medicaid Statistical Information System (MSIS) data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 states and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the MACBIS Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. The 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. States' T-MSIS implementation began on a rolling basis starting April 2016. As of November 2017, 48 states, representing 96 percent of the Medicaid and CHIP population, are submitting T-MSIS data. 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's and states' goals for improved timeliness, reliability, and more robust data analysis processes through monthly updates automated data quality checks, and an increased volume of data provided (i.e., third-party liability, information from managed-care plans, and providers). An integrally related effort known as MACPro, which stands for the Medicaid and CHIP Program, will collect program data to automate state plan amendments 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.

The following milestones were achieved in FY 2017:

Overall Investment Achievements

- Maintained and continued to expand the cloud hosting infrastructure to support business intelligence and data analysis of MACBIS data (T-MSIS and other legacy data).
- Developed and documented new requirements for MACBIS projects (MACPro, T-MSIS).

- Maintained and operated the cloud hosting infrastructure within Amazon Web Services to support MACBIS projects.
- Migration of MACBIS systems (T-MSIS and MACPro) to new infrastructure (v3) on cloud hosting infrastructure.
- Maintained and operated the MACBIS virtual data center hosting infrastructure to support MACBIS operational/legacy projects.
- 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 that contains Medicaid and CHIP eligibility and enrollment data, and this tool will be used by internal stakeholders for ongoing program monitoring and oversight.
- Extensive research and development to uncover data quality issues with states' operational data.
- Engaged stakeholders from the state government, federal government, and industry organizations to improve data quality and uncover needs and associated solutions.
- Implemented an initial infrastructure and framework to support data analytics (MicroStrategy, SAS, and the data warehouse) including support for initial data products (T-MSIS Analytic Files (TAF)).
- Supported data analysis and requests for using Medicaid and CHIP data.
- Provided program/project management and change management support to all MACBIS projects.

T-MSIS

- Provided data to downstream CMS systems (e.g., Chronic Conditions Data Warehouse, IDR) that will consume T-MSIS data.
- Completed state migration from MSIS to T-MSIS.
- Retired legacy system processing (MSIS) and migrated functionality and data as identified in releases for T-MSIS.
- Through managed releases, incorporated performance improvements, improved automation and performance monitoring to optimize processing and provide a sustainable environment for processing a national data set.
- Released an updated T-MSIS data dictionary and set of business rules.
- Significantly improved T-MSIS receipt and control processes, preventing bottlenecks when large files, such as those from certain large states, are received.
- Produced a T-MSIS equivalent file of the MSIS VALIDS file used by existing MSIS data users to provide a T-MSIS format similar to what was used in MSIS.
- Provided dedicated state technical assistance and support to states progressing to T-MSIS go-live, as well as production operational support assistance for states in production. Assistance included: on-boarding; source to target mapping of state

data; state readiness reviews; guiding states to data quality corrections; and supporting, monitoring, and resolution of data quality plans of action. All of these actions improved the timeliness and quality of state data submissions.

- Conducted post-production data quality assessment using 2,000 checks so results can be used for 1) reporting to users, and 2) fixing anomalies reported by states.
- Launched post-production data quality improvement process with states including completion of a comprehensive data quality database.
- Developed TAFs with beneficiary, claims, provider and managed care plan data for T-MSIS data users with initial set of files to be completed in early FY 2018.
- Developed five standardized data analytic tools for analysis on topics including substance abuse disorder and superutilizers that will be tested and used with TAF files.
- Convened Technical Evaluation Panel with Medicaid researchers where they conducted review and analysis with "beta" version of T-MSIS data for data quality and usability.

MACPro

- Significantly enhanced the foundational MACPro application by upgrading the Appian software to version 17.1 which is a more flexible state of the art tool that will provide a better user experience in the application.
- Managed legacy systems and migrated legacy functionality and data as identified in releases for MACPro.
- Developed and implemented new business components:
  - 2016 Adult, Child, and Maternal Infant and Health Quality Measures Reporting
  - 2014 – 2016 Health Homes Quality Measures Reporting
- Medicaid State Plan encompassing eligibility and Medicaid Model Data Lab to MACPro Data Migration.

3.6. 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 the 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.[43] 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, which requires states to submit their UPL demonstrations on an annual basis for all facility benefits.[44] 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.

3.7. Disproportionate Share Hospital Audit and Reporting

On December 19, 2008, CMS promulgated rule CMS-2198-F: Medicaid Program: Disproportionate Share Hospital (DSH) Payments, which implemented section 1001 of the MMA that requires state audits and reports to ensure the appropriate use of DSH payments. The statute required that states submit an annual independent certified audit and report as a condition of receiving Federal Financial Participation (FFP) for DSH payments.

The rule established a December 31, 2009 submission deadline for the first two years of audits and reports, those associated with Medicaid State plan rate years (SPRY) 2005 and 2006. Each subsequent audit and report is due by the December 31st three years subsequent to the completion of the SPRY. The 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.[45]

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

[43] 42 CFR § 447.325.

[44] State Medicaid Director's Letter 13-003 (March 18, 2013), available at https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-003-02.pdf.

[45] Available at https://www.medicaid.gov/medicaid/finance/dsh/index.html.

incurred in furnishing inpatient and outpatient hospital services to Medicaid-eligible patients and the uninsured.

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

Integrate, Analyze, and Share Data to Inform Decision Making

4.1. Provider Enrollment

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

CMS's role in the provider and supplier enrollment process 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 and fraud prevention programs. States directly oversee the provider screening and enrollment process for their own Medicaid programs, and CMS provides regulatory guidance and technical assistance to states.

Medicare Provider Screening and Site Visits

CMS implemented additional screening provisions through a final rule published on February 2, 2011.[46] CMS's regulation establishes three levels of provider and supplier enrollment risk-based screening: "limited"; "moderate"; and "high"; and classification by provider- and supplier-types, subject to upward adjustment in certain circumstances.

Providers and suppliers designated in the "limited" risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider- or supplier-specific requirements. Providers and suppliers designated in the "moderate" risk category are subject to unannounced site visits in addition to all the requirements in the "limited" screening level. Providers and suppliers in the "high" risk category are subject to fingerprint-based criminal background checks (FCBCs) in addition to all of the requirements in the "limited" and "moderate" screening levels. For Medicare, CMS began phasing in the fingerprinting requirements on August 6, 2014. In FY 2017, CMS

[46] 76 FR 5862 (Feb. 2, 2011).

denied approximately 1,259 enrollments and revoked 19 enrollments because of the FCBCs or a failure to respond to a request for fingerprints.

The Advanced Provider Screening (APS) system automatically screens all current and prospective providers and suppliers against a number of data sources, including provider and supplier licensing and criminal records, to identify and highlight potential program integrity issues for proactive investigation by CMS. APS continuously monitors all providers and suppliers against external licensure and criminal data sources to alert CMS of any actionable changes to licensure information or of any criminal flags. In FY 2017, APS conducted more than 2.6 million screenings. These screenings generated more than 21,700 License Continuous Monitoring alerts, and more than 60 Criminal Continuous Monitoring alerts, which resulted in approximately 168 revocations due to felony convictions and over 590 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 2017, 78,568 site visits were conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 17,745 were conducted by the National Supplier Clearinghouse, which conducts site visits for Medicare DME suppliers. This work resulted in 227 revocations due to non-operational site visit determinations for all providers and suppliers.

CMS's provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2017, CMS deactivated 177,525 enrollments and revoked 2,831 enrollments.[47] The site visit and revalidation requirements[48] have contributed to the deactivation[49] and revocation[50] of more than one million enrollment records since CMS started implementing these screening and enrollment requirements (Figure 1).

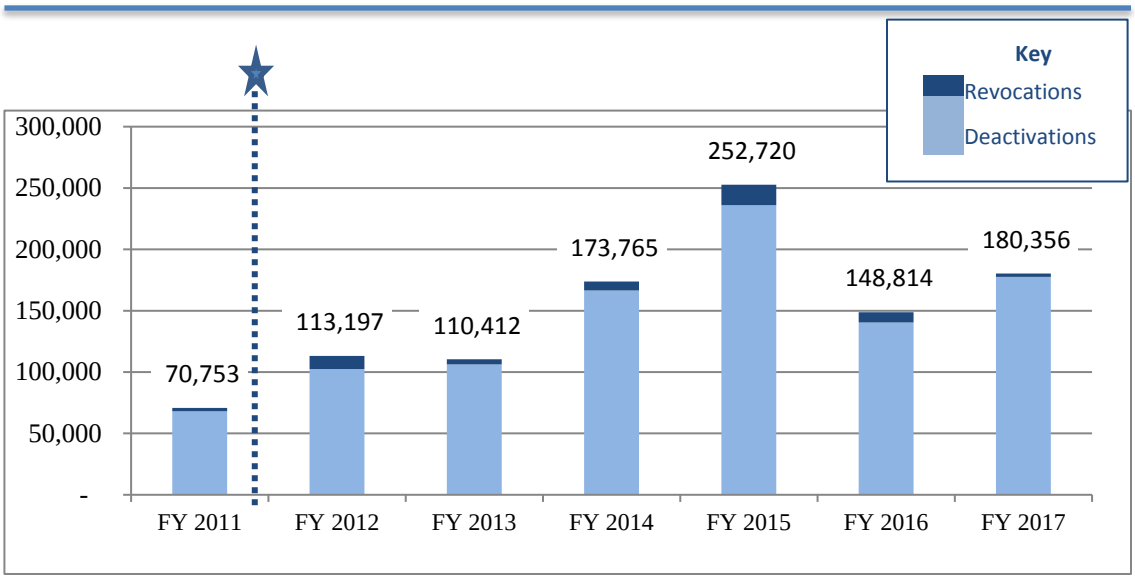
[47] We note that revalidation results are point-in-time results, as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

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

[49] 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.

[50] 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 2017



Provider Revalidation

In FY 2017, CMS continued its revalidation efforts, which includes regular revalidation cycles for all existing two million Medicare providers and suppliers. DMEPOS suppliers are required to revalidate every three years and all other providers and suppliers are required to revalidate every five years. These efforts ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. Similarly, states are also required to revalidate Medicaid providers at least every five years. States may rely on Medicare revalidation results in order to meet revalidation requirements for dually-participating providers and suppliers.

In FY 2017, CMS initiated revalidation for approximately 400,000 providers and suppliers. Of those, 180,000 have successfully completed revalidation and 78,000 have been deactivated. The remaining 142,000 provider revalidations are currently pending processing by the MAC.

Enrollment Special Study

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

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, 2016 through September 30, 2017, the MAC covering Florida (First Coast Service Operations) conducted 6,498 site visits to verify providers' and suppliers' operational status, deactivated 148 practice locations, and revoked or denied 1,137 providers.

