Annual Report to Congress

on the

Medicare and Medicaid Integrity Programs

For Fiscal Year 2012
October 1, 2011 through September 30, 2012

Kathleen Sebelius

Secretary of Health and Human Services

2014

Contents

Executive Summary

This report describes the Centers for Medicare & Medicaid Services' (CMS) program integrity activities during Fiscal Year (FY) 2012. CMS has been required to report on Medicaid program integrity activities since the enactment of the Deficit Reduction Act of 2005 (P.L. 109-171). Section 6402(j) of the Affordable Care Act (P.L. 111-148 and P.L. 111-152) established the requirement that CMS report on Medicare program integrity activities. This report fulfills both of those requirements.

One of CMS's key responsibilities is to protect the Trust Funds and other public resources against losses from fraud and other improper payments and to improve the integrity of the health care system. CMS's program integrity strategy is moving beyond "pay and chase" toward a more effective strategy that identifies fraud before payments are made, keeps bad providers and suppliers out of Medicare and Medicaid in the first place, quickly removes wrongdoers from the program once they are detected, and recovers improper payments as quickly and as swiftly as possible.

The effectiveness of CMS's comprehensive strategy is demonstrated by the results of our activities in FY 2012. In FY 2012, the Zone Program Integrity Contractors (ZPICs) identified $461 million in potential Medicare overpayments for collection, and referred cases totaling $720 million suspect provider billings to law enforcement for investigation. ZPICs also used prepayment and autodenial edits to stop Medicare improper payments totaling $290 million, and imposed payment suspensions that stopped over $15 million in payments to 71 providers. CMS had 319 active payment suspensions in FY 2012. CMS completed the first implementation year of the Fraud Prevention System, which resulted in $115 million in fraudulent payments being stopped, prevented or identified. CMS also saved the Medicare program $483 million in FY 2012 using National Correct Coding Initiative (NCCI) edits. The purpose of the NCCI is to prevent improper payments when incorrect code combinations for Medicare services are reported. In addition, the Medicare Fee- For-Service Recovery Audit program identifies improper payments and makes recommendations to CMS about how to reduce improper payments in the Medicare program. In FY 2012, the program corrected $2.4 billion in improper payments including collecting $2.3 billion in overpayments.

Through the Medicaid Integrity Program, CMS directed the activity of the Audit Medicaid Integrity Contractors, which identified $12.9 million in Medicaid overpayments during FY 2012 for recovery by states. Through the State Medicaid RAC programs, the states have recovered a total federal and state share combined amount of $95.6 million and returned a total of $57.6 million to HHS for FY 2012. CMS also provided direct support to state activities that led to substantial recoveries – including $1.4 billion reported by states for FY 2012. Importantly, CMS has laid the ground work for additional savings with the implementation of innovative technology, and is continuing to refine an approach to measuring the impact of initiatives that achieve cost avoidance.

CMS also coordinated closely with a variety of partners during FY 2012. For example, CMS participated in three national Healthcare Enforcement and Action Team (HEAT) takedowns and took administrative action against 160 Medicare providers and suppliers associated with those law enforcement events in FY 2012. The Command Center opened in July 2012, and provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from OIG

and FBI, clinicians and CMS fraud investigators to collaborate before, during and after the development of fraud leads in real time. Also in FY 2012, HHS and DOJ launched a ground-breaking partnership which unites public and private organizations in the fight against health care fraud. The voluntary, collaborative partnership includes the federal government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups.

The Administration has made a firm commitment to rein in fraud, waste and abuse. Today, with our new authorities and resources provided by Congress, we have more tools than ever before to move beyond pay and chase and to implement important strategic changes in pursuing fraud, waste, and abuse.

1. Introduction

1.1. Statutory requirement to report on the effectiveness of Medicare and Medicaid integrity funds

This report describes the Centers for Medicare & Medicaid Services' (CMS) program integrity activities during Fiscal Year (FY) 2012. CMS is the agency within the Department of Health and Human Services (HHS) responsible for the administration of Medicare, Medicaid and the Children's Health Insurance Program (CHIP), in addition to other programs and activities. By law, CMS must report to Congress on the use and effectiveness of the use of funds for both the Medicare and Medicaid program integrity activities. Program integrity encompasses all causes of improper payments, and covers fraud, waste and abuse. While all payments stemming from fraud are considered "improper payments" not all improper payments constitute fraud. CMS has been required to report on Medicaid program integrity activities since the enactment of the Deficit Reduction Act of 2005 (P.L. 109-171)(DRA)[1]. Section 6402(j) of the Affordable Care Act (P.L. 111-148 and P.L. 111-152) established the requirement that CMS report on Medicare program integrity activities.[2] This report fulfills both of those requirements.[3]

The Medicare Integrity Program was established to protect against Medicare fraud, waste, and abuse, including improper payments. The Health Insurance Portability and Accountability Act of 1996[4] (HIPAA) established mandatory funding for the Medicare Integrity Program that ensured a stable funding source for Medicare program integrity activities, not subject to annual appropriations. The amount specified in HIPAA increased for the first few years and then was

[1] We note that not all Medicaid program integrity activities are funded under the Medicaid Integrity Program, which was created by the DRA in section 1936 of the Social Security Act. However, this report includes other Medicaid program integrity activities to provide a more complete view of Medicaid program integrity.

[2] We note that not all Medicare program integrity-related activities are funded under section 1893 of the Social Security Act; therefore, there may be some fraud or improper payment initiatives that are not included in this Report to Congress. Where applicable in this Report, we have described certain activities funded outside of section 1893 to provide better context for CMS's anti-fraud programs.

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

[4] Public Law 104-191.

capped at $720 million per year in fiscal year 2003 and future years. This funding supports the following program integrity functions performed across CMS: Audits, Medicare Secondary Payer, Medical Review, Provider Outreach and Education, Benefit Integrity, and Provider Enrollment.

CMS received additional mandatory funding for the Medicare Integrity Program (specifically for the Medicare-Medicaid Data Match Project) from the Federal Hospital Insurance Trust Fund in FY 2006 under the Deficit Reduction Act of 2005 (DRA). Additional funding through 2020 and permanent indexing of the mandatory amounts were provided in the Affordable Care Act. Beginning in FY 2009, the Medicare Integrity Program has also received discretionary funding, subject to annual appropriation.

The Deficit Reduction Act (DRA) of 2005[5] (enacted in February 2006) modified section 1936 of the Act to establish the Medicaid Integrity Program and provided CMS with dedicated funding to operate the program. The Medicaid Integrity Program represents the first comprehensive strategy at the federal level to combat fraud, waste, and abuse in the Medicaid program and is one component in the overall effort to ensure Medicaid program integrity.

Under section 1936 of the Act, Congress appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. During FY 2009, this funding reached its initial annual maximum level of $75 million. The Affordable Care Act amended the Act, beginning in FY 2011, to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[6] In FY 2012, the appropriation for the Medicaid Integrity program was $78.334 million. In addition, CMS allotted $17.4 million in carry-over funds from previous fiscal year appropriations, for a total of $95.7 million available for spending in FY 2012. Of these funds, CMS obligated a total of $63,062,027, leaving $40.4 million of carry-over funds for FY 2013 (which included $55.3 million from new budget authority and $7.7million in unexpired recoveries of prior year unpaid obligations).

Appendix I provides information on the Medicare Integrity Program obligations and Appendix II provides information on the Medicaid Integrity Program obligations.

1.2. The Medicare, Medicaid and CHIP programs

In FY 2012, Medicare, Medicaid and CHIP covered over 122 million people, including 50.7 million people on Medicare. The unduplicated annual enrollment for Medicaid and CHIP was 71.1 million with an average monthly enrollment of 56.6 million during the course of FY 2012. CMS directly administers Medicare through contracts with private companies that process 4.5 million claims for Medicare benefits every day. Medicaid is administered by states within the bounds of federal law and regulations, and CMS partners with each state Medicaid program to support program integrity efforts. The 56 separately state-run Medicaid programs process 4.4 million claims per day. To preserve access to quality health care services, CMS is accountable for the protection of the Medicare Trust Funds and other public resources from fraud, waste and abuse, and for the reduction of improper payments in Medicare, Medicaid and CHIP.

[5]Public Law 109-171.
[6]42 U.S.C. 1396u-6(e)(1)(D).

To assist in the reduction of improper payments, CMS has a new approach to program integrity that incorporates six overarching operational principles. The first principle is to coordinate and integrate the Medicare and Medicaid programs to become more effective while reducing burden on the legitimate provider and supplier community. The second principle involves moving beyond the established approach of "pay and chase" operations to innovative prevention and detection activities. Under the third principle, we are developing a risk-based approach for program integrity requirements, rather than operating as if "one size fits all" and our fourth principle is to rethink legacy processes with innovation as a key requirement. Finally, CMS continues its commitment to transparency (fifth principle) by enhancing our engagement with our public and private partners (sixth principle).

1.3 Contractor overview

CMS uses a variety of different contractors to administer and oversee the Medicare and Medicaid programs. Each of these contractors has distinct roles and responsibilities. Certain contractors assist CMS in combating fraud and identifying improper payments, while others support CMS's fraud fighting efforts as part of their broader responsibilities of claims processing and overpayment recovery. CMS's program integrity strategy is moving beyond "pay and chase" toward a more effective strategy that identifies fraud before payments are made, keeps bad providers and suppliers out of Medicare and Medicaid in the first place, quickly removes wrongdoers from the programs once they are detected, and recovers improper payments as quickly as possible. This approach leverages CMS's use of Medicare Administrative Contractors, Zone Program Integrity Contractors, Medicare Drug Integrity Contractors, Medicaid Integrity Contractors, and Medicare and Medicaid Recovery Audit Contractors. A description of each of these contractors is below.

Table 1. Contractors

Contractor	Program	Description Of Program Integrity Responsibilities
Zone Program Integrity Contractors (ZPICs), including Program Safeguard Contractors (PSCs)	Medicare Fee-For-Service	Develop investigative leads generated by the new Fraud Prevention System (FPS) and a variety of other sources, Perform data analysis to identify cases of suspected fraud, waste, and abuse, Implement edits, coordination with the MAC, administrative actions (payment suspensions, prepayment edits, auto denial edits), Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars, Make referrals to law enforcement for potential prosecution,

		Provide support for ongoing law enforcement investigations, Provide feedback and support to CMS to improve the FPS, and Identify improper payments to be recovered.
Medicare Drug Integrity Contactors (MEDICs)	Medicare Part C and D	Coordinate all Part C and Part D program integrity outreach activities for all stakeholders, including plan sponsors and law enforcement, Support compliance and fraud audits of Part C and D plan sponsors, Conduct studies and analysis, Develop educational materials on payment integrity and quality of care issues, Conduct plan sponsor related downstream entities' education and training; and Highlight the value of education in preventing fraud, waste, and abuse in Medicare Part C and D.
Medicare Administrative Contractors (MACs)	Medicare Fee-For-Service	Perform provider and supplier screening and enrollment, Audit the hospital cost reports upon which CMS bases Medicare reimbursements to hospitals, Conduct prepayment and postpayment medical review audits, Perform medical review by analyzing claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims types, Develop and implement prepayment edits, Determine payment amounts for and make payments to providers, suppliers and

		individuals, Provide beneficiary, provider and supplier education, outreach and technical assistance.
Medicare Fee-For-Service Recovery Audit Program	Medicare Fee-For-Service	Conducts postpayment audits to identify a wide range of improper payments. Make recommendations to CMS about how to reduce improper payments in the Medicare Fee-For-Service program.
Part D Recovery Audit Program	Part D	Conducts postpayment reviews to identify a wide range of improper payments.
State Medicaid Recovery Audit Contractors (RACs)	State Medicaid payments to providers	State Medicaid agencies contract with Medicaid RACs to identify and recover overpayments, and identify underpayments made to Medicaid providers.
Medicaid Integrity Contractors (MICs)	Medicaid payments to providers	Review MICs that: Design and apply algorithms and data models to analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities; and Create audit leads for Audit MICs. Audit MICs that: Conduct post-payment audits of all types of Medicaid providers and report identified overpayments to states for recovery; and Provide support to states for hearings and appeals of audits conducted under assigned task order(s). Education MICs that: Develop educational materials on Medicaid payment and program integrity issues, Conduct provider and beneficiary education and training; and Focus on the value of education in preventing

		fraud, waste, and abuse in the Medicaid program.

1.4 Highlights of Medicare and Medicaid program integrity activities

CMS is using its funds effectively to prevent and detect the range of improper payments and fraud. Table 2 highlights Medicare and Medicaid program integrity activities in FY 2012. The amount of recoveries and savings each year may vary significantly, especially if a number of high dollar overpayments are identified in one year. CMS's Medicare contractors play a critical role in the agency's program integrity efforts, including the identification and recovery of improper payments, revoking billing privileges of ineligible providers and suppliers and referring suspected fraud to law enforcement. In FY 2012, the ZPICs identified $461 million in potential Medicare overpayments for collection, and referred cases totaling $720 million suspect provider and supplier billings to law enforcement for investigation. ZPICs also used prepayment and autodenial edits to stop improper payments totaling $290 million, and imposed payment suspensions that stopped over $15 million in payments to 71 providers and suppliers for which CMS determined overpayments. CMS had 319 active payment suspensions in FY 2012. CMS completed the first implementation year of the Fraud Prevention System, which resulted in an estimated$115 million in fraudulent payments being stopped, prevented or identified. CMS also saved the Medicare program $483 million in FY 2012 using NCCI edits developed to date. The purpose of the NCCI is to prevent improper payment when incorrect code combinations for Medicare services are reported. The Medicare FFS Recovery Audit program identifies improper payments and makes recommendations to CMS about how to reduce improper payments in the Medicare program. In FY 2012, the program corrected $2.4 billion in improper payments including collecting $2.3 billion in overpayments.

