2021 REPORT TO CONGRESS

MEDICARE & MEDICAID PROGRAM INTEGRITY

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services

REPORT TO CONGRESS

FY2021 Medicare and Medicaid Integrity Programs

May 2023

Executive Summary

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2021 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's mission for program integrity is to prevent, detect, and combat fraud, waste, and abuse in the Medicare and Medicaid programs. CMS achieves this mission by ensuring that it makes the correct payment to the right entity for services covered under CMS programs. CMS also works with providers, plan sponsors, states, and other stakeholders to support proper enrollment and accurate billing practices.[2] This work focuses on protecting patients while also minimizing unnecessary burden.

As federal health programs are quickly evolving, CMS's program integrity strategy must keep pace to address emerging challenges. To focus its efforts, CMS uses the Government Accountability Office (GAO) Fraud Risk Framework to identify and mitigate program integrity risks in all CMS-administered health care programs. CMS developed a five-pillar program integrity strategy intended to modernize the Agency's approach and protect its programs for future generations. In FY 2021, this strategy focused on stopping bad actors, preventing fraud, mitigating emerging program risks, reducing provider burden, and leveraging new technology.

Medicare Program Integrity

Medicare processes over one billion Fee-for-Service (FFS) claims annually.[3] To do this properly – to "pay it right" – Medicare uses a variety of tools, including provider enrollment, data analysis, investigations, and review of medical records.

In FY 2021, CMS's program integrity activities saved Medicare an estimated $12.7 billion and produced a return on investment (ROI) of $7.3 to 1 (see Table 3 for activity-specific savings).[4] These activities help strengthen the integrity and sustainability of the Medicare program, while promoting quality and the efficient delivery and financing of health care.

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

[2] 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.

[3] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf.

[4] CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes; thus, some Medicare savings amounts may not be directly comparable to amounts in previous reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

In addition to the estimated savings and ROI, CMS's program integrity efforts have contributed to a reduction in the improper payment rate in recent years. The Medicare FFS improper payment rate has decreased from 9.51 percent in 2017 to 6.26 percent in FY 2021.[5]

Medicaid and CHIP Program Integrity

Medicaid and the Children's Health Insurance Program (CHIP) are federal-state partnerships, and these partnerships are central to the programs' success. CMS provides states with guidance to use in meeting statutory and regulatory requirements, technical assistance including tools and data, federal matching funds for their expenditures, and other resources. States fund their share of the programs, and, within federal and state guidelines, operate their individual programs through various activities, such as setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. States and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse. In FY 2021, federal and state collaborative program integrity efforts for Medicaid and CHIP resulted in estimated federal share savings of $2.0 billion (see Table 4 for activity-specific savings).[6]

In 2019, CMS took a significant step in strengthening Medicaid and CHIP program integrity by releasing the FYs 2019-2023 Comprehensive Medicaid Integrity Plan (CMIP). The CMIP seeks to protect taxpayer dollars and is based on the three pillars of flexibility, accountability and integrity.[7] The FY 2024-2028 CMIP is currently under development.

[5] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, at page 109.

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

[7] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf.

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1. Introduction

The Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2021 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. In additional, CMS is responsible for providing direction and guidance to, oversight of, Federally-facilitated Marketplaces (FFMs)[8] and state-based Marketplaces established in the Patient Protection and Affordable Care Act (the Affordable Act).[9] The Medicare and Medicaid Integrity Programs help protect Medicare and Medicaid against fraud, waste, and abuse.

Medicare, Medicaid, CHIP and the Marketplaces provide health care for many Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 64 million beneficiaries in 2021, while Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 83 million beneficiaries in 2021.[10] During 2021, more than 12 million individuals were concurrently enrolled in both the Medicare and Medicaid programs.[11] Approximately 12 million people selected or were automatically re-enrolled in a Marketplace plan during the 2021 Open Enrollment period. [12]

The CMS Center for Program Integrity (CPI) is primarily responsible for implementation of the Medicare Integrity Program and the Medicaid Integrity Program. While other areas of CMS also engage in program integrity-related activities,[13] this report focuses on the program integrity activities led, or that had significant involvement, by CPI.

[8] Although reporting on the Marketplaces is not required by statute, including this information helps inform the public and stakeholders about the full range of our program integrity work.

[9] Public Law 111-148 and Public Law 111-152 collectively constitute the Patient Protection and Affordable Care Act (P.L. 111-148 enacted on March 23, 2010; amended through P.L. 111-152, enacted on March 30, 2010).

[10] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, page i.

[11] Medicare-Medicaid Coordination Office FY 2021 Report to Congress https://www.cms.gov/medicare-medicaid-coordination/medicare-and-medicaid-coordination/medicare-medicaid-coordination-office, page 3.

[12] The 2021 Open Enrollment Report can be found at https://www.cms.gov/files/document/health-insurance-exchanges-2021-open-enrollment-report-final.pdf.

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

During FY 2021, CMS's comprehensive program integrity efforts resulted in estimated Medicare savings of $12.7 billion and estimated Medicaid and CHIP federal share savings[14] of $2.0 billion. This commitment to fiscal integrity allows CMS to focus on efforts to better serve patients and ensure that providers render high-quality care. Section 1.3 of this report provides activity-specific Medicare, Medicaid, and CHIP savings, and Appendix B provides detailed methodologies for all savings metrics.

[14] The Federal Government and states jointly fund the Medicaid program. The Federal Government pays states for a specified percentage of program expenditures, i.e., FMAP. Therefore, program-integrity-related activities in Medicaid result in savings for both states and the Federal Government. CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

CMS Program Integrity Strategy

CMS's mission for program integrity is to prevent, detect and combat fraud, waste, and abuse in the Medicare and Medicaid programs. CMS works diligently to prevent fraudulent claims from being paid and to verify that it is paying the right entity the right amount for services covered under our programs. This work includes providers, states, and other stakeholders to support proper enrollment and accurate billing practices, and focuses on protecting patients while also minimizing unnecessary burden.

CMS's program integrity strategy focuses on stopping bad actors, preventing fraud, mitigating emerging program risks, and reducing provider burden. To focus its program integrity efforts, CMS uses the Government Accountability Office's (GAO) Fraud Risk Framework to identify and mitigate program integrity risks in all CMS-administered health care programs. CMS organized this report around these strategic goals, with each section detailing specific aspects of CMS's program integrity efforts. 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.[15] Section 1893(h)(8) of the Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and the savings to the program.

This report fulfills the reporting requirements with respect to the Medicare and Medicaid Integrity Programs, the Medicare FFS Recovery Audit Contractors (RACs), the Medicare Advantage (MA or Part C) and Medicare Prescription Drug Part D Program (Part D) RACs, and the Medicaid RACs.[16]

[15] 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.

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

1.1.1 Medicare Program Integrity Funding[17]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[18] established mandatory funding for the Medicare Integrity Program, which provided a stable funding source for Medicare program integrity activities that is not subject to annual appropriations. The Affordable Care Act increased the base funding level and applied an annual inflationary adjustment to that base funding level. This funding supports program integrity functions performed across CMS, including: Cost Report Audits, Medicare Secondary Payer (MSP), Medical Review, Provider Outreach and Education, and Benefit Integrity.

CMS receives additional mandatory funding under the Deficit Reduction Act of 2005 (DRA)[19] and the Affordable Care Act, as well as discretionary Health Care Fraud and Abuse Control (HCFAC) program funding, subject to annual appropriation. CMS obligated a total of $1.6 billion in FY 2021 for the Medicare Integrity Program.

1.1.2 Medicaid Program Integrity Funding

The DRA established section 1936 in the Act to create the Medicaid Integrity Program and provided CMS with dedicated funding to operate the program. Under section 1936 of the Act, Congress appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. Beginning in FY 2011, the Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[20] CMS obligated a total of $76.0 million in FY 2021 for the Medicaid Integrity Program. In addition, CMS obligated a total of $113.3 million in FY 2021 for Medicaid program integrity activities using discretionary HCFAC funds.

1.2 Program Integrity in Medicare and Medicaid

CMS is the nation's largest insurer, covering over 147 million Americans through Medicare, Medicaid, CHIP, and the health insurance marketplaces.[21] Medicare is a combination of four programs: Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (MA, also known as Part C), and Medicare Prescription Drug Benefit (Part D). Since 1966, Medicare enrollment has increased from 19 million to almost 64 million individuals.[22]

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[17] Appendix A provides further information on the obligations for program integrity activities for both Medicare and Medicaid. This report includes activities funded outside of the Medicare or Medicaid Integrity Programs. Activities such as CMS Innovation Center models, the Medicare Shared Savings Program (MSSP), and the DMEPOS Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity.

[18] Public Law 104-191 (enacted August 21, 1996).

[19] Public Law 109-171 (enacted February 8, 2006).

[20] 42 U.S.C. 1396u-6(e)(1)(D).

[21] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, at page i.

[22] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, at page i.

Medicare processes over one billion FFS claims a year and accounts for approximately 11 percent of the federal budget.[23]

Medicaid and CHIP are federal-state partnerships, and these partnerships are central to the programs' success. CMS provides states with guidance to use in meeting statutory and regulatory requirements, technical assistance including tools and data, federal matching funds for their expenditures and other resources. States fund their share of the programs, and, within federal and state guidelines, operate their individual programs through activities including setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. States and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misused for fraud, waste, or abuse.

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

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Unified Program Integrity Contractors (UPICs)	Medicare FFS and Medicaid	• Investigate leads generated by the Fraud Prevention System (FPS) and complaints from beneficiaries and a variety of other sources • Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid • Make recommendations to CMS or states for appropriate administrative actions (i.e., revocations and suspensions) to protect the Medicare Trust Funds and Medicaid dollars • Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the Medicare Administrative Contractors • Conduct medical review for Medicare and Medicaid program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exist in Medicare and Medicaid • Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the Unified Case Management System • Identify improper payments to be recovered within Medicare and Medicaid
Medicare Administrative Contractors (MACs)	Medicare FFS	• Process claims, determine proper payment amounts, and pay providers, suppliers, and individuals • Perform provider and supplier screening and enrollment

[23] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, page 3.

		• Audit the Medicare cost reports upon which CMS bases part of Medicare payments to institutional providers, such as hospitals and skilled nursing facilities • Conduct prepayment, post-payment medical review, and prior authorization • Analyze claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims types • Develop and implement prepayment edits • Deliver 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	• Conduct nationwide medical review as directed by CMS • Notifies CMS 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 • Correct improper payments by collecting identified overpayments and restoring identified underpayments • Make recommendations to CMS about how to reduce improper payments in the Medicare FFS program
Coordination of Benefits & Recovery (COB&R) Contractors	Medicare FFS Secondary Payer	• 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
Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC)	Medicare Part C and Part D	• Conduct data analyses of Part C and Part D issues leading to potential identification of improper payments and regulatory non-compliance • Coordinate Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement entities • Support enforcement of Part C and Part D through Program Integrity audits, national audits, and self-audits of plan sponsors.
Investigations Medicare Drug Integrity Contractor (I-MEDIC)	Medicare Part C and Part D	• Detect, prevent, and proactively deter fraud, waste, and abuse for high risk prescribers/pharmacies in Medicare Part C and Part D. • Conduct complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support

Risk Adjustment Data Validation (RADV) Contractors	Medicare Part C	• Perform post-payment review of medical records to validate diagnoses submitted by MA organizations for risk adjustment purposes; maintain systems that house data and support audit functions; develop sampling frameworks for audits; train audited MA organizations on audit processes; calculate payment errors; generate audit reports; and support appeals process
State Medicaid RACs	Medicaid FFS and Managed Care	• Contract with state Medicaid agencies (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers
State Education Contractor	Medicaid	• Provide outreach and technical support to states and to enhance states' efforts in strengthening their Medicaid program integrity efforts • Develop and execute action plans to overcome key barriers and challenges in states' program • Contribute to states' understanding, organization, and approach regarding specific program integrity issues
Marketplace Program Integrity Contractor (MPIC)	Marketplace	• Conduct program integrity oversight of the Federally-facilitated Marketplaces (FFM) and State-Based Marketplaces (SBM) • Collaborate with external stakeholders, including State Departments of Insurance (DOI) and federal law enforcement agencies
Marketplace Complaints Review Contractor (MCRC)	Marketplace	• Review and categorize consumer complaints received through the Marketplace Call Center to support CPI's determination of whether an administrative remedy is appropriate

1.3 Measuring Program Integrity Success

1.3.1 Improper Payment Rates

As required by the Payment Integrity Information Act of 2019 (PIIA),[24] CMS calculates an improper payment rate for Medicare FFS, Part C, and Part D; Medicaid; and CHIP. Table 2 provides the gross improper payment rates (including both overpayments and underpayments) and summarizes trends in the improper payment rates since 2017. Section 4.1 of this report provides specific information on how each program measures improper payments.

Table 2: Reported Improper Payment Rates Trend for Reporting Years 2017-2021[25]

Program	2017	2018	2019	2020	2021
Medicare FFS	9.51%	8.12%	7.25%	6.27%	6.26%

[24] Public Law 116-117 (enacted March 2, 2020).

[25] https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

Part C[26]	8.31%	8.10%	7.87%	6.78%	10.28%
Part D	1.67%	1.66%	0.75%	1.15%	1.33%[27]
Medicaid	10.10%	9.79%	14.9%	21.36%	21.69%
CHIP	8.64%	8.57%	15.83%	27.00%	31.84%[28]

While this report discusses many of the ways that CMS works to reduce the improper payment rates for Medicare, Medicaid, and CHIP, the FY 2021 HHS Agency Financial Report (AFR) also includes a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2021 to reduce improper payments.[29]

1.3.2 Medicare Program Integrity Savings

In FY 2021, CMS's Medicare program integrity activities saved an estimated $12.7 billion.[30] This represents a return on investment (ROI) of $7.3 to 1.[31] CMS provides activity-specific Medicare program integrity savings in Table 3,[32] programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

[26] In FY 2021, CMS implemented refinements to the Part C denominator methodology to only include the population of MA payments reviewed and at risk for diagnostic error, which led to the increase in the FY 2021 error estimate. For prior years, the Part C denominator methodology reflected total MA payments, and included some payments that were non-risk adjusted or based on a different model resulting in a reported error rate that was biased downward, or potentially understated. Therefore, the FY 2021 reporting year is a baseline and should not be compared with prior reporting years.

[27] The reported improper underpayments were overrepresented in the initial reporting for FY 2021. The corrected Part D calculations led to an overall decrease in estimated improper payment rate for FY 2021. The Part D estimate was originally reported as 1.58% (or $1.37 billion), instead of 1.33% (or $1.15 billion).

[28] HHS's PERM program uses a 17-state three-year rotation for measuring Medicaid improper payments. The national Medicaid improper payment rate includes findings from the most recent three cycle measurements so that all 50 states and the District of Columbia are reflected in one rate. For FYs 2015 through 2018, HHS did not conduct the eligibility measurement component of PERM because of changes to the way states adjudicate beneficiary eligibility. In place of the PERM eligibility reviews, HHS required all states to conduct Eligibility Review Pilots that provided more targeted, detailed information on the accuracy of eligibility determinations. For the purpose of computing the overall national improper payment rate, the Medicaid eligibility component improper payment rate was held constant at the FY 2014 national rate of 3.11 percent. Beginning in FY 2019, HHS resumed the eligibility component measurement and reported updated national eligibility improper payment estimates.

[29] https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

[30] CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes; thus, some Medicare savings amounts may not be directly comparable to amounts in previous reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

[31] CMS calculates the fiscal year Medicare program integrity ROI by dividing the total Medicare savings by the total Medicare obligations (i.e., the portion of program integrity obligations summarized in Appendix A that represent funding for the Medicare Integrity Program as well as other funding supporting RACs and provider enrollment). In FY 2021, this amount (i.e., the denominator of the ROI calculation) totaled $1.7 billion.

[32] In addition to the savings provided in Table 3, CMS's program integrity activities may result in other benefits that are difficult to quantify, e.g., potential sentinel effects.

Table 3: Medicare Savings

Type of Medicare Savings [a]	FY 2021 Savings (in millions)
Automated Actions	
National Correct Coding Initiative (NCCI) Procedure-to-Procedure Edits	$194.8
NCCI Medically Unlikely Edits	$313.0
Ordering and Referring Edits	$100.8
Fraud Prevention System Edits	$86.4
MAC Automated Medical Review Edits	$529.4
UPIC Automated Edits	$28.5
Prepayment Review Actions	
Medicare Secondary Payer (MSP) Operations	$6,611.2
Prior Authorization Request Reviews	$32.7
MAC Non-Automated Medical Reviews	$17.8
UPIC Non-Automated Reviews	$6.9
Provider Enrollment Actions	
Revocations	$254.8
Deactivations	$49.7
Overpayment Recoveries	
MSP Operations	$2,809.9
MSP Commercial Repayment Center	$280.6
MAC Post-Payment Medical Reviews	$46.9
Medicare FFS RAC Reviews	$250.0
SMRC Reviews	$133.0
UPIC Post-Payment Reviews	$106.8
Overpayments from Retroactive Revocations	$1.5
Medicare Part D Plan Sponsor Audits	$8.7
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	$166.9
Cost-Based Plan Audits	$5.9
Plan Penalties	
Medicare Part C and Part D Program Audits	$0.1
Medical Loss Ratio Requirement	$303.7
Other Actions	
Payment Suspensions	$256.1
Medicare Part D Reconciliation Data Reviews	$5.4
Party Status Appeals	$13.1
Law Enforcement Referrals	
UPIC Law Enforcement Referrals	$76.8
I-MEDIC Part C and Part D Law Enforcement Referrals	$33.7
Total Savings [b]	**$12,725.1**

[a] Appendix B provides detailed methodologies for all metrics listed in this table.
[b] Savings values may not add to totals due to rounding.