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

The Provider Enrollment, Chain and Ownership System (PECOS) is the Internet-based system that providers and suppliers use to enroll, revalidate, or make changes to their enrollment information in the Medicare FFS program. CMS made significant improvements to the system to make it easier for providers and suppliers to access and use the system. In FY 2017, 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 sponsored outreach events (e.g., Decision Health),
- Organizing the National Provider Enrollment Conference, 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 2017, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including the following changes:

- Implemented a new workflow and form for the Medicare Diabetes Prevention Program suppliers.
- Implemented a simplified one page process flow for CMS 855O form users to easily enroll in Medicare.
- Created a new report for State Users for easy and clear access to enrollment data.
- Implemented an enhancement that streamlines and enables providers and suppliers to make changes to their application even after submission.
- Implemented an enhancement that allows providers and suppliers to view their revalidation due date and other relevant information as part of PECOS revalidation center.
- Enhanced workflow for end users to improve the experience and reduce the user burden.

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

In FY 2017, CMS released the new NPPES system with a modernized interface and enhanced features for managing and enumerating NPIs. This modernization includes:

- 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.
- Bulk upload and bulk enumeration for large organizations.

4.3. Medicaid Provider Enrollment Oversight

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

State Medicaid programs are required to terminate any provider that has been terminated "for cause" by Medicare or another state Medicaid program or CHIP.[51] Additionally, CMS has the discretionary authority to revoke Medicare billing privileges when a state has terminated a provider's or supplier's Medicaid billing privileges for cause. To meet this requirement, CMS has established a process for states to report and share information about Medicaid terminations. States may report to CMS all "for cause" Medicaid terminations of providers who have exhausted all applicable appeal rights, or for whom the timeline for appeal has expired, for inclusion in the CMS provider termination system.

CMS continued to strengthen program integrity in FY 2017 after its 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 to the SMAs to comply with the requirements for provider

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

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 MPEC, a policy manual that, among other things, contains clarified guidance regarding how SMAs may, in certain circumstances, rely on Medicare provider screening activities in lieu of conducting their own.[52] In FY 2017, 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. For some SMAs, this process could reduce their revalidation workload by up to 70 percent. In FY 2017, 13 SMAs had taken advantage of the data compare service. In addition, CMS participated in enrollment conference calls with states and provided webinar trainings on states' use of TIBCO,[53] a managed file transfer internet server that CMS uses to provide revocation, termination, and enrollment data to the states, and on PECOS. CMS also conducts provider enrollment and termination outreach and education at the MII. The most recent course was in April 2017 with 36 states in attendance. Similar outreach and education opportunities are presented annually at the National Association for Medicaid Program Integrity (NAMPI).

In FY 2016, CMS implemented the State Assessment Support Contractor to assist SMAs with the implementation of enrollment processes and sharing of best practices between SMAs. The contractor, with support of CMS representatives, conducts a detailed review of the SMA's enrollment processes at the SMA's request. The focused review and subsequent brainstorming sessions assist the SMA in assessing their current progress to meeting the enrollment and screening requirements and provides recommendations to improve their processes. The emphasis during this assessment is not only on PPACA-related compliance but also includes a review of the SMA's current processes to determine opportunities to become more efficient in other areas of their program. In FY 2017, CMS continued to perform these detailed reviews and compliance assistance site visits and visited 13 states.

4.4. Provider Enrollment Moratoria

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

[52] The MPEC is available at https://www.medicaid.gov/affordable-care-act/downloads/program-integrity/mpec-6232017.pdf.

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

ambulance suppliers).[54] The moratoria also applied to Medicaid and CHIP in those geographic areas. In January 2014, CMS extended these moratoria by 6 months and expanded the moratoria to include HHAs in the areas surrounding Fort Lauderdale, Florida; Dallas and Houston, Texas; and Detroit, Michigan; and Part B, Medicaid, and CHIP ground ambulance suppliers in and around Philadelphia, Pennsylvania.[55] CMS continued to extend these moratoria in 6-month increments.[56]

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

In July 2016, CMS announced the 6-month extension and statewide expansion of the moratoria on the enrollment of HHAs in Florida, Illinois, Michigan, and Texas and of Part B non-emergency ground ambulance suppliers in Texas, New Jersey, and Pennsylvania. In addition, CMS announced the lifting of the moratoria on all Part B emergency ground ambulance suppliers. These moratoria, and the changes described in the document, also applied to the enrollment of HHAs and non-emergency ground ambulance suppliers in Medicaid and CHIP.[57]

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

[54] 78 FR 46339 (July 31, 2013).

[55] 79 FR 6475 (Feb. 4, 2014).

[56] 81 FR 5444 (Feb. 2, 2016).

[57] 81 FR 51120 (Aug. 3, 2016).

Finally, on January 29, 2017[58] and again on July 28, 2017,[59] CMS extended the statewide moratoria of HHAs in Florida, Illinois, Michigan, and Texas, and Part B non-emergency ground ambulance suppliers in New Jersey, Pennsylvania, and Texas for an additional 6 months. These extensions also applied to Medicaid and CHIP.

On August 25, 2017, the President signed the Presidential Disaster Declaration for several counties in the State of Texas due to Hurricane Harvey. After careful review of the potential impact of continued moratoria in Texas and to prevent potential access to care issues, CMS lifted the temporary enrollment moratorium on Medicare Part B non-emergency ground ambulance suppliers effective September 1, 2017. The lifting of the moratorium also applied to Medicaid and CHIP ambulance providers in Texas. CMS announced the lifting of the moratoria on CMS.gov and, in accordance with 42 CFR § 424.570(d), published it in the Federal Register.[60]

4.5. Demonstrations and Models

CMS conducts a number of innovative demonstrations and models designed to develop or demonstrate improved methods for the investigation and prosecution of potential fraud in the provision of care or services and to test innovative payment and service delivery models to reduce program expenditures, while preserving or enhancing the quality of care. Details and the status of demonstrations and models conducted in FY 2017 follow.[61]

Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967[62] authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program.

Prior Authorization of Power Mobility Devices (PMDs)

In FY 2017, CMS continued the Prior Authorization of PMDs Demonstration. On September 1, 2012, CMS implemented the 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 before the service is provided and the claim is submitted for payment. In FY 2014, CMS announced the expansion of the prior authorization

[58] 82 FR 2363 (Jan. 9, 2017).

[59] 82 FR 35122 (July 28, 2017).

[60] 82 FR 51274 (Nov. 03, 2017).

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

[62] Public Law 90-248.

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 claims processed as of March 30, 2017, monthly expenditures for the PMD codes included in the demonstration decreased from $12 million in September 2012 to $2.2 million in September 2016 in the original seven demonstration states, $10 million in September 2012 to $1.7 million in September 2016 in the 12 additional expansion states, and $10 million in September 2012 to $2.2 million in September 2016 in the non-demonstration states. In FY 2015, CMS extended the demonstration to August 31, 2018.[63]

DMEPOS Prior Authorization

Building on the Prior Authorization of PMDs Demonstration, CMS issued a DMEPOS prior authorization final rule in FY 2016 that establishes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization.[64] The rule defines unnecessary utilization as "the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules." The rule also establishes a list of DMEPOS items that could be subject to prior authorization before items or services are provided and payment is made.

In FY 2017, CMS began implementing prior authorization for two types of group 3 power wheelchairs (HCPCS codes K0856 and K0861) in a staggered approach. On March 20, 2017, prior authorization began in Illinois, Missouri, New York, and West Virginia. On July 17, 2017, CMS expanded prior authorization for these two types of power wheelchairs nationwide.

Pre-Claim Review Demonstration for Home Health Services

CMS implemented a Pre-Claim Review Demonstration for Home Health Services in Illinois from August 2016 until March 2017, when it was paused. Under the demonstration, CMS reviewed pre-claim review requests and provisionally affirmed the requests as likely meeting Medicare rules and requirements prior to claim submission. Taking into account stakeholder feedback on this demonstration, CMS is considering a number of structural improvements prior to announcing a revised demonstration.[65]

Models

Section 1115A of the Act authorizes the Secretary, through the Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models in order to

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63 Additional information about this demonstration is available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/PADemo.html.

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

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

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

Prior Authorization for Non-Emergent Hyperbaric Oxygen Therapy

In FY 2017, CMS continued implementing in three states, Michigan, Illinois, and New Jersey, a Prior Authorization Model for Non-Emergent Hyperbaric Oxygen Therapy. Launched in FY 2015, the prior authorization model tests whether prior authorization reduces expenditures while maintaining or improving quality of care. This model is also intended to help ensure services are provided in compliance with applicable Medicare coverage, coding, and payment rules before services are rendered and claims are paid. 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.

Prior to implementing the model, spending on outpatient hyperbaric oxygen therapy in the model states averaged $1.69 million per month. Based on data from the model's first two years, spending decreased to an average of $943,231 per month.[66]

Prior Authorization for Repetitive Scheduled Non-emergent Ambulance Transport

In FY 2017, CMS continued implementing a Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport. This began as a three-year model on December 1, 2014, for transports occurring on or after December 15, 2014, in Pennsylvania, New Jersey, and South Carolina,[67] then, as required by section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),[68] beginning January 1, 2016, five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia were included in the model.[69] On December 4, 2017 and again on November 30, 2018, CMS announced that the model would be extended for one additional year to allow CMS to continue to evaluate the model and determine if the model meets statutory requirements for nationwide expansion under MACRA. It is currently scheduled to end in all states on December 1, 2019. [70, 71]

Expenditure data reflects that in the model's first two years, average spending in the initial three states decreased from $18.9 million to $6.0 million per month, while data

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

67 79 FR 68271 (Nov. 14, 2014)

68 Public Law 114-10.

69 80 FR 64418-19 (Oct. 23, 2015)

70 82 FR 58400 (Dec. 12, 2017)

71 83 FR 62577 (Dec. 4, 2018)

from the first year of the model for the additional states reflects that average spending decreased from $5.7 million to $3.1 million per month.[72]

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

5. Improve the CMS Customer Experience

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

5.1. Improper Payment Rate Measurement

The Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)[73] 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.

Improper payments are not always indicative of fraud, nor do they necessarily represent expenses that should not have occurred. For example, instances where there is insufficient or no documentation to support the payment as proper are cited as improper payments under current Office of Management and Budget guidance. The majority of CMS improper payments are caused by payments that lack the appropriate supporting documentation to confirm their validity. A smaller proportion of CMS improper payments are payments for which CMS determined should not have been made or should have been made in a different amount, representing a known monetary loss to the program. Improper payment rates in this section include both overpayments and underpayments.

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 Comprehensive Error Rate Testing (CERT) program to calculate the improper payment rate in the Medicare FFS program. The CERT program considers any payment that should not have been made or was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment. 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 (AFR) on an annual basis.