Through the Medicaid Integrity Program, CMS directed the activity of the Audit MICs, which identified $12.9 million in Medicaid overpayments during FY 2012 for recovery by states. Through the State Medicaid RAC programs, the states have recovered a total federal and state share combined amount of $95.6 million and returned a total of $57.6 million to HHS for FY 2012. CMS also provided direct support to state activities that led to substantial recoveries – including $1.4 billion reported by states for FY 2012. Importantly, CMS has laid the ground work for additional savings with the implementation of innovative technology, and is continuing to refine an approach to measuring the impact of initiatives that achieve cost avoidance.

Table 2: Highlights of Medicare and Medicaid Program Integrity Activities Fiscal Year 2012 Totals
Medicare

Table 2: Highlights of Medicare and Medicaid Program Integrity Activities Fiscal Year 2012 Totals	
National Correct Coding Initiative procedure- to-procedure edits	$483 million
DME Competitive bidding program[7]	$202.1 million
Zone Program Integrity Contractors (ZPICs)[8]	
Potential Overpayments Identified	$461 million
Cases of Suspect Billing Referred to Law Enforcement[9]	$720 million
Payments prevented through prepayment edits and auto denial edits[10]	$290 million
Medicare Payment Suspensions to providers and suppliers for which CMS determined overpayments	$15 million
Fraud Prevention System[11]	$115 million
Medicare Fee-For-Service Recovery Auditor Program	
Total Improper Payments Corrected	$ 2.4 billion
Overpayments collected	$2.3 billion
Medicaid[12]	

[7]The first year of the competitive bidding program (CY 2011, which ended in FY 2012) resulted in savings of approximately $202.1 million. This represents an overall percentage reduction of 42 percent from lower prices and reduced inappropriate utilization.
[8]These figures include the Medicare-Medicaid Data Match program.
[9] These figures are estimated amounts for cases referred to law enforcement.
[10] Based on billed amounts.
[11]This is from the first implementation year of the FPS, June 2011 to June 2012, which ended in FY 2012.
[12]Unless otherwise noted these amounts represent both federal and state funds.

Table 2: Highlights of Medicare and Medicaid Program Integrity Activities Fiscal Year 2012 Totals	
Medicaid Integrity Contractor identified overpayments[13]	$12.9 million
State Medicaid Recovery Audit Contractors Recoveries	$95.6 million
Federal Share of Medicaid as a result of HCFAC efforts[14]	$835.7 million
FY 2012 State PI Recoveries[15]	$1.4 billion

2. Coordinated and integrated Medicare, Medicaid, and CHIP program integrity programs

Since April 2010, the Medicare and Medicaid program integrity functions have been housed within the Center for Program Integrity (CPI) in CMS. This Center brings together oversight of Medicare and Medicaid program integrity to coordinate resources and best practices for overall program improvement. The Affordable Care Act and the Small Business Jobs Act of 2010 (P.L. 111-240) provided additional authorities and resources to strategically combat fraud, waste and abuse under a coordinated approach in Medicare and Medicaid.

In FY 2012, CMS had 259 full-time employees working in CPI. In CPI, the Medicaid integrity program was supported by approximately 75 employees. The DRA authorized 100 full-time equivalent employees to focus on Medicaid integrity activities and CMS is recruiting staff to fill the remaining Medicaid slots.

CMS's comprehensive program integrity strategy targets the various causes of improper payments, ranging from issues such as incorrect coding, medically unnecessary services, and erroneous billing practices, to intentional deception by billing for services that were never provided. These program integrity activities cut across the agency, and are performed by the Office of Financial Management (OFM), the Center for Medicaid and CHIP Services (CMCS), and the Center for Medicare (CM), in addition to CPI. For example, OFM oversees the Medicare Secondary Payer program, the Improper Payment Measurement programs, and the

[13] A portion of the overpayments identified by Medicaid Integrity Contractors in FY 2012 may be included in the FY 2012 State PI Recoveries reported on the CMS-64.
[14] This figure is from FY 2012 HCFAC Report.
[15] As reported by the States on the CMS-64. In previous years, we have reported State PI recoveries derived from the annual State Program Integrity Assessment (SPIA) data collection. However, in early FY 2013, GAO recommended discontinuing the SPIA (GAO-13-50), and CMS suspended the SPIA data collection. SPIA-reported recoveries include recoveries that are not reportable on the CMS-64, such as DOJ settlements where the federal share is returned directly to the Treasury.

Medicare Fee-For-Service Recovery Audit program. CMS also works closely with law enforcement, including the HHS Office of Inspector General (OIG), the Department of Justice (DOJ) and State Medicaid Fraud Control Units (MFCUs). In FY 2012, CMS enhanced the integration and coordination of Medicare and Medicaid program integrity with the opening of a new CMS Program Integrity Command Center and improving access to Medicare and Medicaid data, as described below.

2.1. Command Center

In FY 2012, CMS made significant progress in speeding up the process of identifying fraud and stopping criminals from defrauding Medicare and Medicaid with the opening of the CMS Program Integrity Command Center. The Command Center is focused on driving innovation and improvement in reducing fraud and improper payments in the Medicare and Medicaid programs by providing a collaborative environment for multi-disciplinary teams to develop consistent approaches for investigation and action. CMS first tested the value of the concept in a pilot Command Center and found that the time needed for making decisions on administrative actions such as payment suspensions can be reduced significantly. The Command Center opened in July 2012, and provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from OIG and FBI, clinicians and CMS fraud investigators to collaborate before, during and after the development of fraud leads in real time. From the opening of the Command Center on July 31, 2012 through September 27, 2012 the Command Center conducted 22 missions, with 290 experts Missions are facilitated collaboration sessions that bring together experts from various disciplines to improve the processes for fraud prevention and early detection in Medicare and Medicaid.

2.2. Improving data to fight fraud in Medicare and Medicaid

To support program integrity work across the agency, CMS has made significant improvements to our databases and analytical systems. CMS is committed to enhancing the quality and availability of Medicare data to states as the agency and law enforcement continue to coordinate efforts, identify potential criminal activities, and prevent fraud on a system-wide basis. CMS is working toward solutions to provide states with sufficient access to CMS data for program integrity purposes, for example by providing Medicare enrollment data. The Office of Information Products and Data Analysis (OIPDA) was established within CMS in May 2012 to make development, management, use, and dissemination of data and information resources a core function of CMS. Over time, the initiative will modernize CMS's complex data systems and policies, and help the agency to achieve the greatest improvements in health care delivery.

As these efforts mature, we expect to be able to more easily transfer the lessons learned from Medicare program integrity analytics and algorithms, including predictive analytics, to the Medicaid Program. As in Medicare, CMS's goal is to prevent Medicaid fraud by using predictive modeling to enhance our analytic capabilities, increasing information-sharing among state Medicaid agencies to detect and deter aberrant billing at the state, regional and national levels.

2.2.1 Integrated Data Repository and One PI

CMS continues to build the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. CMS

is using the IDR to provide broader and easier access to data and enhanced data integration while strengthening and supporting CMS's analytical capabilities. The IDR is currently populated with Medicare Parts A, B, and D paid claims back to January 2006. In FY 2012, CMS has expanded the IDR to include shared systems data, providing access to Part B and Part B-DME claims data from both before and after final payment has been made. This permits prepayment analytics on historical data that can be used to develop analytic models that can be used in the Fraud Prevention System.

CMS is working to integrate new data sources into the IDR. CMS is now requiring Medicare Advantage organizations to submit encounter data for dates of service January 3, 2012 and later. These data will become part of the IDR. CMS is also working to incorporate state Medicaid data into the IDR as required by Affordable Care Act section 6402 while also working with states to improve the quality and consistency of the data from each state, described more fully below.

CMS uses the One Program Integrity (One PI) web-based portal with the IDR to facilitate data sharing with program integrity contractors and law enforcement. The portal provides a single access point to the data within the IDR, as well as analytic tools to review the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. In FY 2012, CMS trained 275 contractors and 44 law enforcement staff, and since October of 2010, a total of 886 program integrity contractors and CMS staff, including 108 law enforcement personnel, have been trained. Additionally in FY 2012, CMS offered mobile, on-site training on One PI for program integrity contractors, enabling the training of large groups of contractor staff while reducing travel costs related to this training.

2.2.2 MACBIS

The MACBIS (Medicaid and CHIP Business Information Solution) initiative is comprised of four key areas of improvement to help prevent fraud, waste, and abuse: program data, operational data, quality data, and performance data of which fall under two specific improvement projects: Transformed-Medicaid Statistical Information System (T-MSIS) focusing on operational data and Medicaid and CHIP Program (MACPro) focusing on program data. The MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

To improve the quality of Medicaid data in general, CMS established the Medicaid and CHIP Business Information Solution (MACBIS) Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. The council's strategy includes:

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

For example, the Council initiated the Transformed MSIS (T-MSIS) pilot project in 11 states representing 40 percent of the nation's Medicaid expenditures. The purpose of this pilot is to create a consolidated format from a variety of state information sources to satisfy multiple Medicaid and CHIP federal information reporting requirements. CMS will use the results and lessons learned from these 11 states as the basis for national implementation in 2014.

FY 2012 activities focused on program and operational data improvements. The program and operational data improvements combined key state program data, provider information and claims and encounter data under a common data model, data dictionary and integrated data environment to allow for new methods to fight fraud, waste and abuse. The data will be used to support detection of fraudulent patterns in state Medicaid programs as well as comparative analytics across state lines.

The accomplishments for FY 2012 include:

- MACBIS – Completed Medicaid & CHIP enterprise data work resulting in an expanded data dictionary.

- T-MSIS – Completed and evaluated an 11-state pilot to test an expanded operational data set; developed a plan to launch a national implementation of T-MSIS in 2014 based on lessons learned from the pilot.

- The Medicaid and CHIP Program System (MACPro) – Collected business requirements, on multiple Medicaid and CHIP program authorities to be used for designing and developing MACPro which will automate the state plan amendment and waiver adjudication process.

- Information Technology Support – Integrated MACBIS processes into CMS's enterprise shared services efforts including, master data management, identity management, and portal development.

2.2.3 The Medicare-Medicaid Data Match Program

CMS is also working with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). CMS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. The Medi-Medi program began as a pilot project California in 2001 and grew to 19 states in FY 2012. CMS is partnering with states that account for most of the expenditures in Medicaid. Participating states include: Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa, Mississippi, Missouri, Nebraska, New York, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas and Utah. Additional states have expressed interest in participating in the Medi-Medi program, and CMS is conducting outreach on the Medi-Medi program at conferences and meetings that focus on Medicaid and Medicare program integrity issues.

Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud across the programs. As a result of the Medi-Medi program, the ZPICs used pre-payment

and autodenial edits to stop improper payments totaling $31 million, identified $40 million in potential overpayments, and referred $447 million to law enforcement.[16] The Medi-Medi program promotes collaboration among state Medicaid agencies, CMS, and law enforcement by targeting resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste and abuse. CMS has implemented many refinements to the program, and is currently assessing ways the program can be improved and be more beneficial to states. CMS is sharing lessons learned from states that have made successful referrals and recouped Medicaid expenditures. CMS is also exploring opportunities to collaborate with states participating in the Medi-Medi program to improve access to timely and robust Medicaid data for Medicaid program integrity activities as well as specific collaborative projects.

3. Prevention and Early Detection

Over the last two years, CMS has implemented powerful new anti-fraud tools based on new authority provided by Congress, and has designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a "pay and chase" approach by focusing new attention on preventing fraud. In addition, CMS is using innovative tools to further enhance our collaboration with our law enforcement partners in detecting and preventing fraud.

In order to apply our comprehensive strategy to the federal-state structure of Medicaid, CMS began evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid programs in FY 2012. CMS is supporting state efforts to ensure that those caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one state will not be able to replicate their scams in another state's Medicaid program. CMS has also continued to focus on developing collaborative auditing projects with the states to more effectively support states' program integrity efforts.

3.1 Summary of rules published in FY 2012

The new authorities granted to HHS and CMS under the Affordable Care Act have been instrumental in CMS's efforts to clamp down on fraudulent activity in the health care sector. In FY 2012, CMS published a Notice of Proposed Rule Making entitled "Medicare Program; Reporting and Returning of Overpayments" on February 16, 2012. This proposed rule would require providers and suppliers, who receive funds under Medicare, to report and return overpayments 60 days after the later of the date that the overpayment was identified, or the date that any corresponding cost report is due.

CMS also published a final rule entitled "Medicare and Medicaid Programs; Changes in Provider and Supplier Enrollment, Ordering and Referring, and Documentation Requirements; and Changes in Provider Agreements" on April 27, 2012. This rule finalized Affordable Care Act provisions that were implemented in a May 5, 2010 interim final rule. It requires all providers of medical or other items or services and suppliers that qualify for a National Provider Identifier

[16]These numbers are included in the totals for ZPIC work on Table 1.