1.3.3 Medicaid and CHIP Program Integrity Savings

States and the Federal Government share mutual obligations and accountability for the integrity of Medicaid and CHIP. This includes the application of effective safeguards to ensure the proper and appropriate use of both federal and state dollars and the provision of quality care to some of the nation's most vulnerable populations. CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from the Medicaid and CHIP financial oversight and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. In FY 2021, these efforts resulted in estimated federal share savings of $2.0 billion. CMS provides activity-specific Medicaid and CHIP federal share savings in Table 4,[33] programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

Table 4: Medicaid and CHIP Savings

Type of Medicaid and CHIP Savings [a]	FY 2021 Federal Share Savings (in millions)
Medicaid and CHIP Financial Oversight	
Averted Medicaid and CHIP Federal Financial Participation	$945.9
Recovered Medicaid and CHIP Federal Financial Participation	$467.7
State-Reported Medicaid Overpayment Recoveries	
UPIC Recoveries	$12.3
State Medicaid RAC Recoveries	$161.1
Office of Inspector General Compliant False Claims Act Recoveries	$1.6
Other State Program Integrity Recoveries	$419.4
Total Savings [b]	**$2,007.9**

[a] Appendix B provides detailed methodologies for all metrics listed in this table.
[b] Savings values may not add to totals due to rounding.

1.4 The Impact of the COVID-19 Public Health Emergency

The Secretary of HHS issued a Public Health Emergency (PHE) declaration on January 31, 2020 as a result of the spread of Coronavirus Disease 2019 (COVID-19). In response, CMS took various actions nationwide to offer individual providers, health care facilities, and states maximum flexibility to provide necessary care during this time. Notably, CMS waived certain Medicare, Medicaid, and CHIP program requirements and conditions of participation under Section 1135 of the Act, which eased certain requirements for affected providers and suppliers. The nationwide waivers and flexibilities created an opportunity for those on the frontlines of the fight against COVID-19 to respond as quickly and effectively as possible.[34]

[33] Medicaid savings may differ in the HHS Agency Financial Report compared to the Report to Congress on the Medicare and Medicaid Integrity Programs because CMS pulls the data from Form CMS-64 at different times.

[34] https://www.cms.gov/newsroom/press-releases/cms-takes-action-nationwide-aggressively-respond-coronavirus-national-emergency.

CMS used the GAO Fraud Risk Framework to identify potential program integrity risks that may have resulted from the COVID-19 PHE waivers and flexibilities, specifically engaging the Vulnerability Collaboration Council (VCC) for this work (see section 4.10 for more information on the VCC process). Potential program integrity risks and vulnerabilities identified by the VCC include:

- **Additional, unnecessary services:** Bad actors may have been offering COVID-19 tests to Medicare beneficiaries in exchange for personal details, including Medicare information, that could be then used to bill for unapproved and illegitimate services. In one fraud scheme, retirement communities were targeted by labs claiming to offer COVID-19 tests, but which also required a blood draw and other medically unnecessary services. Bad actors continue to target beneficiaries in a number of ways, including telemarketing calls, text messages, social media posts, and door-to-door visits. Through these targeted approaches, these bad actors are exploiting the COVID-19 PHE waivers and flexibilities to benefit themselves, often leaving beneficiaries to face potential harm or unexpected costs associated with Medicare or Medicaid denying a claim for an unapproved test.
- **Additional, unnecessary laboratory testing:** Along with a COVID-19 test, performing additional laboratory tests that may or may not be related. For example, some laboratories are billing a COVID-19 test with expensive tests, such as Respiratory Pathogen Panels (RPP), antibiotic resistance, allergy, genetic and cardiac panel testing. Additionally, some laboratories are billing unnecessary respiratory, gastrointestinal, genitourinary, and dermatologic pathogen code sets with the not otherwise specified code CPT 87798.

This work is ongoing and consists of such activities as data analysis and, when appropriate, swift investigative action. For example, CMS performed a geographic analysis to identify providers billing for a high percentage of services rendered to patients who were at great distances from practice locations. Even with telehealth flexibilities put in place, most patients still need to be seen by providers operating within the same geographic area. This analysis helped CMS to identify services that likely had not been provided as well as detect inappropriately ordered drugs and devices.

CMS, along with law enforcement agency partners including the Department of Justice (DOJ), the Department of Health and Human Services Office of Inspector General (HHS-OIG), and others are working together to investigate and prosecute fraud from identified COVID-19 PHE risks and related schemes. This fraud, waste, and abuse mitigation work includes data analyses and studies, targeted investigations, development of Fraud Prevention System (FPS) models and edits, and implementation of new policies.

Additionally, CMS and our federal law enforcement partners have investigated and shared information on several fraud schemes directly associated with the COVID-19 PHE. Identity theft has been a significant factor involved in those schemes. Specific to the COVID-19 PHE, DOJ,

the HHS-OIG and CMS issued a fraud alert warning the public about allegations of fraud and abuse connected to vaccine distribution.[35] Types of suspect activity included:

- requests for payment to get a vaccine, including deposits or fees;
- requests for payment or offers of money to enhance ranking for vaccine eligibility (i.e., getting a better spot in line or on a wait list);
- offers to sell or ship doses of vaccine for payment;
- offers to purchase vaccine record cards containing personal identifying information; and
- fraudulent vaccine cards.

2. Stop Bad Actors

2.1 Major Case Coordination (MCC)

To meet its program integrity objectives, CMS coordinates closely with a variety of other partners, including, but not limited to, the HHS-OIG, DOJ, including the Federal Bureau of Investigation (FBI); State law enforcement officials, including those from state Medicaid Fraud Control Units (MFCUs); and other federal and state agencies.

CMS's MCC initiative provides an opportunity to collaborate before, during, and after the development of fraud leads. This level of collaboration has contributed to several successful coordinated law enforcement actions and helped CMS better identify national fraud trends and program vulnerabilities. In FY 2021, CMS reviewed 1,029 cases at MCC meetings, and law enforcement partners made 607 requests for CMS to refer reviewed cases. Since implementation of the MCC, there have been over 3,200 cases reviewed at MCC, and law enforcement partners have made over 2,000 requests for CMS to refer reviewed cases.

Examples of the ways in which CMS has provided support to the OIG and DOJ throughout fiscal year 2021 include:

- On May 26, 2021, the Department of Justice (DOJ) announced approximately 14 law enforcement indictments of individuals involved in COVID-19 related fraud schemes in a coordinated law enforcement action with the HHS-OIG and CMS. On that day, CMS separately announced that it took adverse administrative actions against over 50 DME suppliers for their involvement in health care fraud schemes relating to abuse of CMS programs during the COVID-19 PHE.[36]
- On September 17, 2021, the DOJ announced criminal charges against 138 defendants, including 42 doctors, nurses, and other licensed medical professionals, in 31 federal districts across the United States for their alleged participation in various health care fraud schemes that resulted in approximately $1.4 billion in alleged losses. In addition,

[35] https://oig.hhs.gov/fraud/consumer-alerts/fraud-alert-covid-19-scams/

[36] https://www.justice.gov/opa/pr/doj-announces-coordinated-law-enforcement-action-combat-health-care-fraud-related-covid-19.

CMS took administrative action against 28 providers on behalf of people with Medicare coverage and to protect the Medicare Trust Fund.[37]

In FY 2021, CMS continued with the MCC process for the Medicaid program, which brings together many of our partners in a forum to discuss Medicaid-related law enforcement referrals. As of September 30, 2021, CMS has participated in 11 Medicaid MCCs, and law enforcement partners have made 22 requests for CMS to refer reviewed cases. As part of the MCC work in 2021, a MCC was conducted with Florida where law enforcement accepted two fraud referrals involving excessive genetic tests, as well as in Kansas where law enforcement accepted a fraud referral related to the overprescribing of opioids which may have led to beneficiaries overdosing. The total dollars paid to these three providers referred is over $16 million. The information gained from the Medicaid MCC process can also be used to identify Medicaid and CHIP vulnerabilities that can lead to improper payments. The level of collaboration resulting from the Medicaid MCC has helped CMS better identify national trends and program vulnerabilities that can lead to fraud and other improper payments.[38]

2.2 Provider Enrollment

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

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

During the COVID-19 PHE, several of the requirements for provider enrollment in the Medicare program were temporarily waived to allow for access to medical care for Medicare beneficiaries.

[37] https://www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion.

[38] FY 2020 HHS AFR, at page 199.

These included, but were not limited to, allowing providers to temporarily enroll in Medicare, permitting licensed providers to render services outside of their state of enrollment, exercising a temporary cessation of the revalidation of providers, waiving finger-print based criminal background checks, and waiving enrollment site visits. CMS began resuming certain provider enrollment activities based on the state of the COVID-19 PHE at the time and the provider's ability to comply. For example, waivers for fingerprint-based criminal background checks and the exercising of a temporary cessation of the revalidation of providers terminated on October 31, 2021.

Similar waivers could be requested by states for their Medicaid programs. Each state could choose which waivers it exercised and could request waivers that were state-specific, so there was not a uniform use of waivers by the states. The waivers in the Medicare and Medicaid programs were necessary to allow beneficiaries to access providers; however, CPI used its fraud risk framework to develop mitigation strategies that it shared with the states.

2.2.1 Medicare Provider Screening and Site Visits

As required by law,[39] CMS established three levels of provider and supplier enrollment risk-based screening: "limited"; "moderate"; "high"; and a classification by provider- and supplier-types, subject to upward adjustment in certain circumstances. [40]

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.

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 to any actionable changes to licensure information or any criminal flags.

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

[36] Sec 6401 Public Law 111-118 (enacted December 19, 2009).

[37] 76 FR 5862 (Feb. 2, 2011).

[38] 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.

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

[40] 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.

contractors validate that the provider or supplier complies with Medicare enrollment requirements during these visits.

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 2021, **CMS denied 5,778 enrollments, deactivated over 120,000 enrollments and revoked about 2,290 enrollments**. [41, 42, 43]

2.3 Provider Revalidation

Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) suppliers are required to revalidate every three years, and all other providers and suppliers are required to revalidate every five years. These efforts help ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. In FY 2021, CMS continued to pause all revalidation efforts for Medicare providers due to the COVID-19 PHE. Revalidation efforts for these providers will resume in FY 2022.

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. Some states have temporarily ceased revalidation for enrolled Medicaid providers during the COVID-19 PHE. CMS has implemented several mitigation efforts to reduce the program integrity impact of this flexibility, including providing guidance to states and developing FAQs on data compare to assist states performing revalidations, and extending revalidation due dates for states.[44]

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[44] CMS offers a data compare service for provider screening that allows a state to rely on Medicare's screening in lieu of conducting state screening.

3. Prevent Fraud

3.1 Unified Program Integrity Contractors (UPICs)

CMS investigates instances of suspected fraud, waste, and abuse in Medicare and Medicaid using the UPICs. The UPICs develop investigations and take actions to prevent inappropriate payments from being made to Medicare and Medicaid providers and suppliers. UPICs perform provider and beneficiary interviews and site visits, take appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and conduct program integrity reviews of medical records. While a variety of other contractors also perform medical review, UPIC reviews are uniquely focused on fraud detection and investigation. For example, the UPICs look for possible falsification of documents that may be associated with an attempt to defraud the Medicare and Medicaid programs. UPICs also provide support and assistance to state Medicaid agencies by performing a number of functions to detect and investigate fraud waste and abuse. Based on the results of all information collected, the UPICs coordinate with CMS and the MACs in taking appropriate administrative action to recover improper payments and prevent future loss of funds, or the UPICs refer the cases to law enforcement.

Various UPIC administrative actions result in Medicare savings, including automated edit claim denials, non-automated review claim denials, provider revocations and deactivations, payment suspensions, overpayment recoveries, and law enforcement referrals.

To maximize the impact of our Medicaid program integrity activities, CPI established expectations for UPICs to focus on high dollar, high risk investigations. As noted in Section 4.8.5 Strengthen Medicaid Data Analytics and Audits, Transformed-Medicaid Statistical Information System (T-MSIS) data is an important resource for program integrity activities.[45] To demonstrate progress, in FY2021, UPICs opened 252 Medicaid investigations or audits using T-MSIS data, a significant increase over the 81 opened in FY20. UPIC Medicaid work in 2021 resulted in 299 final findings reports (FFRs) being issued to 24 states. Further, UPICs increased collaboration with states to 39 states in FY 2021. The most common collaborative investigations and audits were conducted in the areas of hospice, prescribers of opioids, credit balance, laboratories, and general hospital services.

3.2 Part C and D Program Integrity

3.2.1 Medicare Drug Integrity Contractors

The Plan Program Integrity Medicare Drug Integrity Contractor (PPI MEDIC) has a national focus related to plan sponsor oversight regarding adherence to the Medicare Part C and Part D program integrity initiatives, including identification of program vulnerabilities, data analysis, plan sponsor audits, outreach and education, and law enforcement support. As part of its work,

[45] T-MSIS collects Medicaid and CHIP data from states, territories, and the District of Columbia into and houses it in the largest national repository of Medicaid and CHIP beneficiary information. T-MSIS data is crucial for research and policy on Medicaid and CHIP and helps CMS conduct program oversight, administration, and integrity activities.

the PPI MEDIC conducts analyses to identify trends, anomalies, and questionable prescriber and pharmacy practices, including aberrant opioid prescriptions.

The Investigations MEDIC (I-MEDIC) conducts investigations of prescribers and pharmacies, recommends administrative actions, and submits case referrals to law enforcement.

3.2.2 Medical Loss Ratio Requirement

A medical loss ratio (MLR) represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, as opposed to other expenses that do not directly impact patient care or quality (e.g., marketing, profits, salaries, administrative expenses, and agent commissions). The minimum MLR requirement is intended to create incentives for Part C and Part D plan sponsors to reduce overhead expenses, and ensure that taxpayers and enrolled beneficiaries receive value from Medicare Advantage and Part D plans. Part C and Part D plan sponsors must report the MLR for each contract they have with CMS.

A contract must have a minimum MLR of at least 85 percent to avoid financial and other penalties. If a Part C or Part D plan sponsor has a MLR for a contract year that is less than 85 percent, meaning that a plan sponsor used less than 85 percent of its revenue for patient care or quality improvement, the Part C or Part D plan sponsor owes a remittance to CMS. CMS deducts the remittance from the regular monthly plan payments to the Part C or Part D sponsor. Further MLR-related sanctions include a prohibition on enrolling new members after three consecutive years, and contract termination after five consecutive years, of failing to meet the minimum MLR requirement.

3.3 Healthcare Fraud Prevention Partnership (HFPP)

In July 2012, the Secretary of HHS and the U.S. Attorney General announced a groundbreaking partnership to fight fraud, waste, and abuse across the health care system. The HFPP is a voluntary, public-private partnership consisting of the Federal Government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The overall mission of the HFPP is to position itself as a leading 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 materially benefiting efforts to reduce health care fraud, waste, and abuse.

In December 2020, the Consolidated Appropriations Act, 2021[46] was signed into law. This law amended Section 1128C(a) of the Social Security Act (42 U.S.C. 1320a–7c(a)) providing explicit statutory authority for the HFPP including the potential expansion of the public-private partnership analyses.

[46] Public Law 116-260 (enacted December 27, 2020).

In FY 2021, the HFPP reached a total membership level of 222 partner organizations, comprised of five federal agencies, 56 law enforcement agencies, 13 associations, 98 private payers, and 50 state and local partners. Collectively, these organizations represent more than 218 million covered lives, equivalent to more than three in four insured Americans. Sixty-six of the current partners are actively submitting claim level data, representing more than 104 million individuals, or more than one in three insured Americans.

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 its own claims data.

The HFPP uses a diverse variety of approaches to identify vulnerabilities in partner data. These methods include standard searches to detect anomalies that may implicate 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). The HFPP has also expanded its study methodology to collect frequently updated data, including, and consistent with all applicable privacy requirements, personally identifiable information (PII) and protected health information (PHI).

Over 35 billion professional claim lines were submitted by partners through FY 2021 for the purpose of conducting cross-payer analyses. During FY 2021, the HFPP ran 13 studies producing over 600 unique results workbooks distributed to our data-sharing Partners that can be used to identify fraud, waste, and abuse within their organizations. Also, during this period, the HFPP shared over 60 provider and fraud scheme alerts within the Partnership. The HFPP is currently using professional and institutional claims, is collecting pharmacy claims to begin using in studies in FY 2022, and has plans to expand to collect dental claims in the future.

HFPP studies give partners ways to take substantive actions that stop fraudulent and improper payments from going out the door. Examples of studies initiated in FY 2021 include the identification of problematic billing in the following areas:

- Self-care/home management training;
- Deactivated rendering providers;
- Sleep study;
- Allergy services;
- Psychotherapy, physical therapy/occupational therapy improbable days; and
- COVID-19 add-on laboratory testing.

The HFPP also continued its efforts to foster collaboration among partners in FY 2021 by hosting five virtual information-sharing sessions (one specifically for state partners for which the event drew 127 attendees while the average of the other four was over 700 attendees per event), and a new Executive Board which meets quarterly. These meetings are used to share fraud schemes and provider alerts, provide updates on law enforcement activities, and strategize on how to broaden the HFPP's impact in the private and public sectors.

3.4 Medicare Beneficiary Education

CMS undertakes various activities to inform Medicare beneficiaries about the importance of guarding their personal information against identity theft and how they can protect against and report suspected fraud. In FY 2021, CMS communicated key fraud prevention messages in beneficiary channels, including the *Medicare & You* handbook and other beneficiary education materials, through 1-800-MEDICARE, and via Medicare.gov. CMS disseminated similar messages through a wide range of beneficiary touch points, including the Medicare Summary Notice, the Medicare.gov Message Center, social media, a national educational campaign including TV, digital, and print, direct-to-beneficiary emails, and response letters to beneficiary inquiries.