While the factors contributing to improper payments are complex and vary from year to year, the primary causes of improper payments continue to be insufficient documentation

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

and medical necessity errors. In order to reduce improper payments, CMS is working on multiple fronts to meet our improper payment reduction goals, including targeted measures for specific service areas with high improper payment rates (e.g., home health claims) and efforts to address the root causes of improper payments.

The Medicare FFS improper payment rate for FY 2017 was 9.5 percent, representing an estimated $36.2 billion in improper payments.[74]

Payment Error Rate Measurement Program

The Medicaid program and CHIP have been identified as being at high risk for improper payments. To comply with the IPIA, CMS established the Payment Error Rate Measurement (PERM) program to estimate national improper payment rates in Medicaid and CHIP. The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. CMS measures Medicaid and CHIP improper payment rates using 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 2015, 2016, and 2017, was calculated and reported in the HHS FY 2017 AFR. The national Medicaid improper payment rate for FY 2017 was 10.1 percent, representing an estimated $58.7 billion in improper payments including both the federal and state share.

The national Medicaid component improper payment rates in FY 2017 were:

- Medicaid FFS, 12.9 percent;
- Medicaid managed care, 0.3 percent; and
- Medicaid eligibility, 3.1 percent.

The FY 2017 national CHIP improper payment rate, based on measurements conducted in 2015, 2016, and 2017, was 8.6 percent or $1.6 billion in estimated improper payments, including both the federal and state share. The national CHIP component improper payment rates were:

- CHIP FFS, 10.3 percent;
- CHIP managed care, 1.6 percent; and
- CHIP eligibility, 4.2 percent.[75]

Please note that, as mentioned in the HHS FY 2017 AFR, in light of changes to the way states adjudicate eligibility for Medicaid and CHIP under current law, in August 2013 and October 2015, CMS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, CMS will not conduct the eligibility measurement component of PERM. In place of these PERM eligibility reviews, all states

[74] Additional information on the Medicare FFS improper payment methodology and corrective actions can be found in the HHS FY 2017 AFR on pages 184-196.

[75] Additional information on the Medicaid and CHIP improper payment methodology and corrective actions can be found in the HHS FY 2017 AFR on pages 200-210.

are required to conduct Eligibility Review Pilots that provide more targeted, detailed information on the accuracy of eligibility determinations to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility; identify strengths and weaknesses in operations and systems leading to errors; and test the effectiveness of corrections and improvements in reducing or eliminating those errors. During this time, for the purpose of computing the overall national improper payment rate, the Medicaid and CHIP eligibility component improper payment rates are held constant at the FY 2014 national rate of 3.1 percent and 4.2 percent, respectively.

CMS used the Eligibility Review Pilots to test updated PERM eligibility processes, and prepare states for the resumption of the PERM eligibility component measurement. Based on the pilots, CMS updated the eligibility component measurement methodology and published a final rule to update the methodology for the PERM eligibility component.[76] CMS will resume the eligibility component measurement under this final rule and report an updated national eligibility improper payment estimate in FY 2019.

Improper Payment Rate Measurement in the MA and Part D Programs

The MA and Part D programs could also be vulnerable to improper payment to plans by CMS, though this risk is distinct from the type of vulnerability experienced within the traditional Medicare program which has not adopted utilization management practices that have been broadly adopted by other health care financing programs. In compliance with IPIA, CMS makes efforts to address improper payments in MA and Part D. Unlike in Medicare FFS, for MA and Part D, CMS makes prospective, monthly per-capita payments to MA organizations and Part D plan sponsors. Each per-person payment is based in part on a bid amount, approved by CMS, that reflects the plan's estimate of average revenue required to provide coverage of original Medicare (Part A and Part B) benefits to an enrollee with an average risk profile. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on the individual enrollee's health status and demographic factors.[77] In addition, certain Part D prospective payments are reconciled against actual costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The MA payment error estimate reported for FY 2017 was 8.3 percent, or $14.4 billion. The MA payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by MA plans to CMS for payment purposes. Specifically, the estimate reflects the extent to which diagnoses that plans report to CMS lack supporting medical record documentation. The FY 2017 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 2015, where the strata are high, medium, and low risk scores;

[76] 82 FR 31158 (July 5, 2017).

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

- 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 an MA gross payment error amount.

The Part D payment error estimate reported for FY 2017 was 1.7 percent, or $1.3 billion. The Part D payment error measures the payment error related to PDE data, where the majority of error for the program exists. HHS measures the inconsistencies between the information reported on PDEs and the supporting documentation submitted by Part D sponsors: prescription record hardcopies (or medication order, as appropriate), and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error, which is simulated onto a representative sample of beneficiaries to determine the Part D improper payment estimate.[78]

5.2. Healthcare Fraud Prevention Partnership

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

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

In FY 2017, the HFPP reached a membership level of 85 Partner organizations, an increase of 23 percent since FY 2016. Membership is comprised of nine federal agencies, 12 associations, 44 private payers, and 20 state and local partners.

To achieve its objectives, the HFPP uses a “Trusted Third Party” (TTP), a CMS contractor, to act as a “common data aggregator” under the HIPAA Privacy Rules. Under this model, the TTP is able to conduct cross-payer data aggregation and analysis services to identify potential fraud across payers, while ensuring that each Partner only has access to their own claims data.

In FY 2017, the HFPP expanded its study methodology to collect frequently updated data, including personally identifiable information and protected health information.

[78] Additional information on the Medicare Part C and Part D improper payment methodology and corrective actions can be found in the HHS FY 2017 AFR on pages 196-200.

Over 5 billion professional (submitted on a CMS-1500 claim form) claim lines were submitted by Partners in FY 2017 for the purpose of conducting cross-payer analyses. By the end of FY 2017, the HFPP had commenced or completed 15 studies since its inception. These cross-payer studies enable the HFPP to proactively identify vulnerabilities in real time, significantly increasing the value of membership to all Partner organizations. The HFPP is currently using professional claims but is planning to expand to collect institutional, pharmacy, and dental claims in the future.

The HFPP uses a diverse variety of approaches to identify vulnerabilities in Partner data. These methods include standard searches to detect anomalies that may indicate the existence of fraud, waste, and abuse; scanning of incoming claims information against existing data sets, such as lists of deactivated providers; creation of reference files that list providers that may be suspect based on known risks; and creation of informational content to support stakeholders in addressing vulnerabilities (e.g., white papers). Some studies initiated in FY 2017 include the identification of:

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

Additionally, in January 2017, the HFPP released a white paper entitled "Healthcare Payer Strategies to Reduce the Harms of Opioids: The Healthcare Fraud Prevention Partnership's Commitment to the Management of Opioid Misuse and Opioid Use Disorder."[79] The white paper describes best practices for consideration by all health care payers and other relevant stakeholders to effectively address and minimize the harms of opioids while ensuring access to medically-necessary therapies and reducing fraud, waste, and abuse.

5.3. Outreach and Education

Medicare Provider Outreach and Education

One of the goals of provider outreach and education is to reduce the Medicare improper payment rate by 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 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

[79] Available at https://downloads.cms.gov/files/hfpp/hfpp-opioid-white-paper.pdf.

Medicare program, including CMS-developed materials and contractor-developed materials.

CMS-developed materials include Medicare Learning Network® (MLN) educational products, information, and resources for the health care professional community. Specifically, Medicare contractors use MLN Matters articles, which are national education articles prepared in consultation with clinicians, billing experts, and CMS subject matter experts that are tailored by content and language to specific provider type(s) 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.

Medicare 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 suspected fraud. In FY 2017, this effort included the *Medicare & You* handbook and other beneficiary education materials, 1-800-MEDICARE, and Medicare.gov. Similar messages are disseminated through a wide range of beneficiary touch points, including the Medicare Summary Notice, the MyMedicare.gov Message Center, and response letters to beneficiary inquiries.

Beginning in August 2017, CMS conducted a national "Guard Your Card" advertising campaign to alert beneficiaries about scams to obtain their Medicare number and the importance of protecting their number to prevent identify theft and Medicare fraud. The campaign also noted that Medicare will mail new Medicare cards to people with Medicare starting in early 2018 to help prevent personal identity theft. Earned and social media outreach and other promotional efforts continued into the fall to remind beneficiaries to protect their Medicare number and warning them about the types of scams that occur during the Medicare open enrollment period.

The Senior Medicare Patrol (SMP) program, administered by the Administration for Community Living (ACL), is another important way to reach Medicare beneficiaries. The mission of the SMP program is to empower and assist Medicare beneficiaries, their families, and caregivers to prevent, detect, and report health care fraud, errors, and abuse through outreach, counseling, and education. In FY 2017, discretionary HCFAC funds from CMS were allocated to ACL to support the SMP program.

Medicaid Educational Toolkits

CMS uses an online resource for Medicaid program integrity education, which provides public access to educational toolkits covering a variety of topics, such as dental

compliance and beneficiary card sharing.[80] 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.

Outreach and Education of Medicare Advantage and Part D Plans

In FY 2017, HHS continued its training by transitioning existing educational training tools from a private website to the Health Plan Management System (HPMS). This allowed MA and Part D plans the ability to review and use educational presentations, fact sheets, and booklets made specifically for them on the same platform where CMS makes available other pertinent information such as CMS communications, operational information, and policy materials – all within a single system used daily by MA organizations and Part D plan stakeholders.

In FY 2017, HHS also conducted a Fraud, Waste, and Abuse (FWA) Training Mission for Medicare Part C and Prescription Drug Plans. The purpose of the mission was to provide plan sponsors with the latest MA and Part D program integrity updates and for plan sponsors to discuss and share current MA and Part D FWA schemes, trends, investigations, and anti-FWA activities.

5.4. Open Payments

The Open Payments program is a statutorily-required, national disclosure program that promotes transparency and accountability by making information about the financial relationships between the health care industry (applicable manufacturers and group purchasing organizations (GPOs)) and health care providers (physicians and teaching hospitals) available to the public. The Open Payments data includes payments and other transfers of value made to covered recipients (physicians and teaching hospitals), along with ownership and investment interests held by physicians or their immediate family members in the reporting entities. Payments are reported across three main categories: general payments, research payments, and ownership and investment interests.

1) General Payments: Payments or other transfers of value made that are not in connection with a research agreement or research protocol. General payments may include, but are not limited to honoraria, gifts, meals, consulting fees, and travel compensation. Detailed guidance on reported payment categories is available in the Open Payments Final Rule (42 CFR. § 403.904).

2) Research Payments: Payments or other transfers of value made in connection with a formal research agreement or research protocol.

[80] Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.

3) Physician Ownership Information: Information about the ownership or investment interests that physicians or their immediate family members have in the reporting entities.