(NPI) to include their NPI on all enrollment applications for Medicare and Medicaid programs and on all claims for payment submitted under those programs. In addition, it requires physicians and other professionals who are permitted to order and certify certain covered items and services for Medicare beneficiaries to be enrolled in Medicare. These items and services include the following: home health, clinical laboratory, imaging and durable medical equipment prosthetics orthotics and supplies (DMEPOS.) Finally, it establishes document retention and access to documentation requirements for providers and suppliers that order and certify certain items and services for Medicare beneficiaries.

On November 16, 2012, CMS published a final rule that implemented the portion of section 6407 of the Affordable Care Act that established a face-to-face encounter requirement for certain items of DME. The law requires that a physician must document that a physician, nurse practitioner, physician assistant or clinical nurse specialist has had a face-to-face encounter with the patient. The encounter must occur within the 6 months before the order is written for the DME.

3.2 Provider enrollment

Provider enrollment is the gateway to the Medicare and Medicaid programs. CMS's role in the provider enrollment process is different in the Medicare and Medicaid programs. CMS directly administers Medicare, and oversees the enrollment process for providers and suppliers participating in the Medicare FFS program. CMS uses information on provider enrollment to support claims payment, fraud prevention programs, and law enforcement through the sharing of data. As a state-based program, states directly oversee the provider enrollment process for their Medicaid programs and CMS provides technical assistance and regulatory guidance. Additionally, many of the tools CMS is applying in Medicare are being evaluated for use in Medicaid, and are described below.

3.2.1 Provider enrollment improvements and access for states

In FY 2012, CMS made significant improvements to the way providers and suppliers interact with CMS during the enrollment process. The Provider Enrollment, Chain and Ownership System (PECOS) is the database that maintains the official enrollment records of Medicare providers and suppliers. Internet-based PECOS permits providers and suppliers to submit their Medicare enrollment applications via the web. In FY 2012, CMS made improvements that eliminated all paper from the web-based enrollment process. These improvements have made it more efficient for providers and suppliers to submit enrollment applications while enabling CMS to target resources on spotting bad actors during this process.

CMS is also using other tools to identify bad actors, including those provided by the Affordable Care Act. CMS implemented the Affordable Care Act provision requiring levels of screening based on the risk of fraud for categories of providers and suppliers in a final rule that the agency published on February 2, 2011. Categories of providers and suppliers designated as limited risk undergo verification of licensure and a wide range of database checks to ensure compliance with any provider or supplier-specific requirements. Categories of providers and suppliers designated as moderate or high categorical risk are subject to all the requirements in the limited screening level, plus additional screening including unannounced site visits. To increase efficiency across

the Medicare and Medicaid programs, CMS has implemented a system for states to view PECOS enrollment data on Medicare providers and suppliers to determine if they have been screened by Medicare according to the enhanced Affordable Care Act provisions. State Medicaid agencies are able to rely on the Medicare screening in place of re-screening an applicant that participates as a provider in both programs.

CMS is also collaborating with our state partners to ensure that those providers and suppliers caught defrauding Medicare will not be able to defraud Medicaid, and those identified as fraudsters in one state will not be able to replicate their scams in another state's Medicaid program. Specifically, the Affordable Care Act and CMS's implementing regulations require states to terminate from Medicaid providers or suppliers whose Medicare enrollment has been revoked, or that have been terminated for cause by another state's Medicaid program or Children's Health Insurance Program (CHIP). Medicare may also revoke the Medicare enrollment of providers or suppliers that have been terminated for cause by state Medicaid agencies or CHIP. To support state efforts to share this information, CMS implemented a web-based application that allows states to share information regarding terminated providers and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. In FY 2012, 30 states used the portal to share information on their state's terminated providers.

3.2.2 Revalidation

In FY 2012, CMS continued its ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 25, 2011 through the end of FY 2012, CMS enrolled or revalidated enrollment information for approximately 409,150 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. These efforts ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare beneficiaries. As a result of the screening performed as part of revalidation, CMS has moved to revoke and deactivate the billing privileges and enrollment records of providers and suppliers that do not meet Medicare enrollment requirements. In FY 2012, the revalidation activities led to 38,374 deactivations and 6,630 revocations.[17] These initiatives complement the traditional program integrity work and additional provider enrollment enhancements that CMS performs.

3.2.3 Medicaid innovation challenge

In FY 2012, CMS announced another initiative to assist states in their program integrity efforts. On May 30, 2012, CMS launched the "CMS Provider Screening Innovator Challenge." This Challenge addresses our goals of improving our abilities to streamline operations, screen providers, and reduce fraud and abuse. Specifically, the Challenge is an innovation competition to develop a multi-state, multi-program provider screening software application which would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for state and federal programs. Further information about the Challenge is available at www.medicaid.gov.

[17]We note that the revalidation results are preliminary results as deactivated providers could reactivate over time.

3.3 Fraud Prevention System

The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA). Since June 30, 2011, the FPS has used predictive algorithms and other sophisticated analytics nationwide to screen all Medicare fee-for-service (FFS) claims prior to payment. For the first time in the history of the program, CMS is using a system to apply advanced analytics to Medicare FFS claims on a streaming, national basis. CMS uses the FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. When FPS predictive models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation. CMS uses the FPS to identify, prevent, and stop potentially fraudulent claims. The FPS helps CMS target fraudulent providers and suppliers, reduce the administrative and compliance burdens on legitimate ones, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care.

Two of the major stakeholders regularly using the FPS are the ZPICs and the OIG Office of Investigations. When suspect behavior or billing activity is identified, the ZPICs perform specific program integrity functions for the Medicare FFS program. Complementing the ZPICs' traditional activities, ZPICs are now using the FPS as a primary source of leads to prevent, identify, and investigate fraud. The FPS screens claims data before payment is made, allowing CMS to rapidly implement administrative actions, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS generates a prioritized list of leads for ZPICs to review and investigate Medicare fraud in their designated region. The FPS also gives CMS a provider-level view of ZPIC activities and administrative actions, making it a useful management tool.

The OIG Office of Investigations conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. The OIG Office of Investigations enhances its data analysis capabilities with direct access to the FPS. Furthermore, the OIG Office of Investigations participates in and supports a variety of CMS collaborative mission rotations in the Command Center. OIG fraud investigators are involved with developing new FPS models, establishing investigative best practices, pursuing cases in real time with other stakeholders, and attending FPS-related training sessions.

In the first year of the system, CMS stopped, prevented or identified an estimated $115 million in fraudulent payments --an estimated $3 in savings for every $1 spent, a positive return for its first year. [18] The FPS also generated leads for 536 new investigations by CMS's program integrity contractors and augmented information for 511 pre-existing investigations. The SBJA requires CMS to evaluate expansion of the use of predictive analytic technologies for identifying and preventing improper payments beyond Medicare to Medicaid and CHIP. The Secretary must submit a Report to Congress with recommendations for implementation of this requirement by the end of FY 2014, and, based on the results of that report, begin expansion of predictive analytic technologies to Medicaid and CHIP claims by April 2015. Although Medicaid is administered and organized in a distinctly different way than Medicare, we believe there are

[18] http://www.stopmedicarefraud.gov/fraud-rtc12142012.pdf

opportunities to transfer the knowledge and lessons learned using the FPS in Medicare to states for use in Medicaid.

CMS, law enforcement officials, CPI field offices, and the ZPICs use the FPS in combination with other tools to fight fraud, waste and abuse. Incorporating supplemental data sources into the FPS helps identify the characteristics of potentially fraudulent, wasteful or abusive providers and suppliers.

A key resource that supports the FPS in analyzing nationwide claims and building models is the IDR, an existing and continuously expanding repository of nationwide Medicare claims data. To develop and test more comprehensive models more quickly, analysts use historical claims from the national IDR to analyze patterns and develop models for the FPS. In turn, FPS models screen the IDR's aggregate, nationwide, historical information about billing behavior, creating more effective analytics using historical national data in both the development and implementation of the models.

Other data sets used in the FPS include tips acquired from 1-800-MEDICARE and other sources, the Fraud Investigation Database, and the Compromised Numbers Checklist. The Fraud Investigation Database includes information on all investigations developed by CMS's program integrity contractors. The Compromised Numbers Checklist identifies compromised physician and beneficiary identification numbers flagged through fraud investigations, security breach reports, and complaints from providers or beneficiaries

CMS screens every complaint from a Medicare beneficiary or caregiver, an employee, or a concerned citizen received at its national 1-800-MEDICARE Contact Centers for information indicating suspicious behavior or potential fraud. In FY 2012, nearly 45,000 complaints of potential fraud reported by beneficiaries and others to 1-800-MEDICARE passed initial screening and were evaluated further.

3.4 Payment controls

To complement the work done with the FPS, ZPICs coordinate with the MACs to implement administrative actions, including claim edits, payment suspensions, and revocations. ZPICs also refer overpayments to the MACs for collection. In FY 2012, CMS stopped $290 million in improper payments denying claims through pre-payment and autodenial edits that ZPICs recommended to automatically stop improper claims before they are paid. CMS also stopped $15 million in payments to 71 providers and suppliers for which CMS determined overpayments.

In addition to provider and service specific edits, CMS has developed the National Correct Coding Initiative (NCCI), which consists of edits designed to reduce the Medicare Part B and Medicaid error rates. This program was originally implemented in the Medicare program in January 1996 with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians. Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal or gender considerations. In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program. MUEs stop payment for claims that are beyond the maximum units of service that a provider would

report under most circumstances for a single beneficiary on a single data of service. The first MUE edits were implemented January 1, 2007. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation. Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website. Certain edits are not published because of CMS concerns that they may be used or manipulated by fraudulent individuals and entities. The use of the NCCI procedure-to-procedure edits saved the Medicare program $483 million in FY 2012, and the NCCI methodology procedure-to-procedure edits applied to practitioner and outpatient hospital services have prevented the improper payment by Medicare of over $5 billion since 1996 based on savings reports from claims processing contractors.

Section 6507 of the Affordable Care Act requires CMS to notify states which NCCI methodologies are compatible with claims filed with Medicaid and requires states to use these methodologies to process claims filed on or after October 1, 2010.[19] CMS has worked closely with state Medicaid programs, both in groups and individually, to implement the NCCI methodologies. Fully and correctly implementing the NCCI methodologies in state Medicaid programs will be a long-term undertaking by both CMS and the states. However, it is expected to result in significant savings in program expenditures due to reductions in improper payments for Medicaid claims with improper coding, as has occurred in the Medicare program. In FY 2012, CMS simplified the Medicare NCCI edits, and released additional information to the states on the implementation of NCCI.

3.5 Provider audits

3.5.1 ZPIC audits

The primary goal of ZPICs is to investigate instances of suspected fraud, waste, and abuse. ZPICs develop investigations and take a variety of actions to ensure that Medicare Trust Fund monies are not inappropriately paid. They also identify improper payments that are to be recovered by the MAC. Actions that ZPICs take to detect and deter fraud, waste, and abuse in the Medicare Program include performing medical review, in which case ZPICs may request medical records and documentation, and conducting interviews and site visits. The MACs and other contractors also perform medical review to make coverage or coding determinations. However, when ZPICS perform program integrity-directed medical review, their focus may be different, for example looking for possible falsification of documents. As a result of medical review, in addition to identifying overpayments, the ZPIC may request the MAC install a prepayment edit or auto-denial edit to prevent the loss of future funds. In FY 2012, the ZPICs identified $461 million in potential overpayments for collection and referred cases totaling $720 million suspect provider billings to law enforcement for investigation.

[19] CMS reported on the implementation of this requirement in a March 2011 report to Congress, accessible at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/Downloads/ReporttoCongresspdf.pdf

3.5.2 Medical Review/Utilization Review (MR/UR)

Medical Review and Utilization Review are conducted by the MACs to ensure that accurate payments are being made to Medicare providers and suppliers. These activities are targeted to error prevention on services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. CMS has established a priority setting process to assure these reviews focus on areas with potential for improper payment. Medical Review activities can be conducted either on a pre-payment or post-payment basis to guard against improper payments. Medical care must meet certain conditions to be paid for by Medicare.

In FY 2012, CMS allocated an additional $26 million to the MACs to enhance their error rate reduction efforts. The MACs have initiated innovative projects including additional educational and prepayment review efforts. For example, one contractor facilitated a webcast meeting with a hospital system. They conducted a two-hour presentation with representatives from various hospital departments, such as case management, utilization review, medical coding, medical records, physician advisors and physician specialties. Findings relative to inpatient claim review were shared and specific prepayment medical review cases from the hospital were presented. The discussion included a dialogue regarding documentation requirements to support medical necessity.

Also, CMS will continue to provide additional funding in future years to focus on prepay review of claims that have historically resulted in high rates of improper payments. This will assist with reducing the number of improper payments, and as a result, reducing the error rate, by stopping improper payments before the claims are paid.

3.5.3 Provider cost report audits

Auditing is one of CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, nursing homes, and end-stage renal dialysis facilities who are paid on an interim basis and whose costs are settled through the submission of an annual Medicare cost report. Although many providers have their claims paid through a prospective payment system (PPS), several items continue to be paid on an interim basis, with the final payment being made through the cost report reconciliation process. The cost report includes calculations of the final payment amount for items such as direct and indirect medical education (GME and IME), disproportionate share hospital (DSH) payments, and Medicare bad debts. In addition, some providers, such as critical access hospitals and cancer hospitals, are paid based on costs reported on their cost reports. Each year Medicare pays in excess of $10 billion in DSH payments, $10 billion in Medical Education payments (GME and IME) and $2 billion in bad debt reimbursement. In addition, critical access hospitals and cancer hospitals are paid approximately $6 billion each year.