3.5 National Correct Coding Initiative (NCCI)

NCCI promotes national correct coding methodologies and reduces improper coding that may result in inappropriate payments in Medicare Part B and Medicaid. NCCI Procedure-to-Procedure edits prevent inappropriate payment for billing code pairs that should not generally be reported together by the same provider for the same beneficiary and date of service, while NCCI Medically Unlikely Edits define for each HCPCS/CPT code the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service.

Section 1903(r) of the Social Security Act requires states to use NCCI methodologies to process applicable Medicaid claims. CMS provides assistance for state Medicaid agencies to use NCCI methodologies in their Medicaid programs.

4. Mitigate Emerging Programmatic Risks

4.1 Improper Payment Rate Measurement

An improper payment is a payment that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The term improper payment includes; any payment to an ineligible recipient; any payment for an ineligible good or service; any duplicate payment; or any payment for a good or service not received, except for those payments where authorized by law. However, improper payments that are cited do not always necessarily represent expenses that should not have occurred. For example, instances where there is no or insufficient documentation to support the payment as proper or improper are cited as improper payments.

The FY 2021 HHS AFR includes a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2021 to reduce improper payments. [47]

4.2 Recovery Audit Programs

4.2.1 Medicare Fee for Service (FFS)

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

As required by section 1893(h), RACs are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to, providers. The RACs negotiate their contingency fees at the time of the contract award. The RAC must return the contingency fee if an improper payment determination is overturned at any level of appeal.

In FY 2021 the program identified approximately $390.28 million in overpayments and recovered $327.31 million.[48] During FY 2021, the majority of Medicare FFS RAC collections were from outpatient claim reviews. CMS regularly evaluates the RACs' performance and adherence to program requirements by using an independent validation contractor and CMS staff that conduct site visits to observe contractor performance requirements and conduct desk audits on claims to confirm that all aspects of program requirements are performed correctly and completely. Such oversight contributes to the RACs' proper identification of underpayments and overpayments and program success. Additionally, in FY 2021, the Medicare FFS RACs had an

[47] https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html.

[48] https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program.

84 percent overpayment recovery rate and continued to make recommendations to CMS to improve program operations and prevent improper payments.[49]

Amounts Identified in FY 2021 by Fee-for-Service (FFS) RAC Region

FFS RAC Region/Name	Overpayment Amount Identified (in millions)	Underpayment Amount Identified (in millions)	Overpayment Amount Recovered (in millions)
1. Performant	$75.85	$1.25	$58.22
2. Cotiviti	$93.81	$10.21	$81.13
3. Cotiviti	$50.01	$5.79	$39.30
4. Cotiviti GOV Services	$120.01	$7.28	$112.75
5. Performant	$50.49	$.01	$35.91
TOTALS	$390.28	$24.53	$327.31

4.2.2 Part C and Part D

Section 1893(h) of the Act expands the RAC program to Medicare Part C and Part D. However, despite the success of RACs in Medicare FFS, RAC vendors have found the incentives for performing recovery audits of the Medicare Part C program not viable because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes.

The same objectives that a Part C RAC would pursue (i.e., identifying and recouping overpayments) are being met through contract-level Risk Adjustment Data Validation (RADV) audits conducted by CMS with the use of non-RAC contractors that perform medical record review, payment error calculations, and other supportive tasks. The contract-level RADV audit program is the primary corrective action to reduce the Part C improper payment rate through the identification and collection of overpayments. Through contract-level RADV audits, medical records are reviewed and MAOs are held financially accountable when the MAO-submitted diagnostic data for risk adjustment purposes does not conform to program rules.

In a similar circumstance to the Part C RADV, the objectives that a Part D RAC would pursue (i.e., identifying and recouping overpayments) are being met by the PPI MEDIC, a non-RAC contractor. The PPI MEDIC's workload is substantially like that which a Part D RAC would pursue, and the PPI MEDIC has a robust program to identify improper payments. After the PPI MEDIC identifies improper payments, CMS requests that plan sponsors delete PDE records that are associated with potential overpayments. Subsequently, CMS validates whether plan sponsors

[49] https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/proposed-rac-topics.

delete the PDE records and do not resubmit such PDE records for payment. As noted previously, the PPI MEDIC's responsibilities relate to plan oversight and pertain to specific initiatives like data analysis, health plan audits, outreach and education, and law enforcement support.

4.2.3 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 CMS. Sixteen states currently have operational RAC programs.[50] Federal law provides authority for states to request an exception from the Medicaid RAC requirement(s). As of FY 2021, 35 states and the District of Columbia have CMS-approved exceptions to Medicaid RAC implementation (for example, because of the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS).

4.3 Medicare Fee-for-Service Medical Review

Consistent with sections 1815(a), 1833(e), 1862(a)(1), and 1893 of the Act, CMS is required to protect the Medicare Trust Funds by taking corrective actions to prevent and reduce improper payments. CMS contracts with a variety of medical review contractors, including the MACs and SMRC, to perform medical review for claims paid by the Medicare FFS program.[51] Medical review involves both automated and manual processes to help ensure that only claims for items and services that meet all Medicare coverage, payment, and coding requirements are paid. Medical review activities concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing (CERT) results, and oversight agency findings that indicate questionable billing patterns. CMS incorporates provider feedback processes, such as one-on-one education and detailed medical review results notifications, to encourage proper billing.

4.3.1 Targeted Probe and Educate

CMS's Targeted Probe and Educate (TPE) program helps providers and suppliers reduce claim denials and appeals through one-on-one education by the MAC. As part of TPE, the MACs focus on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the conclusion of each round. Providers/suppliers are also offered individualized education during each round of review to more efficiently fix simple problems. The goal of TPE is to help providers and suppliers meet Medicare's payment policy requirements. TPE also reduces burden on those providers and suppliers who, based on data analysis, are already submitting claims that are compliant with

[50] Arizona, California, Colorado, Connecticut, Georgia, Hawaii, Illinois, Minnesota, Nevada, New Mexico, New York, North Carolina, Oregon, South Carolina, Texas, and West Virginia

[51] The UPICs also perform medical review, as discussed in section 3.1, as well as the Recovery Audit Contractors, as discussed in section 3.3.

Medicare policy.[52] In FY 2021, MACs primarily conducted non-TPE service-specific post-payment medical reviews due to the COVID-19 PHE.

4.3.2 Supplemental Medical Review

CMS uses a Supplemental Medical Review Contractor (SMRC) to perform and/or provide support for a variety of tasks aimed at reducing improper payments in the Medicare FFS program. One of the SMRC's primary tasks is conducting nationwide medical review of Medicare Part A, Part B and DMEPOS claims, as directed by CMS. The focus of the reviews may include, but are not limited to, issues identified by CMS internal data analysis; the CERT program; professional organizations; and other Federal agencies, such as the OIG and GAO. Medical records and related documents are reviewed to determine whether claims were billed in compliance with Medicare's coverage, coding, and payment rules. Examples of what the SMRC may look for within medical records includes, but is not limited to:

- Possible falsification or other evidence of alterations of medical record documentation including, but not limited to: obliterated sections; missing pages, inserted pages, white out; and excessive late entries;
- Evidence that the service billed for was actually provided and/or provided as billed; or,
- Patterns and trends that may indicate potential fraud, waste, and abuse.

4.3.3 DMEPOS Prior Authorization

CMS utilizes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization. CMS defines unnecessary utilization as "the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules."[53] CMS also establishes a list of DMEPOS items that could be subject to prior authorization before items or services are provided and payment is made. [54] During FY 2021, CMS expanded a prior authorization requirement for six Lower Limb Prosthetic codes nationwide (L5856, L5857, L5858, L5973, L5980, and L5987). CMS initially required prior authorization of these codes beginning on September 1, 2020 in California, Michigan, Pennsylvania, and Texas.

4.3.4 Hospital Outpatient Department Prior Authorization

Using its authority under section 1833(t)(2)(F) of the Social Security Act, CMS finalized a regulation through the Calendar Year 2020 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule (CMS-1717-FC)

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

[53] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.234.

[54] Final Rule 1713-F, effective January 1, 2020, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Prior-Authorization-Process-for-Certain-Durable-Medical-Equipment-Prosthetic-Orthotics-Supplies-Items.

establishing a nationwide prior authorization process and requirements for certain hospital outpatient services that demonstrate significant increases in volume. Beginning July 1, 2020, CMS required prior authorization as a condition of payment for the following services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. As part of the Calendar Year 2021 Outpatient Prospective Payment System/Ambulatory Surgical Center Final Rule (CMS -1736-FC), and effective July 1, 2021, CMS added cervical fusion with disc removal and implanted spinal neurostimulators to the list of services requiring prior authorization under this process. Prior authorization of hospital outpatient department services serves as a method for controlling unnecessary increases in the volume of these services as claims must be associated with a provisional affirmative prior authorization decision to be eligible for payment.

4.4 Medicare Provider Cost Report Audits

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

The cost report audit process provides a method to detect improper payments, as well as reasons these improper payments have occurred. These reasons for improper payments provide insight into potential payment vulnerabilities, the recognition of which can strengthen and focus the program integrity response. The audit process includes the timely receipt and acceptance of provider cost reports, the performance of desk reviews, audits of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines whether providers have been paid properly, in accordance with CMS regulations and instructions.

4.5 Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program, Section 1862(b)(2), ensures that Medicare pays appropriately when another entity has "primary" payment responsibility (that is, expected to pay for care before Medicare), and, should another primary payer be identified, recovers funds that Medicare paid initially or conditionally. Sections 1862(b)(7) and (8) of the Act, as added by Section 111 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Extension Act of 2007 (MMSEA),[55] added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under Group Health Plan (GHP) arrangements, as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payments from liability insurance (including self-insurance), no-fault insurance, or workers' compensation, collectively referred to as Non-Group Health Plan (NGHP) insurance. This mandatory insurer

[55] Public Law 110-173 (enacted December 29, 2007).

reporting continues to be the primary source of new MSP information reported to CMS from group health plans and other insurers, and the annual number of new MSP records posted to CMS's systems remains more than twice the number posted before this provision's implementation.

The MSP RAC, also known as the MSP Commercial Repayment Center (CRC), reviews the CMS collected information regarding beneficiaries that had or have primary coverage through a GHP and situations where a NGHP has or had primary payment responsibility. When GHP or NGHP information is incomplete, Medicare FFS may mistakenly pay for services as the primary payer. The CRC recovers mistaken Medicare payments from the entity that had primary responsibility (typically the employer or other plan sponsor, insurer, or claims processing administrator). The CRC also recovers conditional payments where an NGHP applicable plan had primary payment responsibility. The CRC is a single contractor with national jurisdiction.

4.6 Medicaid and CHIP Program Integrity

The Medicaid and CHIP programs are federal-state partnerships, and these partnerships are central to the programs' success. While states have primary responsibility for direct oversight of their programs, CMS plays a critical role in ensuring that states are compliant with federal statute and regulations. As a result, CMS undertakes a wide array of activities to oversee and support states' Medicaid and CHIP program integrity efforts.

Section 1936(d) of the Act directs the Secretary to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. In FY 2020, CMS released the Comprehensive Medicaid Integrity Plan (CMIP), which sets forth CMS's strategy to safeguard the integrity of the Medicaid program for FYs 2019-2023.[56] Highlights of the program integrity elements from the CMIP that CMS engaged in during FY 2021 are described in greater detail in the following sections.

4.6.1 Eligibility and Payment Integrity

A large driver of the Medicaid and CHIP improper payment rates in FY 2021 was state noncompliance with various beneficiary eligibility requirements and processes. Making accurate beneficiary eligibility determinations helps protect the integrity of the Medicaid program and CHIP, as well as taxpayer dollars. CMS reintegrated the eligibility component of the PERM measurement in 2019, resulting in a significant increase in the improper payment rates in FYs 2019-2021.[57] To ensure oversight of states' beneficiary eligibility determinations, in FY 2021, CMS conducted several oversight activities, described below.

Medicaid Eligibility Quality Control (MEQC) Program

Under the MEQC program, states design and conduct pilots to evaluate the processes that determine an individual's eligibility for Medicaid and CHIP benefits. The states conduct these MEQC pilots during the two-year intervals ("off-years") that occur between their triennial PERM review years, allowing states to implement prospective improvements in eligibility

[56] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf.

[57] https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf.

determination processes prior to their next PERM review. Consistent with federal requirements, states have great flexibility in designing pilots to focus on vulnerable or error-prone areas as identified by the PERM program and by the state. In addition, states are required to devote part of their MEQC pilots to reviews of improper denials or terminations, which are not addressed through PERM reviews. For more information regarding the MEQC program, see the FY 2019-2023 Comprehensive Medicaid Integrity Plan.[58]

In FY 2021, CMS worked with the Cycle 1 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission in November, 2020; the Cycle 2 states to complete their MEQC reviews and prepare their summary-level reports and corrective action plans for submission in November 2021; and the Cycle 3 states to design their MEQC pilots and state their case reviews in January 2021. Because of COVID-19's impact, CMS issued revised supplemental MEQC guidance in May 2021 that reduced state burden by applying uniform summary reporting requirements and deadline extensions to all cycles, as well as a reduced workload requirement for Cycle 2 and Cycle 3 states.[59]

Audits of Beneficiary Eligibility Determinations

To ensure compliance with eligibility and enrollment requirements, CMS conducts beneficiary eligibility audits for Medicaid and CHIP. These audits include assessments of state eligibility policies, processes, and systems.[60] CMS is also calculating the amounts inappropriately paid, if any, to the states due to improper eligibility determinations. In FY 2021, CMS initiated additional beneficiary eligibility reviews in Pennsylvania, Kansas, Missouri, and Connecticut. The reviews are currently ongoing and in various stages of the review process.

4.6.2 Review of State Program Integrity Activities

Conducting oversight of states' program integrity activities is an important component of CMS's plan to protect the integrity of the Medicaid program. Specifically, CMS conducts state program integrity reviews and provides oversight and monitoring of states' PERM Corrective Active Plans (CAPs) to ensure that states are complying with federal rules and requirements.

State Program Integrity Reviews

CMS conducts focused reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. Focused program integrity reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities.

In addition to focused reviews, CMS also conducts desk reviews of states' program integrity activities to increase the number of states and topics that are assessed each year. In FY 2021, CMS conducted 57 desk reviews related to states' responses to the opioid crisis, terminated

[58] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf.

[59] https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2021.pdf, page 228.

[60] FY 2020 HHS AFR.

providers, payment suspensions implemented, states' investigation of services after death, and states' corrective actions that had been completed from previous program integrity reviews.

PERM CAP Oversight and Monitoring

In an intensive effort to solve the root causes of payment errors identified by the PERM program, CMS provides support and technical assistance to states as they develop and implement their PERM CAPs, and CMS monitors and evaluates their CAPs' effectiveness. CMS requires states to meet more stringent PERM CAP requirements if they have consecutive PERM eligibility improper payment rates exceeding the 3 percent national standard, pursuant to section 1903(u) of the Act.

In FY 2021, CMS continued to implement a more robust state-specific CAP process that provides enhanced technical assistance and guidance to states. CMS works with states to coordinate state development of CAPs which addresses each error and deficiency identified during the PERM cycle. After CAP submissions, CMS monitors and provides continuous technical assistance to ensure states are making progress on implementing effective corrective actions to address each error and deficiency. CMS encourages states to share any and all state identified lessons learned as they implement their CAPs. This helps other states evaluate their CAPs and helps CMS to identify areas for future guidance and education.

4.6.3 Medicaid Managed Care MLR Reviews

A key component of CMS' Medicaid managed care oversight strategy is conducting targeted reviews of some states' Medicaid Managed Care Plans' (MCPs) financial reporting. Many states have adopted risk mitigation strategies, such as remittance arrangements based on a minimum MLR, as a standard for MCPs to meet, and CMS is reviewing MCP experiences to make sure claims experience matches the MLRs that MCPs reported. These MLR reviews include a review of high-risk vulnerabilities.

In FY 2020, CMS released a final report for a review of California's Medicaid MCPs' financial reporting, focusing on MLRs and rate setting.[61] In FY 2021, CMS conducted a risk-based assessment to identify future states for review. In January 2021, CMS initiated a review of Oregon's 16 Medicaid Coordinated Care Organizations (CCOs) MLR reporting for the Medicaid managed care population to determine if coordinated care organizations complied with state and federal reporting requirements for annual MLR reporting, if minimum MLR remittance calculations for the state's Medicaid coordinated care organizations were accurately reported, and if remittances, if any, were received from the coordinated care organizations.

4.6.4 State Access to Medicare Data

Over 12 million Americans are dually enrolled in Medicare and Medicaid, and providers and managed care plans that serve Medicaid patients often participate in Medicare as well. This overlap means that Medicare program integrity data offers the potential to greatly enhance state Medicaid program integrity efforts. Analyzing both Medicare and Medicaid claims data enables CMS and states to detect duplicate and other improper payments for services billed to both

[61] https://www.cms.gov/files/document/california-medical-loss-ratio-examination-report.pdf.

programs. Sharing information among federal and state investigators about aberrant providers or plans can improve the identification of improper billing and optimize investigative resources. Through the State Data Resource Center (SDRC), state Medicaid agencies may request Medicare data, free of charge, for individuals who are dually enrolled in Medicare and Medicaid to support care coordination and program integrity functions, such as preventing duplicate payments by Medicare and Medicaid.

CMS also administers the Medicare-Medicaid Data Match (Medi-Medi) program, through which Medicare and Medicaid claims are matched at the provider and beneficiary level to check for duplicate payments and other types of improper payments. State participation is voluntary; as of September 2021, 26 states participate in the Medi-Medi program. CMS's UPICs perform analyses of Medicare-Medicaid matched data and collaborate with state Medicaid agencies to conduct investigations and audits. Medi-Medi functionality matches Medicaid and Medicare claims and other data to identify improper billing and utilization patterns. Analyses performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making it 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.