CMS publishes financial data for each program year[81] by June 30 of the following year, as well as updates from previous program periods. In addition, CMS updates, or "refreshes," the Open Payments data at least once each year after its initial publication. These updates include data corrections made since the initial publication of data that were submitted by applicable manufacturers and GPOs.

In FY 2017, CMS published 12.0 million payment records, transfers of value, or instances of ownership/investment interest reported during calendar year 2016. These financial transactions totaled $8.2 billion.

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, health care industry financial relationships and provides the public with information to enable them to make informed decisions about their health care. 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 (https://openpaymentsdata.cms.gov/). Manufacturers and GPOs self-report the data displayed on the Open Payments website.

In an effort to increase and improve consumer use of the Open Payments data, CMS made two significant enhancements to the public website:

- The Payments by State page allows the user to view national averages, total dollar amount received in payments per state and a summary of the natures of payments received by each state. These enhancements are presented by a map and a pie chart, respectively. The pie chart is sortable by both national and individual state views.
- The physician profile page was updated to include a physician compare feature. This feature enables users to view the physician as a sole practitioner as well as where they fall in comparison with other physicians in their like specialty. The physician compare feature is available for view by both total dollar value of general payments as well as total amount of general transactions that took place.

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 2017. 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.

[81] The program year coincides with the calendar year. In this case, the program year is the calendar year ended December 31, 2016.

The summary table below shows the number of records and value of payments published through FY 2017.

Table 6: Summary of Program Year Data

Summary of Program Year Data[1, 2]				
	2013[3]	**2014**	**2015**	**2016**
Total Number of Records[4]	4.5 million	12.0 million	12.3 million	12.0 million
Total Value of Payments (in dollars)	$4.1 billion	$7.9 billion	$8.1 billion	$8.2 billion

[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] All numbers above 10,000 have been rounded.
[3] Program Year 2013 was a partial year of data collection (August 2013 – December 2013).
[4] A record is defined as a single row in a dataset that was reported by an applicable manufacturer or GPO.

Appendix A - Table of Program Integrity Actual Obligations

CMS Program Integrity Obligations (amounts in thousands)[82]	FY 2017 Actual Amounts (in thousands)
Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden	
Program Integrity Staffing and Support	$163,909
Integrity Continuum	$11,451
Fraud Prevention System	$29,974
Program Integrity Modeling and Analytics	$27,572
One PI Data Analysis	$36,276
Benefits Integrity	$169,801
Medical Review	$182,653
Provider Audit	$155,977
Medicare Secondary Payer	$148,500
Medi-Medi	$60,909
Medicare Part C and Part D	$172,443
Appeals Initiatives	$5,061
Administration for Community Living (ACL) Senior Medicare Patrols	$18,572
Medicare Recovery Audit Program[83]	$91,472
Balance Program Integrity Initiatives Aimed to Protect Beneficiaries and the Trust Fund while Minimizing Provider Burden Subtotal[84]	$1,274,570
Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden	
Advanced Provider Screening	$23,082
Provider Enrollment, Chain and Ownership System (PECOS)	$38,649
Section 6401 Provider Screening/Other Enrollment[85]	$11,544
National Supplier Clearinghouse	$16,864
Integrate, Analyze, and Share Data to Inform Decision Making and Reduce Stakeholder Burden Subtotal	$90,139
Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs	

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

[83] 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.

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

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

Appendix A - Table of Program Integrity Actual Obligations

CMS Program Integrity Obligations (amounts in thousands)[82]	FY 2017 Actual Amounts (in thousands)
State Medicaid Access to Data and Support	$89,292
Share Best Practices with States and Allow Flexibility in Program Integrity Approaches while Improving Accountability in Medicaid Programs Subtotal	$89,292
Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education	
Outreach and Education	$47,993
Healthcare Fraud Prevention Partnership	$12,758
Open Payments	$24,845
Improper Payment Rate Measurement Activities	$61,605
Probable Fraud Measurement Study	$0
Clarify and Simplify Program Requirements through Collaboration, Transparency, Outreach, and Education Subtotal	$147,201
Total CMS Program Integrity Obligations[86]	$1,601,202

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

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

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 those attributable to 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 with 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[87] in the absence of these actions. CMS describes prevention activities in four categories: automated actions, prepayment review actions, provider enrollment actions, and other actions. The following sections describe the methodologies used to determine the prevention savings in the FY 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings*.

Type of Medicare Savings	Medicare Program
Prevention Savings	
Automated Actions	
National Correct Coding Initiative (NCCI) – Procedure-to-Procedure (PTP) Edits	Fee-for-Service (FFS)
NCCI – Medically Unlikely Edits (MUEs)	FFS
Ordering and Referring (O&R) Edits	FFS
Fraud Prevention System (FPS) Edits	FFS

[87] 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
Medicare Administrative Contractor (MAC) Automated Medical Review Edits	FFS
Zone Program Integrity Contractor (ZPIC)/Unified Program Integrity Contractor (UPIC) Automated Edits	FFS
Prepayment Review Actions	
Medicare Secondary Payer (MSP) Operations	FFS
MAC Non-Automated Medical Reviews	FFS
ZPIC/UPIC Prepayment Reviews	FFS
Provider Enrollment Actions	
Revocations	FFS
Deactivations	FFS
Other Actions	
Payment Suspensions	FFS
Medicare Part D Reconciliation Data Reviews	Part D

1 Automated Actions

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

- National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits
- NCCI Medically Unlikely Edits (MUEs)
- Ordering and Referring (O&R) Edits
- Fraud Prevention System (FPS) Edits
- Medicare Administrative Contractor (MAC) Automated Medical Review Edits
- Zone Program Integrity Contractor (ZPIC)/Unified Program Integrity Contractor (UPIC)[88] Automated Edits

1.1 National Correct Coding Initiative Procedure-to-Procedure Edits

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

[88] CMS has begun transitioning contracts to UPICs, which perform the functions of ZPICs and Medicaid Integrity Contractors. The Northeastern and Midwestern UPIC jurisdictions became fully operational in FY 2017.

CMS developed the NCCI edits to promote national correct coding practices and reduce inappropriate payments from improper coding in Medicare Part B claims. The coding decisions for these edits are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, Medicare policies, coding guidelines developed by national societies, and standards of medical and surgical practice. NCCI edit tables are refined and updated quarterly to address changes in coding guidelines and additions, deletions, and modifications of Healthcare Common Procedural Coding System (HCPCS)/CPT codes.[89] NCCI edits apply to services rendered by the same provider for the same beneficiary on the same date of service (DOS).

First implemented in 1996, NCCI PTP edits prevent inappropriate payment for services that should not be billed together for the same provider, beneficiary, and DOS. Each PTP edit applies to a specific pair of HCPCS/CPT codes. CMS uses PTP edits for pairs of codes where one code should not be reported with another code for a variety of reasons. For example: a) one code may represent a component of a more comprehensive code, or b) the codes may be mutually exclusive due to anatomic, gender, or temporal reasons. One code in each edit pair is defined as eligible for payment. If the two codes of an edit pair are billed for the same provider, beneficiary, and DOS, the edit automatically allows payment for the claim line containing the eligible code and denies payment for the claim line containing the other code.

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

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

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

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

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.

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, provider, beneficiary, and DOS. 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 contain a system-generated price, specifically the Medicare-approved charge if the claim line had been fully payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[90] 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.[91] For each unique cutback, CMS first determines the cutback amount by subtracting the allowed payment amount from the system-generated or average price. CMS then multiplies the cutback amount by 80% to estimate what Medicare did not have to pay.

Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/cutback services. Specifically, where there are 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

[90] 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.

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

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.[92]

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 a MUE, accounting for any subsequently paid units of service.
Data Source:	MCS, Viable Information Processing Systems (VIPS) Medicare System (VMS), and Fiscal Intermediary Shared System (FISS) claims data in the IDR

First implemented in 2007, NCCI MUEs prevent payment for the billing of an inappropriate quantity of the same service[93] rendered by the same provider for the same beneficiary on the same DOS. A MUE for a given service defines the maximum units of that service that a provider would report under most circumstances for the same beneficiary on the same DOS. MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS edit, the MUE value is compared to the sum of all UOS for the same HCPCS/CPT code, provider, beneficiary, and DOS on claim lines of the current claim and paid claim lines of previously submitted claims. If the sum of all UOS exceeds the MUE value, all UOS for that HCPCS/CPT code and DOS are denied on the current claim.

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

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

[92] 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.

[93] For the purposes of this document, the term “service” generally refers to an item or service.

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.

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 a MUE. During processing, claim lines may be denied for multiple errors. CMS attributes savings to MUEs only when a MUE code is the system's highest priority reason for denying a claim line.

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

Pricing MUE Denials

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

- *MCS:* In MCS, most denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[94] CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, most MUE denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, 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

[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.

equipment, etc.).[95] 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.[96] 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 an 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 characteristics, including the claim type, claims processing contractor, HCPCS modifier, 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

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 a 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

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

[96] 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.

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.[97] O&R edits prevent inappropriate payment for items or services when the ordering/referring provider: 1) does not have an approved Medicare enrollment record or a valid opt-out affidavit and a valid National Provider Identifier (NPI) or 2) is not eligible to order or refer items or services for Medicare beneficiaries.[98]

If a claim line does not pass the ordering/referring provider requirements, the O&R edit logic automatically denies or rejects the claim line.[99] This prevents payment to the billing provider, i.e., the provider who furnished the item or service based on the order or referral. CMS regularly updates a public ordering/referring data file containing the NPIs and names of physicians and eligible professionals who have approved Medicare enrollment records or valid opt-out affidavits on file and are of a type/specialty that is eligible to order and refer. Billing providers may reference this information to ensure that the physicians and eligible professionals from whom they accept orders and referrals meet Medicare's criteria.

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

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

[98] 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.

[99] 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.

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, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, O&R denial or rejection of claim lines that share the same HCPCS code, rendering provider, beneficiary, and DOS.

Pricing O&R Edit Denials and Rejections

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

- *MCS:* In MCS, most denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same calendar year for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[100] CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, few O&R edit denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the competitive bid or fee schedule region, fiscal quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing,

[100] 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.

new or used equipment, etc.).[101] 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 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 a FPS edit, accounting for any subsequently paid claim lines.
Data Source:	1) FPS and 2) CWF claims data

The FPS is capable of evaluating claims for episodes of care that span different service types or providers (e.g., inpatient care, outpatient and practitioner services, and DME) as well as those that span multiple visits over a period of time. Because of its integrated potential fraud identification capabilities, CMS implements both edits and analytical models in the FPS to address vulnerabilities for fraud, waste, and abuse on a national level. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if a FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as a FPS model[102] 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

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

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

under Medicare policy. FPS edits occur after NCCI, prepayment, and local MAC edits but prior to some CWF edits. Providers have the right to appeal FPS edit denials through the Medicare FFS appeals process. Unlike for denials, providers may not appeal FPS rejections, but they are allowed to resubmit their claims with additional or corrected information.