The audit process includes the timely receipt and acceptance of provider cost reports, desk review and audit of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines that providers are paid properly, in accordance with CMS regulations and instructions. CMS contracts with fiscal intermediaries (FIs) and Medicare Administrative Contractors (MACs) to provide these audit services. In FY 2012, approximately

42,000 Medicare cost reports were accepted by the FIs and MACs, and tentative settlements were completed for 20,000 cost reports. In addition, approximately 21,000 desk reviews and 3,000 audits were completed. The MACs that perform this audit work are reviewed annually to ensure the accuracy of their work. CMS works closely with its contractors to increase efficiencies and to develop ways to improve the audit process.

3.5.4 Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is an important program that protects both Medicare beneficiaries and the sustainability of the Medicare Trust Funds. The MSP program ensures that, when Medicare is a secondary payer (the insurance that pays after another "primary" insurance), Medicare does not pay or recovers Medicare funds paid conditionally for claims that are the responsibility of that primary insurance.

Implementation of the mandatory insurer reporting requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007 resulted in a significant increase in new MSP information reported to CMS from group health plans and other insurers. In 2008, CMS identified 6.6 million instances of other health insurance coverage that was primary to Medicare. In 2012, CMS identified 16 million instances of other health insurance coverage that was primary to Medicare.

CMS also leverages technology in its MSP program to make Medicare information directly accessible to beneficiaries, their representatives, and the industry. We have expanded the MyMedicare.gov website to provide specific beneficiary information in a secure and readily accessible way. Through MyMedicare.gov, a beneficiary can access eligibility and enrollment information, learn about coverage options, review Medicare claims, and view MSP information. As of July 2012, beneficiaries can go to the My MSP page of www.MyMedicare.gov to see the Medicare reimbursement amount for their individual case, including information on associated claims. They can request and receive updates for newly processed claims within 48 hours. Authorized representatives for a beneficiary can access the portal by using www.cob.cms.hhs.gov/msprp. These improved processes not only provide more timely data to beneficiaries and their representatives, but also allow them to better manage their case. Currently, CMS is working to increase the efficiency of its MSP program by implementing a new contracting strategy that will provide stakeholders with one central point of contact for all aspects of MSP operations, allowing for consolidation of information and a single MSP web site. In FY 2012, a new MSP Integration Contractor and MSP Systems Contractor were awarded and are operational. A new Business Program Operations Contractor and MSP Recovery Audit Contractor will be implemented in 2013. CMS's long term goal is to improve operational efficiencies for both CMS and its external stakeholders while increasing MSP savings to the Trust Funds.

3.5.5 Part C and D Program Integrity Oversight

In FY 2012, CMS funded the Program Integrity Technical Assistance contractor to support Part C and Part D program integrity strategy, ROI methodology, performance measure database maintenance, development of program risk assessment processes, ad hoc studies analysis and other technical assistance as requested. Through a contractor, CMS has conducted outreach

efforts for all Part C and Part D program integrity activities and to provide support for compliance audits and fraud audits. CMS also contracted with a Compliance and Enforcement Medicare Drug Integrity Contractor (MEDIC) to conduct ad-hoc studies and analysis with a special focus on select geographic areas. These contractors perform all Medicare Advantage and Part D program integrity work, including:

- Managing all incoming complaints about Part C and Part D fraud, waste, and abuse;
- Utilizing new and innovative techniques to monitor and analyze information to help identify potential fraud;
- Working with law enforcement, MA, and prescription drug plans, consumer groups, and other key partners to protect consumers and enforce Medicare's rules;
- Providing basic tips for consumers on how to protect themselves from potential scams;
- Identifying program vulnerabilities; and
- Performing proactive research utilizing all available data to find trends in order to ferret out fraud, waste, and abuse activities.

During FY 2012, the national benefit integrity MEDIC received approximately 408 actionable complaints per month; processed 41 requests for information from law enforcement per month; and referred an average of 36 cases to law enforcement per month. The National Benefit Integrity MEDIC supported OIG and DOJ with data analysis and investigative case development that resulted in 23 arrests, 27 indictments and 14 convictions.

One case produced a 34-count indictment and included a group of 25 individuals and 26 pharmacies owned by one individual in the Detroit area involving approximately $38 million in Medicare funds. The owner and five other individuals were found guilty at the trial. The owner and others were convicted of paying cash kickbacks and other forms of illegal remuneration to physicians in exchange for those physicians writing prescriptions for expensive medications without regard to medical necessity. Sentencing for the owner is still pending. Of the original 26 indictees all but eight have been either convicted or have pled guilty.

The NBI MEDIC has also been a key participant in investigating a Part D drug scheme that originated in West Hollywood, California. The scheme has now spread to other areas of the country including Nevada, Louisiana, and Kentucky. Many case referrals have resulted from this project and formed the basis for multiple indictments. Two individuals from California were indicted for attempting to fill fraudulent prescriptions in Kentucky and charged with aggravated identity theft, and health care fraud. The trial is pending.

In addition to the work of the MEDICs, CMS enhanced other Part C and Part D oversight functions in FY 2012 to address new complexities facing law enforcement, and improve plan performance assessment and surveillance, including through secret shopper activities, audit programs, and routine compliance and enforcement tracking. Also in FY 2012, CMS conducted 33 program audits of sponsoring organizations and tested for compliance with program requirements relating to Part D formulary and benefit administration, Part C and D organization coverage determinations, appeals, and grievances, Part C access, Enrollment/Disenrollment, Late Enrollment Penalty (LEP), independent agent and broker oversight, and compliance program effectiveness. These audits covered programs that accounted for 27 percent of all MA and

Prescription Drug Plan contracts and 28 percent of all beneficiaries enrolled as of September 2012.

3.6 Medicare C and D Marketing Oversight

CMS also strengthened program integrity in MA and Part D through marketing surveillance activities and compliance actions based on surveillance activities, such as secret shopping and examining newspaper ads for unreported marketing events and content. These activities have improved plan sponsor oversight of marketing activities and lessened incidents of agent/broker marketplace misconduct.

For the 2012 Annual Enrollment Period, CMS conducted 1,661 secret shopping events. Secret shopping is the undercover surveillance of formal, public MA and Part D plan marketing events to ensure agents and brokers are providing accurate information to Medicare beneficiaries and are in compliance with CMS marketing rules for Parts C and D. Of the 1,661 shops, almost 80 percent had no validated deficiencies and were considered entirely compliant with Medicare regulations. The percentage of plan sponsors with no validated deficiencies improved from 2011 to 2012, with 31 of 84 plan sponsors (36.9 percent) having no deficiencies noted from events shopped (from 18.7 percent plan sponsors in 2011). This improvement demonstrates a continued increase in compliance likely due in part to CMS's market surveillance efforts. CMS estimates that over 850,000 beneficiaries that attended marketing events during the 2012 enrollment period were protected by CMS's marketing surveillance efforts this year.

Unreported Marketing Events

The unreported marketing events initiative was an effort to determine if plan sponsors appropriately reported and represented their sales events activity to CMS. The CMS contractor reviewed daily and weekly print publications in U.S. domestic markets nationwide, including advertisements from Armenian, English, Korean, Mandarin, Russian and Spanish publications. None of the reviewed Armenian or Russian publications contained Medicare marketing events. Each of the remaining language publications advertised marketing events that were not properly reported to CMS in a timely manner.

Under CMS's direction, the surveillance contractor reviewed 9,714 unique events (derived from 2,162 Medicare advertisements in 579 newspapers) collected from October 24, 2011 through December 29, 2011 from a total of 86 plan sponsors. Results by plan sponsor included: 42 plan sponsors (approx. 49 percent) submitted all clipped marketing events to CMS; an additional 41 plans (approx. 4 percent) submitted at least 95 percent of clipped marketing events to CMS; and 3 plan sponsors (approx. 4 percent) failed to submit at least 5 percent of their clipped events. These three plan sponsors were issued notices of non-compliance for their failure to submit at least 95 percent of all of their events to CMS.

- Compliance Actions Based on Surveillance Activities: CMS may issue the following types of letters to sponsors who have had deficiencies related to our surveillance. They include Technical Assistance Letters (which are not formal compliance letters), Notices of Non-Compliance, Warning Letters, and Ad-hoc Corrective Action Plans (CAPs). Listed below are the compliance actions taken for each primary surveillance activity.

Compliance Action	Secret Shopping Events*	Unreported Marketing Events
Technical Assistance Letter*	105	0
Notice of Non-compliance	12	3
Warning Letter with Business Plan	1	0
Ad-hoc CAP	0	0
Total Letters Issued	118	3

*Totals include results from both AEP and post-AEP shopping.

*Technical Assistance Letters were sent to plan sponsors that were shopped, but either did not meet the minimum number of shops, no matter how many deficiencies were found, or had minimal findings.

3.7 National Medicaid Audit Program

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers and audit providers' claims to identify overpayments. After a pilot phase of performing test audits in collaboration with selected states, CMS launched the National Medicaid Audit Program (NMAP) to expand the audit program to across the country. CMS has used two types of Medicaid Integrity Contractors (MICs) to review and audit Medicaid claims to identify overpayments. Review MICs design and apply algorithms and data models to analyze Medicaid claims data to identify aberrant claims and generate audit target leads, while Audit MICs conduct post-payment audits to identify overpayments. The first audit assignments were made to Audit MICs in September 2008, and CMS has continuously reviewed the results of the audit program to monitor its performance.

CMS has learned important lessons during the initial years of the NMAP. Beginning in early 2010, CMS determined through internal analysis, environmental assessments, discussions with stakeholders, and reviews of contractor performance that the initial auditing model of the Medicaid Integrity Program required fundamental changes to effectively support states in their efforts to combat fraud, waste, and abuse in their Medicaid programs. In the initial years of the NMAP, the Review MICs had developed audit targets based on MSIS data, a quarterly extract of states' Medicaid claims data. However, MSIS data turned out to be incomplete and lack up-to-date claim adjustments, and CMS found that these limitations too often resulted in lengthy audits and low returns.

As a result, in February 2011, CMS stopped assigning audits to MICs based solely on MSIS data, and reconfigured the NMAP to a more effective and less burdensome strategy of collaborative projects with states, based primarily on states' up-to-date Medicaid claims data. Collaborative audits allow states to augment their own program integrity audit capacity by leveraging the resources of CMS and its Audit MICs. In one year CMS has almost tripled the NMAP-identified overpayments from $4.6 million in FY 2011 to $12.9 million in FY 2012. In FY 2012, both the OIG and the Government Accountability Office (GAO) issued reports focused

on results of the National Medicaid Audit Program and noted CMS's efforts to improve its program and expand collaborative audits with states with greater success.

In addition, during FY 2012 CMS engaged in a re-evaluation of options to consolidate the work of MICs into a more effective structure. As a first step, CMS determined that, as a consequence of the NMAP redesign, the nature and volume of collaborative audits did not require the same Review MIC capacity for provider data review.

CMS has several other initiatives underway to improve the quality of Medicaid data available to federal contractors. CMS is obtaining extracts of Medicaid claims data from several states for special projects (i.e., data from each state's MMIS, or Medicaid Management Information System), leveraging data from the Medicare-Medicaid Data Match program, and expanding the MSIS data set with additional data elements important for fraud detection in a pilot project known as Transformed MSIS (T-MSIS).

In FY 2012, CMS continued its focus on working jointly with states to develop collaborative audits. These audits combine the resources of CMS and the MICs to assist states in addressing suspicious payments including algorithm development, data mining, auditors, and medical review staff. Through this process, this promising approach more effectively uses resources in support of states in their program integrity efforts. The collaborative process includes a discussion between the state and CMS regarding potential audit issues and the states' provision of MMIS data for data mining. The state together with CMS determines the audit processes the MICs follow during the collaborative audit. In some instances, the Audit MICs conduct the entire audit. In other cases, the Audit MICs supplement state resources by providing medical review staff and other resources.

Some examples of collaborative audits include:

- CMS worked collaboratively with one state to pilot credit balance audits. The purpose of the audits was to determine whether Medicaid credit balances recorded in the hospital accounting records for inpatient and outpatient services represented overpayments that the hospitals should have returned to the Medicaid Program in a timely manner. The results of the audits are being used to evaluate the feasibility of expansion to other states.

- CMS has worked successfully with one state to conduct a data match between Medicare Part D and Medicaid pharmacy to identify duplicate payments. The goal of the project is to identify overpayments for dual eligible beneficiaries in which Medicaid agencies paid for pharmacy claims that were also paid by Medicare Part D. CMS is working with other states to run the same data match.

Additionally, collaborative audit projects have been developed with states in a number of areas:

- Pharmacy
- Hospice
- Emergency services for non-citizens
- Mental Health
- Dental services
- Finance - Cost Report
- Drug Diversion
- Diabetic Equipment - Test Strips
- Transportation
- Hospital credit balance

Collaborative audits are demonstrating a more effective approach to coordinating federal and state audit efforts and resources to better meet states' needs resulting in more timely and accurate audits. Since the earliest collaborative audits were assigned to the MICs in January 2010 through the end of FY 2012, CMS developed 218 collaborative audits with 22 states that represent 60 percent of Medicaid spending. Further, of the 153 total audits assigned in FY 2012, 146 or roughly 95 percent are considered collaborative audits. CMS expects to have collaborative projects with 30 states by the end of FY 2013.