4.6.5 Strengthen Medicaid Data Analytics and Audits

Strong data collection and analysis will enable smarter efforts to tackle fraud, waste, and abuse. CMS is enhancing data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs.

CMS works closely with states to ensure that CMS and oversight bodies have access to the best, most complete, and accurate Medicaid data to support program integrity activities and to improve monitoring, oversight, and evaluation of Medicaid and CHIP aimed at protecting coverage, health equity and driving innovation and whole person care for the program's beneficiaries. All 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands are submitting data on their programs on an ongoing basis to the T-MSIS. Each year, CMS partners with states to improve the quality of the overall dataset, and holds states accountable for correcting high priority data areas. As a result of these efforts with states to improve the data, historical T-MSIS data can now be used for analysis and to inform program integrity. CMS releases a research version of T-MSIS data called the T-MSIS Analytic Files (TAF), with data for calendar years 2014-2020, to federal partners and stakeholders, and publicly releases research files for calendar years 2014-2020. This marks the timeliest ever availability of Medicaid and CHIP data. To allow users to explore the data, CMS also releases the Data Quality (DQ) Atlas. This interactive, web-based tool helps policymakers, analysts, researchers, and other stakeholders explore the quality and usability of the TAF to determine whether the data can meet their analytic needs.

Due to the COVID-19, in FY 2020 CMS exercised its enforcement discretion by temporarily suspending all improper payment related engagement/communications, and data requests to providers and state agencies from CMS, as disclosed in HHS' FY 2020 AFR. CMS adjusted the sample size for the FY 2021 Medicaid and CHIP measurement programs to account for ongoing challenges incurred by providers and states during COVID-19 while continuing to maintain appropriate accountability measures and meet the statutory obligations.

4.6.6 Provider Screening and Enrollment

As part of its oversight role in Medicaid, CMS works closely with state Medicaid agencies to provide regulatory guidance, technical assistance, and other support with respect to provider screening and enrollment. Waivers were implemented during the COVID-19 PHE to allow states to temporarily enroll providers, temporarily cease revalidation of providers, waive the collection of fingerprints for 5% or greater owners of high-risk providers, waive payment of application fee, waive site visits, and waive in-state/territory licensure requirements. Unless modified by rules or regulations, these waivers will expire at the end of the COVID-19 PHE.

Provider Screening Data Sources

CMS has significantly expanded data sources available to states for provider screening and enrollment over the past few years and continues to enhance the usability of these data sources through ongoing work with state partners. All 50 states, the District of Columbia, and Puerto Rico have access to these databases through an online portal, the Data Exchange (DEX) system. DEX allows CMS to share Medicare revocation data with the Medicaid programs of every state, which in turn use DEX to share terminated Medicaid and CHIP provider information with CMS and other states. DEX also provides states with access to the Social Security Administration's Death Master File, as well as Medicare Exclusion Database extracts, which contain the HHS-OIG's data regarding individuals and entities excluded from federally funded health care programs. CMS will continue to work with states to ensure adoption of the DEX system and to determine the need for future enhancements that may benefit states.

Since FY 2014, state non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments. To reduce the burden of conducting screening for new enrollments and revalidation of Medicaid providers, CMS allows states to use provider-screening results from Medicare, CHIP, or other State Medicaid agencies. To assist in this work, CMS currently offers a data compare service for provider screening that allows a state to rely on Medicare's screening in lieu of conducting state screening. This service reduces state burden, particularly for provider revalidation, because it allows states to remove dually enrolled providers from their revalidation workload. CMS also returns information on providers found to have deactivated National Provider Identifiers (NPIs), or to be deceased, excluded by the HHS OIG, or revoked by Medicare or terminated for cause by a State Medicaid Agency (thus allowing the state or territory to take deactivation or termination action against the provider, as applicable).

In FY 2021, seven additional states had participated in the data compare service, while 33 states have taken advantage of the service since its inception. CMS will continue to work with states on an ongoing basis to promote the advantages of the data compare service to work toward the goal of expanding use of the service to all states.

Provider Enrollment: Guidance and Technical Assistance

To help states strengthen their provider screening and enrollment processes, CMS offers guidance and technical assistance to states. As part of this ongoing effort, CMS continues to update guidance and expand these services to all states through the following activities:

- In FY 2021, CMS published updates to the Medicaid Provider Enrollment Compendium (MPEC), a resource of sub-regulatory guidance to assist states in the implementation of provider screening and enrollment requirements, to clarify Medicaid provider enrollment policies and procedures for the states.[62]

- CMS holds monthly calls with states to understand challenges or barriers states currently face, to facilitate the exchange of noteworthy practices among states, and to respond to questions regarding guidance or other provider enrollment issues. CMS has also dedicated an additional monthly call focused entirely on provider enrollment and screening issues in Medicaid managed care.

Screening Medicaid Providers

As part of the Medicaid Program Integrity Strategy, CMS began piloting a centralized process to screen Medicaid-only providers on behalf of states on an opt-in basis, similar to the current process in place for Medicare. The purpose of this effort is to explore whether centralization of Medicaid provider screening can reduce state and provider burden, better ensure that providers are screened appropriately based on categories of risk, and address a major source of improper payments. CMS recruited two states, Iowa and Missouri, and began screening their Medicaid-only providers through databases for valid licenses, criminal background checks, and the federal Treasury's Do Not Pay portal in late FY 2019. CMS evaluated the pilot impact and results and expanded the service to additional states in FY 2021. Oklahoma, Nevada, North Dakota, Tennessee, Colorado, Rhode Island, Oregon, and West Virginia are also participating in the pilot, and CMS continues to contact other states to gauge interest.

4.6.7 Medicaid Integrity Institute

CMS offers training, at no cost to states, to state program integrity staff through the Medicaid Integrity Institute (MII), which historically provided both classroom training and distance learning webinars to enhance the professional qualifications of state Medicaid integrity staff across the nation. The MII offers a program of courses and examinations for the Certified Program Integrity Professional designation, which is recognized by the American Association of Professional Coders and the National Health Care Anti-Fraud Association. Courses at the MII also provide opportunities to discuss emerging trends, support new initiatives, and strengthen collaboration among state and federal partners.

For FY 2021, CMS cancelled all in-person courses after the start of the COVID-19 PHE, and established virtual courses to continue educational offerings. Despite this change, state interest and participation were strong, consistent with previous years. The list of courses included a trend in Medicaid COVID Vulnerabilities, PERM Corrective Action Symposium, and an Education & Outreach for the Territories Workgroup.

[62] https://www.medicaid.gov/sites/default/files/2021-05/mpec-3222021.pdf.

4.7 Demonstrations and Models

CMS conducts a number of innovative demonstrations and models designed to test improved methods for the prevention, identification and prosecution of potential fraud, waste and abuse, with the goal of reducing program expenditures while preserving or enhancing the quality of care.[63]

4.7.1 Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967[64] 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.

Review Choice Demonstration for Home Health Services

In FY 2020, CMS began implementing the Review Choice Demonstration for Home Health Services (RCD), based on stakeholder feedback on CMS's previous Pre-Claim Review Demonstration in Illinois, Ohio, and Texas.[65] CMS continued implementing the demonstration in FY 2021 with the inclusion of North Carolina and Florida, initially phasing in these states' participation to help ease the transition during the COVID-19 PHE, but moving to full implementation by September 1, 2021. The demonstration offers providers increased flexibility and choice, as well as risk-based changes to reward providers who show compliance with Medicare home health policies. The demonstration gives providers in the demonstration states an initial choice of three options – pre-claim review, post-payment review, or minimal post-payment review with a 25 percent payment reduction for all home health services. A provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the demonstration.

The demonstration runs for five years and applies to Home Health and Hospice Medicare Administrative Contractor (HH/H MAC) Jurisdiction M (Palmetto GBA) providers operating in Illinois, Ohio, Texas, North Carolina, and Florida, with the option to expand to other states in the Palmetto Jurisdiction M. This demonstration assists in developing improved methods to identify, investigate, and prosecute potential fraud in order to protect the Medicare Trust Funds, potentially reduces the rate of improper payments, and improves provider compliance with Medicare rules and requirements.

4.7.2 Models

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

[63] 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.

[64] Public Law. 90-248 (enacted January 1, 1968).

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

Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport

On September 22, 2020, CMS announced that it would expand the Medicare Prior Authorization Model for Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT) nationwide. Medicare Part B covers medically necessary RSNAT services, most often for dialysis treatment. An evaluation found that the model was successful in reducing RSNAT services and total Medicare spending while maintaining overall quality of, and access to, care.

In FY 2021, CMS continued the model in New Jersey, Pennsylvania, South Carolina, North Carolina, Virginia, West Virginia, Maryland, the District of Columbia, and Delaware.[65] On November 20, 2020, CMS published a Federal Register Notice announcing nationwide expansion of the model, as the model had met all expansion criteria under section 1834(l)(16) of the Act (as added by section 515(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (P.L. 114-10) (MACRA). Expansion to the remaining states was delayed due to the COVID-19 PHE, but, on August 27, 2021, CMS published an additional Federal Register Notice announcing the implementation dates for all remaining states and territories.

4.8 Federally-facilitated Marketplaces

CMS continued expanding and refining program integrity operations for the Federally-facilitated Marketplace (FFM) during FY 2021 by continuing to work on improving the prevention, detection, and mitigation of fraud and misconduct in the FFM. In FY 2021, the Marketplace Complaints Review Contractor (MCRC) triaged more than 15,000 complaints from consumers who alleged that they had been enrolled in FFM insurance policies without their consent, that incorrect information had been submitted on an application by an insurance agent or broker, or that other misconduct had occurred. CMS worked with health insurance issuers to verify and cancel over 6,000 cases of unauthorized enrollment. CMS and its program integrity contractors continuously analyzed plan enrollments and other types of data to identify trends and early warning signs of fraud, conducted dozens of investigations of outlier and high-risk agents and brokers, and referred egregious cases to the HHS-OIG and states' Departments of Insurance (DOI). CMS also performed license verifications to identify agents and brokers who were potentially noncompliant with states' licensure statutes and regulations and reported license non-compliance to the DOIs. When cases of agent and broker misconduct warranted it, CMS took administrative actions including blocking access to the FFM to prevent consumer harm, and suspending or terminating CMS' agreements with the agents and brokers. CMS also supported ongoing OIG and DOI investigations by fulfilling requests for records regarding consumer FFM enrollments and financial assistance, complaints, and results of CMS investigations. Thirty-two (32) such requests were received and fulfilled in FY 2021. CMS also hosted meetings with SBMs every other month to share best practices for identifying and deterring fraud, and notifying

[65] For more information, please visit: 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-

SBMs of specific schemes and schemers being investigated by the FFM and/or one or more SBMs.

4.9. Open Payments

The Open Payments program is a statutorily required, national disclosure program that promotes transparency and accountability by making information about the financial relationships between the health care industry (reporting entities)[66] and certain health care providers (covered recipients)[67] available to the public.

The Open Payments data includes payments and other transfers of value made by reporting entities to covered recipients, along with ownership and investment interests in the reporting entities held by physicians or their immediate family members. Full details on the Open Payments program can be found in the Annual Report to Congress on the Open Payments Program.[68]

On January 1, 2021, the statutory Open Payments program expansion under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment For Patients and Communities Act[69] (hereinafter referred to as "SUPPORT Act") went into effect. See rulemaking at 85 Fed. Reg. 69153 (Nov. 2, 2020).

The SUPPORT Act expands the Open Payments definition of a covered recipient to include: Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Anesthesiologist Assistants, and Certified Nurse Midwives. The SUPPORT Act also removed the prohibition on making NPIs publicly available in Open Payments data, thus giving the Open Payments Program the authority to include NPIs in its public datasets.

Reporting entities are now required to collect and submit data related to certain interactions they hold with these additional covered recipients. Reporting entities will submit their Program Year 2021 data at the beginning of Calendar Year 2022 and this data will be publicly displayed by June 30, 2022.

In addition to the changes set forth in the SUPPORT Act, the revisions that were made through the Calendar Year 2020 Medicare Physician Fee Schedule rulemaking[70] became effective on January 1, 2021. These revisions include updates to the Nature of Payment categories and updated device reporting requirements.

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[66] Reporting entities refers to applicable manufacturers and group purchasing organizations (GPOs) required to report payments or transfers of value to covered recipients under the Open Payments Program (42 USC §1320a-7h).

[67] For Program Year 2020, covered recipients are any physicians (excluding medical residents) who are not employees of the applicable manufacturer that is reporting the payment; or teaching hospitals that receive payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which such information is available.

[68] FY20 Annual Report to Congress on the Open Payments Program.

[69] Public Law 115-271 (enacted October 24, 2018).

[70] 84 Fed. Reg. 62914 (Nov. 15, 2019).

4.10 The Vulnerability Collaboration Council

To detect and combat fraud, waste, and abuse, CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the VCC, is comprised of CMS leadership and subject matter experts who work collaboratively to identify vulnerabilities that lead to fraud, waste, and abuse and develop comprehensive risk strategies to mitigate these vulnerabilities. CMS aligned the VCC's risk-based approach with GAO's Fraud Risk Framework (GAO-15-593SP). By aligning with the GAO framework, CMS standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the design and implementation of specific mitigation activities that are regularly evaluated and adapted to adjust to changing circumstances. In FY 2021, CMS focused on the potential vulnerabilities arising from the waivers and flexibilities that CMS issued as a result of the COVID-19 PHE, as well as specific high-risk benefits and services such as durable medical equipment, prosthetics, orthotics, and supplies.[71]

[71] https://www.hhs.gov/sites/default/files/fy-2021-hhs-agency-financial-report.pdf, page 200.

5. Reduce Provider Burden

5.1 Outreach and Education – Medicare Fee-for-Service

One of the goals of provider outreach and education in the Medicare FFS program is to reduce improper payments by ensuring that providers have 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, CERT program data, and other relevant sources. Medicare contractors use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program, including CMS-developed materials and MAC-developed materials.

CMS-developed materials including Medicare Learning Network® (MLN) educational content for the health care providers. For example, MLN Matters articles explain national Medicare policies on coverage, billing and payment rules for specific provider types. Other MLN products, such as webinars, fact sheets, and listserv messages are also used to provide educational messages to CMS stakeholders. MAC-developed materials include education on local coverage policies and listserv messages tailored to the relevant MAC jurisdiction. CMS receives significant positive feedback from providers and suppliers on the value of these educational materials.

5.2 Outreach and Education – Medicare Parts C and Part D

CMS shares educational training tools for MA and Part D plans on the Health Plan Management System (HPMS). MA and Part D plans are able to access educational presentations, fact sheets, and booklets on the same HPMS platform where CMS makes available other pertinent information such as CMS communications, operational information, and policy materials.

CMS also develops training events on Medicare Parts C and Part D fraud schemes; fraud prevention techniques; and anti-fraud, waste, and abuse activities. Attendees at these events may include participants from Medicare Parts C and Part D plans, law enforcement, the PPI MEDIC, and the I-MEDIC. Attendees reported an overwhelmingly positive experience, and also provided feedback about topics for future training events.

5.3 Provider Compliance Focus Groups

Focus groups are a way for providers and CMS employees to meet in-person or via the web to share ideas and collect feedback and opinions on a number of programs and projects that CMS administers. All focus group meetings include an “open mic” session during which participants are encouraged to ask questions and provide feedback about Medicare FFS compliance topics. Participants are encouraged to ask questions and be actively engaged throughout the half-day events.

Appendix A - Program Integrity Obligations

CMS Program Integrity Obligations[72]	FY 2021 Actual Amounts (in thousands)
Audits & Appeals	
Audits	$308,362
Appeals Initiatives	$11,267
Audits & Appeals Subtotal	$319,629
Medical Review	
Medical Review Subtotal	$299,680
Medicare Secondary Payer	
Medicare Secondary Payer Subtotal	$112,749
PI Investigation, Systems & Analytics	
Benefits Integrity	$176,348
PI Modeling & Analytics	$57,878
Systems	$117,363
Marketplace Program Integrity[73]	$17,797
PI Investigation, Systems & Analytics Subtotal	$369,386
Technical Assistance, Outreach & Education	
Outreach and Education – Medicare	$48,692
Outreach and Education – Medicaid	$20,477
Healthcare Fraud Prevention Partnership	$21,617
Senior Medicare Patrol	$20,000
Technical Assistance, Outreach & Education Subtotal	$110,786
Provider Enrollment & Screening	
Provider Enrollment, Chain and Ownership System (PECOS)	$59,411
Advanced Provider Screening	$32,671
National Supplier Clearinghouse	$13,830
Section 6401 Provider Screening/Other Enrollment[74]	$33,399
Provider Enrollment & Screening Subtotal	$139,311

[72] This table represents total CMS obligations under HCFAC and DRA. This table also includes funding under the Medicare Recovery Audit Program as well as activities funded with provider enrollment user fees.

[73] These Marketplace activities are funded with discretionary HCFAC resources.

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

CMS Program Integrity Obligations[72]	FY 2021 Actual Amounts (in thousands)
Error Rate Measurement[75]	
Error Rate Measurement Subtotal	$87,551
Provider & Plan Oversight	
Open Payments	$20,183
Parts C & D	$26,580
Medicaid	$8,508
Provider & Plan Oversight Subtotal	$55,271
Program Support & Administration	
Program Support & Administration Subtotal	$323,852
Recovery Audit Contractors[76]	
Recovery Audit Contractors Subtotal	$131,326
Total CMS Program Integrity Obligations[77]	$1,949,542

[75] In addition to Medicare, Medicaid and CHIP, this includes Marketplace activities funded with discretionary HCFAC resources.

[76] 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.