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

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

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

1.5 Medicare Administrative Contractor Automated Medical Review Edits

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied by MAC automated medical review edits, accounting for reversals or subsequently paid claim lines.
Data Source:	1) MACs' FISS reports 2) MCS and VMS claims data in the IDR

The MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. CMS awards a geographic jurisdiction to each MAC to process and pay Medicare Part A and Part B medical claims[103] or DME claims. The MACs perform a variety of operational functions, but this document focuses on MAC activities in support of program integrity.

CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program,[104] the

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

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

Government Accountability Office (GAO), HHS-OIG, the Medicare FFS Recovery Audit Contractors (RACs), and other sources. The MACs' medical review efforts focus on reducing payment errors; thus the MACs refer cases of potential fraud to ZPICs/UPICs. The MACs conduct most of their medical review activities prior to payment using both automated and non-automated, or manual, methods (see Section 2.2 for non-automated medical reviews that occur prior to payment and Section 5.3 for post-payment medical reviews).[105]

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

Providers have the right to use the Medicare FFS appeals process to appeal denials resulting from MAC automated medical review edits.

To estimate savings attributable to MAC automated medical review edits, CMS currently uses MAC reports for the FISS-related portion and standardized calculations for the MCS- and VMS-related portions.[106]

Estimating Savings in FISS

The MACs report their medical review savings in CMS-defined activity categories, including a specific category for automated medical review. The MACs currently use different methods for calculating savings from automated medical review edits in FISS. Because a denial occurs before the system assigns the price 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 edit was implemented, less amounts from denial decisions that were reversed.

Estimating Savings in MCS and VMS

For MCS and VMS, CMS calculates savings attributable to MAC automated medical review edit denials in three steps: 1) identifying MAC automated medical review edit denials, 2) pricing

[105] In FY 2017, CMS separated the MAC medical review prevention savings into two categories, automated medical review edits and non-automated medical reviews. In Table 3: Medicare Savings of the FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, the previously combined savings metric is labeled "Medicare Administrative Contractor Medical Reviews" in the Prevention Savings section.

[106] In FY 2017, CMS updated the methodology for determining savings attributable to MAC medical review activities for claims processed in MCS and VMS.

MAC automated medical review edit denials, and 3) accounting for subsequent payment of previously denied services.

1. Identifying MAC Automated Medical Review Edit Denials

In both MCS and VMS, system logic set up by the MACs automatically appends a specific Program Integrity Management Reporting (PIMR) activity code[107] to claim lines that fail an automated medical review edit. In MCS, CMS identifies automated medical review denials as those denied claim lines tagged with the automated PIMR activity code and a medical review audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies automated medical review denials as those denied claim lines with a combination of the automated PIMR activity code and a medical review edit code in the automated range provided by each MAC.[108]

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

2. Pricing MAC Automated Medical Review Edit Denials

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

- *MCS:* In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[109] 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.

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

[108] In VMS, CMS does not currently have a comprehensive way to determine if a MAC medical review denial is the system's highest priority reason for denying the claim line. Partially to this end, CMS excludes from savings those denied claim lines where the highest priority reason is denial as a duplicate claim line, rather than denial due to MAC medical review.

[109] 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.

- *VMS:* In VMS, some of the MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the 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.).[110] 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.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are one or more subsequently paid claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claim lines include those that were processed after the earliest denial 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 denied claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of MAC automated medical review edit savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals.

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

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied by ZPIC/UPIC-initiated automated edits, adjusted for historical appeals experience.
Data Source:	1) CMS Analysis, Reporting, and Tracking (CMS ART) fields D5c and E3c, 2) UPIC reports, 3) Paid amount adjustment factor, and 4) Appeals adjustment factor

The primary goal of ZPICs/UPICs is to identify cases of suspected fraud, waste, and abuse; develop cases thoroughly and in a timely manner; and take immediate action to ensure that Medicare Trust Fund monies are not inappropriately paid. ZPICs/UPICs have teams of

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

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[111] to cover the nation, and each ZPIC/UPIC operates in a specific zone. ZPICs/UPICs receive leads about potential fraud from several sources, including complaints, MACs, FPS, CMS, and the Department of Health and Human Services Office of the Inspector General (HHS-OIG). ZPICs/UPICs also conduct their own proactive data analysis to look for aberrant billing patterns.

During investigations, ZPICs/UPICs may request and review medical records from providers; analyze data; conduct interviews with beneficiaries, providers, or other medical personnel; and conduct onsite visits to provider locations. Based on the findings and sometimes CMS's approval, ZPICs/UPICs initiate appropriate administrative actions, such as denying or suspending payment that should not be made to a provider due to reliable evidence of fraud or abuse.[112]

Automated edits are among the administrative actions a ZPIC/UPIC may initiate. A ZPIC/UPIC may request that the MAC within its jurisdiction implement automated edits[113] to address program integrity issues and prevent the loss of future Medicare funds. Depending on the issue, these ZPIC/UPIC-initiated edits may automatically deny payment for 1) non-covered, incorrectly coded, or inappropriately billed services, 2) services submitted by suspicious providers, or 3) certain types of services for beneficiaries identified as part of a fraud scheme. In most cases, the MACs must comply with ZPICs'/UPICs' requests to install automated edits in the relevant local claims processing system. Providers have the right to appeal automated edit denials through the Medicare FFS appeals process.

ZPICs report savings due to their automated edits through the CMS ART portal, and UPICs provide savings reports to CMS. The savings reports are based on summaries of denied claim lines received from the MACs. Savings reflect claim lines denied during the fiscal year, regardless of when edit installation occurred. CMS compiles the savings reports from all jurisdictions and estimates actual savings using the following adjustment factors:

1. *Paid amount adjustment factor:*[114] ZPIC/UPIC 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

[111] In FY 2017, two UPIC jurisdictions became fully operational, and five ZPIC zones remained active.

[112] The administrative actions that may result from ZPIC/UPIC investigations include automated edits, prepayment reviews (Section 2.3) provider enrollment revocations and deactivations (Section 3), payment suspensions (Section 4.1), post-payment reviews (Section 5.6), and referrals to law enforcement (Section 9.1).

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

[114] The paid amount adjustment factor is based on FPS methodology certified by HHS-OIG.

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:*[115] 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 Prepayment Review Actions

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

- Medicare Secondary Payer (MSP) Operations[116]
- MAC Non-Automated Medical Reviews
- ZPIC/UPIC Prepayment Reviews

2.1 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

[115] The appeals adjustment factor is based on FPS methodology certified by HHS-OIG.

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

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)[117]
- Liability insurance (including self-insurance)[118]
- No-fault insurance[119]
- Workers' compensation (WC)[120]

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

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

In order to prevent erroneous primary payments, CMS records MSP information for beneficiaries in the CWF, which is the system that maintains beneficiary claims history and entitlement information. Incoming claims are automatically checked against MSP records. System logic built into the CWF 1) allows Medicare to pay correctly when incoming claims are correctly

[117] 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.

[118] 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.

[119] 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.

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

billed to Medicare as a secondary payer and 2) enables the CWF to automatically deny or reject a claim that is erroneously billed to Medicare as the primary payer.

Some MSP-related claims may require manual intervention by the MACs. A claims examiner reviews the claim and information about other coverage. Depending on the findings regarding payment responsibility, the claim may be adjusted such that Medicare only makes a secondary payment, or the claim may be rejected or denied. The MACs then attribute costs avoided to the associated MSP records.[121]

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.[122] For WCMSAs,[123] the full amount set aside is reported in the fiscal year during which the agreement is set up. Since Medicare does not receive ongoing WC claims, yearly savings due to WCMSAs cannot be determined.

2.2 Medicare Administrative Contractor Non-Automated Medical Reviews

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied prior to payment by MAC non-automated medical reviews, accounting for reversals or subsequently paid claim lines.
Data Source:	1) MACs' FISS reports 2) MCS and VMS claims data in the IDR

In addition to automated medical review edits (see Section 1.5), the MACs conduct non-automated, or manual, medical reviews where there is risk for improper payments. In FISS, MCS, and VMS, the MACs implement prepayment medical review edits, which suspend all or part of a claim possessing the targeted criteria for review. The MACs may request additional documentation from providers (i.e., through an ADR), and specific time frames apply to

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

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

[123] 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.

providers' submission of documentation and the MACs' completion of reviews. Each MAC has a medical review staff of trained clinicians and claims analysts, who review claims and associated documentation in order to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, up- or down-coded for adjusted payment. The MACs may also offer providers education to resolve errors and improve future accuracy.

Providers have the right to use the Medicare FFS appeals process to appeal denials resulting from MAC non-automated medical reviews.

To estimate savings attributable to MAC non-automated medical reviews, CMS currently uses MAC reports for the FISS-related portion and standardized calculations for the MCS- and VMS-related portions.[124]

Estimating Savings in FISS

The MACs report their medical review savings in CMS-defined activity categories, and the non-automated categories include routine medical review, demand bill claims review, prepay complex provider specific review, prepay complex service specific review, and prepay complex probe review. The MACs currently use different methods for calculating savings from non-automated medical reviews in FISS. Because a denial occurs before the system assigns the price 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 prepayment review edit was implemented, less amounts from denial decisions that were reversed.

Estimating Savings in MCS and VMS

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

1. Identifying MAC Non-Automated Medical Review Denials

In both MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line. The non-automated PIMR categories include manual routine review, complex manual review, and complex probe review. In MCS, CMS identifies non-automated medical review denials as those denied claim lines tagged with a non-automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies non-automated medical review denials as those denied claim

[124] In FY 2017, CMS updated the methodology for determining savings attributable to MAC medical review activities for claims processed in MCS and VMS.

lines with a combination of a non-automated PIMR activity code and a medical review edit code in the non-automated ranges provided by each MAC.[125] For both MCS and VMS, CMS only counts savings from the earliest or unique medical review denial of claim lines that share the same HCPCS code, rendering provider, beneficiary, and DOS.

2. Pricing MAC Non-Automated Medical Review Denials

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

- *MCS:* In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same calendar year that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[126] CMS multiplies the system-generated or average price by 80% to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, the majority of MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the 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.).[127] 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.

3. Accounting for Subsequent Payment

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

[126] 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.

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

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. Specifically, where there are one or more subsequently paid claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claim lines include those that were processed after the earliest denial 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 denied claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of MAC non-automated medical review savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals.