While the focus has been on engaging states in collaborative audits, there remain a number of older audits based solely on Medicaid Statistical Information System data (MSIS). As reports from OIG and GAO point out, MSIS data has certain limitations such as lacking up-to-date claim adjustments that occur at the state level. While MSIS audits have resulted in numerous challenges, some have produced results that are worth pursuing. Therefore, in FY 2012 CMS conducted a cost-benefit analysis of all active MSIS-based traditional audits to assess their viability. As a result, 170 non-productive audits were discontinued, allowing contractors to focus on productive areas.

Overall, the National Medicaid Audit Program identified $12.9 million in overpayments in FY 2012.[20] This is an increase of 182 percent over FY 2011. Of the 84 Final Audit Reports issued in FY 2012, 8 were collaborative audits which represent roughly $2 million in overpayments with an average overpayment of $254,000 per audit. In contrast, the 76 traditional audits had an average overpayment of roughly $143,000.

4 Risk-based approach

CMS is leveraging a variety of information and tools to target resources to become more effective and efficient in our program integrity activities. Throughout FY 2012, CMS worked with the OIG and CMS contractors to identify and address program vulnerabilities. CMS also provided education to a variety of stakeholders, including providers, plans, and states, to help mitigate fraud, waste and abuse on the front lines.

4.1 Highlights of program integrity activities in response to OIG recommendations

In FY 2012, CMS has taken action to address recommendations from the OIG on program vulnerabilities. Brief descriptions of actions taken in response to OIG's priority recommendations are below.

- Bad debts to hospitals - OIG recommends that CMS seek legislation or legislative authority to eliminate (or reduce) Medicare payments to hospitals for bad debt associated with beneficiaries' failure to pay their deductibles and coinsurance and modify Medicare's bad debt policies. Section 3201 of the Middle Class Tax Relief and Job Creation Act of 2012 reduced Medicare bad debt payments to hospitals and skilled nursing facilities to 65 percent from 70 percent beginning with FY 2013 in a proposed

[20]The $12.9 million in identified overpayments includes one Final Audit Report which was not released to the state until June 2013, due to a pending fraud referral to law enforcement.

rule published on July 11, 2012 (77 Fed. Reg. 40951). In addition, the provision also reduced bad debt payments for certain other providers to 65 percent. The reduction to bad debt payments for these providers is required to be phased in over 3 years.

- Hospice claims - OIG recommends that CMS strengthen its monitoring practices for hospice claims for beneficiaries in nursing homes by using targeted medical reviews and other oversight mechanisms. CMS began exploring preliminary requirements to begin the implementation of the Affordable Care Act, § 3132(b), which requires reviews of hospices with a certain percentage of its population having lengths of stay greater than 180 days and a discussion of this review is included in the FY 2014 Proposed Hospice Wage Index and Payment Rate Update.
- Enhanced oversight Independent Diagnostic Testing Facilities (IDTFs) - OIG recommends that CMS implement unannounced site visits and other actions to prevent improper payments to IDTFs. In FY 2012, CMS performed site visits on 3915 IDTF providers nationwide, and revoked billing privileges of 243 IDTF enrollments.
- Prescriber Identifiers on Part D Claims - OIG recommends that CMS ensure the validity of prescriber identifiers on Part D claims. In FY 2012, CMS published a final rule that requires Part D plan sponsors to submit to CMS only PDE records that contain an active and valid individual prescriber NPI. (42 CFR § 423.120(c).)
- Part D reimbursement of atypical antipsychotic drugs - OIG recommends that CMS ensure that Part D Sponsors have information needed to make accurate coverage and reimbursement determinations for atypical antipsychotic drugs. CMS published a final rule on April 12, 2012 regarding Part D drug utilization in long-term-care (LTC) settings. (77 Fed. Reg. 22072.).
- Medicaid reimbursement of prescription drugs - OIG recommends that CMS develop national pharmacy acquisition cost data as a benchmark for reimbursing prescription drugs in Medicaid. In a February 2012 proposed rule CMS proposed to replace the term ‘‘estimated acquisition cost’’ with ‘‘actual acquisition cost” to provide states with a more accurate reference price to base reimbursement for prescription drugs. (77 Fed. Reg. 5318). As a supporting initiative, CMS’s Survey of Retail Prices will provide state Medicaid agencies with an array of covered outpatient drug prices that are based on acquisition costs and consumer purchase prices that they can use to compare their own pricing methodologies and payments to those derived from the surveys.

4.2 Recovery Audit programs

4.2.1 Medicare Fee-For Service (FFS)

In FY 2012, the Medicare FFS Recovery Audit program corrected $2.4 billion in improper payments including recovering $2.3 billion in overpayments. FY 2012 recoveries continued to grow and were 187 percent higher than recoveries in FY 2011.

During FY 2012, the Recovery Auditors focused their reviews on short hospital stays and claims for Durable Medical Equipment. This approach is consistent with CMS’s focus to lower the Medicare error rate. CMS expects that implementation of certain corrective actions will lower collections in the future as they will prevent future improper payments from being made. CMS continues to monitor and make continuous improvements to the Recovery Audit program.

4.2.2 Part D and Part C Recovery Audit program

Section 6411(b) of the Affordable Care Act expanded the use of recovery audit contractors (RAC) to Medicare Part C and Part D. CMS has initiated implementation of Part C and Part D RACs. The Part D Recovery Audit contract has national jurisdiction and is dedicated to identifying improper payments and providing information to CMS to help prevent future improper payments. The Part D RACs initial review focused on identifying improper payments for prescriptions written by excluded prescribers or filled by excluded pharmacies in contract year 2007. In June 2012, Part D Plan Sponsors were notified of overpayments identified related to the 2007 excluded prescriber review and recoupment began in November 2012. The review for years 2008 through 2011 will be performed for excluded prescribers and pharmacies in the next fiscal year. The Part D RAC may examine additional issues such as invalid prescriber ID (for years 2010 and after), duplicate payments, and direct and indirect remuneration for 2008-2011.

In FY 2012, CMS developed the procurement strategy for the Part C RAC after reviewing the implementation options. The Part C Recovery Auditor will identify improper payments related to issues including the coordination of benefits in End Stage Renal Disease, Hospice and Medicare Secondary Payer (MSP), and provide information to CMS to help prevent future improper payments.

4.2.3 Medicaid

State Medicaid agencies contract with Medicaid Recovery Audit Contractors (RACs), to identify and recover overpayments, and identify underpayments made to Medicaid providers. CMS implemented section 6411(a) of the Affordable Care Act in a final rule published on September 16, 2011, adding a new subpart F to 42 C.F.R. part 455 and requiring states to implement Medicaid RAC programs by January 1, 2012. Pursuant to 42 C.F.R. § 455.516, states may request exceptions to the new regulatory requirements by submitting a State Plan Amendment (SPA) for CMS review and approval. During FY 2012, several states requested exceptions to certain requirements such as the January 1, 2012 implementation date, the 3-year maximum claims look back period and the requirement that their RACs hire a full-time Medical Director.

As of September 30, 2012, 36 states had implemented Medicaid RAC programs, and CMS had granted five U.S. Territories complete exceptions from implementing RAC programs. CMS granted exceptions to 21 states to delay the implementation date of January 1, 2012. In their reasons for requesting exceptions, states cited staff shortages and procurement delays for their inability to procure RAC contracts by the required effective date.

CMS's role with the Medicaid RAC program focuses on providing guidance to states as they implement their Medicaid RAC programs; collecting state reports on the progress of those programs; and encouraging states to make their Medicaid RAC programs as transparent as possible. During FY 2012, CMS facilitated transparency and data collection through the Medicaid RACs-At-A-Glance website. RACs-At-A-Glance features state-reported information on each state's Medicaid RAC program, including contact information for the state program integrity director; the name of each RAC vendor and medical director; contingency fee rates for the identification and recovery of overpayments; fee structure for the identification of underpayments; user-friendly charts and data state profile pages. CMS launched the second

phase of the Medicaid RACs-At-A-Glance website in September 2012. In addition to enhancing the website, CMS has provided sub-regulatory guidance and technical assistance to states through webinars and teleconferences. Topics included Medicare Best Practices: Technical Assistance for states, CMS – 64: RAC reporting of recoveries for states, RAC Fraud Referrals to the state Medicaid Agencies, Performance Metrics, and State User training for RACs At-A-Glance Phase II.

For FY 2012, nine states reported recoveries totaling $95.6 million in the federal and state share combined amount (Total Computable) and returned a total of $57.6 million (federal share).[21]

4.3 Education and Assistance

One of the goals of provider education and outreach is to reduce the Medicare error rate by giving Medicare fee-for-service providers the timely and accurate information they need to bill correctly. The Medicare Fee-For-Service claims processing contractors educate Medicare providers and their staff about Medicare policies and procedures, significant changes to the Medicare program, and issues identified through review of provider inquiries, claim submission errors, medical review data, and error rate testing. 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. These include MedLearn articles, Open Door Forums and listserv messages. CMS receives significant positive feedback from providers on the value of educational materials.

CMS also conducted significant fee-for-service provider and supplier education and outreach effort on the enrollment revalidation project, which began in September 2011. Given the scope of the project is to revalidate all 1.5 million Medicare providers and suppliers, CMS took a proactive approach in reaching out to provider groups to encourage their members to revalidate their enrollment information. CMS engaged directly with major provider associations, such as the American Medical Association and the Medical Group Management Association, and conducted face-to-face meetings and telephone conference calls with other medical and professional associations' representatives. In FY 2012, CMS has continued to conduct significant outreach and education on all aspects of provider enrollment thru national provider calls, quarterly provider focus groups and presenting at national conferences.

CMS uses the Outreach and Education MEDIC to provide Part C and D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups. . During the FY 2012 Part C and D fraud work group meetings, approximately 150 industry professionals exchange fraud fighting information each quarter. On average, 80 organizations are represented at each meeting. The MEDIC has also launched a fraud and abuse outreach website that has received over 4,500 hits between April and September 2012.

The Education Medicaid Integrity Contractor (MIC) works with a variety of stakeholders in the development of educational materials to enhance awareness of Medicaid fraud, waste and abuse among providers, beneficiaries, managed care organizations, and others. In FY 2012, the

[21] As reported on the CMS - 64.

education effort has been divided into two projects with one focusing on a targeted provider education program and the other focusing on developing materials for a broader audience (providers, beneficiaries, managed care organizations, and others) based on priority areas that CMS, state Medicaid officials and the Education MIC identified as lacking education information related to fraud, abuse, and payment. These priority areas were identified by stakeholder engagement and environment scans. The materials are developed with the expertise of stakeholders from state Medicaid agencies, law enforcement agencies, provider and advocacy organizations, and other relevant groups.

In FY 2012, as part of the targeted provider education program, the Education MIC developed provider education materials to promote best practices for five therapeutic drug classes that were identified as having high potential improper payment rates. These best practices are designed to combat overprescribing and overutilization of prescription drugs, while enhancing quality of care. Materials focused on the importance of prescribing drugs within the dosage guidelines approved by the FDA. The program was conducted in three states in FY 2012 and CMS will be gathering post implementation data from these states for analysis of the program's results in FY 2013.

In FY 2012, the Education MIC attended 5 stakeholder conferences, 2 pilot state trainings, and reached 1,713 persons though staffing exhibit booths and distributing 33,963 educational products including 25,893 fraud reporting postcards for providers and beneficiaries. The Education MIC also conducted 29 train-the-trainer sessions for states on six educational toolkits in topics on dental compliance, managed care compliance, drug diversion, medical identity theft and beneficiary card sharing. The Education MIC also presented at many of the conferences, on PI topics including the role of a strong compliance program to promote PI in Medicaid managed care and the responsibility of Medicaid beneficiaries to protect and not share their Medicaid cards. Where possible, CMS seeks to develop synergies with Medicare PI outreach activities, especially for dual beneficiaries.

4.4 State Medicaid Program Integrity Reviews

CMS has conducted comprehensive, regulation-based reviews of states' program integrity activities since FY 2008 on a triennial basis. These comprehensive reviews cover operations of the state's program integrity unit, provider enrollment and disclosures, managed care program integrity operations, and interaction between the state's Medicaid agency and its MFCU. The goals of the reviews have been:

- Assess the effectiveness of the state's program integrity efforts;
- Determine if the state's policies, procedures, and practices comply with federal regulations; and
- Identify and disseminate program vulnerabilities and best practices.

As part of a process of continuous improvement, CMS began work in FY 2012 to redesign the state program integrity review guide to achieve an increased focus on program vulnerabilities and risk, reduce the burden of the reviews on the states, and identify more opportunities for technical assistance to the states. Accordingly, CMS intends to pilot test a new review guide in

six states in FY 2013, and will conduct an evaluation of the pilot system and make necessary adjustments for the future.

In FY 2012, CMS conducted 18 comprehensive state program integrity reviews in Alabama, Arizona, California, Colorado, Florida, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New Hampshire, New Jersey, Rhode Island, Washington, Washington D.C., and West Virginia. For each of the states listed, this was the second time it had been subject to a comprehensive program integrity review by CMS since 2007. The second comprehensive review cycle provides CMS with the opportunity to make on-site assessments of the states' corrective actions, compare previous findings to current findings, and make an assessment of the states' progress in combating fraud, waste, and abuse. At the end of FY 2012, CMS had reviewed each state twice except for Alaska, Hawaii, Indiana, Kansas, Montana, New York, Ohio, and South Dakota.