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

Appendix B – Program Integrity Savings Methodologies

Medicare Savings Methodologies

1. Introduction to Medicare Savings Methodologies

CMS conducts a variety of program integrity activities to combat fraud, waste, and abuse in Medicare, including the Medicare fee-for-service (FFS) program (also known as Medicare Part A and Part B), Medicare Advantage (MA; also known as Medicare Part C), and the Medicare prescription drug benefit program (Medicare Part D). In *Table 3: Medicare Savings* of the *FY 2021 Report to Congress on the Medicare and Medicaid Integrity Programs*, CMS quantifies savings attributable to program-integrity-funded actions taken as a result of detecting improper behavior. CMS measures savings using methodologies specific to the nature of each type of action. Depending on the type of action, savings may represent an amount Medicare did not have to pay, a projected amount Medicare avoided paying, an actual amount that Medicare recovered, or an estimated amount that Medicare expects to realize. The following sections describe the methodologies CMS uses to calculate the amounts presented in *Table 3: Medicare Savings*.

2. Automated Actions in Medicare

Automated actions prevent improper payments to providers[78] 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
- Unified Program Integrity Contractor (UPIC) Automated Edits

2.1. 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) and Fiscal Intermediary Shared System (FISS) claims data in the CMS Integrated Data Repository (IDR)

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

CMS developed 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.[79] NCCI edits apply to services rendered by the same provider for the same beneficiary on the same date of service (DOS).

NCCI PTP edits prevent inappropriate payment when incorrect code combinations are billed 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, in general, should not be reported with another code for a variety of reasons; for example, one code may represent a component of a more comprehensive code, or 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, and certain facility services. Practitioner and ambulatory surgical PTP edits occur in MCS, and facility service PTP edits occur in FISS. Facility service PTP edits apply to claims subject to the Outpatient Code Editor (OCE) for the Outpatient Prospective Payment System (OPPS), i.e., outpatient hospital services and other facility services including, but not limited to, Part B skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), and certain claims for home health agencies (HHAs). PTP edits occur 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, the claims processing system automatically reduces the allowed payment for the payable code by the amount previously allowed for its non-payable code pair (referred to as a cutback in this document).[80]

When justified by clinical circumstances and documented in the medical record, providers may append an NCCI-PTP-associated modifier to some codes to bypass certain 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

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

[80] The PTP edits savings metric includes the cutback amounts from such claim lines in MCS only, as reduced allowed payments almost never occur in conjunction with PTP edit denials in FISS.

could resubmit the service with corrected information that makes the claim payable. Providers also have the right to appeal PTP edit denials/cutbacks through the Medicare FFS appeals process.

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

1. Identifying PTP Edit Denials and Cutbacks

System logic in MCS or FISS automatically appends a specific reduction/audit or reason 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.[81]

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

2. Pricing PTP Edit Denials and Cutbacks

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/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 quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[82] For each unique denial, CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did

[81] Because claims can be denied at the claim- and/or claim-line level in FISS, CMS considers PTP-denied claim lines in PTP edit savings *only if* there is no claim-level denial for a non-PTP-edit reason.

[82] 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 multiplied by 70 percent 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.

not have to pay the provider.[83, 84] 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 percent to estimate what Medicare did not have to pay.

- *FISS*: Unlike MCS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each PTP denial based on the applicable pricing mechanism.[85] CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) OPPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from PTP denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

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

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/resubmission.[86]

[83] In the methodology for this and other edits involving Part B services, CMS uses 80 percent 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 percent or the beneficiary would have paid 100 percent as part of his/her deductible.

[84] Generally, in the methodology for this and other edits across MCS, FISS, and the Viable Information Processing Systems (VIPS) Medicare System (VMS), CMS multiplies savings estimates by 98 percent to account for sequestration. However, the sequestration payment adjustment was suspended for claims with dates of service between May 1, 2020 and December 31, 2021 due to the Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020), Consolidated Appropriations Act (2021), and Act to Prevent Across-the-Board Direct Spending Cuts and for Other Purposes (2021). Thus, for claims meeting these specifications, CMS does not multiply savings estimates by 98 percent.

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

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

2.2. National Correct Coding Initiative Medically Unlikely Edits

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

First implemented in 2007, NCCI MUEs prevent payment for billing an inappropriate quantity of the same service[87] rendered by the same provider for the same beneficiary on the same DOS. An MUE for a given service defines the maximum units of that service that a provider would report under most circumstances for the same beneficiary on the same DOS. MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS edit, the MUE value is compared to the sum of all UOS for the same HCPCS/CPT code, provider, beneficiary, and DOS on claim lines of the current claim and paid claim lines of previously submitted claims. If the sum of all UOS exceeds the MUE value, all UOS for that HCPCS/CPT code and DOS are denied on the current claim.

Before claims are sent to CWF, NCCI MUEs apply to claims for the following:

- Practitioner and ambulatory surgical center services. These MUEs are implemented in MCS.
- Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). These MUEs are implemented in VMS.
- Hospital outpatient services, other Part B hospital services, critical access hospital services, and freestanding non-residential opioid treatment programs.[88] These MUEs are implemented in FISS.

If a HCPCS/CPT code has an MUE adjudicated as a claim line edit, and when justified by clinical circumstances documented in the medical record, providers may use specific modifiers to report the same HCPCS/CPT code on separate claim lines in order to receive payment for medically necessary services in excess of the MUE value. After an MUE denial, a provider could resubmit the service with corrected information that makes the claim payable. Providers also have the right to use the Medicare FFS appeals process to appeal denials due to either claim line or DOS MUEs.

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

1. Identifying MUE Denials

System logic in MCS, VMS, and FISS automatically appends a specific reduction/audit, action, or reason code, respectively, to claim lines that fail an MUE. During processing, claim lines may be

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

[88] CMS began applying MUEs to freestanding non-residential opioid treatment program claims in July 2021.

denied for multiple errors. CMS attributes savings to MUEs only when an MUE code is the system's highest priority reason for denying a claim line.[89]

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

2. 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 quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[90] CMS multiplies the system-generated or average price by 80 percent 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 ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[91] CMS multiplies the system-generated or average price by 80 percent 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

[89] Because claims can be denied at the claim- and/or claim-line level in FISS, CMS considers MUE-denied claim lines in MUE savings *only if* there is no claim-level denial for a non-MUE reason.

[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 multiplied by 70 percent 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] 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 percent 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.

mechanism.[92] CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) OPPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from MUE denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied services. First, CMS removes any savings from denied claim lines where the provider was subsequently paid for UOS above the MUE value, which may be due to medical necessity. Specifically, CMS does not count an MUE denial toward savings if the total paid UOS for claim lines with the same claim type code, HCPCS code, provider, beneficiary, and DOS as that denial exceed the MUE value. Second, CMS subtracts the allowed payment amount for any subsequently paid claim lines with UOS below the MUE value. Specifically, for claim lines with the same claim type code, HCPCS code, provider, beneficiary, and DOS and total paid UOS below the MUE value, CMS subtracts the allowed payment amount for the subsequently paid UOS from the priced amount for the earliest denial, up to that priced amount, to obtain the remaining savings. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial. All amounts used in these steps have the estimated beneficiary coinsurance removed.

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

2.3. 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, VMS, and FISS 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, DMEPOS, and home health claims that require identification of the

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

ordering/referring provider.[93] 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.[94] Part B clinical laboratory and imaging, DMEPOS, and home health O&R edits are implemented in MCS, VMS, and FISS, respectively, before claims are sent to CWF.

If a claim or claim line does not pass the ordering/referring provider requirements, the O&R edit logic automatically denies or rejects the claim or claim line. 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.

CMS calculates savings attributable to O&R edits in three steps: 1) identifying O&R edit denials/rejections, 2) pricing these denials/rejections, and 3) accounting for subsequent payment of previously denied/rejected services.

1. Identifying O&R Edit Denials and Rejections

System logic in MCS and VMS automatically appends a specific reduction/audit 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.

In FISS, CMS identifies O&R denials/rejections at the claim level to ensure appropriate attribution of savings. When a home health claim fails an O&R edit, system logic automatically appends a specific reason code to the claim, indicating that the O&R edit was the reason for denying or rejecting the entire claim.

When a claim or 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 processed O&R denial/rejection among matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines as those that share the same

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

[94] 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.

HCPCS code, rendering provider, beneficiary, and DOS. In FISS, CMS considers matching claims as those that share the same claim type code, beneficiary, provider, and DOS (i.e., the start date of the home health episode of care).

2. 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 quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[95] CMS multiplies the system-generated or average price by 80 percent 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 ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[96] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* FISS does not store the priced amount of denied/rejected claims; thus, CMS approximates the price for each O&R denial/rejection by replicating the home health prospective payment system (PPS) pricing formula.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/rejected services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied/rejected service, CMS subtracts the allowed payment amount of those subsequently paid claims or 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 on or after the

[95] 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 multiplied by 70 percent 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] 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 percent 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.

date of the earliest denial/rejection and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial. In FISS, these attributes are the same claim type code, beneficiary, provider, and DOS as the denial. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

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

2.4. Fraud Prevention System Edits

Savings:	The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or rejected due to an FPS edit, accounting for any subsequently paid claim lines.
Data Source:	1) FPS and 2) CWF claims data

The FPS is capable of evaluating claims for episodes of care that span different service types or providers (e.g., inpatient care, outpatient and practitioner services, and DME) as well as those that span multiple visits over a period of time. Because of its integrated potential fraud identification capabilities, CMS implements both edits and analytical models in the FPS to address vulnerabilities for fraud, waste, and abuse on a national level. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if an FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as an FPS model[97] or provider education, are better suited for the issue. CMS continuously develops new FPS edits and updates existing edits.

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

When a claim line is denied or rejected, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, FPS denial or rejection of claim lines that share the same HCPCS code, provider, beneficiary, and DOS. For most denied or rejected claim lines, FPS automatically generates the price, i.e., the amount Medicare would have paid for that claim line. The pricing data fields are the Medicare payment amount for Part A claims and the provider reimbursement amount

[97] 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 UPICs.

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 on or 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.

2.5. Medicare Administrative Contractor Automated Medical Review Edits

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

The MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. CMS awards a geographic jurisdiction to each MAC to process and pay Medicare Part A and Part B medical claims[98] 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,[99] the Government Accountability Office (GAO), the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Medicare FFS Recovery Audit Contractors (RACs), and other sources. The MACs' medical review efforts focus on reducing payment errors; thus, the MACs refer cases of potential fraud to UPICs. The MACs conduct most of their medical review activities prior to payment using both automated and non-automated, or manual, methods (see Appendix B Section 3.2 for non-automated medical reviews that occur prior to payment and Appendix B Section 5.3 for post-payment medical reviews).

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

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

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

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

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

1. Identifying MAC Automated Medical Review Edit Denials

System logic in MCS and VMS automatically appends a specific Program Integrity Management Reporting (PIMR) activity code[100] to claim lines that fail an automated medical review edit. In MCS, CMS identifies automated medical review denials as those denied claim lines tagged with the MAC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies automated medical review denials as those denied claim lines with a combination of the MAC-specific automated PIMR activity code and a medical review edit code in the automated range provided by each MAC.[101]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of automated review.[102] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[103] or claim line level.[104]

[100] 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.

[101] 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 (i.e., a non-automated PIMR activity code and a medical review edit code in the 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 in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over MAC medical review denials.

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

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

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

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

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 quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[105] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, some MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[106] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated medical review denial

[105] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

[106] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

based on the applicable pricing mechanism.[107] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

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

2.6. Unified Program Integrity Contractor Automated Edits

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

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

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

During investigations, 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 CMS's approval, 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.[108]

Automated edits are among the administrative actions a UPIC may initiate. A UPIC may request that the MAC within its jurisdiction implement automated edits[109] to address program integrity issues and prevent the loss of future Medicare funds. In most cases, the MACs must comply with UPICs' requests to install automated edits in the relevant local claims processing system. Depending on the issue, these UPIC-initiated edits may automatically deny payment for 1) non-covered, incorrectly coded, or inappropriately billed services, 2) services submitted by suspicious providers, or 3) certain types of services for beneficiaries identified as part of a fraud scheme. Another type of UPIC automated edit denies claim lines that had been suspended for non-automated review but the provider did not respond in a timely manner to an ADR. Providers have the right to appeal UPIC automated edit denials through the Medicare FFS appeals process.

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

1. Identifying UPIC Automated Edit Denials

System logic in MCS and VMS automatically appends a specific PIMR activity code to claim lines that fail an automated edit. In MCS, CMS identifies UPIC automated edit denials as those denied claim lines tagged with the UPIC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies automated edit denials as those denied claim lines with the UPIC-specific automated PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.[110]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC automated denials as those denied claims or claim lines with a UPIC-specific code as the denial

[108] The administrative actions that may result from UPIC investigations include automated edits, non-automated reviews (Appendix B Section 3.4) provider enrollment revocations and deactivations (Appendix B Section 4), payment suspensions (Appendix B Section 8.1), post-payment reviews (Appendix B Section 5.6), and referrals to law enforcement (Appendix B Section 9.1).

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

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

reason and a UPIC-specific edit reason code or PIMR code indicative of automated review.[111] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[112] or claim line level.[113]

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

2. Pricing UPIC Automated Edit Denials

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

- *MCS:* In MCS, most UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[114] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

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

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

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

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

[114] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[115] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated denial based on the applicable pricing mechanism.[116] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

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

3. Prepayment Review Actions in Medicare

CMS undertakes activities that subject some claims (or claim precursors) to prepayment manual examination 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 in Medicare FFS:

[115] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

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

- Medicare Secondary Payer (MSP) Operations[117]
- Prior Authorization Request Reviews
- MAC Non-Automated Medical Reviews
- UPIC Non-Automated Reviews

3.1. Medicare Secondary Payer Operations

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

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

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

- Group health plan (GHP)[118]
- Liability insurance (including self-insurance)[119]
- No-fault insurance[120]
- Workers' compensation (WC)[121]

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

[118] 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.

[119] 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.

[120] 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.

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

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 Appendix B sections 5.1 and 5.2 for additional information about recovery efforts). CMS collects information about Medicare beneficiaries' other health insurance or coverage through a variety of methods. These methods include mandatory reporting by other insurers regarding covered Medicare beneficiaries, beneficiary self-reporting of other coverage, and claims investigations. In addition, Medicare providers are obligated to ask Medicare beneficiaries about other coverage and submit that information with Medicare claims.

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

Some MSP-related claims may require manual intervention by the MACs. A claims examiner reviews the claim and information about other coverage. Depending on the findings regarding payment responsibility, the claim may be adjusted such that Medicare only makes a secondary payment, or the claim may be rejected or denied. The MACs then attribute costs avoided to the associated MSP records.[122]

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 Appendix B 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.[123] For WCMSAs,[124] the full amount set aside is reported in the fiscal year during which the agreement is

[122] 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.

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

[124] 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.

set up. Because Medicare does not receive ongoing WC claims, yearly savings due to WCMSAs cannot be determined.

3.2. Prior Authorization Request Reviews

Savings:	The estimated amount Medicare did not have to pay due to the MACs' non-affirmative decisions about prior authorization requests, accounting for subsequently affirmed prior authorization requests.
Data Source:	MAC reports

CMS's prior authorization initiatives help ensure compliance with Medicare rules. For a service requiring prior authorization, a provider must submit to their MAC a prior authorization request containing supporting medical documentation.[125] The MAC reviews the request and issues the provider a decision either provisionally affirming that a future claim will likely meet Medicare coverage requirements[126] or not affirming coverage.

An associated affirmed prior authorization decision is a condition of payment for services subject to prior authorization. Following non-affirmative decisions, providers may modify requests and are permitted unlimited resubmissions. The MACs create unique tracking numbers (UTNs) for prior authorization decisions, and a provider must include the relevant UTN when submitting a claim. If a UTN is absent or associated with a non-affirmative prior authorization decision, the MAC will deny the claim.[127]

The services that CMS selects for prior authorization have been susceptible to unnecessary utilization in the past. CMS may add or discontinue prior authorization initiatives depending on operational considerations and ongoing assessment of vulnerabilities to the Medicare Trust Funds.[128] CMS currently estimates prior authorization request review savings, i.e., savings due to the MACs' non-affirmative decisions on prior authorization requests, as related to its initiative involving selected DMEPOS.[129, 130] Under this initiative, CMS requires prior authorization for selected HCPCS codes in the categories of power mobility devices, orthoses, lower limb

[125] Medicare's medical necessity and documentation requirements do not change under prior authorization; instead, that documentation is required earlier in the health care delivery and payment process.

[126] It is possible that the forthcoming, actual claim could be denied due to, e.g., the claim failing to meet technical requirements that can only be evaluated after the claim has been submitted for formal processing or information not available at the time of the prior authorization request. The standard Medicare FFS appeals process applies to denied claims subject prior authorization requirements.

[127] There are circumstances in which providers submit claims knowing that Medicare will deny those claims. For example, documentation of Medicare's denial may be required before Medicaid will pay for a particular service.

[128] In FY 2021, CMS's initiatives included prior authorization for selected DMEPOS; hospital outpatient department services; and repetitive, scheduled non-emergent ambulance transport.

[129] CMS implemented this savings methodology as of FY 2021; however, prior authorization of selected DMEPOS first began in 2017 with two HCPCS codes.

[130] Prior authorization occurs before a claim is submitted to Medicare claims processing systems, thus, CMS must use MAC reports to quantify prior authorization operations. Currently, standardized data on prior authorization non-affirmative decisions is only available for the DMEPOS initiative.

prosthetics, and pressure-reducing support surfaces. The list of HCPCS codes is subject to change, which CMS announces via Federal Register notices.[131]

To calculate savings attributable to non-affirmative prior authorization decisions, CMS collects data from the DME MACs detailing, for each HCPCS code and state combination, the number of unique prior authorization requests that were submitted during the reporting period and had a non-affirmative decision status as of the final date of the reporting period. Given that providers are allowed unlimited resubmissions of requests, CMS does not count savings for multiple non-affirmative decisions of the same prior authorization request or if an initially non-affirmed request subsequently receives an affirmative decision during the reporting period.