2.3 Zone Program Integrity Contractor/Unified Program Integrity Contractor Prepayment Reviews

Savings:	The estimated amount Medicare FFS did not have to pay for claim lines denied after ZPIC/UPIC-initiated prepayment review edits, adjusted for historical appeals experience.
Data Source:	1) CMS ART fields C1f1 and E2c, 2) UPIC reports, 3) Paid amount adjustment factor, and 4) Appeals adjustment factor

In addition to automated edits (see Section 1.6), a ZPIC/UPIC may request that the MAC in their jurisdiction implement prepayment review edits in the local claims processing system[128] to identify and suspend claims for medical review prior to payment.

During prepayment review, the MAC sends an ADR to the provider under review. In that notice, the provider is instructed to provide the necessary medical record documentation to the ZPIC/UPIC for further review. In accordance with CMS guidance, the provider must submit the necessary documentation to the ZPIC/UPIC within 45 calendar days or the claims are denied.[129] Once the documentation is received, the ZPIC/UPIC examines the medical records for compliance with Medicare policy while determining if there is evidence of fraud, waste, or abuse. When the medical documentation does not support the services billed by the provider, the ZPIC/UPIC denies or adjusts payment for the claims.

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

ZPICs report savings due to prepayment review through the CMS ART portal, and UPICs provide savings reports to CMS. The savings reports are based on summaries of denied claim

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

[129] 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.

lines received from the MACs. Savings reflect claim lines denied during the fiscal year, regardless of when prepayment review edit installation occurred. CMS compiles the savings reports from all jurisdictions and estimates actual savings using the following adjustment factors:

1. *Paid amount adjustment factor:*[130] ZPIC/UPIC 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:*[131] 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.

3 Provider Enrollment Actions

Providers must enroll in the Medicare FFS program to be paid for covered services they furnish to Medicare beneficiaries. In order to enroll, providers must submit a 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 reasons, if a provider is 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 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

[130] The paid amount adjustment factor is based on FPS methodology certified by HHS-OIG.

[131] The appeals adjustment factor is based on FPS methodology certified by HHS-OIG.

costs assuming a revoked or deactivated provider would have continued the same billing patterns.

3.1 Revocations

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

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

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

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

CMS calculates costs avoided for fully revoked providers at the level of the NPI for individual providers and the Employer Identification Number (EIN) for provider organizations. CMS defines a full revocation as a NPI or EIN with at least one enrollment that became revoked 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 PECOS. Because providers have appeal rights, the savings metric only includes revocations in place for at least 90 days that have not been overturned on appeal. CMS captures CWF claims data 90 days after the end of the fiscal year to allow time for claims adjudication and appeals.

CMS estimates the amount that Medicare did not pay fully revoked providers in two steps: 1) projecting costs avoided and 2) accounting for billing picked up by active providers. CMS

includes a given revoked provider in the savings calculation for the fiscal year in which the provider became fully revoked.

Projecting Costs Avoided

CMS projects what Medicare would have paid a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider's revocation date.[132] Using the paid claims in this 12-month period, CMS calculates the weighted moving average for each month of the revoked provider's re-enrollment bar to project the Medicare payments that provider would have received. The sum of the payment projections for each month represents the costs avoided for the revoked provider during the length of its re-enrollment bar.

Accounting for Billing Picked Up by Active Providers

CMS multiplies the sum of the projected costs avoided for all fully revoked providers by a standard, service-type-specific proportion of Medicare's payments representing services not expected to be shifted to other active providers. This cost avoidance adjustment factor is derived from a historical sample of all revoked providers and their beneficiaries. CMS calculates each service-type-specific cost avoidance adjustment factor as the following ratio:[133]

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

Since other providers may subsequently bill for the beneficiaries of revoked providers, this factor more conservatively estimates savings by removing the expected portion of the costs avoided projection for those services previously billed by revoked providers and subsequently expected to be picked up by active providers.[134]

[132] 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.

[133] The cost avoidance adjustment factor is based on FPS methodology certified by HHS-OIG.

[134] In FY 2017, CMS added the cost avoidance adjustment factor to the methodology for determining savings attributable to revocations.

3.2 Deactivations

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

CMS has multiple regulatory reasons 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), and failure to respond to a revalidation request. Unlike revocations, deactivations have no re-enrollment bars. In most cases, a provider can reactivate its enrollment in Medicare at any time by submitting a new enrollment application or recertifying the information on file.

In determining savings, CMS excludes deactivation reasons that do not represent active intervention to promote program integrity.[135] CMS calculates costs avoided for fully deactivated providers at the level of the NPI for individual providers and the EIN for provider organizations. CMS defines a full deactivation as a NPI or EIN with at least one enrollment that became deactivated during the fiscal year, no other approved or revoked enrollments, and no active PTANs or CCNs. CMS verifies fully deactivated providers in PECOS. CMS captures CWF claims data 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 fully deactivated providers in three steps: 1) projecting costs avoided, 2) accounting for reactivations within 12 months, and 2) accounting for billing picked up by active providers. CMS includes a given deactivated provider in the savings calculation for the fiscal year in which the provider became fully deactivated.

Projecting Costs Avoided

CMS projects what Medicare would have paid a fully deactivated provider based on the 12 months of claims history preceding the provider's 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.

[135] For example, CMS does not count savings if a provider is deactivated due to death or voluntary withdrawal from Medicare.

Accounting for Reactivations within 12 Months

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

Accounting for Billing Picked Up by Active Providers

After accounting for reactivations within 12 months, CMS multiplies the costs avoided projection by a standard, service-type-specific proportion of Medicare's payments representing services not expected to be shifted to other active providers. This cost avoidance adjustment factor is derived from a historical sample of all revoked providers and their beneficiaries. CMS calculates each service-type-specific cost avoidance adjustment factor as the following ratio:[136]

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

Since other providers may subsequently bill for the beneficiaries of deactivated providers, this factor more conservatively estimates savings by removing the expected portion of the costs avoided projection for those services previously billed by deactivated providers and subsequently expected to be picked up by active providers.[137]

[136] The cost avoidance adjustment factor is based on FPS methodology certified by HHS-OIG. CMS uses the same service-type-specific cost avoidance adjustment factors in the savings methodologies for revocations and deactivations.

[137] In FY 2017, CMS added the cost avoidance adjustment factor to the methodology for determining savings attributable to deactivations. CMS also conducted an inventory of PECOS deactivation reason codes and excluded from the savings calculation additional reasons that did not represent active program integrity intervention.

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 sum of the differences in escrow amounts from payment suspensions active at the end 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), 2) UPIC reports, and 3) 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 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. 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/UPICs 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/UPIC 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. For tracking purposes, the ZPIC or UPIC also enters the suspension information into the FID or Unified Case Management (UCM) system, respectively.

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/UPIC 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 calculates savings based only on those payment suspensions that were still active at the end of the fiscal year.[138] For each of these payment suspensions, CMS calculates the difference in the escrow amount, i.e., the amount held in escrow at the end of the fiscal year subtracted by the amount held in escrow at the beginning of the fiscal year. In order to estimate the amount that will be retained by Medicare, CMS multiplies the sum of the escrow differences 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.[139] CMS reports this adjusted amount as savings.[140]

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[141] and direct and indirect remuneration (DIR)[142] reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payment.

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[138] In other words, this metric excludes amounts that had been held in escrow during the year, but where the payment suspension was terminated before the end of the fiscal year. Those funds would be released to the provider or used to offset an overpayment referred to the MAC for recovery. In FY 2017, CMS updated the methodology for calculating savings attributable to payment suspensions.

[139] The payment suspension adjustment factor is based on FPS methodology certified by HHS-OIG.

[140] 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.

[141] 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.

[142] 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.

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 2017 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.[143]

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)[144] 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[145]
- 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.[146] The Part D data analysis

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

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

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

[146] 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.[147] The calculation of data quality review savings typically uses benefit-year data captured in September following the benefit year.[148] 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 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.[149] Sponsors must also include good faith estimates for DIR that is expected for the applicable contract year but has not yet been received.

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

CMS uses the reviewed and finalized DIR data in the year-end Part D payment reconciliation process for each plan, specifically to determine the reconciliation amounts for Medicare's reinsurance subsidy and risk corridor payment/recoupment. Holding all other data constant, CMS also runs a reconciliation simulation for each plan using the initially-submitted DIR data to calculate what the reinsurance and risk corridor amounts would have been. For each type of

[147] 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.

[148] 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.

[149] 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.

payment, CMS subtracts the actual amount from the simulated amount.[150] CMS calculates savings from DIR review as the sum of these reinsurance and risk corridor differences across all plans.[151] 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 2017 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 Post-Payment Medical Reviews	FFS
Medicare FFS Recovery Audit Contractor (RAC) Reviews	FFS
Supplemental Medical Review Contractor (SMRC) Reviews	FFS
ZPIC/UPIC Post-Payment Reviews	FFS
Retroactive Revocations	FFS
Overpayments Related to Risk Adjustment Data	Part C and Part D
Medicare Part D Plan Sponsor Audits	Part D
Medicare Part D RAC Reviews	Part D
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	FFS
Cost-Based Plan Audits	Cost-Based Plans
Plan Penalties	
Medicare Part C and Part D Program Audits	Part C and Part D
Medical Loss Ratio (MLR) Requirement	Part C and Part D
Other Actions	

[150] 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.

[151] 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
Party Status Appeals Initiative	FFS
Law Enforcement Referrals	
ZPIC/UPIC Law Enforcement Referrals	FFS
NBI MEDIC Part C Law Enforcement Referrals	Part C
NBI MEDIC Part D Law Enforcement Referrals	Part D

5 Overpayment Recoveries

Given the volume of claims submitted to Medicare, CMS cannot review every claim prior to payment. Thus, CMS conducts a wide range of post-payment activities to identify improper payments and recover overpayments. An overpayment is any amount a provider or plan receives in excess of amounts properly payable under Medicare statutes and regulations. Overpayments are considered debts owed to the federal government, and CMS has the authority to recover these amounts. CMS reports savings from the following overpayment[152] recovery activities:

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

- *Medicare Part C and Part D*
  - Overpayments Related to Risk Adjustment Data
  - Medicare Part D Plan Sponsor Audits
  - Medicare Part D RAC Reviews

5.1 Medicare Secondary Payer Operations

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

[152] 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.

CMS's MSP operations include the recovery of mistaken and conditional payments made by Medicare, when another payer has primary payment responsibility (see Section 2.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.[153] 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 reimburse CMS for the conditional payments. Outstanding debts are referred to the Department of the Treasury for further collection action.

The MACs conduct MSP-related recovery from providers.[154] Activities include identifying claims to be recovered, requesting and receiving repayment, and referring unresolved debts to the Department of the Treasury. Most of the MACs' recovery efforts occur through claims processing. The MACs conduct post-payment adjustments for claims that another insurer/entity should have paid in part or full. In cases of duplicate primary payment by Medicare and another insurer/entity—i.e., the provider received a primary payment from both Medicare and another insurer/entity for a given episode of care—the MACs recover Medicare's portion from the provider.