The most common findings and vulnerabilities identified in the reviews to date include:

Most Common Findings:[22]

- Failure to collect required ownership, control, and criminal conviction disclosures;
- Failure to require the disclosure of business transaction information;
- Failure to report adverse actions states had taken on providers to OIG;
- Failure to conduct searches for federally excluded providers; and
- Incomplete implementation of key program integrity provisions of the Affordable Care Act

Most Common Vulnerabilities:

- Inadequate protections in the managed care provider enrollment process;
- Lack of exclusion checking at the time of initial provider enrollment and thereafter;
- Not verifying with enrollees whether services billed by providers were received; and
- Not reporting to OIG adverse actions taken on managed care provider applications

CMS requires states to submit corrective action plans (CAPs) addressing each finding and vulnerability identified during their review within 30 days of release of the report. CMS staff reviews each state's CAP submission and discusses any issues with the state during a conference call and sends a follow-up letter outlining the concerns and issues. CMS may conduct follow-up reviews to determine if states have implemented some or all of the corrective actions. During subsequent reviews, CMS notes the progress each state has made in correcting inadequacies and vulnerabilities identified in previous reviews.

In June 2012, CMS also issued its fourth Program Integrity Review Annual Summary Report,[23] which includes a compendium of data collected from comprehensive integrity reviews that have

[22]Findings represent those activities where the state has demonstrated less than full compliance with a provision of the program integrity regulations at 42 CFR 455.

had final reports issued during the calendar year. The report includes information about effective practices, areas of vulnerability, and areas of regulatory non-compliance. Providing states with a compendium of program integrity activity and benchmarks for easy reference adds value to our collective effort to improve the overall integrity of the Medicaid program.

4.5 State Medicaid Program Integrity Assessment

The State Program Integrity Assessment (SPIA) is an annual activity to collect state Medicaid program integrity data, develop profiles for each state based on these data, determine areas to provide states with technical support and assistance, and develop measures to assess states' performance in an ongoing manner. SPIA began in 2008 and represents the first national baseline collection of data on state Medicaid integrity activities for the purposes of program evaluation and technical assistance support. Through SPIA, the states and CMS are able to measure their collective progress in improving the overall integrity of the Medicaid program.

In FY 2012, CMS completed the fourth national collection of SPIA data representing FY 2010 activity. The self-reported data from the states for FY 2010 showed more than 4,135 Program Integrity FTEs were employed by the states and a total of $426.3 million was expended on PI activities. This represents a 2.5 percent decrease in staff and an 8.3 percent increase in funding dedicated to Medicaid PI activities from FY 2009. States reported that they conducted 74,511 audits resulting in the recovery of more than $798.2 million. This was a 39 percent decrease in audits performed, resulting in a 20 percent decrease in recoveries from audits and a 9.2 percent decrease in overpayments identified by audits.[24] While states performed fewer audits in FY 2010, other program integrity activities such as provider enrollment oversight, pre-payment screening, and managed care oversight all increased during FY 2010.

5. Innovation

In FY 2012, CMS took significant steps to modernize its operations. In addition to the new technology discussed earlier in this report, CMS began testing new payment methods and controls to curb fraud, waste and abuse in key program areas. CMS also continued to phase in the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program as required by law.

5.1 DMEPOS competitive bidding

The Medicare DMEPOS competitive bidding program has saved the Medicare Fee-for-Service program approximately $202.1 million in its first year of implementation, a percentage drop in expenditures of over 42 percent in the nine markets currently participating in the program.[25]

---

[23]CMS publishes this report annually and makes it available to the public on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html

[24] In early FY 2013, GAO recommended discontinuing the SPIA to avoid duplication with other efforts (GAO-13-50). CMS suspended the SPIA data collection pending a re-evaluation of the survey instrument.

[24]CMS, Competitive Bidding Update, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/DMEPOSCompetitiveBid/Downloads/Competitive-Bidding-Update-One-Year-Implementation.pdf, April 17, 2012.

CMS implemented an active surveillance and monitoring program to identify any issues and has found no disruption in access or identified negative health consequences for Medicare beneficiaries. CMS claims monitoring results are supported by the fact that the agency has largely received routine beneficiary or caregiver inquiries with only minimal complaints. On July 1, 2013, the program will be expanded to 91 additional metropolitan areas and a national mail order program for diabetic testing supplies as required by the Medicare Improvements for Patients and Providers Act of 2008 and the Affordable Care Act of 2010. The CMS Office of the Actuary (OACT) estimates that the program will save the Medicare Part B Trust Fund $25.7 billion over 10 years and beneficiaries are expected to save an estimated $17.2 billion during the same 10 year period due to the reduction in coinsurance and reduced premiums.

Given the success of the Round 1 implementation, the Round 2 and national mail-order programs will work essentially the same as the Round 1 program. We note that we implemented a few important improvements to the bidding process. First, we strengthened our bona fide bid review process. We built on the rigorous, comprehensive process used in Round 1 to check that very low bids are sustainable by improving our bidder education so that it more strongly emphasized the need to submit bids that include the cost for the supplier to buy the item, overhead, and profit and applying tougher screens for the highest cost, highest volume items that have the greatest impact on a supplier's composite bid. We also enhanced our successful bidder education program by improving and streamlining the request for bids instructions, updating policy fact sheets, and offering a series of educational webcasts that are available on demand.

5.2 Demonstrations

CMS conducts demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse and reduce improper payments. Reductions in improper payments will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. The status of each demonstration is detailed below.

5.2.1 Prior Authorization of Power Mobility Device Demonstration

In FY 2012, CMS implemented the Prior Authorization of Power Mobility Device demonstration for all people with Medicare who reside in seven states where historically there has been extensive evidence of fraud or improper payments (CA, FL, IL, MI, NY, NC and TX). The demonstration implemented prior authorization, a tool used by private-sector health care payers to prevent improper payments and deter fraud. The demonstration began for orders written on or after September 1, 2012. Based on initial data, spending per month on power mobility devices in the 7 demonstration states has decreased after September 2012.

5.2.2 Part A to B Rebilling Demonstration

CMS implemented the Part A to Part B Rebilling demonstration on January 1, 2012. The demonstration allowed participating hospitals to re-bill for 90 percent of the allowable Part B payment when a Medicare contractor denies a Part A inpatient short stay claim on the basis that the inpatient admission was not reasonable and necessary. Hospitals were allowed to rebill for certain Part B ancillary services only. Participation in this demonstration was limited to a representative sample of 380 qualifying hospitals nationwide that volunteered to be part of the program. This demonstration was expected to lower the Medicare fee-for-service error rate as

payments that would be allowable under Part B if the patient was originally treated as an outpatient rather than admitted as an inpatient was no longer be considered in error. Participating hospitals were not permitted to charge beneficiaries for any additional co-pay or out-of-pocket costs.[26]

5.2.3 Recovery Audit Prepayment Review Demonstration

CMS implemented the Recovery Audit Prepayment Review demonstration in August 2012. This demonstration allows Medicare Recovery Auditors to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RAs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews will focus on seven states with high incidences of fraud and improper payments (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration seeks to develop improved methods to investigate and prosecute fraud in order to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments. This demonstration will also help lower the error rate by preventing improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur.

6 Transparency and Accountability

CMS is committed to reporting information on the fiscal security of the Medicare and Medicaid programs. In FY 2012, CMS met its obligations to report on its error rates, while making progress on the development of new measures to provide a more precise picture of CMS's opportunities and challenges for improvement.

6.1 Error rate measurement

Below are the historical trends in the improper payment rates for the various programs since 2009: Medicare Fee-for-Service, Medicaid, CHIP, Medicare Part C and Medicare Part D.

[26] The Administrator issued Ruling No. CMS-1455-R on March 13, 2013. (78 FR 16614). The Ruling establishes a policy under which, when a Part A inpatient claim for a hospital inpatient admission is denied as not reasonable and necessary, the hospital may submit a Part B inpatient claim for those services that would have been reasonable and necessary if the beneficiary had been treated as an outpatient, rather than admitted as an inpatient. Because the Ruling establishes a policy that applies to all hospitals and provides for full payment of rebilled Part B inpatient services (rather than the 90% payment provided for under the demo), the Ruling terminated the Part A to Part B Rebilling Demonstration. In the Fiscal Year 2014 Hospital Inpatient Prospective Payment System final rule (78 FR 50496), CMS established a permanent policy related to billing Part B inpatient services following a denial of a Part A claim for an inpatient stay as not reasonable and necessary.

	Reported Improper Payment Rates			
Program	**2009**	**2010**	**2011**	**2012**
Medicare FFS	10. 8%	10.5%	8.6%	8.5%
Part C	15.4%	14.1%	11%	11.4%
Part D	N/A	N/A	3.2%	3.1%
Medicaid	9.6%	9.4%	8.1%	7.1%
CHIP[27]	N/A	N/A	N/A	8.2%

Additional information about previous year's improper payment rates can be found at http://www.paymentaccuracy.gov.

6.1.1 Medicare Fee-for Service

CMS developed the Comprehensive Error Rate Testing program to measure improper payments in Medicare FFS. The program requires independent reviewers to periodically review a systematic random sample of claims that are identified after they are accepted into the claims processing system. These sampled claims are then tracked through the system to the final disposition. The independent reviewers perform medical review on the sample of claims to ensure that the payment was appropriately paid or denied. CMS publishes an annual report with the Medicare FFS error rate and breaks out rates by type of claim, clinical setting and type of error.

While all payments stemming from fraud are considered "improper payments" not all improper payments constitute fraud. Many improper payments result from errors in billing or lack of certifying signatures on claims. In order to help reduce improper payments CMS is working on multiple fronts to meet our improper payment reduction goals, including increased prepayment medical review, enhanced analytics, expanded education and outreach to the provider and supplier communities, and expanded review of paid claims by the Medicare FFS Recovery Auditors.

The FY 2012 Medicare FFS improper payment rate was 8.5 percent, representing $29.6 billion in improper payments compared to the FY 2011 improper payment rate of 8.6 percent. This rate takes into account a methodological change to the improper payment error rate calculation.

[27] Unlike the Medicaid improper payment rate, the FY 2012 CHIP improper payment rate represents a single year of data from the 17 states measured projected nationally. HHS reported an error rate for CHIP for the first time since 2008 in the Department of Health and Humans Services FY 2012 Agency Financial Report. HHS did not report a CHIP error rate in FYs 2009 through 2011 due to a statutory requirement. In the FY 2014 Agency Financial Report, HHS will report a baseline for the CHIP improper payment rate based on measuring all 50 states and the District of Columbia

Information on the methodological change to the Medicare FFS improper payment error rate calculation can be found in the 2012 HHS Annual Financial Report (http://www.hhs.gov/afr/hhs_agency_financial_report_fy_2012-oai.pdf).

6.1.2 Medicare C/D

In compliance with the Improper Payments Elimination and Recovery Act (IPERA), CMS has enhanced its efforts to address improper payments. Unlike Medicare Fee-For-Service, CMS makes prospective, monthly per-capita payments to MA organizations and Part D plan sponsors. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, certain Part D prospective payments are reconciled against actual costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The MA payment error estimate reported for FY 2012 (based on payment year 2010) is 11.4 percent, or $13.1 billion. The Part C payment error estimate has remained relatively constant compared to FY 2011 of 11.0 percent. The FY 2012 Part C payment error estimate presents the combined impact on Part C payments of two sources of error: Part C payment system error and the Risk Adjustment error. Most of the Part C payment error is driven by errors in risk adjustment data (clinical diagnosis data) submitted by Part C plans to CMS for payment purposes. Specifically, the Risk Adjustment Error estimate reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

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

On February 24, 2012, HHS released the Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits. The notice clarifies the final audit methodology that will be implemented for audited contracts going forward. Payment year 2011 is the first year that CMS will conduct payment recovery based on extrapolated estimates. CMS expects to audit about 30 MA contracts each year.

Additionally, the CY 2007 contract-level RADV audits are in the final stages. In FY 2012, CMS conducted payment recovery (at the beneficiary level) for the five contracts involved in the CY 2007 RADV pilot audits.

The Part D payment error estimate reported for FY 2012 (based on payment year 2010) is 3.1 percent, or $1.59 billion. The FY 2012 Part D error estimate presents the combined impact on Part D payments of five sources of error: Part D payment system error; payment error related to

low income subsidy status; payment error related to incorrect Medicaid status; payment error related to prescription drug event data validation; and payment error related to direct and indirect remuneration.

6.1.3 Medicaid

The Improper Payments Information Act (IPIA) of 2002, amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA), requires each agency to periodically review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, submit those estimates to Congress, and report on actions the Agency is taking to reduce improper payments.

GAO and OMB have identified the Medicaid program and CHIP as at risk for significant erroneous payments. To comply with the IPIA and IPERA, CMS established the Payment Error Rate Measurement (PERM) Program to estimate improper payment error rates in Medicaid and CHIP. The error rates are based on reviews of the fee-for-service (FFS), managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. CMS uses federal contractors to measure Medicaid and CHIP error rates using a 17-state rotation so that each state is reviewed every three years. In 2006, CMS first measured the fee-for-service component of Medicaid. Starting in 2007, PERM was expanded to measure error rates for fee-for-service, managed care, and eligibility in both Medicaid and CHIP.