To quantify the amount that Medicare did not have to pay, CMS estimates what the price would have been for the HCPCS codes represented in non-affirmed prior authorization requests. CMS uses pricing methodologies based on whether an item can be rented or not, and if an item can be rented, whether beneficiaries typically choose to rent or purchase the item. The following categories provide further pricing estimation details:

- *Non-Rental Equipment:* A small number of HCPCS codes subject to prior authorization cannot be rented. The number of non-affirmed prior authorization requests for each of these HCPCS codes within each state is counted and priced using the average of the rural and non-rural non-Competitive Bidding Area (CBA)[132] fee schedule rates for each HCPCS code. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

- *Equipment Typically Purchased, Rather than Rented:* Among items that can be rented or purchased, a HCPCS code is designated as typically purchased within a given state if 50 percent or more of the claim lines billed for that HCPCS code and state combination are identified as purchases (new or used), as assessed for dates of service in the calendar year prior to the calendar year that marks the beginning of the reporting fiscal year.[133] The number of non-affirmed prior authorization requests for each HCPCS code and state combination in this category is counted and priced using the average of the rural and non-rural non-CBA fee schedule rates for new equipment for each HCPCS code. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

- *Equipment Typically Rented, Rather than Purchased:* Among items that can be rented or purchased, a HCPCS code is designated as typically rented within a given state if over 50 percent of the claim lines billed for that HCPCS code and state combination are identified as rentals, as assessed for dates of service in the calendar year prior to the calendar year that marks the beginning of the reporting fiscal year. The average rental length is calculated for

[131] In addition, CMS may initially implement the prior authorization of a particular HCPCS code in a few states and then subsequently expand the requirement nationwide.

[132] DME payment policy typically distinguishes between payment in rural and non-rural areas. Because CMS currently only has access to data at the state level for non-affirmed prior authorization requests, CMS utilizes an average of rural and non-rural rates to price equipment.

[133] For example, the beginning of FY 2021 (10/1/2020) falls in calendar year 2020. Therefore, CMS used data from calendar year 2019 to determine whether a HCPCS code in a given state is typically purchased or rented.

each HCPCS code and state combination using the same reference data. CMS determines the price according to whether or not a HCPCS code has been billed in CBAs, as detailed below. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

- *CBAs only:* If all claim lines for a given HCPCS code and state combination were paid using the CBA fee schedule, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced by taking the average of the state's CBA fee schedule rates for the given HCPCS code and multiplying it by the average number of rental months for the HCPCS code and state combination. This priced amount also accounts for a 60% (as related to power mobility devices) or 25% (as related to all other rentals) reduction in the payment rate for rental months four and after if the average number of rental months is four or more.

- *Non-CBAs only:* If none of the claim lines for a given HCPCS code and state combination were paid using the CBA fee schedule, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced by taking the average of the rural and non-rural non-CBA fee schedule rates for the given HCPCS code and state combination and multiplying it by the average number of rental months for the HCPCS code and state combination. This priced amount also accounts for a 60% (as related to power mobility devices) or 25% (as related to all other rentals) reduction in the payment rate for rental months four and after if the average number of rental months is four or more

- *Both CBAs and non-CBAs:* If claim lines for a given HCPCS code and state combination were paid using both the CBA and non-CBA fee schedules, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced using the mean of the state's average CBA fee schedule rate across all regions for the given HCPCS code and the average of the rural and non-rural non-CBA fee schedule rates for the given HCPCS code and state combination. This amount is then multiplied by the average number of rental months for the HCPCS code and state combination, also accounting for a 60% (as related to power mobility devices) or 25% (as related to all other rentals) reduction in the payment rate for months four and after if the average number of rental months is four or more.

3.3. Medicare Administrative Contractor Non-Automated Medical Reviews

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

In addition to automated medical review edits (see Appendix B Section 2.5), the MACs conduct non-automated, or manual, medical reviews where there is risk for improper payment. In MCS, VMS, and FISS, the MACs implement non-automated medical review edits, which suspend all or

part of a claim possessing the targeted criteria for review. The MACs may request additional documentation from providers (i.e., through an ADR), and specific time frames apply to providers' submission of documentation and the MACs' completion of reviews. Each MAC has a medical review staff of trained clinicians and claims analysts, who review claims and associated documentation in order to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, are up- or down-coded for adjusted payment. The MACs also offer providers education to resolve errors and improve future accuracy.[134] Providers have the right to appeal MAC non-automated medical review denials through the Medicare FFS appeals process.

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

1. Identifying MAC Non-Automated Medical Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.[135] In MCS, CMS identifies non-automated medical review denials as those denied claim lines tagged with a MAC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies non-automated medical review denials as those denied claim lines with a combination of a MAC-specific non-automated review PIMR activity code and a medical review edit code in the non-automated ranges provided by each MAC.[136]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC non-automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of non-automated medical review.[137] For services subject to claim-level reimbursement,

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

[135] The MAC non-automated PIMR categories include manual routine review, prepayment complex manual review, and prepayment complex manual probe review.

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

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

CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[138] or claim line level.[139]

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

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 quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[140] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, some MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[141] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

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

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

[140] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

[141] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated medical review denial based on the applicable pricing mechanism.[142] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

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

3.4. Unified Program Integrity Contractor Non-Automated Reviews

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

In addition to automated edits (see Appendix B Section 2.6), a UPIC may request that the MAC in their jurisdiction implement non-automated prepayment review edits in the local claims processing system[143] to identify and suspend claims for medical review prior to payment.

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

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

To initiate non-automated review, the MAC sends an ADR to the provider under review. In that notice, the provider is instructed to provide the necessary medical record documentation to the UPIC for further review. In accordance with CMS guidance, the provider must submit the necessary documentation to the UPIC within 45 calendar days or the claims are denied.[144] Once the documentation is received, the 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 UPIC denies or adjusts payment for the claims. Providers have the right to appeal UPIC non-automated review denials through the Medicare FFS appeals process.

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

1. Identifying UPIC Non-Automated Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.[145] In MCS, CMS identifies UPIC non-automated review denials as those denied claim lines tagged with a UPIC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies non-automated review denials as those denied claim lines with a UPIC-specific non-automated review PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.[146]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC non-automated review denials as those denied claims or claim lines with a UPIC-specific code as the denial reason and a UPIC-specific edit reason code or PIMR code indicative of non-automated review.[147] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[148] or claim line level.[149]

CMS only counts savings from the earliest processed non-automated review denial among matching claims or claim lines. In MCS and VMS, CMS considers matching claim lines as those that share

[144] 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.

[145] The program integrity contractor non-automated PIMR categories include manual routine review, prepayment complex probe review, prepayment complex provider-specific review, and prepayment complex manual review.

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

[147] The MACs annually provide CMS with lists of edit and denial reason codes used for UPICs.

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

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

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

2. Pricing UPIC Non-Automated Review Denials

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

- *MCS:* In MCS, most UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[150] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, the majority of UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[151] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated review denial based on the applicable pricing mechanism.[152] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating

[150] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

[151] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent 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.

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

the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

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

4. Provider Enrollment Actions in Medicare

Providers must enroll in the Medicare FFS program to be paid for covered services they furnish to Medicare beneficiaries. In order to enroll, providers must submit a paper CMS-855 or CMS-20134 enrollment application or a corresponding online application through the Provider Enrollment, Chain, and Ownership System (PECOS) and then undergo risk-based screening. If a prospective provider does not meet eligibility requirements, CMS denies enrollment. Once enrolled, providers are responsible for keeping their enrollment information (e.g., address, practice location, adverse legal actions, etc.) up-to-date. CMS may revoke or deactivate a currently enrolled provider's Medicare billing privileges if the provider's behavior triggers one or more of the 20 revocation reasons or three deactivation reasons.

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

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

4.1. Revocations

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

CMS has 20 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 10 years with the ability to bar re-enrollment for up to 20 years if a provider is revoked for a second time. CMS may also add up to three years to a provider's existing re-enrollment bar if it determines that the provider is attempting to circumvent its existing re-enrollment bar by enrolling in Medicare under a different name, numerical identifier, or business identity.

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 reversed. If CMS denies the CAP, the provider cannot appeal that decision but may continue through the appeals process for the revocation determination.

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

CMS calculates costs avoided for fully revoked providers at the professional identifier and provider type level.[153] As the professional identifier, CMS uses the NPI for individual providers and the Employer Identification Number (EIN) for provider organizations. CMS defines a full revocation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a revocation within the fiscal year. To calculate savings, CMS captures PECOS enrollment data and CWF claims data as of 90 days after the end of the fiscal year to allow time for revocation appeals as well as for claims submission, adjudication, and appeals/resubmission.

[153] CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DME supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

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.

1. Projecting Costs Avoided

CMS projects what Medicare would have paid a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider's full revocation date.[154] Using the paid claims in this 12-month period and placing higher weights on previous months of billing, 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.[155] 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.

2. Accounting for Billing Picked Up by Active Providers

CMS uses provider-type-specific adjustment factors to account for beneficiaries receiving care from other providers after their original provider is revoked. Each adjustment factor estimates the percentage of a revoked provider's previous billing not expected to be shifted to other active providers. Thus, an adjustment factor represents the proportion of projected costs avoided that CMS expects Medicare to realize as savings due to a revocation. To estimate savings due to fully revoking a provider, CMS multiplies the projected costs avoided for that provider by the appropriate provider-type-specific adjustment factor.

CMS developed the provider-type-specific adjustment factors by analyzing the change in service utilization by the beneficiaries of a historical sample of fully-revoked providers.[156] For each fully-revoked provider in the sample, CMS identified the beneficiaries and which services they received from that provider in the 180 days before the revocation became effective. CMS then calculated the following amounts:

- *Pre-revocation payments to the revoked provider*: Payments to the revoked provider for services rendered to the identified beneficiaries during the 180 days preceding the provider's revocation
- *Pre-revocation payments to all providers*: Payments to any provider, including the revoked provider, for the same types of services furnished to the beneficiaries identified above (i.e., those who appeared in the revoked provider's billing) during the 180 days preceding the revoked provider's revocation

[154] 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. For a given provider, CMS starts the methodological historical payment window with the date of the earliest service that was paid within the 18 months preceding the provider's revocation date. The historical payment window ends 12 months after that start date or on the revocation date, whichever is earlier.

[155] For a provider with a historical payment window spanning fewer than nine months, CMS uses a simpler but mathematically sufficient linear projection methodology based on the provider's average payment in the historical payment window, instead of the weighted moving average projection methodology.

[156] CMS's calculation of cost avoidance adjustment factors is based on methodology certified by HHS-OIG.

- *Post-revocation payments to all providers*: Payments to any provider for the same types of services furnished to the same beneficiaries identified above during the 180 days following the revoked provider's revocation

For each provider type, CMS summed each of the amounts—i.e., the pre-revocation payments to a revoked provider, the pre-revocation payments to all providers, and the post-revocation payments to all providers—that it calculated for each fully-revoked provider in that provider type category. CMS then calculated each provider-type-specific adjustment factor as the following ratio:

$$\frac{(\sum Pre\text{-}revocation\ payments\ to\ all\ providers\ -\sum Post\text{-}revocation\ payments\ to\ all\ providers)}{\sum Pre\text{-}revocation\ payments\ to\ a\ revoked\ provider}$$

4.2. Deactivations

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

CMS has three regulatory reasons upon which to deactivate, or stop, a provider's billing privileges. These reasons are no submission of Medicare claims for 12 consecutive calendar months, failure to report a change in information (e.g., practice location, billing services, or ownership), and failure to respond to a CMS notice to submit or certify enrollment information.[157] 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. For all deactivation reasons, a provider may file a rebuttal to challenge the deactivation. A rebuttal is an opportunity for the provider to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should not have been deactivated. Only one rebuttal request may be submitted per deactivation.

CMS calculates costs avoided for fully deactivated providers at the professional identifier and provider type level.[158] As the professional identifier, CMS uses the NPI for individual providers and the EIN for provider organizations. CMS defines a full deactivation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a program-integrity-related deactivation within the fiscal year. To calculate savings, CMS captures PECOS enrollment

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

[158] CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DME supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

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

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 3) accounting for billing picked up by active providers.

1. Projecting Costs Avoided

CMS projects what Medicare would have paid a fully deactivated provider based on the 12 months of claims history preceding the provider's full deactivation date. Using the paid claims in this period and placing higher weights on previous months of billing, 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.

2. Accounting for Reactivations within 12 Months

Because deactivated providers can reactivate their enrollments at any time, CMS uses reactivation correction factors to more conservatively estimate savings. CMS calculates a reactivation correction factor specific to each deactivation reason, and each reactivation correction factor represents the proportion of a previous, reference fiscal year's total deactivation savings attributed to providers who remained deactivated for 12 months or more. For a given fully deactivated provider, CMS multiplies the projected costs avoided for that provider by the appropriate reason-specific reactivation correction factor.

3. Accounting for Billing Picked Up by Active Providers

CMS uses provider-type-specific adjustment factors to account for beneficiaries receiving care from other providers after their original provider is deactivated. Each adjustment factor estimates the percentage of a deactivated provider's previous billing not expected to be shifted to other active providers. Thus, an adjustment factor represents the proportion of projected costs avoided (after applying the reactivation correction factor) that CMS expects Medicare to realize as savings due to a deactivation. To estimate savings due to fully deactivating a provider, CMS multiplies the projected costs avoided (after applying the reactivation correction factor) for that provider by the appropriate provider-type-specific adjustment factor.

CMS developed the provider-type-specific adjustment factors by analyzing the change in service utilization by the beneficiaries of a historical sample of fully-deactivated providers.[159] For each fully-deactivated provider in the sample, CMS identified the beneficiaries and which services they received from that provider in the 180 days before the deactivation became effective. CMS then calculated the following amounts:

- *Pre-deactivation payments to the deactivated provider*: Payments to the deactivated provider for services rendered to the identified beneficiaries during the 180 days preceding the provider's deactivation

[159] CMS's calculation of cost avoidance adjustment factors is based on methodology certified by HHS-OIG.

- *Pre-deactivation payments to all providers*: Payments to any provider, including the deactivated provider, for the same types of services furnished to the beneficiaries identified above (i.e., those who appeared in the deactivated provider's billing) during the 180 days preceding the deactivated provider's deactivation

- *Post-deactivation payments to all providers*: Payments to any provider for the same types of services furnished to the same beneficiaries identified above during the 180 days following the deactivated provider's deactivation

For each provider type, CMS summed each of the amounts—i.e., the pre-deactivation payments to a deactivated provider, the pre-deactivation payments to all providers, and the post-deactivation payments to all providers—that it calculated for each fully-deactivated provider in that provider type category. CMS then calculated each provider-type-specific adjustment factor as the following ratio:

$$\frac{(\sum Pre\text{-}deactivation\ payments\ to\ all\ providers - \sum Post\text{-}deactivation\ payments\ to\ all\ providers)}{\sum Pre\text{-}deactivation\ payments\ to\ a\ deactivated\ provider}$$

5. Overpayment Recoveries in Medicare

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[160] 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
  - UPIC Post-Payment Reviews
  - Overpayments from Retroactive Revocations

- *Medicare Part D:* Medicare Part D Plan Sponsor Audits

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.

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

Data Source: 1) CROWD system and 2) CMS records of global settlements with liability insurers

CMS's MSP operations include the recovery of mistaken and conditional payments made by Medicare, when another payer has primary payment responsibility (see Appendix B Section 3.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.[161] 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. CMS initiates recovery actions once information about primary coverage becomes available, either through new reporting or settlement of a case.

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

The MACs conduct MSP-related recovery from providers.[162] 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.

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

[162] 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 Appendix B sections 3.1 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.[163] CMS calculates the CRC savings as the sum of direct payments from debtors and delinquent debt collections from the Department of the Treasury, minus excess collections that were refunded.[164, 165]

5.3. Medicare Administrative Contractor Post-Payment Medical Reviews

Savings:	The amount of MAC-identified overpayments that Medicare FFS recovered, minus the amount that had been collected on MAC-identified overpayments overturned on appeal in the fiscal year.
Data Source:	Healthcare Integrated General Ledger Accounting System (HIGLAS)

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

[164] 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.

[165] CMS does not include interest collected as savings; however, interest may be included in net MSP CRC collections amounts provided in other reports (e.g., the Medicare Secondary Payer Commercial Repayment Center Report to Congress).

While the MACs primarily focus on preventing improper payments (see Appendix B sections 2.5 and 3.3), 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. 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, Part B, and DME receivables.[166] 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.[167] Therefore, there may be overpayments identified by a MAC 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 an identified overpayment. In those instances, the receivable is closed in HIGLAS, and CMS does not include the amounts in the savings metric.

5.4. Medicare Fee-for-Service Recovery Audit Contractor Reviews

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

[166] In FY 2020, CMS transitioned DME overpayments tracking and data from VMS to HIGLAS. While HIGLAS was CMS's primary data source for FY 2021 overpayment collections, CMS also referenced information in VMS about a few transitioned accounts receivable records.

[167] Due to data limitations, CMS reports collections on MAC-identified overpayments demanded on or after October 1, 2018. It is possible that the MACs tag some non-MAC-medical-review overpayments with the medical review tag, which would inflate savings.

CMS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.[168] 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, 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.[169]

Both the Medicare FFS RACs and the MACs record information in the RACDW, 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

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

[169] 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.

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

5.5. Supplemental Medical Review Contractor Reviews

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

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

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

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 requests the necessary documentation through letters sent to providers. The SMRC does not perform a review for any claim previously reviewed by another review 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 and 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 an updated findings letter detailing the outcome of the D&E session.

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

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

5.6. Unified Program Integrity Contractor Post-Payment Reviews

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

During the course of an investigation, a UPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a UPIC requests additional documentation from a provider. The provider must submit documentation within a specified time frame, though a UPIC has the discretion to grant extensions.[170] If a provider does not submit the requested documentation in a timely manner, the UPIC denies the claims.