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

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

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

5.2 Medicare Secondary Payer Commercial Repayment Center

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

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

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

CMS reports recovered Medicare payments in the fiscal year during which they are collected.[155] CMS calculates the CRC savings as the sum of direct payments from debtors and delinquent debt collections from the Department of the Treasury, subtracted by excess collections that were refunded.[156]

5.3 Medicare Administrative Contractor Post-Payment Medical Reviews

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

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

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

While the MACs primarily focus on preventing improper payments (see sections 1.5 and 2.2), they may also conduct some post-payment review of claims when there is the likelihood of a sustained or high level of payment error. When conducting a post-payment review, a MAC may request additional documentation from a provider. The provider must submit documentation within a specified time frame, though the MAC has 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.[157]

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

[157] In Table 3: Medicare Savings of the FY 2016 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, this savings metric is labeled “MAC Medical Reviews” in the Recovered Savings section.

CMS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.[158] The Medicare FFS RACs' reviews focus on service-specific issues related to national and local Medicare policy. CMS approves all new issues for potential audits before the Medicare FFS RACs begin reviews. The Medicare FFS RACs may submit proposed review issues to CMS on a rolling basis. At times, CMS will also send the Medicare FFS RACs issues of potential improper payments identified by the MACs, ZPICs/UPICs, or external entities (e.g., HHS-OIG and GAO). Each Medicare FFS RAC has the option to accept or decline these issues for review. CMS can also require the RACs to conduct specific reviews.

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

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

After the discussion period, the Medicare FFS RAC refers an identified improper payment to the MAC in the appropriate claims processing jurisdiction. The MAC then adjusts the associated claim(s) in order to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Providers who disagree with a Medicare FFS RAC's improper payment determination have the right to use the Medicare FFS appeals process.[159]

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[158] 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.

[159] 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.

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.[160] 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.

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,[161] and Program for Evaluating Payment Patterns Electronic Report (PEPPER)[162]
- 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

[160] The original Medicare FFS RACs remain under contract with CMS until 2018 for administrative purposes. The FY 2017 savings for Medicare FFS RAC reviews include amounts from both the original and the new Medicare FFS RAC contracts.

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

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

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 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/Unified Program Integrity Contractor Post-Payment Reviews

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

During the course of an investigation, a ZPIC/UPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a ZPIC/UPIC requests additional documentation from a provider. The provider must submit documentation within a specified time frame, though a ZPIC/UPIC has the discretion to grant extensions.[163] If a provider does not submit the requested documentation in a timely manner, the ZPIC/UPIC denies the claims.

The ZPIC's/UPIC's clinical team reviews the provider's submitted documentation to determine if the claims billed to Medicare were appropriate. If claims are denied or adjusted during the

[163] 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.

post-payment review, the ZPIC/UPIC calculates an overpayment in accordance with the Program Integrity Manual.

Once a post-payment review is complete, the ZPIC/UPIC provides the results of the medical review to the provider[164] 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.[165] Therefore, there may be overpayments identified by a ZPIC/UPIC in a prior fiscal year for which collections accrued in the current fiscal year. Offsets or recoupments made on overpayments that are fully or partially overturned on appeal are removed from savings in the fiscal year during which the appeal is processed.

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

5.7 Retroactive Revocations

Savings:	The amount of overpayments identified due to full, retroactive revocations, multiplied by a historical proportion that Medicare FFS expects to recover.
Data Source:	1) PECOS, 2) CMS revocations log, and 3) IDR claims data

When a provider is revoked from Medicare, the effective date is 30 days from the mailing of the letter notifying the provider of the revocation, except for those revocation reasons applied retroactively as specified in regulation. For example, if an investigator determines that a provider's license is suspended, CMS sets the effective date of that provider's revocation as the

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

[165] 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 was updated from that used in prior fiscal years' calculations.

date the license was suspended. CMS has the authority to recover payments made to an ineligible provider. As part of their standard operating procedures, the MACs attempt to recover overpayments when a provider is retroactively revoked.

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

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

1. *Identify overpayments associated with full, retroactive revocations*: CMS sums the amounts paid to fully,[166] 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.[167]

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 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.

[166] See Section 3.1 for the definition of a fully-revoked provider.

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

CMS's risk adjustment models[168] generate a risk score for a given beneficiary based on the beneficiary's 1) demographic characteristics for the current payment year[169] and 2) relevant diagnosis codes[170] from services provided in the previous payment year.[171] 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.

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.[172]

CMS re-calculates risk scores for prior payment years for the purpose of recovering plan-identified overpayments. Each calendar year, CMS expects to announce one or more prior payment years subject to re-calculation and payment adjustment.[173] 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.

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[168] 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.

[169] 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.

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

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

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

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

5.9 Medicare Part D Plan Sponsor Audits

Medicare Part D Plan Sponsor Audits include the following activities:

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

In the FY 2017 Annual Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings* provides the sum of savings from both initiatives.[174]

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.

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.

[174] FY 2017 is the first year that CMS has reported savings from the Medicare Part D plan sponsor self-audits in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

Medicare Part D Plan Sponsor Self-Audits

Savings:	The amount of overpayments that Medicare recovered from Part D plan sponsors due to self-audits.
Data Source:	Self-audit attestations and close-out letters

Since calendar year 2015, CMS has used Medicare Part D plan sponsor self-audits to evaluate the appropriateness of questionable payments for Part D covered drugs identified through data analysis. CMS conducts data analysis to identify high-risk areas for inappropriate Medicare Part D payments and plan sponsors with potential overpayments for recovery. CMS provides notification to Part D plan sponsors to conduct a self-audit. Upon completion of the plan sponsor self-audit review, CMS validates whether plan sponsors have deleted the identified inappropriate PDE records. CMS reports self-audit savings in the fiscal year during which the PDE records are deleted.

5.10 Medicare Part D Recovery Audit Contractor Reviews

Savings:	The amount of Medicare Part D RAC-identified overpayments that Medicare recovered from Part D plan sponsors.
Data Source:	Plan payment adjustment forms

The Medicare Part D RAC[175] reviewed post-reconciliation PDE records to identify improper payments made under the Medicare Part D benefit.[176] 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[177] or unauthorized prescribers[178] 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.

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[175] The Medicare Part D RAC contract ended on December 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 ended on March 1, 2018.

[176] During FY 2017, Medicare Part D RAC activities included the appeals and recoupment process. The audits, validations, and Notification of Improper Payments issuance were all completed during FY 2016.

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

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

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

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

6 Cost Report Payment Accuracy

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

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

6.1 Provider Cost Report Reviews and Audits

Savings:	The difference between as-submitted or revised reimbursable cost requests submitted by providers and the settlement amounts, as determined through audits or desk reviews, for each cost item submitted in Medicare FFS provider cost reports.
Data Source:	System for Tracking for Audit and Reimbursement Reports 104 and 106, as entered by the MACs

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

- Pass-through costs for hospitals paid under a prospective payment system (PPS)[179]

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

- 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[180] 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)[181] reports are available, whichever date is later.[182] The annual cost report contains provider information, such as facility characteristics, utilization data, costs, charges by cost center (in total and for Medicare), accumulation of Medicare claims data (e.g., days, discharges, charges, deductible and coinsurance amounts, etc.), and financial statement data.

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

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

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

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

A provider may appeal disputed adjustments if the Medicare reimbursement amount in controversy is at least $1,000. An appeal request must be filed within 180 days of receiving the

[180] 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.

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

[182] 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.

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.[183]

CMS determines savings from the settlement of provider cost reports by calculating the difference between reimbursable costs per the providers' initial or revised cost reports and the settlement amounts resulting from audits or desk reviews.[184] CMS reports savings in the fiscal year during which an NPR is issued. If a successful appeal results in a revised NPR, CMS reports adjustments to savings in the fiscal year the revised NPR is issued.

6.2 Cost-Based Plan Audits

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

CMS reimburses Medicare cost-based plans based on the reasonable costs incurred for delivering Medicare-covered services to enrollees.[185] Medicare cost-based plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans operated under Section 1876 of the Social Security Act and Health Care Prepayment Plans (HCPPs) established under Section 1833 of the Social Security Act.

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

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

[184] In FY 2017, CMS updated the methodology for determining savings attributable to provider cost report reviews and audits.

[185] 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.

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.[186] 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 sponsors to be audited. Selection of plan sponsors for audit is primarily based on annual risk

[186] 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.

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 or have the substantial likelihood of adversely affecting enrollees,[187] CMS has the authority to impose CMPs against plan sponsors. Other enforcement actions include intermediate sanctions (e.g., suspension of marketing, enrollment, or payment) and terminations. The number of violations and history of noncompliance are factored into the enforcement action taken. All enforcement actions may be appealed. CMP appeal requests must be filed no later than 60 days after receiving a CMP notice.

Effective contract year 2017, CMS implemented the final methodology for calculating CMPs.[188] Under the final methodology, CMS calculates a CMP using standard penalty amounts multiplied either by the number of affected enrollees (per-enrollee basis) or the number of affected contracts (per-determination basis). After CMS calculates the standard penalty amount, it adds any aggravating factor penalty amounts, which are also calculated on a per-enrollee or per-determination basis. An example of an aggravating factor is a history of prior offense. CMPs are limited to maximum amounts per violation based on the enrollment size of the organization.

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

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[187] 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.

[188] CMS published the final CMP methodology on December 15, 2016. Since the first quarter of FY 2017, October–December 2016, was part of contract year 2016, CMS's pilot CMP calculation methodology still applied during that period. Under the pilot methodology, CMS calculated 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. CMPs were limited to maximum amounts per violation.

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

A MLR represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, rather than for overhead expenses. MA organizations and Part D sponsors must report the MLR for each contract they have with CMS. A contract must have a minimum MLR of at least 85% to avoid financial and other penalties. Contracts beginning in 2014 or later are subject to this statutory requirement.[189] 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.

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

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

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

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

If a MA organization or Part D sponsor has a 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

[189] 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.

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, a MLR is considered final and may not be appealed. Savings are reported in the fiscal year during which remittances are recovered.[190]

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 do not apply.

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, beneficiary, or state Medicaid agency dissatisfied with an initial determination may request an appeal. The Medicare FFS appeals process includes five levels:[191]

- 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.

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

[191] 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.

- Level 2: Reconsideration by a QIC[192] 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).[193] The amount remaining in controversy must meet the threshold requirement.
- Level 4: Review by the Medicare Appeals Council within the HHS DAB.[194] There are no requirements regarding the amount of money in controversy.
- Level 5: Judicial review in U.S. District Court. The amount remaining in controversy must meet the threshold requirement.