HHS calculated, and reported in the FY 2012 Agency Financial Report, the three-year weighted average national Medicaid error rate that includes the rates reported in fiscal years 2010, 2011, and 2012. This three-year rolling national error rate is 7.1 percent, totaling $19.2 billion in improper payments. This represents a drop in the improper payment rate from FY 2011 (8.1 percent). The 17 states reviewed in FY 2012 were the same states reviewed in FY 2009. The improper payment rate for these states dropped from 8.7 percent in FY 2009 to 5.8 percent in FY 2012 causing the three-year Medicaid improper payment rate to decrease. The most significant improvement was in the eligibility component which dropped from 6.7 percent to 3.3 percent. The weighted national error components rates are as follows: Medicaid FFS, 3.0 percent; Medicaid managed care, 0.3 percent; and Medicaid eligibility, 4.9 percent. The most common cause of errors in fee-for-service claims is lack of sufficient documentation to support the payment. The vast majority of the eligibility errors were due to beneficiaries found to be ineligible or whose eligibility status could not be determined.

Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited HHS from calculating or publishing any national or state-specific error rates for CHIP until six months after a new PERM final rule was effective. In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempted HHS from completing a 2011 CHIP improper payment rate. On August 11, 2010, as part of enhanced efforts to reduce improper payments in federal programs, HHS issued the final regulations that fully implemented improvements to the PERM program. Therefore, HHS commenced CHIP error rate measurement in 2011 and is reporting the single-year FY 2012 national CHIP error rate in the FY 2012 Agency Financial Report. The FY 2012 national CHIP error rate is 8.2 percent or $0.7 billion in estimated improper payments. The national component error rates are as follows: CHIP FFS –6.9 percent; CHIP managed care –0.1 percent; and CHIP eligibility –5.8 percent. The majority of

improper payments were a result of cases reviewed for eligibility that were not eligible, providers billing the wrong number of units, policy violations, and lack of documentation.

CMS is currently measuring cycles that will be reported in 2013 and 2014. CMS expects the error rates to decline in future years through program maturation and corrective action initiatives implemented at the state and federal levels.

As a result of the Executive Order 13520—Reducing Improper Payments and Eliminating Waste in federal Programs, the PERM program has added several new requirements including reporting on the Treasury payment accuracy website and reporting comprehensive improper payment measurement and reduction activities to OIG.

6.2 Supplemental measures

In FY 2010, CMS launched the first National Supplemental Measure Project to measure improper payments in the area of pharmacy claims (overprescribing of certain drugs). After data collection from participating states in Regions III (Mid-Atlantic) and IV (Southeast), CMS calculated the baseline measures for this project in late 2011. During FY 2012, CMS finalized and approved educational materials on five drug classes identified as having high potential improper payment rates, launching a targeted education program with the first state in June of 2012. Final results from data collected after the educational intervention are expected in FY 2013.

6.3 Probable fraud measurement pilot

While CMS calculates improper payments error rates in Medicare and Medicaid as described above, there is no reliable estimate of the amount of fraud in the Medicare program. Documenting the baseline amount of fraud in Medicare is of critical importance, as it allows officials to evaluate the success of ongoing fraud prevention activities. In collaboration with the HHS Office of the Assistant Secretary for Planning and Evaluation, CMS developed the methodology for the first nationally representative estimate of the extent of probable fraud in the Medicare fee-for-service program in FY 2011. In FY 2012, CMS developed the measurement tools for the pilot, and collaborated with government partners, including the Assistant Secretary for Public Affairs, on the strategy for implementation.

This project will estimate probable fraud within the area of home health agencies to pilot test the measurement approach and calculate a service-specific estimate. This pilot is measuring "probable fraud" because "fraud" is a legal determination that CMS cannot make on its own. A review panel of experienced health care analysts, clinicians, policy experts, and fraud investigators will review all collected data and determine if there is sufficient evidence to warrant a referral to law enforcement. After the completion of this pilot, CMS will assess the value of expanding the measurement to other areas of health care.

7. Partnership Program Integrity Stakeholders

In FY 2012, CMS collaborated with key partners in unprecedented and exciting initiatives. CMS complemented our long-standing relationships with State Medicaid Agencies and law enforcement with coordinated use of new authorities and tools, and implemented a partnership with private organizations that is expanding the fight against fraud nationwide and across

programs. Finally, CMS took significant steps to implement transparency measures that will empower the nation's medical care consumers.

7.1 State Medicaid Agencies

To further its mandate under the DRA to provide effective support and assistance to states to combat fraud and abuse in their Medicaid programs, CMS provides training to state program integrity staff, works in direct partnership with states on field investigations targeted to high risk areas, and provides technical assistance to states to enhance State Medicaid program integrity activities.

7.1.1 Medicaid Integrity Institute

Established through an interagency agreement with the U.S. Department of Justice, the Medicaid Integrity Institute (MII) is located within DOJ's National Advocacy Center, in Columbia, SC. The first MII course was held in February 2008. As the first national Medicaid program integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and collaboration among states in a structured learning environment.

In May 2012, the Certification and Credentialing Working Group convened at the MII to continue its work on one of CMS's top priorities, defining and developing a plan for credentialing and certifying MII courses. This group identified three phases of implementation, including a basic phase to analyze the core concepts for three MII courses, Basic Skills and Techniques in Medicaid Fraud Detection, Program Integrity Fundamentals, and Specialized Skills in Medicaid Fraud Detection. Mastery of these courses will require passing an exam for each course. The tests were developed by an instructional design expert along with members of the working group. The first Certified Program Integrity Professional (CPIP) designation is scheduled to be issued in FY 2013, depending on state employee participation in the certification training.

In FY 2012, the MII provided training to 919 state employees and officials from 50 states, the District of Columbia and Puerto Rico. From its inception in 2008 through FY 2012, CMS has trained 3,383 state employees through 82 courses at the MII at no cost to the states. The training in FY 2012 included the following courses:

- Medicaid Issues Symposium
- CMS-64 and Program Integrity Accounting Seminar
- Specialized Skills in Medicaid Fraud Detection
- Evaluation and Management Boot Camp (3 classes)
- ICD-10 Basics Boot Camp
- Emerging Trends in Medicaid Benefit Integrity Symposium
- Emerging Trends in Managed Care Seminar
- Investigation Data Collaboration: Acquisition, Analysis, and Use
- Emerging Trends in Home Health and Personal Care Services
- CPT Outpatient Coding Boot Camp
- Program Integrity Directors Symposium
- Emerging Trends in Pharmacy Symposium

- Faculty Development Seminar
- CPT Inpatient Coding/DRG Boot Camp
- Data Expert Symposium
- Medical Record Auditing Program
- Basic Skills in Medicaid Fraud Detection Program
- Interviewing and Interrogation Program
- Program Integrity Fundamentals Program

7.1.2 Special Investigation Projects

CMS also provides states assistance with "boots on the ground" for targeted special investigative activities. In 2012, CMS staff assisted the Florida Agency for Health Care Administration in two joint field investigations of assisted living facilities (ALFs). A total of 192 ALFs were reviewed on-site. The investigations resulted in over 260 sanctions and referrals as well as roughly $950,000 in state-reported fines and paid claims reversals.

7.1.3 Program Integrity Oversight of Managed Care Organizations

Recognizing the substantial penetration of managed care into the Medicaid program, CMS began work in FY 2012 to assist State Medicaid agencies in improving their oversight of program integrity in managed care. CMS has collaborated with states to obtain feedback regarding states' needs and requirements to begin the design of a rigorous framework of oversight activities.

CMS conducted extensive research during FY 2012 to survey program integrity issues as they relate to managed care. This research included consideration of tools used to ensure program integrity in Medicare managed care as well as findings from the OIG that pertain to fraud and abuse in the managed care sector. This research resulted in several potential approaches to assist states with ensuring that program integrity safeguards are in place and that Medicaid expenditures for managed care services are properly utilized. Going forward, CMS will evaluate these approaches for implementation, and update and expand its guidance to states for addressing fraud and abuse in Medicaid managed care.

7.1.4 Technical Assistance

In FY 2012, CMS responded to 481 requests for technical assistance from 46 states and numerous other providers and stakeholders. The other stakeholders included CMS contractors, the DOJ and U.S. Attorneys' Offices, the FBI, the OIG, state MFCUs, and other HHS agencies. The most common topics included requests for statistical assistance related to criminal and civil court actions, policy and regulatory requirements governing disclosures, provider exclusions and enrollment, the National Medicaid Audit Program, and specific fraud referrals.

Other examples of assistance provided to the states by CMS included:

- Vaccines for Children Program (VFC): In FY 2012, CMS staff made 5 referrals to the states as part of guidelines set forth in FY 2011.
- Regional/small state calls, TAG meetings, and Other Outreach Activities
    - CMS staff continue to host quarterly calls of regional program integrity directors and a monthly call in which the program integrity directors of the 14 smallest

Medicaid programs participate. These calls have been useful in giving program integrity directors a chance discuss issues among themselves and solicit new approaches and effective solutions to problems from their peers.

- CMS leadership and staff continued to engage with the CMS Medicaid Fraud & Abuse Technical Advisory Group on a variety of policies and issues in Medicaid program integrity.
- In FY 2012, CMS's Medicaid program integrity New York field office hosted semi-annual meetings of all major program integrity stakeholders in area covered by CMS's New York Regional Office. These meetings were attended by Medicaid and Medicare program integrity staff, Medicare contractor staff, state Medicaid agency and Medicaid Fraud Control Unit personnel, as well as representatives of other law enforcement agencies including the FBI and OIG, and oversight agencies. The meetings provided attendees with updates on Medicaid and Medicare activities in the region, presentations on recent fraud cases of interest, and interactive panel discussions of current fraud issues and problems.
- CMS provided Medicaid program integrity educational materials to the joint HHS-DOJ fraud summits in Dallas (February 2012) and Chicago (April 2012).
- Medicaid program integrity staff also supported and provided educational materials to the September 2012 Provider Fraud Awareness Month events in Illinois which were co-sponsored by the Illinois Medical Society and HHS.
- CMS hosted three all-state calls, two open door forums, and three webinars on Medicaid program integrity topics, such as the Medicaid RAC and new payment suspension requirements.
- CMS held eight Medicaid 101 training sessions for CMS staff between September and November 2011.
- In FY 2012, CMS staff participated in 10 conferences as participants and presenters.

7.2 Federal Law Enforcement

7.2.1 HEAT strike force

In 2012, CMS supported three successful takedowns by the Medicare Fraud Strike Forces, a part of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), a cabinet-level task force led by Secretary Kathleen Sebelius and Attorney General Eric Holder that was established in 2009. CMS participated in three national HEAT takedowns and took administrative action against 160 providers and suppliers associated with those law enforcement events in FY 2012.

CMS provides ongoing data analytic support to the Strike Force teams from investigation to prosecution, and often imposes administrative actions concurrent with takedowns. Under our enhanced Affordable Care Act authorities, CMS can impose payment suspensions on these defendants based on credible allegations of fraud, helping to ensure beneficiaries are protected and that claims are not paid during the suspension.

7.2.2 Field offices

CMS maintains three PI field offices in high vulnerability areas of the country (New York City, Los Angeles, and Miami) that provide an on-the-ground presence in known fraud "hot zones" and work closely with the joint HHS and DOJ Health Care Fraud Prevention & Enforcement Action Team known as "HEAT." The HEAT initiative includes the Medicare Fraud Strike Force that operates around the country to target and mitigate emerging fraud schemes. All three field offices have staff that are designated HEAT Strike Force liaisons that coordinate with law enforcement, facilitate data analyses, and expedite payment suspension requests.

Many special projects originate from the field offices and these projects produce significant savings. The field offices conduct data analysis to identify local vulnerabilities and coordinate special projects with Medicare contractors and state and local agencies on issues that have a national or regional impact. For example, the Miami Field Office has implemented a comprehensive multipronged approach to address all aspects of healthcare fraud in South Florida and has served as a testing ground for the efforts that may eventually be expanded to a national level.

7.2.3 Department of Justice prosecutions

CMS routinely provides statistical assistance to U.S. Attorney Offices around the country. This support contributed to the successful prosecution of 116 cases during FY 2012 in which defendants received a total of 188 months in prison, 24 months of probation and supervised release and settlements, 100 hours of community service, a five year corporate integrity agreement, one loss of medical license for five years and restitution totaling $114,071,442.

7.2.4 Training and access to data

CMS provides law enforcement with training on a variety of program tools and access to data. In addition to providing law enforcement with access and training on One PI, the portal that provides access to the IDR, CMS has tailored the Next Generation Desktop (NGD) for law enforcement purposes, providing investigators the ability to examine all claims associated with a specific provider tax ID or a Medicare beneficiary. CMS implemented enhancements to the NGD in September of 2012 as a result of specific requests from law enforcement for enhanced views of provider data.

7.3 Beneficiary education

In FY 2012, CMS worked with the Assistant Secretary for Public Affairs to expand the Fraud Prevention Campaign, which was launched in January 2010 to increase public awareness about Medicare's fight against fraud. Outreach included a national television campaign featuring a "cracking-down" on fraud advertisement, print, and digital advertising as well as targeted advertising in various languages ("in-language" advertising). Such advertising included print and radio advertising in Russian in New York, Armenian in Los Angeles and Spanish in Miami. The national television advertising delivered an estimated 140,580,420 views. The digital advertising delivered an additional 11.1 million views of the "cracking-down" spot.

In FY 2012, CMS also released a redesign of the statement that informs Medicare beneficiaries about their claims for Medicare services and benefits. The redesigned statement, known as the Medicare Summary Notice (MSN), became available online in March 2012, and,

starting in 2013, will be mailed out quarterly to beneficiaries. This MSN redesign is part of a new initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips," which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. CMS will take additional actions this year to make information about benefits, providers, and claims more accessible and easier to understand for seniors and people with disabilities who have Medicare. This MSN redesign reflects more than 18 months of research and feedback from beneficiaries to provide enhanced customer service and respond to suggestions and input.

7.3.1 Hotlines

CMS also continued a successful initiative aimed at increasing fraud reporting in South Florida. As part of a two-year infusion therapy demonstration, CMS established a special fraud hotline in 2007 to protect Medicare beneficiaries in South Florida from fraudulent providers of infusion therapy. As a result of the hotline's success, in FY 2009 CMS expanded the scope of this infusion therapy fraud hotline to handle all Medicare fraud-related calls in South Florida; this hotline remained in effect in FY 2012. The fraud hotline number is included on monthly MSNs sent to beneficiaries in Miami-Dade, Broward and Palm Beach counties.

As of August 31, 2012, the hotline has received more than 86,535 calls leading to 954 new fraud investigations. In addition, the ZPIC has placed 191 providers on prepayment review saving $14 million, revoked or deactivated 157 provider numbers, requested $125.4 million in overpayments, referred 42 cases to law enforcement, and sent 133 Immediate Advisements to the OIG. Additionally, law enforcement has seized $3 million in provider bank accounts.

7.4 Healthcare Fraud Prevention Partnership

In FY 2012, HHS and DOJ launched a ground-breaking Healthcare Fraud Prevention Partnership (HFPP) which unites public and private organizations in the fight against health care fraud. The voluntary, collaborative partnership includes the federal government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups. The central mission of the HFPP is to collect and review data across public and private payors to uncover trends, patterns, and schemes which collectively provide new or augmented leads to detect and prevent fraud – and which could not be discovered by a single payor alone.

The HFPP is designed to share information and best practices to:

- Improve fraud detection
- Prevent payment of fraudulent health care billings
- Find and stop schemes that cut across public and private payers

The HFPP goals are to:

- Help those on the front lines of industry anti-fraud efforts share their insights with investigators, prosecutors, policymakers, and others
- Help law enforcement officials identify and prevent suspicious activities

- Protect patients' confidential information
- Use the full range of tools and authorities provided by the Affordable Care Act and other laws to combat and prosecute illegal actions

The following organizations are among the first to join this partnership:

- America's Health Insurance Plans
- Amerigroup Corporation
- Blue Cross and Blue Shield Association
- Blue Cross and Blue Shield of Louisiana
- Centers for Medicare & Medicaid Services
- Coalition Against Insurance Fraud
- Federal Bureau of Investigations
- Health and Human Services Office of Inspector General
- Humana Inc.
- Independence Blue Cross
- National Association of Insurance Commissioners
- National Association of Medicaid Fraud Control Units
- National Health Care Anti-Fraud Association
- National Insurance Crime Bureau
- New York Office of Medicaid Inspector General
- Travelers
- Tufts Health Plan
- UnitedHealth Group
- U.S. Department of Health and Human Services
- U.S. Department of Justice
- WellPoint, Inc.

Work continues to effectively structure the HFPP in a manner which allows protected and efficient data exchange considering the relevant rules and statutes governing such interactions.

7.5 Open Payments Program (ACA 6002) "Physician Payment Sunshine Act"

On December 14, 2011, CMS published the proposed rule for Section 6002 of the Affordable Care Act (commonly referred to as the Physician Payment Sunshine Act) entitled "Transparency Reports and Reporting of Physician Ownership or Investment Interests." This requires annual reporting by applicable manufacturers (defined as manufacturers of drugs, devices, biologicals, or medical supplies covered by Medicare, Medicaid, or CHIP) of payments or other transfers of value to a non-employee physician or a teaching hospital. This increased transparency is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers. Now termed the Open Payments program by CMS, the provision also requires reporting by applicable manufacturers and group purchasing organizations (defined as purchasing, arranging for, or negotiating the purchase of a drug, device, biological, or medical supply covered by Medicare, Medicaid, or CHIP) of any physician ownership or investment interests in such entities. CMS will post the information on a publically-available website.

These applicable manufacturers, group purchasing organizations, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication. This process of reporting and public posting will be an annual process. Further, the provision sets civil money penalties for noncompliance, and the establishment of procedures for reporting and for making the reported information publicly available on the internet.

Annual reports to Congress and reports to States are also required and must include aggregate information reported by each applicable manufacturer or group purchasing organization, and any enforcement actions or penalties imposed during the preceding year. Finally, the provision preempts any duplicative State or local laws or regulations.

Further information regarding this program can be located at http://go.cms.gov/openpayments

8 Conclusion

FY 2012 was another significant year for program integrity accomplishments at the Centers for Medicare & Medicaid Services. CMS leveraged its new authorities and resources from the Affordable Care Act and saw results from its new anti-fraud tools such as the Fraud Prevention System and enrollment revalidation project. CMS also took significant steps to significantly improve Medicaid program integrity by redesigning the National Medicaid Audit Program and enhancing its data strategy to support CMS's antifraud and operational activities. CMS has made unprecedented progress in engaging our law enforcement partners during major nationwide takedowns to stop the flow of dollars as soon as possible, and is working with private organizations, including insurers, to put pressure on criminals regardless of where they are hiding and what program they are trying to defraud.

The effectiveness of CMS's comprehensive strategy is demonstrated by the results of our activities in FY 2012. The ZPICs took actions that resulted in the identification and prevention of potentially $1.5 billion in improper payments for Medicare Parts A and B for FY 2012. The Medicare Fee-For-Service Recovery Audit Program recovered collected $2.3 billion in overpayments. Finally, the Medicaid integrity program provided direct support to state activities that have led to the recovery of $1.4 billion in FY 2012. CMS has also laid the ground work for additional savings with the implementation of innovative technology, and is continuing to refine an approach to measuring the impact of initiatives that achieve cost avoidance.

Looking Forward

Medicare, Medicaid, and CHIP fraud affects every American by draining critical resources from our health care system, and contributes to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable citizens, not just the federal government.

The Administration has made a firm commitment to rein in fraud, waste and abuse. Today, with our new authorities and resources provided by Congress we have more tools than ever before to move beyond pay and chase and to implement important strategic changes in pursuing fraud, waste, and abuse.

Appendix I: Table of Medicare Integrity Program Obligations

The following chart represents total obligations for the Medicare Integrity Program between 10/1/2010 through 9/30/2011. The funding streams include the Mandatory Medicare Integrity Program, MIP Affordable Care Act, Discretionary Medicare Integrity Program and Predictive Modeling (by way of the Small Business Jobs Act 2010).

I. New Legislative Authorities and Executive Orders		Total Dollars in thousands
A.	Implementation of Title VI of the Affordable Care Act	
	Section 6002 Reporting of Physician Ownership or Investment Interests	$1,873
	Section 6401 Provider Screening/Other Enrollment	$25,281
	Section 6402 Enhanced Medicare PI	$9,701
	Section 6411 Expansion of RAC for Parts C & D	$2,279
	Total – Implementation of Title VI of the Affordable Care Act	$39,134
B.	Implementation of the Predictive Analytics Required under Small Business Jobs Act of 2010	
	Predictive Modeling (1)	$39,266
	Total - Implementation of the Predictive Analytics Required under Small Business Jobs Act of 2010	$39,266
C.	Executive Orders	
	Reducing Improper Payments	$41,788
	Total – Executive Orders	$41,788
	Total – New Legislative Authorities and Executive Orders	$120,188
II. The Medicare Integrity Program		
A.	Prevent Excessive Payments	
	Zoned Program Integrity Contractors (ZPIC)	$2,091
	Benefits Integrity (ZPIC and PSC activity)	$125,429
	Medicare & Medicaid Data match (Medi-Medi)	$37,872
	Provider Cost Report Audit	$169,258

	Medicare Secondary Payer (MSP)	$165,747
	Medical Review/Utilization Review (MR/UR)	$140,339
	Total – Prevent Excessive Payments	$640,736
B.	Program Integrity Oversight Efforts	
	Fraud System Enhancements	$2,949
	One PI Data Analysis	$14,329
	Provider Enrollment and Chain Ownership System (PECOS)	$20,501
	Enhanced Provider Oversight	$2,262
	National Supplier Clearinghouse	$17,005
	Compromised Numbers Checklist	$2,345
	HEAT Support/Strike Force Teams	$60
	Health Care Fraud Prevention Partnership	$2,882
	Appeals Initiatives	$3,317
	Probable Fraud Measurement Study	$3,480
	Total – Program Integrity Oversight Efforts	$69,130
C.	Program Integrity Activities in Medicare Advantage and Medicare Part D	
	Medicare Drug Integrity Contractors (MEDICs)	$20,023
	Part C & D Contract/Plan Oversight	$25,275
	Monitoring, Performance Assessment, and Surveillance	$40,304
	Compliance/Enforcement	$20,676
	Program Audit	$39,366
	Total – Program Integrity Activities in Medicare Advantage and Medicare Part D	$145,644
D.	Program Integrity Special Initiatives	
	DME Initiatives	$6,016
	Fraud & Abuse Customer Service Initiative	$6,586
	Automated Provider Screening	$22,052
	1-800 Medicare Integration	$1,196
	Medicare Summary Notice	

	Improvements	$78
	Technology & Strategic Decision Support	$3,463
	Total – Program Integrity Special Initiatives	$39,391
E.	Error Rate Measurement and Reduction Activities	
	Comprehensive Error Rate Testing Program (CERT) -- Medicare FFS	$19,052
	Provider Education and Outreach	$37,132
	Medicare FFS Recovery Audit Program non-add (2)	*[$228,042]*
	Total – Error Rate Measurement and Reduction Activities	$56,184
F.	Program Support and Administration	
	Field Offices/Rapid Response/ and Oversight Staffing	$40,925
	Total – Program Support and Administration	$40,925
	Total – The Medicare Integrity Program	$992,010
Total CMS Medicare Integrity Program Obligations		$ 1,112,198

(1) This activity was funded by the Small Business Jobs Act of 2010.
(2) The cost of the Medicare FFS Recovery Audit program is paid from the program's collections. This cost includes all administrative costs and contingency fee payments. These payments are made and all other collections are returned to the appropriate Medicare Trust Fund. The $228.042 million is not included in the Error Rate Measurement and Reduction Activities obligations.

Appendix II: Table of Medicaid Integrity Program Obligations

I. Deficit Reduction Act (DRA) of 2005 Medicaid Integrity Program Activities		Total Dollars in thousands
A. Staffing & Program		

	Support/Administration		
	Subtotal - Staffing & Program Support/Administration		$16,250
B.	Program Support Contracts		
	Subtotal - Program Support Contracts		$1,062
C.	Medicaid Integrity Contracts		
	Audit Medicaid Integrity Contracts		$14,233
	Review of Provider Medicaid Integrity Contracts		$8,566
	Education Medicaid Integrity Contracts		$6,474
	Prior Year Obligations		$7,677
	Subtotal - Medicaid Integrity Contracts		$36,950
D.	Support & Assistance to states		
	Subtotal - Support & Assistance to states		$69
E.	Data Management, Information Technology Infrastructure		
	Subtotal - Data Management, Information Technology Infrastructure		$8,731
	Total - Deficit Reduction Act obligations		$63,062
II. HCFAC Discretionary Medicaid			
	MACBIS		$22,724
	National Correct Coding Initiative		$730
	State Readiness, Enrollment and Eligibility		$7,496
	Information Technology		$7,994
	Payment Error Rate Measurement (1)		$8,673
	Total - HCFAC Discretionary Medicaid obligations(2)		$47,617
Total DRA & HCFAC Discretionary Medicaid Obligations			$ 110,679

(1) The amount listed above represents funding from HCFAC Medicaid Discretionary only.

(2) Total obligations is the sum of $30.552M from FY 2011 carryover and $17.065M from the FY 2012 appropriation.

Appendix III: Related Reports and Publications

REPORT	LAST ISSUED	AVAILABILITY
Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2009-2013	July 2009	http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Program-Integrity/Downloads/cmip-2009-2013.pdf
The Health Care Fraud and Abuse Control Program Annual Report	FY 2012	https://oig.hhs.gov/reports-and-publications/hcfac/index.asp
Annual Summary Report of Comprehensive Program Integrity Reviews (includes Medicaid Integrity Program Best Practices)	June 2012	http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/2012pisummary.pdf
Comprehensive state program integrity review reports	FY 2012	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Program-Integrity-Review-Reports-List.html
The CMS Financial Report	FY 2012	http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2012_CMS_Financial_Report.pdf
FY 2012 President's Budget for HHS	FY 2012	http://www.hhs.gov/about/budget/index.html
The Comprehensive Error Rate Testing Annual Reports	FY 2012	https://www.cms.gov/CERT/CR/list.asp