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

Once a post-payment review is complete, the UPIC provides the results of the medical review to the provider[171] and refers the overpayment to the MAC in its jurisdiction for recovery. The MAC then adjusts the Part A, Part B, or DME claims associated with the overpayment in the respective shared claims processing system, and the provider is issued a demand letter requesting repayment of the overpayment. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. The MAC may also recover overpayments from an escrow account when CMS terminates a payment suspension. 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.

[170] 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.

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

Overpayment recoveries are tracked in HIGLAS for Part A, Part B, and DME receivables.[172] CMS calculates savings as the sum of collections received for Part A, Part B, and DME receivables in the fiscal year during which the collection occurred. Therefore, there may be overpayments identified by a UPIC (or a previous Medicare FFS program integrity contractor) 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 UPIC-identified overpayment. In those instances, the receivable is closed in HIGLAS, and CMS does not include the amounts in the savings metric.

5.7. Overpayments from 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) CWF claims data

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

Providers are afforded the same CAP and appeal opportunities (see Appendix B Section 4.1), 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:

- *Identify overpayments associated with full, retroactive revocations*: CMS sums the amounts paid to fully,[173] 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.[174]

[172] In FY 2020, CMS transitioned DME overpayments tracking and data from VMS to HIGLAS. While HIGLAS was CMS's primary data source for FY 2021 overpayment collections, CMS also referenced information in VMS about a few transitioned accounts receivable records.

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

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

- *Adjust for historical recovery experience*: To estimate actual recoveries, CMS multiplies the amount of identified overpayments by a proxy, provider-type-specific adjustment factor based on the MACs' historical recovery rate of overpayments identified by previous Medicare FFS program integrity contractors. Based on a historical sample, each provider-type-specific adjustment factor is the ratio of the total amount of overpayments recovered by the MAC to the total amount of overpayments referred by previous Medicare FFS program integrity contractors.

5.8. Medicare Part D Plan Sponsor Audits

Medicare Part D Plan Sponsor Audits include the following activities:

- Plan Program Integrity (PPI) Medicare Drug Integrity Contractor (MEDIC)[175] Part D Data Analysis Projects
- Medicare Part D Plan Sponsor Self-Audits

In the *FY 2021 Report to Congress on the Medicare and Medicaid Integrity Programs*, *Table 3: Medicare Savings* provides the sum of savings from both initiatives.

Plan Program 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 PPI MEDIC data analysis projects.
Data Source:	PPI MEDIC data analysis report for each project

CMS contracts with the PPI MEDIC, a program integrity contractor that assists with detecting and preventing fraud, waste, and abuse in the Medicare Part D program. The PPI 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 prescription drug event (PDE) records,[176] Medicare FFS claims, plan formularies, and drug prior authorization information.

The PPI MEDIC submits its findings of improper payments to CMS and, once approved, 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 PPI MEDIC validates the deletion.

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

Medicare Part D Plan Sponsor Self-Audits

[175] The PPI MEDIC replaced the former National Benefit Integrity (NBI) MEDIC. The NBI MEDIC contract ended in September 2020.

[176] 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.

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

CMS uses Medicare Part D plan sponsor self-audits to evaluate the appropriateness of questionable payments for Part D covered drugs identified through data analysis. CMS contracts with the PPI MEDIC to conduct data analysis that identifies 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 and the PPI MEDIC validate 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.

6. Cost Report Payment Accuracy in Medicare

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 related to Medicare FFS and cost-based plans, respectively:

- 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 PPS[177]
- 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

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

- Bad debts[178] claimed by all provider types

A provider must file its annual cost report with its respective MAC five months after the end of the provider's fiscal year. The annual cost report contains provider information such as facility characteristics, utilization data, costs, charges by cost center (in total and for Medicare), accumulation of Medicare claims data (e.g., days, discharges, charges, deductible and coinsurance amounts, etc.), and financial statement data.

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

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

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

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

A provider may appeal disputed adjustments if the Medicare reimbursement amount in controversy is at least $1,000. An appeal request must be filed within 180 days of receiving the NPR. Appeals disputing amounts of at least $1,000 but less than $10,000 are filed with the MAC and the CMS Appeals Support Contractor, as are any appeals filed by organ procurement organizations or histocompatibility laboratories regardless of the amount in controversy. 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.

[178] 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.

A reopening is allowed within three years of an original NPR or a revised NPR concerning the same issue for reopening.[179]

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

6.2. Cost-Based Plan Audits

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

CMS reimburses Medicare cost-based plans based on the reasonable costs incurred for delivering Medicare-covered services to enrollees.[180] Medicare cost-based plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans operated under Section 1876 of the Social Security Act and Health Care Prepayment Plans (HCPPs) established under Section 1833 of the Social Security Act.

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

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

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

[180] 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.

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.[181] 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 in Medicare

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 Medicare Part C and Part D plan sponsors, due to the following:

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

7.1. Medicare Part C and Part D Program Audits

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

CMS conducts program audits of MA organizations, Part D plan sponsors, and organizations offering Medicare-Medicaid plans (MMPs), hereafter, collectively referred to as plan sponsors. Program audits evaluate plan sponsors' compliance with core program requirements and ability to provide enrollees with access to health care services and prescription drugs. A routine program audit covers all of a plan sponsor's MA, MA-Prescription Drug (MA-PD), prescription drug plan (PDP), and MMP contracts with CMS. CMS annually determines the plan sponsors to be audited. CMS relies on a number of factors when selecting plan sponsors for audit, including performance data collected by or reported to CMS, complaints, and other factors that could increase a sponsor's risk of non-compliance (e.g., significant increases in enrollment, a large number of changes to a sponsor's drug formulary for a new plan year, or switching to a new pharmacy benefit manager close to the beginning of a new plan year). 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

[181] 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.

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

If audits or other monitoring activities[182] determine compliance violations that adversely affected or have the substantial likelihood of adversely affecting enrollees,[183] CMS has the authority to impose CMPs against plan sponsors. Other enforcement actions include intermediate sanctions (e.g., suspension of marketing, enrollment, or payment) and terminations. The number of violations and history of noncompliance are factored into the enforcement action taken. All enforcement actions may be appealed. CMP appeal requests must be filed no later than 60 days after receiving a CMP notice.

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

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

7.2. Medical Loss Ratio Requirement

Savings:	The sum of remittances recovered from MA organizations and Part D sponsors during the fiscal year, where each remittance equals the revenue of the MA organization or Part D sponsor contract for the relevant 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 data forms provided to CMS

[182] In addition to program audits, CMS conducts other monitoring activities that may reveal compliance violations and result in CMPs. Not all of CMS's other monitoring activities may be directly funded by the Medicare Integrity Program; however, CMS reports on resulting CMPs to comprehensively quantify its efforts to address compliance violations.

[183] 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.

An MLR represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, rather than for such other items as profit or 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 percent to avoid financial and other penalties. Contracts beginning in 2014 or later are subject to this statutory requirement.[184] The minimum MLR requirement is intended to create incentives for MA organizations and Part D sponsors to reduce amounts retained as profit or spent on overhead expenses, such as marketing, salaries, administrative costs, and agent commissions, in order to help ensure that taxpayers and enrolled beneficiaries receive value from Medicare health and drug plans.

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

- Incurred claims for clinical services*
- Incurred claims for prescription drugs
- Activities that improve health care quality
- 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 an MA organization or Part D sponsor has an MLR for a contract year that is less than 85 percent, 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. If an MA or Part D contract fails to meet the minimum MLR requirement for three consecutive contract years, it is subject to enrollment sanctions. If an MA or Part D contract fails to meet the minimum MLR requirement for five consecutive contract years, it is subject to contract termination.

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 MA organization or Part D sponsor and reviewed by CMS, an MLR is considered final and may not be appealed. Savings are

[184] 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 for coordinated care plans, i.e., health maintenance organization and preferred provider organization plans, must include at least one MA-PD plan, while private FFS MA plans are not required and Medical Savings Account MA plans are not permitted to cover Part D benefits; 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. As discussed in the May 23, 2013 Medicare MLR final rule (78 FR 31284, 31285), CMS waived the MLR requirement for PACE organizations.

reported in the fiscal year during which remittances are recovered.[185, 186] A contract's MLR and the amount of any remittance owed to CMS for a contract year are calculated using the rules in effect during, and applicable with respect to, that contract year, unless otherwise specified. As a result, the savings that are reported in a fiscal year, which are based on remittances owed for a specific contract year (e.g., remittances included in FY 2021 savings are based on remittances owed for contract year 2019), will not reflect the impact of any MLR rule changes that did not become applicable until after that contract year.[187] Additional savings related to any plan corrections to MLR reporting for prior contract years would also be reported in the fiscal year during which the revised remittances were recovered (e.g., remittances included in FY 2021 savings include remittances owed for plan corrections to contract year 2018).

CMS applies credibility adjustments to the MLRs of certain contracts with relatively low enrollment and to Medical Savings Account (MSA) contracts. A credibility adjustment is a method to address the impact of claims variability on the experience of smaller contracts by adjusting the MLR upward. CMS defines the enrollment levels for credibility adjustments separately for MA and Part D stand-alone contracts. A contract with enrollment at or between specified levels (i.e., a partially-credible contract) may add a scaled credibility adjustment (between 1.0 percent and 8.4 percent) to its MLR. This adjusted MLR is used both to determine whether the 85 percent requirement has been met and to calculate the amount of any remittance owed to CMS. Contracts with enrollment levels above the full-credibility threshold do not receive a credibility adjustment. For contracts with enrollment below a specified level (i.e., non-credible contracts), the remittance requirement and other sanctions for failure to meet the minimum MLR requirement do not apply. MA MSA contracts receive a separate deductible factor to account for how MSA MA plans use higher than average deductibles as part of the statutory plan design.

8. Other Actions in Medicare

CMS reports savings attributable to the following other activities related to Medicare FFS and Medicare Part D:

- *Medicare FFS:*
  - Payment Suspensions
  - Party Status Appeals

- *Medicare Part D*: Medicare Part D Reconciliation Data Reviews

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

[186] Remittances for a contract year are collected approximately eighteen months after the end of the applicable contract year. For example, remittances for contract year 2019 were collected in July 2021.

[187] For example, in the Medicare Program; Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE Program final rule (83 FR 16440), CMS finalized changes to the MLR regulations that would allow MA organization and Part D sponsors to include in the MLR numerator as quality improvement activities (QIAs) all amounts spent on fraud reduction activities (including fraud prevention, fraud detection, and fraud recovery) and medication therapy management (MTM) programs that meet the requirements of 42 CFR 423.153(d). Because these changes had an applicability date of January 1, 2019, they did not impact the amounts remitted in FY 2020 by MA and Part D contracts that failed to meet the 85 percent MLR requirement for contract year 2018.

8.1. Payment Suspensions

Savings:	The projected amount Medicare FFS did not pay providers during payment suspension, based on each provider's historically paid claims and adjusted to exclude the amount of billing adjudicated as payable during the projection period.
Data Source:	1) Unified Case Management (UCM) system, 2) PECOS, and 3) IDR claims data during the period of and 12 months prior to payment suspension for each provider

CMS has authority to suspend payment to a provider when there is reliable information that an overpayment exists, when payments to be made may not be correct, or when there is a credible allegation of fraud existing against a provider. When CMS approves a payment suspension, program integrity contractors (e.g., UPICs) coordinate with the MACs to implement a payment suspension edit to withhold, i.e., suspend, payment for allowable claims submitted during the period of payment suspension. In accordance with federal regulations, CMS implements payment suspensions for 180 days. A one-time extension of an additional 180 days may be allowed. Exceptions to these time limits may be made if the payment suspension is based on credible allegations of fraud. In accordance with 42 C.F.R. § 405.372(e), upon termination of a payment suspension, withheld funds are first applied to any Medicare overpayment assessed on the provider and second to other CMS or HHS obligations. In the absence of a legal requirement to another entity, any excess is released to the provider.

CMS estimates costs avoided from payment suspensions at the level of the NPI and provider billing identifier, which is the CMS Certification Number (CCN) for Part A providers, the Provider Transaction Access Number (PTAN) for individual and organizational Part B providers, and the National Supplier Clearinghouse (NSC) number for DMEPOS suppliers.

CMS estimates the amount that Medicare did not pay providers on payment suspension in three steps: 1) projecting costs avoided, 2) accounting for billing adjudicated as payable during the projection period, and 3) accounting for revoked or deactivated providers. CMS includes a given provider in the savings calculation for the fiscal year in which CMS first implemented the provider's payment suspension. CMS captures claims data 90 days after the end of the fiscal year to allow time for claims submission and adjudication.

1. Projecting costs avoided

CMS projects what Medicare would have paid a provider on payment suspension based on the 12 months of claims history preceding the payment suspension effectuated date. Using the paid claims in this period, CMS calculates the weighted moving average for each month in a future six-month period to project the Medicare payments that provider would have received.[188] The sum of the

[188] Within the 12-month look-back period, CMS identifies the date of the earliest processed payment and then determines the number of months from that date to the payment suspension effectuated date; this span is the historical payment window. For a provider with a historical payment window spanning fewer than six months, CMS uses a simpler but mathematically sufficient linear projection methodology based on the provider's average payment in the historical payment window, instead of the weighted moving average projection methodology.

payment projections for each month represents the costs avoided for the provider during their six-month payment suspension period.

In the case that a provider's payment suspension is shorter than six months (e.g., the payment suspension has a termination date less than 180 days from effectuated date, or the provider is revoked or deactivated during the payment suspension), CMS adjusts the cost avoidance projection to reflect the length of payment suspension.

2. Accounting for billing adjudicated as payable during the projection period

To estimate savings, CMS subtracts the amount for claims processed during the payment suspension and adjudicated as payable from the cost avoidance projection, as this amount is either paid to the provider or used to settle any unpaid overpayment upon payment suspension termination. For providers whose payment suspension projection period is contained within the fiscal year, CMS subtracts suspended payments from the cost avoidance projection. For providers placed on payment suspension late in the fiscal year and therefore for whom CMS does not have complete claims information, CMS projects the payable amount that would be suspended based on known claims adjudicated as payable during the payment suspension. CMS then subtracts this amount from the cost avoidance projection.

3. Accounting for revoked and deactivated providers

To avoid overlap with other metrics' projected savings, CMS excludes from payment suspension savings those providers revoked within three years or deactivated for a program integrity reason within one year prior to the payment suspension effectuated date.

If a provider was revoked or deactivated after CMS implemented a payment suspension, but prior to payment suspension termination (for those providers with a termination date within the fiscal year), CMS uses the date of revocation or deactivation as the termination date for the payment suspension, therefore only projecting costs avoided up to the point the provider was no longer approved to bill Medicare FFS.

8.2. Party Status Appeals

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

The Medicare FFS appeals process includes five levels:[189]

- *Level 1:* Redetermination by a MAC is a review of the claim and supporting documentation by an employee who did not take part in the initial claim determination.

[189] 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[190] is an independent review of the initial determination, including 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 or a review of the administrative record by an attorney adjudicator within the HHS Office of Medicare Hearings and Appeals (OMHA).[191] The amount remaining in controversy must meet the threshold requirement for this appeal level.
- *Level 4:* Review by the Medicare Appeals Council within the HHS DAB.[192] There are no requirements regarding the amount remaining in controversy for this appeal level.
- *Level 5:* Judicial review in U.S. District Court. The amount remaining in controversy must meet the threshold requirement for this appeal level.

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

In support of Medicare program integrity efforts, CMS funds QICs' participation as a party in ALJ hearings in accordance with party status appeals regulatory provisions in 42 CFR § 405.1012.[193] 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, a witness, or as a party to an ALJ hearing. As a non-party participant, a QIC may file position papers and/or submit written testimony to clarify factual or policy issues in a case.[194] As a witness, the QIC's activities are limited to supporting a party in responding to policy or factual issues related to a particular case. 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 participate as a

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

[191] OMHA is independent of CMS.

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

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

[194] 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.

party.[195] 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,[196] CMS considers the estimated amount in controversy for upheld and dismissed cases as savings.[197] 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 or attorney adjudicator'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.

8.3. 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 PDP or an 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 statutory 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 PDE records and direct and indirect remuneration (DIR)[198] reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payment.

CMS validates both PDE and DIR data in advance of reconciliation and quantifies savings for each initiative, as described in the following sections. In the *FY 2021 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.

Prescription Drug Event Data Quality Review

[195] 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 (42 CFR § 405.1010).

[196] A case is dismissed when the ALJ or attorney adjudicator determines that the appellant or appeal did not meet certain procedural requirements. Appellant withdrawals are also counted under case dismissals.

[197] 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.

[198] 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.

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)[199] 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[200]
- 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.[201] The Part D data analysis contractor stops reviewing and flagging PDEs for a given benefit year when CMS finalizes payment reconciliation, typically in September following the benefit year.

Among the PDEs flagged during pre-reconciliation data quality review, CMS quantifies savings by summing the differences in gross covered drug costs between the initial and corrected versions of PDEs adjusted or deleted by plan sponsors. This metric represents the reduction in drug costs included in the payment reconciliation process.[202] The calculation of data quality review savings

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

[200] 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.

[201] 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.

[202] 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.

typically uses benefit-year data captured in September following the benefit year.[203] 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.[204] Sponsors must also include good faith estimates for DIR that is expected for the applicable contract year but has not yet been received.

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

CMS uses the reviewed and finalized DIR data in the year-end Part D payment reconciliation process for each plan, specifically to determine the reconciliation amounts for Medicare's reinsurance subsidy and risk corridor payment/recoupment. Holding all other data constant, CMS also runs a reconciliation simulation for each plan using the initially submitted DIR data to calculate what the reinsurance and risk corridor amounts would have been. For each type of payment, CMS subtracts the actual amount from the simulated amount.[205] CMS calculates the impact from the DIR review as the sum of these reinsurance and risk corridor differences across all plans.[206] For a given benefit year, CMS reports the impact in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

[203] 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.

[204] 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.

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

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

9. Law Enforcement Referrals in Medicare

UPICs (see Appendix B sections 2.6, 3.4, and 5.6) and the Investigations MEDIC (I-MEDIC) identify and investigate cases of suspected fraud related to Medicare FFS and Medicare Part C and Part D, respectively. UPIC and I-MEDIC investigations may involve providers, beneficiaries, and/or other entities. Once a UPIC or the I-MEDIC has gathered evidence to substantiate allegations of suspected fraud, CMS requires the contractor to refer such cases to law enforcement (e.g., HHS-OIG or DOJ) for consideration of civil or criminal prosecution.

In certain types of cases, UPICs and the I-MEDIC must make an immediate advisement to HHS-OIG without first conducting or completing an investigation. For example, a UPIC or the I-MEDIC must immediately advise HHS-OIG upon receiving allegations of kickbacks, bribes, or other illegal remuneration. As another example, the I-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.

When a UPIC or the I-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.[207] If law enforcement accepts the referral, the UPIC or the I-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 DOJ routes Medicare recoveries to CMS or the plan sponsor. The following sections describe how CMS reports savings attributable to UPICs' and the I-MEDIC's law enforcement referrals.

9.1. Unified Program Integrity Contractor Law Enforcement Referrals

Savings:	The estimated amount Medicare expects to recover from UPIC-referred cases accepted by law enforcement, adjusted for historical recovery experience.
Data Source:	1) UCM system and 2) Law enforcement adjustment factor

CMS reports on the value of UPICs' referrals accepted by law enforcement during the fiscal year, regardless of when the case concludes. Because the timeline of case resolution varies, CMS estimates the amount Medicare expects to recover by multiplying the value of the referrals by a law enforcement adjustment factor. This factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to amounts previously referred by Medicare FFS program integrity contractors.

[207] CMS requires contractors to estimate the value of the case based on a three-year lookback paid amount for claims associated with the alleged fraudulent activities.

9.2. Investigations Medicare Drug Integrity Contractor Part C and Part D Law Enforcement Referrals

Savings:	The estimated amount Medicare expects to recover from I-MEDIC-referred Part C and Part D cases accepted by law enforcement, adjusted for historical recovery experience.
Data Source:	1) UCM system and 2) Part C/D law enforcement adjustment factors

CMS reports on the value of the I-MEDIC's Part C and Part D referrals accepted by law enforcement during the fiscal year, regardless of when the case concludes. Because the timeline of case resolution varies, CMS estimates the amount Medicare[208] expects to recover by multiplying the value of the referrals by a Part-C-specific, Part-D-specific, or combined Part C and Part D law enforcement adjustment factor depending on the nature of each case. Each factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to the amounts referred by the former NBI MEDIC.

Medicaid and Children's Health Insurance Program Savings Methodologies

10. Introduction to Medicaid and Children's Health Insurance Program Savings

Medicaid and Children's Health Insurance Program (CHIP) costs are shared between states and the federal government. To receive federal Medicaid and CHIP funds, states provide an estimated budget of their prospective costs, and the federal government contributes a specific percentage of these costs as a grant to the state. CMS determines the federal contribution amount using the Federal Medical Assistance Percentage (FMAP). States then submit actual expenditure reports,[209] which CMS uses to reconcile grant amounts. States are required to report their expenditures to CMS within 30 days of the end of each quarter[210] and may adjust their past reporting for up to two years after an expenditure was made.

States and CMS share accountability for Medicaid and CHIP program integrity and ensuring proper use of both federal and state dollars. As such, CMS and the states collaborate to combat improper payments through multiple strategies. In *Table 4: Medicaid and CHIP Savings* of the *FY 2021 Report to Congress on the Medicare and Medicaid Integrity Programs*, CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from Medicaid and CHIP

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

[209] States submit quarterly expenditure reports on forms CMS-64 and CMS-21 for Medicaid and CHIP, respectively. The CMS-64 and CMS-21 are records of actual, state-certified costs of running Medicaid and CHIP. States are responsible for maintaining supporting documentation for all reported expenditures.

[210] 42 CFR § 430.30(c).

financial oversight and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. The following sections describe the methodologies used to determine these savings.

11. Medicaid and CHIP Financial Oversight

CMS financial management staff engage in financial oversight to ensure that state expenditures claimed for federal matching under Medicaid and CHIP are programmatically reasonable, allowable, and allocable in accordance with federal laws, regulations, and policy guidance. Federal funds paid to the state are referred to as the Federal Financial Participation (FFP). States are required to submit Medicaid and CHIP budget and expenditure data through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES), which applies the appropriate FMAP to each expenditure to determine the FFP. CMS reports Medicaid and CHIP financial oversight savings as improper FFP that was either 1) averted due to financial management staff intervention or 2) recovered following financial management staff review or assistance in response to and resolution of financial issues.

11.1. Averted Medicaid and CHIP Federal Financial Participation

Savings:	The total amount of FFP for which states agree to voluntarily 1) enter a credit adjustment on their expenditure report, 2) retract from their expenditure report, or 3) make a prior period credit adjustment on the current or a future expenditure report.
Data Source:	CMS's Medicaid and CHIP averted FFP at-risk form

CMS financial management staff work to ensure that states submit Medicaid and CHIP claims only for allowable expenditures. CMS uses the following activities to identify potentially improper, i.e., "at-risk," FFP:

- Review of quarterly expenditure reports
- Technical assistance to states on financial management issues

If at-risk FFP is identified prior to finalizing the quarterly expenditure report, the state may make a credit adjustment on their expenditure report for the amount in question or retract the claim associated with the at-risk FFP. If identified after finalizing the expenditure report, the state agrees in writing and makes a prior period credit adjustment,[211] which retroactively adjusts the claim in question and offsets the at-risk FFP for which the state already received reimbursement. Averted Medicaid and CHIP FFP represents the total dollar amount of at-risk FFP that was prevented or offset due to CMS financial management staff intervention and oversight during the fiscal year.

[211] States may adjust claims from prior quarters by either increasing or decreasing the amount of the claim, and therefore increasing or decreasing the FFP. These adjustments often reflect resolved disputes between CMS and the state or reclassifications of expenditures.

CMS financial management staff submit the averted FFP at-risk form to their division management. CMS only reports approved amounts in the total averted Medicaid and CHIP FFP.

11.2. Recovered Medicaid and CHIP Federal Financial Participation

Savings:	The total amount of at-risk FFP that the states returned to CMS as a result of CMS financial oversight activities.
Data Source:	CMS's financial performance spreadsheet

CMS financial management staff identify potential improperly paid FFP through:

- Quarterly expenditure report reviews
- Annual financial management reviews
- Department of Health and Human Services Office of Inspector General (HHS-OIG) audits

If CMS and the state cannot resolve the issue and the state does not agree to return the improperly paid FFP, CMS initiates a disallowance action requiring the state to return the FFP.[212]

States have the right to request administrative reconsideration and/or DAB review to appeal a disallowance action within 60 days of receiving a disallowance letter. CMS may recover the disallowance amount if, following the DAB appeal, a decision has been rendered in CMS's favor or if the state did not appeal the disallowance and the 60-day filing period for an appeal has lapsed. CMS counts a disallowance as recovered once the state returns the associated FFP to CMS.

The total recovered Medicaid and CHIP FFP includes all at-risk FFP that has been recouped or returned to CMS within the fiscal year; thus, some amounts may be associated with financial issues identified in prior fiscal years. The total recovered Medicaid and CHIP FFP does not include any amounts actively under appeal.[213]

12. State-Reported Medicaid Overpayment Recoveries

States report Medicaid overpayment recoveries made through collaborative federal-state programs and state-level initiatives, including 1) UPICs, 2) state Medicaid RACs, 3) HHS-OIG-compliant false claims acts, and 4) other state program integrity activities.

As states and the federal government share in the cost of Medicaid, so too do the states and federal government share in overpayment recoveries. States have one year to return the federal share of an

[212] 42 CFR § 430.42.

[213] If FFP is appealed beyond the HHS DAB, CMS does not include these amounts in the total recovered Medicaid and CHIP FFP, even when the ultimate ruling is in CMS's favor.

identified overpayment;[214] thus, some of the recovered amounts reported in the current fiscal year may be related to amounts identified in the previous fiscal year.

12.1. Unified Program Integrity Contractor Recoveries

Savings:	The total recovered federal share of Medicaid overpayments identified by UPICs.
Data Source:	State Medicaid program integrity quarterly reports, specifically: • Form CMS 64.9C1, Line 5 • Form CMS 64.9OFWA, Line 5

In collaboration with states, CMS's UPICs conduct post-payment investigations and audits of Medicaid providers throughout the country and report identified overpayments to the states for recovery. CMS and the states collaborate to select issues and providers for audits. Any Medicaid provider, including FFS providers, managed care entities, and managed care network providers, may be subject to audit.[215] After the associated states and providers have the opportunity to comment on any identified overpayments, CMS sends the states the final audit reports/final findings reports documenting total overpayments for recovery. States are responsible for sending demand letters to the appropriate providers, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their state's administrative process.

CMS reports the recovered federal share of Medicaid overpayments identified by UPICs in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit.

12.2. State Medicaid Recovery Audit Contractor Recoveries

Savings:	The total recovered federal share of Medicaid overpayments identified by state Medicaid RACs, after subtracting contingency fees.
Data Source:	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Lines 9E and 10E

Unless CMS grants an exception, states must contract with one or more Medicaid RACs to identify and recover overpayments as well as identify underpayments made to Medicaid providers. States

[214] States have one year from the date of discovery to return the full federal share of an identified overpayment, regardless of the amount the state succeeds in collecting from the associated provider(s) (42 CFR § 433.300-316). If a state is unable to collect an overpayment because the provider is bankrupt or out of business, the state is not required to refund the federal share (42 CFR § 433.318).

[215] According to 42 CFR § 438.608(d)(1), state contracts with managed care organizations specify the retention policies for the treatment overpayment recoveries. Thus, not all Medicaid managed care audits conducted by UPICs may result in overpayment recoveries to the state and federal government.

determine the operations and focus areas for Medicaid RAC audits. CMS requires states to have an appeals process for providers seeking review of Medicaid RAC findings.

CMS reports the recovered federal share of Medicaid overpayments identified by Medicaid RACs in the fiscal year during which the recovery occurred. The calculation of the recovered federal share includes 1) the federal share of amounts collected by states within the one-year time limit, plus 2) the federal share of amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit, less 3) the federal share of Medicaid RAC fees.[216] The recovered federal share includes any necessary adjustments to previously-reported federal share amounts. For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

12.3. Office of Inspector General Compliant False Claims Act Recoveries

Savings:	The net federal share of Medicaid false or fraudulent payments recovered as a result of state action under an HHS-OIG-compliant false claims act, after subtracting the state financial incentive.
Data Source:	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Line 9C2

Many states have false claims acts that establish civil liability to the state for individuals and entities that knowingly submit false or fraudulent claims under the state Medicaid program. If a state obtains a recovery related to false or fraudulent Medicaid claims, the federal government is entitled to a share of the recovery, in the same proportion as the FMAP. To encourage states to pursue civil Medicaid fraud, section 1909 of the Act includes a financial incentive for states if their false claims acts meet certain requirements.[217] HHS-OIG, in consultation with the U.S. Attorney General, determines if a state's false claims act qualifies for the incentive, which is a 10-percentage-point increase in a state's share of recovered amounts.

CMS reports the net federal share of Medicaid false or fraudulent payments recovered under states' HHS-OIG-compliant false claims acts in the fiscal year during which the recoveries occurred. A state's compliance is subject to review before CMS awards a state the financial incentive; thus, the financial incentive does not appear in Form CMS 64 Summary, Line 9C2. Instead, CMS gives states the financial incentive on a finalization grant award. To report savings, CMS conservatively estimates the net federal share of recovered Medicaid false or fraudulent payments by subtracting out the state financial incentive for all states that report in Form CMS 64 Summary, Line 9C2.

[216] CMS contributes the federal share of Medicaid RAC fees in the same proportion as the FMAP, up to the highest contingency fee rate of Medicare RACs.

[217] Refer to https://oig.hhs.gov/fraud/state-false-claims-act-reviews for more information on HHS-OIG's requirements for states to receive the financial incentive.

12.4. Other State Program Integrity Recoveries

Savings:	The total recovered federal share of Medicaid overpayments identified through other state-level program integrity activities.
Data Source:	State Medicaid program integrity quarterly reports, specifically: • Form CMS 64.9C1, Lines 1A, 1B, 1C, 2, 3, 4, 6, and 8 • Form CMS 64.9OFWA, Lines 1A, 1B, 1C, 2, 3, 4, 6, 8, and 9

The states undertake a variety of program integrity activities to identify and recover improper payments, including the following:

- Provider audits
- Medicaid Fraud Control Unit (MFCU) investigations[218]
- Data mining activities conducted by state Medicaid agencies as well as MFCUs
- Settlements and judgments
- Civil monetary penalties

CMS reports the recovered federal share of Medicaid overpayments identified through state-level program integrity activities in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit. The recovered federal share includes any necessary adjustments to previously-reported federal share amounts.[219] For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

[218] Refer to https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu for more information on MFCUs.

[219] States report total adjustments, which could be related to UPIC and/or other state program integrity activities.

Appendix C – Acronyms and Abbreviations

Acronym	Description
ADR	Additional Documentation Request
AFR	[HHS] Agency Financial Report
ALJ	Administrative Law Judge
APS	Advanced Provider Screening [system]
BCRC	Benefits Coordination & Recovery Center
CAP	Corrective Action Plan
CARES	Coronavirus Aid, Relief and Economic Security
CBA	Competitive Bidding Area
CBES	CHIP Budget and Expenditure System
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMIP	Comprehensive Medicaid Integrity Plan
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
COB&R	Coordination of Benefits & Recovery
CORF	Comprehensive Outpatient Rehabilitation Facility
CPI	[CMS] Center for Program Integrity
COVID-19	Coronavirus Disease 2019
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
DEX	Data Exchange System
DIR	Direct and Indirect Remuneration
DME	Durable Medical Equipment

Acronym	Description
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOI	Department of Insurance
DOJ	Department of Justice
DOS	Date of Service
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EIN	Employee Identification Number
FCBC	Fingerprint-based Criminal Background Check
FFM	Federally-facilitated Marketplace
FFP	Federal Financial Participation
FFS	Fee-for-Service
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
GME	Graduate Medical Education
GPO	Group Purchasing Organization
HCFAC	Health Care Fraud and Abuse Control Program
HCPCS	Healthcare Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
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
IME	Indirect Medical Education

Acronym	Description
IPPS	Inpatient Prospective Payment System
MAC	Medicare Administrative Contractor
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug
MAS	Medicare Appeals System
MBES	Medicaid Budget and Expenditure System
MCC	Major Case Coordination
MCRC	Marketplace Complaint Review Contractor
MCS	Multi-Carrier System
Medi-Medi	Medicare-Medicaid Data Match
MEQC	Medicaid Eligibility Quality Control Program
MFCU	Medicaid Fraud Control Unit
MII	Medicaid Integrity Institute
MLN	Medicare Learning Network®
MLR	Medical Loss Ratio
MMP	Medicare -Medicaid Plans
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MPEC	Medicaid Provider Enrollment Compendium
MPIC	Medicaid Program Integrity Contractor
MSIS	Medicaid Statistical Information System
MSP	Medicare Secondary Payer
MSSP	Medicare Shared Savings Program
MTM	Medication Therapy Management
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NGHP	Non-Group Health Plan
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
OCE	Outpatient Code Editor

Acronym	Description
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
OPD	Outpatient Department
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
PERM	Payment Error Rate Measurement
PHE	Public Health Emergency
PHI	Protected Health Information
PII	Personally Identifiable Information
PIIA	Payment Information Integrity Act
PIMR	Program Integrity Management Reporting
PPI MEDIC	Plan Program Integrity Medicare Drug Integrity Contract
PPS	Prospective Payment System
PTP	Procedure-to-Procedure [Edit]
QIC	Qualified Independent Contractor
RAC	Recovery Audit Contractor
RACDW	RAC Data Warehouse
RADV	Risk Adjustment Data Validation
RCD	Review Choice Demonstration
ROI	Return on Investment
RPP	Respiratory Pathogens Panels
RSNAT	Repetitive Scheduled Non-Emergent Ambulance Transport
SBM	State-based Marketplace

Acronym	Description
SMA	State Medicaid Agency
SMRC	Supplemental Medical Review Contractor
SNF	Skilled Nursing Facility
T-MSIS	Transformed-Medicaid Statistical Information System
TPE	Targeted Probe and Educate
UCM	Unified Case Management [system]
UOS	Unit of Service
UPIC	Unified Program Integrity Contractor
UOS	Units of Service
USC	United States Code
UTN	Unique Tracking Number
VCC	Vulnerability Collaboration Council
VIPS	Viable Information Processing Systems
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement

Appendix D - Statutes Referenced in this Report

Public Law	Title	Short Title
74-271	The Social Security Act	The Act
90-248	Social Security Amendments of 1967	
104-191	Health Insurance Portability and Accountability Act of 1996	HIPAA
109-171	Deficit Reduction Act of 2005	DRA
110-173	Medicare, Medicaid and SCHIP Extension Act of 2007	MMSEA
111-148	Patient Protection and Affordable Care Act	
111-152	Health Care and Education Reconciliation Act of 2010	
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA
116-117	Payment Integrity Information Act of 2019	PIIA
116-136	Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020)	CARES
Rulemaking at 85 Fed. Reg. 69153	Open Payments program expansion under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment For Patients and Communities Act	SUPPORT