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

CMS's party status appeals initiative supports Medicare program integrity efforts by funding QICs' participation as a party in ALJ hearings in accordance with 42 CFR § 405.1012.[195] In addition to QICs' performance of Level 2 appeals, a QIC may elect to participate in Level 3 appeals, either as a non-party participant in the proceedings on a request for an ALJ hearing or as a party to an ALJ hearing. As a non-party participant, a QIC may file position papers and/or provide testimony to clarify factual or policy issues in a case.[196] As a party to an ALJ hearing, a QIC can better defend the Level 2 decision by filing position papers, submitting evidence, providing testimony to clarify factual or policy issues, calling witnesses, or cross-examining the witnesses of other parties. The additional rights afforded to parties are extremely beneficial to the ALJ hearing and the QIC's ability to successfully defend a claim denial.

Each fiscal year, CMS determines the funding for and number of hearings in which the QICs are able to participate as a party. The QICs receive the ALJ Notices of Hearing and identify hearings in which they elect to participate as a party. Within ten days of a QIC receiving a hearing notice, a QIC must notify the ALJ, the appellant, and all other parties that it intends to

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

[193] OMHA is independent of CMS.

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

[195] CMS or one of its contractors (e.g., a MAC, QIC, RAC, ZPIC, UPIC etc.) may elect to participate as a party in ALJ appeals, except when an unrepresented beneficiary files the hearing request.

[196] The QICs may elect non-party participation in accordance with 42 CFR § 405.1010. Non-party participation is incorporated into the QICs' operational activities and is not part of this savings metric.

participate as a party.[197] Generally, the QICs elect party status when there are significant amounts in controversy, national policy implications, or particular areas of interest for CMS.

When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully upholds the prior decision or dismisses the case,[198] CMS considers the estimated amount in controversy as savings.[199] Savings are based on the "item original amount" field from the MAS. For both prepayment denials and overpayment determinations, this field represents the billed amount submitted by the provider for claims or claim lines under appeal. CMS reports savings in the fiscal year during which the QIC receives notice of the ALJ's ruling to uphold the prior decision or dismiss the case. CMS does not currently adjust reported savings if the appellant pursues further appeal rights and receives a favorable decision at Level 4 or Level 5.

9 Law Enforcement Referrals

ZPICs/UPICs (see sections 1.6, 2.3, and 5.6) and the NBI MEDIC (see Section 5.9) identify and investigate cases of suspected fraud related to Medicare FFS and Medicare Part C and Part D, respectively. ZPICs'/UPICs' and the NBI MEDIC's investigations may involve providers, beneficiaries, and/or other entities. Once a ZPIC/UPIC or the NBI MEDIC has gathered evidence to substantiate allegations of suspected fraud, CMS requires the contractor to refer such cases to the HHS-OIG Office of Investigations for consideration of civil or criminal prosecution.

In certain types of cases, ZPICs/UPICs and the NBI MEDIC must make an immediate referral to HHS-OIG without first conducting an investigation. For example, a ZPIC/UPIC or the NBI MEDIC must immediately advise HHS-OIG upon receiving allegations of kickbacks or bribes. As another example, the NBI MEDIC must immediately advise HHS-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/UPIC 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/UPIC or the NBI MEDIC refers a case to law enforcement for criminal or civil investigation, it reports the estimated value of the case to CMS, typically based on total paid amounts for the alleged fraudulent activities. If law enforcement accepts the referral, the ZPIC/UPIC or the NBI MEDIC remains available to assist and provide information at the request of law enforcement. When cases result in restitution, judgments, fines, and/or settlements, the Department of Justice (DOJ) routes Medicare recoveries to CMS or the plan sponsor. The

[197] If multiple entities, i.e., CMS and/or contractors, file an election to be a party to a hearing, the first entity to file its election is made a party to the hearing. The other entities are made participants in the proceedings under 42 CFR § 405.1010 and may file position papers and/or written testimony. The ALJ has discretion to allow additional parties if necessary for a full examination of the matters at issue.

[198] 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.

[199] 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.

following sections describe how CMS reports savings attributable to ZPICs'/UPICs' and the NBI MEDIC's law enforcement referrals.

9.1 Zone Program Integrity Contractor/Unified Program Integrity Contractor Law Enforcement Referrals

Savings:	The estimated amount Medicare expects to recover from cases referred to law enforcement by the ZPICs/UPIC, adjusted for historical recovery experience.
Data Source:	1) CMS ART fields B6 and B2b, 2) UPIC reports, and 3) Law enforcement adjustment factor

CMS reports the value of ZPICs'/UPICs' 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.[200] This factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to the original amount referred by ZPICs/UPICs.

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.[201] 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

[200] The law enforcement adjustment factor is based on FPS methodology certified by HHS-OIG.

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

Regarding the NBI MEDIC's Part D cases referred to law enforcement, CMS reports the amount of court-ordered restitution, fines, forfeitures, and settlements.[202] CMS reports these amounts in the fiscal year during which a court issues a final judgment or commitment order.

[202] 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).[203] 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.[204] 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)/UPICs 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 MICs/UPICs and providing states with technical assistance and training to build their internal capacity to conduct Medicaid program integrity activities. CMS's

[203] 42 CFR § 433.300-316

[204] 42 CFR § 433.318

guidance and 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/Unified Program Integrity Contractors

In collaboration with states, CMS's Audit MICs/UPICs[205] 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/final findings reports documenting total overpayments for recovery. States are responsible for sending demand letters to the appropriate providers, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their state's administrative process.

The category of general fraud, waste, and abuse recoveries includes the recovered amount (federal and state shares) of Medicaid overpayments identified by Audit MICs/UPICs. 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/UPICs, 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/UPICs 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

[205] CMS has begun transitioning the Audit MICs' workload to UPICs. Audit MICs remain fully operational in the geographic areas not covered by fully operational UPICs.

- Medicaid Fraud Control Unit (MFCU) investigations[206]
- Data mining activities[207] conducted by state Medicaid agencies as well as MFCUs
- Settlements
- 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. 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)[208]
- Qui tam provisions that are at least as effective as those described in the FCA[209]
- Filing under seal for 60 days with review by the state's attorney general

[206] 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. 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.

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

[208] 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.

[209] 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.

- Civil penalty at least equal to the amount authorized under the FCA

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.

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

Acronym	Description
ACL	Administration for Community Living
ACO	Accountable Care Organization
ADR	Additional Documentation Request
AFR	[HHS] Agency Financial Report
ALJ	Administrative Law Judge
ANOC	Annual Notice of Change
APS	Advanced Provider Screening [system]
BCRC	Benefits Coordination & Recovery Center
CAP	Corrective Action Plan
CCN	CMS Certification Number
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CMS ART	CMS Analysis, Reporting, and Tracking
COB&R	Coordination of Benefits & Recovery
CPI	[CMS] Center for Program Integrity
CPIP	Certified Program Integrity Professional
CPT	Common Procedural Terminology
CRC	Commercial Repayment Center [Recovery Auditor]
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
DAB	Departmental Appeals Board
DDPS	Drug Data Processing System
D/E	Discussion/Education
DEA	Drug Enforcement Administration

Acronym	Description
DIR	Direct and Indirect Remuneration
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOJ	Department of Justice
DOS	Date of Service
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EDPS	Encounter Data Processing System
EIN	Employee Identification Number
EOC	Evidence of Coverage
FATHOM	First-Look Analysis Tool for Hospital Outlier Monitoring
FBI	Federal Bureau of Investigation
FCA	False Claims Act
FCBC	Fingerprint-based Criminal Background Check
FFP	Federal Financial Participation
FFS	Fee-for-Service
FID	Fraud Investigation Database
FISS	Fiscal Intermediary Shared System
FMAP	Federal Medical Assistance Percentage
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
GPO	Group Purchasing Organization
HASP	Hospital Appeals Settlement Process
HCFAC	Health Care Fraud and Abuse Control Program
HCPCS	Healthcare Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HEAT	Healthcare Enforcement and Action Team
HFPP	Healthcare Fraud Prevention Partnership

Acronym	Description
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
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
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug
MAS	Medicare Appeals System
MCS	Multi-Carrier System
MEDIC	Medicare Drug Integrity Contractor
Medi-Medi	Medicare-Medicaid Data Match
MFCU	Medicaid Fraud Control Unit
MIC	Medicaid Integrity Contractor
MII	Medicaid Integrity Institute
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MLN	Medicare Learning Network®
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MPEC	Medicaid Provider Enrollment Compendium

Acronym	Description
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
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
OEOCR	Office of Equal Employment Opportunity & Civil Rights
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
One PI	One Program Integrity
OPPS	Outpatient Prospective Payment System
ORM	Ongoing Responsibility for Medicals
O&R	Ordering and Referring [Edit]
PACE	Program of All-Inclusive Care for the Elderly
Part C	Medicare Advantage Part C Program
Part D	Medicare Prescription Drug Program
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PEPPER	Program for Evaluating Payment Patterns Electronic Report
PERM	Payment Error Rate Measurement
PI Board	Program Integrity Board
PLATO™	Predictive Learning Analytics Tracking Outcome
PMD	Power Mobility Device
PPS	Prospective Payment System
PS&R	Provider Statistical and Reimbursement [System or Report]
PSC	Program Safeguard Contractor

Acronym	Description
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
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
SMRC	Supplemental Medical Review Contractor
SOW	Statement of Work
SPRY	[Medicaid] State Plan Rate Year
TAF	T-MSIS Analytic Files
TDD	Telecommunication Device for the Deaf
T-MSIS	Transformed-Medicaid Statistical Information System
TTY	Text Telephone
UCM	Unified Case Management [system]
UOS	Unit of Service
UPIC	Unified Program Integrity Contractor
UPL	Upper Payment Limit
USC	United States Code
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement
ZPIC	Zone Program Integrity Contractor

Appendix E - Statutes Referenced in this Report

Public Law	Title	Short Title
74-271	The Social Security Act	The Act
90-248	Social Security Amendments of 1967	
104-191	Health Insurance Portability and Accountability Act of 1996	HIPAA
107-300	Improper Payments Information Act of 2002	IPIA
108-173	Medicare Prescription Drug, Improvement, and Modernization Act of 2003	MMA
109-171	Deficit Reduction Act of 2005	DRA
110-173	Medicare, Medicaid and SCHIP Extension Act of 2007	MMSEA
110-275	Medicare Improvements for Patients and Providers Act of 2008	MIPPA
111-148	Patient Protection and Affordable Care Act	
111-152	Health Care and Education Reconciliation Act of 2010	
111-204	Improper Payments Elimination and Recovery Act of 2010	IPERA
111-240	Small Business Jobs Act of 2010	SBJA
111-3	Children's Health Insurance Program Reauthorization Act of 2009	CHIPRA
111-309	Medicare and Medicaid Extenders Act of 2010	
112-242	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012	SMART Act
112-248	Improper Payments Elimination and Recovery Improvement Act of 2012	IPERIA
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA