

Annual Report to Congress
on the
Medicare and Medicaid Integrity Programs
For Fiscal Year 2011
October 1, 2010, through September 30, 2011

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Executive Summary

This report describes Medicare and Medicaid Program Integrity activities conducted by the Centers for Medicare & Medicaid Services (CMS) during Fiscal Year (FY) 2011. 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 funds for both the Medicare and Medicaid integrity programs. CMS has been required to report on the effectiveness of Medicaid integrity program funds since the passage of the Deficit Reduction Act of 2005. Section 6402(j) of the Affordable Care Act established a new requirement for CMS to report on the effectiveness of Medicare integrity program funds used for activities described in section 1893 of the Social Security Act.¹ This report fulfills both of those requirements.²

In FY 2011, over 48 million seniors and persons with disabilities, and 60 million low-income people and their families relied on Medicare, Medicaid, and CHIP to receive health care services in the United States. Medicare alone is served by 1.5 million providers and suppliers, and approximately 20,000 providers and suppliers apply each month to participate in the program. Every day, Medicare receives and processes 4.5 million claims. At the same time, the 56 separate state-run Medicaid programs process 4.4 million claims per day.

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. In April 2010, Secretary Sebelius created the Center for Program Integrity (CPI), dedicated to preventing and detecting fraud, waste, and abuse in Medicare, Medicaid, and CHIP. By bringing Medicare and Medicaid program integrity functions together under one management structure, CMS has improved the coordination of resources and activities to prevent and detect fraud, waste, and abuse in these programs.

Program integrity (PI) activities target the various causes of improper payments, ranging from incorrect coding, medically unnecessary services, and erroneous billing practices, to intentional deception by billing for services that were never provided and other types of fraud. Because PI activities are conducted across CMS, CPI coordinates other CMS components to implement a comprehensive PI strategy. In addition, CMS works closely with our law enforcement partners, including the Department of Health and Human Services' Office of Inspector General (OIG), the Department of Justice (DOJ), and State Medicaid Fraud Control Units, as well as private sector partners, to develop innovative strategies to reduce health care fraud and abuse across the country.

¹We note that not all 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' anti-fraud programs.

²CMS 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' program integrity activities.

In FY 2011, CMS supported a successful nationwide takedown by the Medicare Fraud Strike Force operations, 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, established in 2009. In FY 2011, HEAT expanded to Dallas and Chicago, bringing the total number of Strike Forces to nine locations. In September 2011, HEAT announced a takedown in eight cities, resulting in charges against 91 defendants for their alleged participation in Medicare fraud schemes involving more than \$290 million in false billing.

CMS provides ongoing data analytic support to our law enforcement partners from investigation to prosecution, and often imposes administrative actions in coordination with takedowns. Under our enhanced Affordable Care Act authorities, CMS can impose payment suspensions based on credible allegations of fraud, helping to ensure beneficiaries are protected and fraudulent claims are no longer paid.

Effective Use of Funds and Program Savings

CMS is using its funds effectively to prevent and detect the range of improper payments and fraud. Table 1 highlights some of CMS’s program integrity accomplishments in FY 2011. CMS’ PI contractors play a critical role in CMS’s anti-fraud efforts by investigating leads identified by CMS, Medicare beneficiaries, and other sources reporting potential fraud in the Medicare Fee-for-Service (FFS) program. In FY 2011, the Zone Program Integrity Contractors (ZPICs) identified \$618 million in potential overpayments for collection and referred cases totaling \$428 million in suspect provider billings to law enforcement for investigation. CMS also used prepayment edits and auto denial edits to stop improper payments totaling \$224 million, and imposed payment suspensions that have prevented over \$31 million from being paid to providers found to have Medicare overpayments. The Medicare FFS Recovery Audit Program identifies improper payments and recommends to CMS ways to reduce improper payments in the Medicare FFS program. In 2011, the program identified approximately \$939 million in improper payments; as a result, CMS collected \$797.4 million in overpayments and returned to providers \$141.9 million in underpayments.

The Medicaid Integrity Program provides direct support to state activities that have led to substantial recoveries. In FY 2009, based on the most recent data available, states reported recovering \$2.3 billion as a result of their PI efforts. CMS has also laid the ground work for additional savings with the implementation of innovative technology and is refining an approach to measuring the impact of initiatives that avoid improper costs to Medicaid. CMS implemented the final requirements for state Medicaid Recovery Audit Contractors, which states engage and control to identify improper payments made to their state Medicaid providers. These efforts have led to the return of the state and federal share of improper payments.

<p>Table 1: Highlights of Medicare and Medicaid Program Integrity Activities Conducted by CMS Fiscal Year 2011 Totals (October 1, 2010 - September 30, 2011)</p>
<p>Medicare</p>

Table 1: Highlights of Medicare and Medicaid Program Integrity Activities Conducted by CMS Fiscal Year 2011 Totals (October 1, 2010 - September 30, 2011)	
Zone Program Integrity Contractors (ZPIC)	
Potential Overpayments Identified	\$618 million
Cases of Suspect Billing Referred to Law Enforcement	\$428 million
Payments prevented through prepayment edits and auto denial edits identified by ZPICs only	\$224 million
Medicare Payment Suspensions that resulted in recoveries against suspect providers.	\$31 million
Revocations	2,791
Medicare Fee-For-Service Recovery Auditor Program	
Total Improper Payments Corrected	\$939.3 million
Overpayments collected	\$797.4 million
Underpayments Returned to Providers	\$141.9 million
Medicaid	
Medicaid Integrity Contractor estimated overpayments (FY 2011)	\$4.6 million
FY 2009 State PI Recoveries ³	\$2.3 billion ⁴

FY 2011 Implementation of Legislative Initiatives

On March 23, 2010, Congress enacted the Affordable Care Act.⁵ As part of the significant changes made to improve Medicare and Medicaid, the Affordable Care Act provided CMS with unprecedented new and substantially strengthened authorities to enhance the oversight of

³Most recent data available.

⁴Centers for Medicare & Medicaid Services' State Program Integrity Assessment Federal Fiscal Year 2009 Executive Summary. Available at: www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fy09spiaexecsum.pdf.

⁵The Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) amended, in part, the Patient Protection and Affordable Care Act and, collectively, they are referred to as the Affordable Care Act.

Medicare, Medicaid, and CHIP. The law's new requirements are helping shift the focus to fraud prevention, which has enabled CMS to move beyond the pay and chase approach to a more data-driven approach. These activities are complemented by new tools and resources provided by the Small Business Jobs Act of 2010 (SBJA), which required and provided support for CMS to apply predictive modeling technology on Medicare Fee-For-Service claims prior to payment.

The Medicare Integrity Program

The Health Insurance Portability and Accountability Act of 1996⁶ (HIPAA) was enacted on August 21, 1996, and established the Medicare Integrity Program in section 1893 of the Social Security Act (the Act). Section 6402(j) of the Affordable Care Act amended section 1893 of the Act by adding the requirement that the Secretary must submit a report to Congress that identifies the use of Medicare Integrity Program funds, including funds transferred from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Insurance Trust Fund under section 1841, and the effectiveness of the use of such funds no later than 180 days after the end of each fiscal year, beginning in 2011.

The Medicare Integrity Program was established to protect against Medicare fraud, waste, and abuse, including improper payments. The Affordable Care Act has made significant enhancements to CMS' program integrity activities by building on many of the agency's existing initiatives. Under the funding provided by the Medicare Integrity Program, CMS has undertaken a variety of activities that fall into the following categories:⁷

Preventing excessive payments – Oversight activities involving the Zone Program Integrity Contractors, Medicare Secondary Payer program, provider audit, medical review, and the Medicare and Medicaid data match program.

Program integrity oversight efforts – Oversight activities such as provider enrollment and screening; including maintenance and enhancement of the Provider Enrollment, Chain, and Ownership System (PECOS); the OnePI data analytic tool, and provider outreach and education.

Medicare Advantage and Part D Plan oversight – Oversight activities of plans including the Medicare Drug Integrity Contractors (MEDIC), marketing surveillance, error rate measurement, and audit activities. In January 2011, CMS awarded a Part D Recovery Audit contract in and solicited public comments on approaches to implementation of a Recovery Auditor Contractor (RAC) program for Part C plans.

Program Integrity initiatives – Oversight activities to address emerging needs and test innovative methods to address program vulnerabilities. These include the durable medical equipment (DME) "Stop Gap" activities, provider screening pilots, and additional support for the Administration on Aging's⁸ Senior Medicare Patrol.

⁶Public Law 104-191.

⁷The categories are used to define Medicare Integrity Program Obligations as reported in the CMS Annual Performance Budget. See Section II, Medicare Program Integrity, for more information.

⁸The Administration on Aging became part of the Administration for Community Living in April 2012.

Medicare Fee-For-Service Error Rate Measurement – Oversight activities 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 RACs.

The Medicaid Integrity Program⁹

The Deficit Reduction Act (DRA) of 2005¹⁰ was signed into law on February 8, 2006, creating section 1936 of the Act establishing the Medicaid Integrity Program. Section 1936 of the Act provided increased resources to the Secretary of HHS to devise an effective national strategy to combat Medicaid provider fraud, waste, and abuse.

The Medicaid Integrity Program performs two key activities that protect the Medicaid program: 1) oversee Medicaid provider activities by auditing claims, identifying overpayments, and educating providers and others on Medicaid program integrity issues through contractors, and 2) provide effective support and assistance to states in their efforts to combat Medicaid provider fraud, waste, and abuse.

CMS has made significant progress in developing a strong program to combat Medicaid provider fraud, waste, and abuse, while also identifying limitations in certain activities. CMS uses the funding for the Medicaid Integrity Program to perform activities in the following categories:

Audit – In FY 2011, the Audit Medicaid Integrity Contractors (MICs) and CMS efforts identified \$4.6 million in estimated overpayments, bringing the cumulative total to \$15.2 million since the beginning of the program. FY 2011 marked the third full year of the National Medicaid Audit Program, and CMS recognized the need to modify and enhance its audit activities. Consequently, CMS substantially expanded efforts to collaborate with states to identify vulnerabilities and providers to be audited.

State Support – In FY 2011, CMS completed 16 comprehensive state program integrity reviews, identifying problems that warranted improvement or correction in state operations, and assisted states in their efforts to remedy these issues to fulfill the statutory requirement to provide support and assistance to state Medicaid program integrity efforts,. CMS also highlighted commendable state practices and responded to numerous state requests for technical support. In addition, CMS hosted conference calls to discuss Medicaid program integrity issues and best practices and issued guidance on policy and regulatory issues, including several provisions of the Affordable Care Act. CMS' goal is for one state's best practice to become a model for all states' common practice. To support this goal, CMS provides the states with a compendium of program integrity practices and benchmarks which adds value to our collective effort to improve the overall integrity of the Medicaid program.

⁹In FY 2011, CMS obligated \$75,701,811 for the implementation of the Medicaid Integrity Program. This does not take into account adjustments made in prior years. Note that the Medicaid Integrity Program includes only funding authorized in the DRA, so this figure does not represent all obligations related to Medicaid program integrity.

¹⁰Public Law 109-171.

Data Analytics – In FY 2011, CMS identified substantial data and information technology challenges in the operations of the Medicaid Integrity Program. Through a series of internal evaluations, CMS found that the Medicaid Statistical Information System (MSIS), the main Medicaid data source available at the federal level, severely limited CMS’ ability to conduct data analytics and to support audit target selection. At the same time, significant efforts went into better identifying areas at risk for overpayments and enhancing the accuracy of provider audit target selection.

Education – From its 2008 inception through FY 2011, CMS trained 2,464 state employees through 58 courses at the Medicaid Integrity Institute (MII) at no cost to the states, demonstrating a long-standing commitment to the professional education of state program integrity staff. Courses have included: an orientation to Medicaid program integrity; programs to enhance investigative and analytical skills to maximize program integrity efforts; and a symposium to exchange ideas, create best practice models, and identify emerging fraud trends. States frequently report immediate value and benefit from the MII training. In addition to MII courses, CMS used its Medicaid integrity education contractor to conduct provider education and training on payment integrity, utilization, and quality of care issues in FY 2011.

Introduction

In FY 2011, CMS was organized into seven centers and eight offices that provide program management for designated areas. In April 2010, Secretary Sebelius announced the alignment of Medicare and Medicaid program integrity functions with the creation of the Center for Program Integrity (CPI) in CMS. This newly-established Center brought together the oversight of Medicare Program Integrity and Medicaid Program Integrity to coordinate resources and best practices for overall program improvement. Today, CPI is the lead component in the agency for the prevention and detection of fraud, waste, and abuse in Medicare, Medicaid, and CHIP. Program integrity (PI) activities target the range of causes of improper payments, from mistakes such as incorrect coding or erroneous billing practices, to the provision concerning medically unnecessary services or intentional deception by billing for services that were never provided. As part of CMS's comprehensive approach to program integrity, CPI coordinates with other components across CMS. For example, the Office of Financial Management (OFM), which oversees the Medicare Secondary Payer program, leads the work on the Improper Payment Rate measurement programs and administers the Medicare Fee-For-Service (FFS) Recovery Audit Program. Similarly, the Center for Medicaid and CHIP Services (CMCS) oversees financial management of the states' implementation of the Medicaid program.

SECTION I: NEW LEGISLATIVE AUTHORITIES AND EXECUTIVE ORDERS

In FY 2011, CMS implemented significant provisions of the Affordable Care Act that have provided critical new antifraud tools. The agency also implemented an innovative predictive analytic system, as required under the Small Business Jobs Act of 2010.

SECTION I: NEW LEGISLATIVE AUTHORITIES AND EXECUTIVE ORDERS

A. Implementation of Title VI of the Affordable Care Act¹¹

The program integrity provisions in Title VI of the Affordable Care Act provided an unprecedented opportunity to strengthen the integrity of Medicare, Medicaid, and CHIP.¹² The Affordable Care Act enabled CMS to develop a coordinated and strategic approach for many Medicare, Medicaid, and CHIP program integrity policies. CMS established risk-based provider and supplier enrollment screening requirements that are parallel across Medicare, Medicaid and CHIP, allowing states to rely on Medicare screening of providers who also participate in Medicaid, and CHIP. Under the Affordable Care Act, CMS has implemented the authority to suspend payments pending an investigation of a credible allegation of fraud, and the authority to impose temporary provider and supplier enrollment moratoria in certain instances, including

¹¹CMS has obligated \$28,698,369 for the implementation of the Affordable Care Act program integrity provisions for Medicare. CMS has obligated discretionary HCFAC funds for the implementation of the Affordable Care Act program integrity provisions for Medicaid.

¹²This section does not detail the implementation of all provisions in Section VI of the Affordable Care Act.

when the Secretary determines there is a significant potential for fraud, waste, or abuse. State Medicaid Agencies are now required to terminate a Medicaid provider if they have been terminated “for cause” from Medicare or any other Medicaid program or CHIP.

1. Provider Screening and Other Enrollment Requirements (Section 6401 of the Affordable Care Act)

Section 6401 of the Affordable Care Act created new requirements for the enhanced screening and oversight of providers and suppliers, which strengthened enrollment safeguards. To assist with the implementation of these new risk-based requirements, CMS awarded a contract for an automated screening system and is making major modifications and improvements to the Medicare provider enrollment system and database (PECOS). Further, in FY 2011, CMS procured a national site visit contractor to support increased on-site inspections.

CMS established levels of risk for categories of providers and suppliers in a final rule effective on March 25, 2011. These risk-based screening requirements will increase the identification of providers and suppliers that do not meet enrollment requirements and enable CMS to deny their enrollment applications or revoke their billing privileges if they are already enrolled. Categories of providers and suppliers designated as limited risk will 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.

Under our new rules, providers and suppliers in the moderate level of risk category must undergo an on-site visit before enrolling or upon revalidation. This new requirement expanded on-site inspections to many providers and suppliers that, prior to the Affordable Care Act, were not subject to such site visits in order to enroll in the Medicare program. CMS estimated an additional 50,000 inspections will be conducted by March 2015 to ensure Medicare providers and suppliers are operational and meet all regulatory enrollment requirements. CMS issued a request for proposals for a national site visit contractor in September 2011 and awarded the contract in December 2011 to increase the efficiency and standardization of the site visits. It consolidated the site visit workload for all Medicare Parts A/B Medicare Administrative Contractor (MAC) jurisdictions; DME site visits will continue to be performed by the National Supplier Clearinghouse (NSC).

Providers and suppliers designated in the high level of risk are subject to the limited and moderate screening procedures and will also undergo a fingerprint-based criminal background check once CMS procures an FBI-approved contractor. Individuals with a five percent or more direct or indirect ownership in newly enrolling home health and DME companies, and providers and suppliers that hit certain triggers (such as those providers and suppliers that are subject to a payment suspension or providers that have been terminated from a Medicaid program), will be required to submit fingerprints for completion of an FBI criminal background check. In order to access FBI systems and receive criminal history record information, CMS is required to procure a contract with one or more FBI-approved channelers to access FBI systems and receive criminal history record information on behalf of CMS.

To complement these new screening requirements, CMS awarded a contract for an automated provider screening (APS) system in September 2011. The APS is designed to validate enrollment information against a variety of public and private data sources prior to enrollment and monitor for changes in information on a continuous basis. The goal of APS is to replace the time- and resource-intensive manual review of multiple data sources. CMS anticipates that the new process will decrease the application processing time, enable CMS to continuously monitor the accuracy of its enrollment data, and assess applicants' risk to the program using standard analyses of provider and supplier data.

Section 6401 of the Affordable Care Act also requires the revalidation of all currently-enrolled providers and suppliers under the screening procedures that became effective on March 25, 2011. CMS began the revalidation project in September 2011 with providers and suppliers that posed an elevated risk to the Medicare program. The first phase of the revalidation project included approximately 100,000 providers and suppliers that had not updated their enrollment information since the implementation of PECOS. To streamline the ambitious revalidation project, CMS has taken a number of steps to engage the provider and supplier community. We are working closely with our partners in the provider and supplier community to improve users' experience with Medicare provider enrollment. The American Medical Association and other organizations have participated in periodic meetings that collect ongoing provider feedback from frequent users of our enrollment systems regarding potential systems improvements. As a result of these meetings and other proactive outreach to the provider community we have implemented significant changes to our enrollment systems, such as an online enrollment option, with widespread provider satisfaction. As an additional service, CMS began posting a list of all providers and suppliers that have been sent a revalidation notice on www.CMS.gov.

States are required to screen all Medicaid and CHIP providers according to the risk of fraud, waste, or abuse, consistent with the provider screening procedures established by the Secretary for Medicare under Affordable Care Act section 6401. To minimize the duplication of efforts between CMS and states, CMS stated that for dually-participating providers, a state Medicaid or CHIP agency may rely on the screening performed by Medicare or by another state in the federal regulations implementing this provision.

Section 6401 of the Affordable Care Act requires an application fee on institutional providers and suppliers to cover the costs of the new screening requirements and other program integrity efforts. This includes institutional providers and suppliers that are initially enrolling in Medicare, adding a practice location, or revalidating their enrollment information. The fee requirements do not apply to physicians, non-physician practitioners, physician group practices, and non-physician group practices. The fee amount and formula for updating the fee annually are specified in statute. For calendar year 2011, the application fee was \$505, and it was adjusted based on the Consumer Price Index for urban consumers (CPI-U) in calendar year 2012 to \$523, and will be adjusted yearly based on the percentage change in the CPI-U.

The final rule that took effect March 25, 2011, also implemented the authority to impose a temporary enrollment moratorium on new Medicare, Medicaid, and CHIP providers or suppliers. CMS may exercise this authority under certain circumstances, such as when the Secretary has determined that it would be needed to address the significant potential for fraud, waste, or abuse.

CMS is currently evaluating the circumstances under which use of the moratorium authority would be an appropriate and effective program integrity tool to combat fraudulent activity. CMS will publish a notice in the *Federal Register* announcing any temporary enrollment moratorium and the agency's rationale supporting its decision.

2. Enhanced Medicare and Medicaid Program Integrity Requirements (Section 6402 of the Affordable Care Act)¹³

Section 6402 of the Affordable Care Act also includes many key provisions to enhance Medicare and Medicaid program integrity such as expanded authority to impose payment suspensions. As part of the final rule on provider screening that became effective on March 25, 2011, CMS issued regulations regarding suspension of payments pending an investigation of a credible allegation of fraud. CMS also issued an Informational Bulletin and a list of Frequently Asked Questions for state Medicaid agencies on March 25, 2011, since this enhanced suspension authority applies to Medicaid as well. CMS is working closely with the OIG in using this new authority. CMS payment suspensions led to over \$31 million in recoveries against suspect providers and suppliers for overpayments determined in FY 2011.

Section 6402 included the requirement that persons (defined as provider, supplier, Medicaid managed care organization, Medicare Advantage [MA] organization or a Medicare Part D Prescription Drug Plan sponsor) report and return identified overpayments by the later of 60 days after identification or when a cost report, if applicable, is due. Before the Affordable Care Act, providers and suppliers did not face an explicit deadline for returning taxpayers' money. Failure to report and return the overpayment within the applicable time frame could constitute a violation of the False Claims Act. Providers and suppliers also could be subject to civil monetary penalties or excluded from participating in federal health care programs for failure to report and return an overpayment. Section 6402 also included provisions regarding new data and systems requirements and an increase in the Health Care Fraud and Abuse Control (HCFAC) funding.

3. Face-to-Face encounter with patient required before physicians may certify certain services (Section 6407 of the Affordable Care Act)

CMS issued a final rule on November 17, 2010, implementing the requirement that, prior to certification of a patient for home health services, the certifying physician must document that he or she, or an allowed nonphysician practitioner, had a face-to-face encounter with the patient and that the clinical findings of that encounter support the eligibility requirements for the Medicare home health benefit. The requirements were effective for certifications for patients whose care started on or after January 1, 2011. In the November 4, 2011 final rule, CMS clarified that physicians or nonphysician practitioners in an acute or post-acute facility may inform the certifying physician of the face-to-face encounter with the patient, and the certifying physician must document that the clinical findings of that encounter support the eligibility requirements for the Medicare home health benefit.

¹³ Although section 6402 of the Affordable Care Act includes the Integrated Data Repository (IDR), this report is organized by budget accounts, and information about the IDR can be found on page 25.

4. Termination of provider participation under Medicaid if terminated under Medicare or other State Plan (Section 6501 of the Affordable Care Act)

Section 6501 of the Affordable Care Act requires states to terminate providers who have been terminated from Medicare, any other state Medicaid program, or CHIP. CMS implemented this provision as part of the final rule effective on March 25, 2011, clarifying that the requirement applies only where a provider has been terminated for cause. To support state efforts to share information on terminated providers, CMS developed and implemented a web-based application that provides a more efficient federal-state partnership to allow states to share information regarding providers that have been terminated for cause and to view information on Medicare providers and suppliers that have had their billing privileges revoked for cause. To assist states in the implementation of this provision, CMS conducted several Open Door Forums and webinars, and issued two guidance documents.

5. Expansion of RAC to Medicaid and Parts C & D¹⁴ (Section 6411 of the Affordable Care Act)

Section 6411(a) of the Affordable Care Act requires each state and territory to establish a Medicaid Recovery Auditor Contractor (RAC) program subject to such exceptions or requirements as the Secretary may require. A State Medicaid Director (SMD) letter was issued on October 1, 2010, that required states to establish Medicaid RAC programs, in accordance with the Affordable Care Act, by December 31, 2010. A notice of proposed rulemaking was issued on November 10, 2010, and a final rule was published on September 16, 2011, requiring states to implement Medicaid RAC programs by January 1, 2012. CMS has projected that the Medicaid RAC program will result in \$2.1 billion in savings over five years, of which \$910 million will be returned to states. In addition to providing regulatory and sub-regulatory guidance, CMS hosted a series of technical assistance webinars and teleconferences for states to aid them with their RAC program implementation. Topics included an overview of the Medicaid RAC Final rule, Medicare RAC best practices, Medicaid RAC fraud referrals, and state reporting on performance metrics.

To facilitate state reporting of RAC activity, CMS launched a state Medicaid RACs At-A-Glance webpage in February 2011. CMS plans to update the webpage in phases. The first phase provided basic information about each state's RAC State Plan Amendment (SPA) submission and the status of the SPA. The webpage also offers a link for the public to submit feedback. The second phase of the webpage will launch in FY 2012 and will allow states to report on the status of each state's RAC contract.

Section 6411 of the Affordable Care Act also requires expansion of RACs to Medicare Parts C and D. These RACs will be required to: 1) ensure that each MA plan and prescription drug plan has an anti-fraud plan in place and to review the effectiveness of each such plan, 2) examine claims for reinsurance payments under section 1860D-15(b) of the Act to determine whether

¹⁴On September 29, 2011, CMS issued its first report to Congress on the implementation of the RAC programs, which included the status of the Medicaid, Medicare Advantage and Part D RAC programs.

prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and 3) review estimates submitted by prescription drug plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

CMS awarded a Part D RAC contract in January 2011. Due to the nature of the Part C payment structure, CMS solicited public comments on approaches to implementation of a Part C RAC. CMS has reviewed comments received and is currently in the process of developing a strategy for the implementation of a Part C RAC.

B. Implementation of Predictive Analytics Required Under Small Business Jobs Act of 2010¹⁵

The Fraud Prevention System (FPS)

In addition to funds received under the Medicare Integrity Program, CMS received funding for a new predictive analytic tool under the Small Jobs Business Act of 2010¹⁶ (SBJA), which was enacted on September 21, 2010. Section 4241 of the SBJA appropriated \$100 million, available until expended, to carry out the anti-fraud provision requiring CMS to adopt predictive analytic technologies to identify and prevent fraud, waste, and abuse in the Medicare Fee-For-Service program. The law required CMS to issue a request for proposals by January 1, 2011, and to implement the technology in the ten states identified by the Secretary as having the highest risk of waste, fraud, or abuse by July 1, 2011. CMS launched the predictive analytic system, the Fraud Prevention System (FPS), on June 30, 2011, one day before the Congressional statutory implementation deadline. Since that time, the technology has been screening every Medicare Part A and B claim nationwide against complex algorithms developed to detect fraud in billing and claims activity. By going nationwide within the first year, CMS expedited the implementation schedule established by Congress, which did not require predictive analytics to be nationwide until January 1, 2014. The agency chose to implement in this manner because nationwide application of the system provided for enhanced effectiveness and operational efficiency. CMS is exploring the expansion of its predictive modeling technology to Medicaid and CHIP beginning April 2015, as required by the SBJA.

The FPS identifies suspicious behavior by using predictive technology similar to systems used in the credit card industry. 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 and its program integrity contractors use the FPS to identify, prevent, and stop potentially fraudulent claims. The FPS helps CMS target fraudulent providers, reduce the administrative and compliance burdens on legitimate ones, and prevent fraud so that funds are not diverted from providing beneficiaries with

¹⁵CMS has obligated \$27,242,007 to the implementation of the Small Business Jobs Act in FY 2011.

¹⁶P.L. 111-240.

access to quality health care.

To effectively counter the variety of ever-evolving healthcare fraud schemes, FPS models have varying levels of sophistication—from relatively simple models that identify violations of straightforward payment rules, such as billing for timed services that would be impossible to perform in the time period claimed, to complex models that use multiple characteristics of a provider’s history and current billing activity to estimate the likelihood that unusual claims activity may be an indication of fraud. To develop and test more comprehensive models more quickly, analysts use historical claims from the Integrated Data Repository (IDR) to analyze patterns and develop models for the FPS. CMS regularly updates the FPS software to add models that use new strategies for analyzing claims along with models that target new program vulnerabilities. The FPS is supporting hundreds of new and ongoing investigations and has led to hundreds of interviews with beneficiaries. Under the law, a full report to Congress of the system’s results is required following the first full implementation year, with a statement of certification by the OIG.

The SBJA requires CMS to complete an analysis of the cost-effectiveness and feasibility of expanding predictive analytics technology to Medicaid and CHIP. Based on this analysis, the law requires CMS to determine whether to expand predictive analytics to Medicaid and CHIP by April 1, 2015. In 2011, CMS began an effort to assess the current environment and future plans in the use of predictive analytics for PI purposes in Medicaid, including the following:

- 1) Establishing a baseline of state activities and efforts;
- 2) Assessing foundational requirements necessary to implement predictive analytics; and
- 3) Identifying opportunities to leverage existing CMS initiatives, and to collaborate with states to develop and test solutions to determine cost-effectiveness and feasibility of the expansion of predictive analytics technology in Medicaid and CHIP.

The assessment includes a focus on the operational differences between Medicare and Medicaid, and the flexibilities in how states administer their Medicaid programs. A key consideration is that applying predictive analytics technology on the prepayment side in Medicaid can only be done by the state or in partnership between the federal government and the state. We are planning a comprehensive approach to applying predictive analytics to the Medicaid program in partnership with states.

C. Executive Orders

On November 23, 2009, the President issued “*Executive Order 13520, Reducing Improper Payments and Eliminating Waste in Federal Programs.*”

Under the Executive Order, agencies with high-priority programs are required to establish annual or semi-annual measurements and plans for reducing improper payments, and meet certain other reporting requirements. Medicare FFS reports an annual error rate through the Comprehensive Error Rate Testing (CERT) program, and Medicaid and CHIP report an annual error rate through the Payment Error Rate Measurement (PERM) program.

CMS calculated and reported in its FY 2011 Agency Financial Report (AFR), the three-year weighted average national Medicaid error rate that includes the rates reported in fiscal years 2009, 2010, and 2011. The three-year rolling national error rate was 8.1 percent, totaling \$21.9 billion in improper payments, which represented a drop from FY 2010's 9.4 percent improper payment rate. The weighted national component error rates are as follows: Medicaid FFS, 2.7 percent; Medicaid managed care, 0.3 percent; and Medicaid eligibility, 6.1 percent. The most common cause of errors in FFS claims was 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.

The PERM final rule (75 FR 48816), which specifies the methodology by which payment error is measured in Medicaid and CHIP, was published on August 11, 2010, and became effective September 10, 2010. This final rule implements provisions from the *Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)* with regard to the PERM program. Section 601 of *CHIPRA* prohibits HHS from calculating or publishing any national or state-specific error rates for CHIP until six months after the new PERM final rule was effective. In addition, Section 205(c) of the *Medicare and Medicaid Extenders Act of 2010* exempted CMS from calculating or publishing a FY 2011 CHIP error rate.¹⁷ CMS did not report a CHIP national error rate in its FY 2009, 2010, or 2011 AFR, but will publish a CHIP error rate in its FY 2012 AFR. CMS has been working with states since 2010 to refine existing Medicaid measures and to define new measurements that accurately reflect performance and improvement in reducing improper payments. These include those areas historically known to be vulnerable to improper payments such as inpatient hospitals, home health agencies, long-term care providers, and prescription drugs. The goal is to develop protocols to evaluate state PERM corrective action plans and measure the progress of states and CMS to reduce improper payments.

SECTION II: THE MEDICARE INTEGRITY PROGRAM

Use of Medicare Funds

HIPAA established mandatory funding for the Medicare Integrity Program that ensured a stable funding source for Medicare program integrity activities from the Federal Hospital Insurance Trust Fund, not subject to annual appropriations. The amount specified in HIPAA increased for the first few years and then was 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.

¹⁷The reporting period for PERM improper payment error rates is the fiscal year prior to the year the rates are reported, so, for example, improper payment error rates reported in FY 2010 and 2011 represented FY 2009 and 2010 data, respectively.

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 also received discretionary funding, subject to annual appropriation.

This section provides a comprehensive discussion of Medicare program integrity efforts, including those funded by the Medicare Integrity Program, the Health Care Fraud and Abuse Control Program (HCFAC), and the Small Business Job Acts. The activities supported by funding sources other than the Medicare Integrity Program are included to provide a full and more complete description of Medicare program integrity efforts.

The Medicare Integrity Program activities are grouped under six broad funding categories. The attached chart displays FY 2011 obligations for each of these six categories and for several sub-activities within each category. In response to a Government Accountability Office audit of the Medicaid Integrity Program, CMS is undertaking an effort to refine the current methodology to calculate the return-on-investment (ROI) of the Medicare Integrity Program. CMS intends to report a ROI in future annual reports.

The chart below summarizes the FY 2011 budget obligations and a narrative description of this information is provided on the following pages.

A description of the activities pursuant to the Affordable Care Act and Small Business Jobs Act can be found in the section titled “New Legislative Authorities and Executive Orders”.

A. Prevent Excessive Payments¹⁸

1. Benefit Integrity (ZPIC and PSC activity)

Benefit Integrity activities prevent and detect Medicare fraud, waste, and abuse through collaborative efforts with the OIG, DOJ, and other CMS partners. To support these activities, CMS contracts with private sector investigators, known as Zone Program Integrity Contractors (ZPICs). CMS has been transitioning from the Program Safeguard Contractors (PSCs) to the new ZPIC contracts. In FY 2011, CMS awarded one ZPIC contract, bringing the total to six awarded ZPIC contracts. The ZPIC contract strategy improves the ability to analyze provider activity across all benefit categories; achieves an economy of scale through the consolidation of contractor management; streamlines data and other IT requirements; consolidates facility costs and reduces CMS costs in acquisition, management, and oversight.

Table 2 – ZPIC Contract Award Status

¹⁸CMS obligated \$643,593,600 for Medicare program integrity activities to prevent excessive payments in FY 2011.

CMS ZONES	CONTRACTOR	AWARD DATE
Zone 1 (CA, NV, HI)	Safeguard Services	September 2010
Zone 2 (WA, OR, ID, MT, ND, SD, WY, NE, UT, AZ, KS, IA, MO, AK)	AdvanceMed	September 2009
Zone 3 (MN, WI, MI, IL, IN, OH, KY)	Cahaba	April 2011
Zone 4 (CO, NM, OK, TX)	Health Integrity	September 2008
Zone 5 (AR, LA, MS, AL, GA, TN, NC, WV, VA)	AdvanceMed	February 2009
Zone 6 (PA, MD, DE, NJ, NY, CT, RI, MA, NH, VT, ME)	Under Protest	September 2011
Zone 7 (FL, PR, VI)	Safeguard Services	September 2008

Under the direction of CMS, ZPICs investigate leads generated by the FPS; perform regional data analysis to identify cases of suspected fraud, waste, and abuse; make recommendations to CMS for appropriate administrative actions to protect the Medicare Trust Funds; refer cases to law enforcement for potential prosecution; provide support for ongoing investigations; and identify improper payments for recovery by the Medicare Administrative Contractor (MAC).

Specific functions of the ZPICs include:

- Conducting investigations in accordance with the priorities established by CMS's FPS;
- Performing data analysis in coordination with CMS's FPS;
- Identifying the need for administrative actions such as payment suspensions and revocation of billing privileges; and
- Referring cases to law enforcement for consideration and initiation of civil or criminal prosecution.

In performing these functions, ZPICs may, as appropriate, pursue the following individual or combined actions:

- Refer providers for the revocation of billing privileges;
- Refer providers for the suspension of payments;
- Request medical records and documentation from providers;
- Conduct provider and beneficiary interviews;
- Conduct on-site visits; and,
- Refer cases to law enforcement.

In FY 2011, ZPICs took actions that resulted in the prevention and identification of \$1.3 billion in improper payments for Medicare Parts A and B. ZPIC-recommended prepayment and autodenials edits saved \$224 million by stopping payments before they were made, referred providers who have billed an estimated \$428 million to law enforcement, and referred \$618 million in overpayments for collection. CMS is committed to continuing to improve the automated controls that are in place. These actions assist in the identification of potentially suspect providers, and assist in the removal of such providers from the Medicare program, which

is the ultimate goal of the strategic approach to PI. In FY 2011, CMS revoked the billing privileges of 2,791 providers and suppliers that did not meet the requirements for Medicare enrollment.

2. Medicare & Medicaid Data Match (Medi-Medi)

The Medicare-Medicaid Data Match program enables CMS and participating state Medicaid agencies to collaboratively analyze billing trends across the Medicare and Medicaid programs using matched data to identify potential fraud, waste, and abuse patterns. The Medi-Medi program began as a pilot project with California in 2001. In FY 2011, CMS partnered with the 16 states that account for more than half of all Medicaid expenditures: New York, New Jersey, Pennsylvania, North Carolina, Georgia, Florida, California, Texas, Colorado, Oklahoma, Utah, Iowa, Ohio, Mississippi, Missouri, and Arkansas.

Matching Medicare and Medicaid data can reveal patterns or trends that may not be evident when analyzing claims data from each program independently. The Medi-Medi program promotes communication and collaboration among state Medicaid agencies, CMS, and law enforcement to focus resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse.

The Medi-Medi program has been and continues to be a useful tool in helping to fight fraud, waste, and abuse. While CMS has already implemented many refinements to the program, CMS is currently assessing ways the program can be improved and be more beneficial to states. For example, CMS provides all states, including states participating in the Medi-Medi program, with access to the Internet-based Fraud Investigation database (FID) upon request. To support use by the states, FID training and user guidance was provided at the 2011 annual National Association for Medicaid Program Integrity (NAMPI) conference.

3. Provider Cost Report Audits

Auditing is one of CMS's primary instruments to safeguard non-claim-related payments made to institutional providers such as hospitals, nursing homes, end-stage renal dialysis facilities and home health agencies paid on a prospective payment system (PPS). These providers are required to file an annual Medicare cost report, which is a summary of the provider's costs, charges, and statistics for the year. Although many providers have their claims paid through 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 approximately \$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. These audits are critical to ensure that cost reports are accurate to help safeguard the Medicare Trust funds.

The audit process includes the receipt and acceptance of 40,000 provider cost reports. When the cost report includes information to determine the amount of a provider's payments, the report undergoes a desk review. The desk review uses a risk assessment to determine if any issues require audit prior to the final settlement of the cost report. The issues identified as needing to be audited are reviewed by Medicare contractors, either at the contractor's location or at the provider's location. Source documentation is reviewed as part of the audit to determine the proper payment amount. Once the audit is complete the cost report is settled and the provider is issued a Notice of Program Reimbursement (NPR). If the NPR identifies an amount due the provider, a payment is issued to the provider with the NPR. If the NPR identifies an amount due the Medicare program, a demand letter is sent to the provider for repayment of the overpayment. The NPR contains appeal rights if the provider disagrees with the determination. 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.

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 the secondary payer (the insurance that pays after another "primary" insurance), Medicare does not pay or recovers Medicare funds paid for claims that are the responsibility of another party. The implementation of the mandatory insurer reporting requirements in section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 resulted in a significant increase in new MSP information reported to CMS from group health plans, liability insurance (such as homeowner's insurance, no-fault insurance, and automobile insurance), and workers' compensation insurers. The number of MSP records posted to CMS's systems significantly increased from 6.6 million in 2008 to 15.0 million in 2011.

To reduce the burden on industry while protecting the Medicare Trust Fund, CMS has implemented the following changes: a minimum threshold of \$25 for all recovery demands, a \$300 threshold for certain liability settlements, and a self-service information feature to its customer service line. Additional information regarding these changes to the MSP program is available at the Medicare Secondary Payer Recovery Contractor web site: www.msprc.info.

CMS also leverages technology to improve processes by making Medicare information directly accessible to beneficiaries, their representatives, and the industry. MyMedicare.gov was expanded 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. CMS also created mechanisms to securely exchange beneficiary data to ensure beneficiary claims are paid timely and to pursue recoveries when necessary. We have also developed mechanisms to automate many of the reporting and recovery processes.

CMS is currently working to further streamline the MSP process 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 website. CMS's long-term goal is to continue improving operational efficiencies for both CMS and its external stakeholders while increasing MSP savings to the Trust Fund.

5. Medical Review/Utilization Review (MR/UR)

Medical Review and Utilization Review are other tools CMS uses to ensure accurate payments are being made to Medicare providers. The MACs¹⁹ conduct MR and UR activities and target their efforts at error prevention on those services and items that pose the greatest financial risk to the Medicare program and that represent the best investment of resources. This requires establishing a priority setting process to assure MR/UR focuses on areas with the greatest potential for improper payment.

MR activities can be conducted either on a pre-payment or post-payment basis. Medical review activities serve to guard against inappropriate benefit payments by ensuring that the medical care provided meets all of the following conditions:

1. Coverage Conditions

- The service fits one of the benefit categories described in Title XVIII of the Social Security Act (Act) and is covered under the Medicare program;
- It is not excluded by the Act; and
- It is reasonable and necessary within the meaning of section 1862(a)(1)(A) of the Act for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member.

2. Coding Conditions

- The service code listed on the claim was actually the service delivered as supported by the medical record.

3. Other (e.g., payment) Conditions

- An example would be for a Power Mobility Device there must be a face-to-face examination and an order that includes seven elements.

In FY 2011, CMS allocated an additional \$25 million to the MACs for MR/UR to enhance their error rate reduction efforts. The MACs have initiated innovative projects including additional educational and prepayment review efforts including:

- One MAC initiated the “Mobile Medicare” project focusing on hospitals with high error rates for one day inpatient hospital stay claims. The MAC: 1) visited selected hospitals; 2) reviewed a sample of claims; 3) shared the findings; 4) provided suggestions to correct any identified errors; and 5) conducted a follow-up review three months later. When the MACs first conducted their review, they found an average error rate of 44 percent at the

¹⁹MACs are Medicare contractors that process fee-for-service claims develop and adopt local coverage decisions. MACs analyze claims to determine provider compliance with Medicare coverage, coding, and billing rules and take appropriate corrective action when providers are found to be non-compliant. Certain MACs process claims for Medicare Parts A and B, while separate MACs, DME MACs, process claims for durable medical equipment.

selected hospitals. After the intervention, the average error rate dropped to only seven percent at those hospitals.

- All four Durable Medical Equipment (DME) MACs are participating in a targeted educational effort to collaboratively lower the DME error rate. They are conducting in-person intervention visits with upper management from large national DME suppliers with high DME error rates (e.g. glucose monitors and test strips). The suppliers receiving this intervention are showing improvement and have started to lower their error rates. For example, one supplier reduced its error rate by 25 percent after the intervention visit.

CMS will 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, thus reducing the error rate, before the claims are paid.

6. Probable Fraud Measurement Pilot

The Probable Fraud Measurement Pilot aims to establish an estimate of the amount of probable fraud in the Medicare fee-for-service home health benefit. Health care fraud is a source of considerable concern in the Medicare program, but a statistically valid estimate of the rate of fraud in Medicare does not currently exist. In FY 2011, CMS, in collaboration with the Office of the Assistant Secretary for Planning and Evaluation (ASPE), worked with a technical expert panel to develop a sound methodology for a pilot to estimate the percentage of national Medicare fee-for-service payments in home health made based on claims that are probable fraud. CMS has designated revalidating home health agencies as having a “moderate categorical risk” of fraud, waste or abuse, while newly enrolling home health agencies are one of two service areas that CMS has designated as having a “high categorical risk” of fraud, waste, and abuse. This pilot focuses on probable fraud rather than “actual fraud” because determining fraud requires legal proof of intent. CMS will use this estimate as a baseline to measure the relative effectiveness of initiatives or programs intended to prevent fraud.

B. Program Integrity Oversight Efforts²⁰

1. Fraud Database Enhancements

CMS is committed to continuously improving processes and enhancing existing program integrity controls as needed. CMS is also committed to improving the data sources and systems available to support key antifraud activities. In FY 2011, CMS invested funds to improve the Compromised Number Checklist (CNC), which contains the unique identifiers for approximately 5,134 compromised providers and suppliers and approximately 284,152 beneficiaries whose Health Insurance Claim Number (HICN) is known or strongly suspected to have been compromised. This information is then used to evaluate suspect claims, open investigations, take administrative actions, or refer cases to law enforcement, as appropriate. CMS began testing a methodology to identify the reasons why beneficiary HICNs appear in the CNC. Once verified, the HICNs will be incorporated into the FPS to identify schemes or patterns indicative of fraud.

²⁰CMS obligated \$71,933,296 for Medicare program integrity oversight efforts in FY 2011.

2. IDR and One Program Integrity (One PI)

The IDR is a CMS enterprise data resource used for a variety of business purposes across the agency and is a key data source that supports the FPS in analyzing nationwide claims and building models. The IDR combines both historical and current data, allowing CMS and FPS analysts to track patterns of fraud over time and to see how those patterns evolve. The IDR is currently populated with seven years of historical Medicare Part A, Part B, and DMEPOS paid claims as well as Part D encounter data.

CMS worked throughout 2011 to enable the integration of all stages of shared system claims data in the IDR, which would provide access in the IDR to prepayment claims data. Efforts included detailed analysis of the various data to be integrated, extensive consultation with claims data consolidation experts and the development of a consolidated data model and harmonization rules. These foundational activities ensure that IDR users will be able to perform analytics across all phases of a claim and across all claim types. We are also working to include the expanded set of data elements from states' Medicaid Management Information Systems that the Affordable Care Act requires states to report. This more robust state data set will be used alongside Medicare claims data in the IDR to detect potential fraud, waste, and abuse across Medicare and Medicaid. CMS intends to incorporate Medicaid data for all 50 states into IDR by the end of FY 2014.

The IDR is accessed through One Program Integrity (One PI), a centralized, Internet-based portal that allows in-house CMS specialists, supporting contractors, and law enforcement to leverage sophisticated tools and methodologies to analyze program integrity data. One PI provides investigators with information critical to their work. CMS has been working closely with law enforcement to provide training and support in the use of One PI for their needs. The IDR and the One PI portal provide a comprehensive view of Medicare data including claims, beneficiary, and drug information, and Medicaid data will be integrated in the future. The IDR provides greater information sharing, broader and easier access to data, enhanced data integration, and increased security and privacy of data, while strengthening our analytical capabilities. The IDR makes fraud prevention and detection efforts more effective and efficient by eliminating duplicative efforts.

3. Provider Enrollment, Chain and Ownership System (PECOS)

During 2011, CMS made improving customer service a primary goal, and by doing so has begun to change the way providers and suppliers view and interact with CMS. Provider enrollment is the registration and verification gateway to the Medicare Program. PECOS is the database where official enrollment records of Medicare providers, suppliers, and associated groups are maintained. Information on provider enrollment is used to support claims payment, fraud prevention programs, and law enforcement through the sharing of data. PECOS is enhanced as needed to align with changes in statute, regulations, and agency needs, as well as user feedback. Education and outreach for PECOS is provided to the Medicare contractors and the provider and

supplier community through multiple sources including quarterly focus groups, medical associations, and open door forums.

CMS's customer-service-driven improvement strategy focuses on the customer's experience with Internet-based PECOS, eliminating paper from the customer's interaction with CMS by creating an all-digital process, and increasing communication with both external and internal customers. As a result of the changes made throughout 2011 CMS has seen an increase in the submission of web applications, especially for institutional providers, group practices, and DME suppliers.

4. Enhanced Provider and Supplier Oversight

The South Florida Enrollment Special Study is a joint project between the MAC and ZPIC to use and improve the existing processes for swift administrative actions. The ZPIC, upon referral by the MAC, performs on-site provider and supplier visits, with the primary goal of targeting sham providers and suppliers based on knowledge of common fraud schemes. Since the project began in July 2009 it has produced significant results including an increased number of revocations, deactivations, and prepay edit savings. As of September 30, 2011, the project has accounted for \$46.2 million in savings, with \$24.3 million in the past year. The project has also provided valuable information which CMS has used to identify and implement programmatic changes that have proven successful to deter and prevent Medicare fraud.

5. The National Supplier Clearinghouse (NSC)

CMS contracts with the NSC for the receipt, review, and processing of applications from organizations and individuals seeking to become suppliers of durable medical equipment, prosthetics, orthotics, and suppliers (DMEPOS) in the Medicare program. This process includes conducting on-site visits and implementing safeguards to ensure that only legitimate suppliers enter or remain in Medicare. One of the recent monitoring safeguards implemented by the NSC in 2011 was the random audit of pharmacies that were exempted from accreditation requirements based upon Medicare billing levels. The NSC conducted a review of 363 pharmacies that resulted in the revocation action of 31 pharmacies for noncompliance. To provide even greater oversight of the DMEPOS supplier community, the March 25, 2011, final rule has doubled the site visits that the NSC is expected to perform as result of the enhanced screening procedures.

C. Program Integrity Activities in Medicare Advantage and Medicare Part D²¹

1. Medicare Drug Integrity Contractor (MEDIC)

CMS contracts with the MEDIC to prevent and detect MA and Medicare Part D fraud, waste, and abuse. The MEDIC supports PI functions such as MA and Medicare Part D complaint intake and response, data analysis, outreach and education, and technical assistance.

²¹CMS obligated \$143,367, 569 for Medicare program integrity activities related to Medicare Advantage and Part D in FY 2011.

In FY 2011, CMS established a program for outreach and education of MA (Part C) and Medicare Prescription Drug (Part D) plan sponsors as part of the MEDIC contract. Under this task, the MEDIC is responsible for coordinating all Part C and Part D program integrity outreach activities for all stakeholders, including plan sponsors and law enforcement. The MEDIC also supports both compliance and fraud audits. Additionally, CMS funds the Program Integrity Technical Assistance contractor to support Part C and Part D PI strategy, ROI methodology, performance measure database maintenance, development of program risk assessment processes, and other technical assistance as requested.

CMS also contracted with the Compliance and Enforcement MEDIC to conduct ad-hoc studies and analysis with a special focus on select geographic areas. In FY 2011, the national benefit integrity MEDIC received approximately 342 actionable complaints per month; processed 34 requests for information from law enforcement per month; and referred an average of 36 cases per month. The national benefit integrity MEDIC supported OIG and DOJ with data analysis and investigative case development that assisted in achieving four guilty pleas, seven arrests and eight indictments. 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.

2. Medicare Advantage & Part D Contract/Plan Oversight

In addition to the work of the MEDIC, CMS enhanced other MA and Part D oversight functions in FY 2011 to address new complexities facing law enforcement; contract and plan oversight functions; monitor plan performance assessment and surveillance; secret shopper activities; audit programs; and conduct routine compliance and enforcement tracking. In FY 2011, CMS conducted 11 program audits of sponsoring organizations and tested for compliance with program requirements relating to Part D formulary and benefit administration, Part D coverage determinations, appeals and grievances, independent agent and broker oversight, and compliance program effectiveness. These audits covered programs that accounted for 25 percent of all MA and Prescription Drug Plan contracts and 42 percent of all beneficiaries enrolled as of May 2011. Additionally, in FY 2011, CMS issued more than 1,300 compliance actions to MA and Part D sponsors covering a wide range of topics such as benefit administration, bid submission, call letter requirements, claims processing, formulary administration, low income subsidy administration, and payment concerns.

CMS also strengthened PI in MA and Part D through marketing surveillance activities and compliance actions based on surveillance activities:

- **Marketing Surveillance Activities:** In FY 2011, CMS conducted many marketing surveillance activities, such as secret shopping and examining newspaper ads for unreported marketing events and content. These activities improved plan sponsor oversight of marketing activities and lessened incidents of agent and broker marketplace misconduct.

For the 2011 Annual Enrollment Period (AEP), CMS conducted a record 1,938 secret shopping events, an increase of 125.9 percent from the 2010 AEP. 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 our marketing rules for Parts C and D. CMS believes that its significant outreach efforts helped decrease deficiencies for formal marketing events. The number of “absolute statements” (such as “we are the best” or “we are number one”) made about MA and Part D decreased from 54 instances during the 2010 AEP season to 32 instances during the 2011 AEP season. In addition, the number of events that were reported to CMS that did not take place decreased from 115 during the 2010 AEP season to 53 during the 2011 AEP season. AEP data for 2011 demonstrated that the communication efforts were effective and the message was well received by plan sponsors and other external stakeholders.

Targeted Observations

During the 2011 AEP, the Targeted Observation (TO) initiative captured observations of alleged marketing misrepresentation by agents or brokers in settings outside of formal sales presentations. CMS created this surveillance activity following concerns about plan sponsors approaching beneficiaries outside of retail stores, misrepresenting products at informal informational tables, and other conduct that would not be captured through CMS’s previous surveillance strategy. TOs were conducted based on information received from internal and external partners. CMS performed 31 TOs on 11 plan sponsors, and performed four TOs not attributed to any particular plan sponsor. The TOs were prompted by alleged agent misbehavior at various settings, including kiosks in megastores and door-to-door solicitations. Other TOs investigated unsolicited phone calls and the use of lead generator websites that appeared to be endorsed by CMS.

Plan sponsors were able to review the results and take action as appropriate, ranging from training to agent termination. Without specific direction from CMS, plan sponsors may use the information found through the TO process to make a determination to take action against a particular agent. Specifically, two plan sponsors each voluntarily terminated an agent for engaging in egregious marketing activities. One agent was using “scare tactics” by stating that beneficiaries could only receive their prescription drugs through the specific retail store’s pharmacy. The agent utilized superlatives in describing the plan sponsor’s products, stated that Medicare was going away, and told the beneficiaries that they needed to sign up for his plan or they would not have any drug coverage next year. CMS believes that expanding the use of TOs will provide additional opportunities to monitor agents and brokers in settings outside of formal sales presentations to determine if violations occur during non-formal public encounters.

Unreported Marketing Events

The unreported marketing events initiative was an effort to determine if plan sponsors were appropriately reporting and representing their sales events activity to CMS. During the 2011 AEP, the CMS contractor reviewed daily and weekly print publications in U.S. domestic markets nationwide, including advertisements in publications in English, Spanish, Korean, Armenian, and Mandarin Chinese. The contractor then determined if

event information identified in the “clipped” advertisements was properly reported to CMS in a timely manner.

Under CMS’s direction, a surveillance contractor reviewed advertisements that accounted for 5,256 unique events from October to December 2010. The advertisements reviewed encompassed a total of 75 plan sponsors, of which 57 submitted 100 percent of the clipped marketing events to HPMS in an accurate and timely manner. The remaining 18 plan sponsors had one or more deficiencies, with a total of 232 deficiencies identified.

- **Compliance Actions Based on Surveillance Activities:** In order of severity, potential compliance actions consist of Technical Assistance Letters (informal compliance actions), Notices of Non-Compliance, Warning Letters with a Request for Business Plan, and Ad-hoc Corrective Action Plans (CAPs). Listed below are the compliance actions taken during the 2011 AEP for each primary surveillance activity.
- *2011 AEP Surveillance-Related Compliance Actions*

Compliance Action	Secret Shopping Events	Unreported Marketing Events
Technical Assistance Letter*	102	17
Notice of Non-compliance	18	1
Warning Letter with Business Plan	4	0
Ad-hoc CAP	0	0
Total Letters Issued	124	18

**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.*

For non-marketing related issues uncovered during a TO, CMS referred these issues to appropriate entities, including state Departments of Insurance and CMS Account Managers. In addition, CMS referred issues to the MEDIC responsible for investigating potential fraud, waste, and abuse in the MA and Part D programs.

3. Program Audit

CMS conducts program audits to review and assess previously supplied documentation to ensure compliance with program requirements. Additional funding has been provided to this area in order to reduce fraud, waste, and abuse. Ensuring accuracy of payments for the appropriate amounts for the appropriate services is critical in order to reduce improper payments. This category includes funding for Performance Measurement and Technical Assistance for MA and

Special Need Plans, MA and D Audits (one-third), Risk Adjustment Data Validation, and Retiree Drug System (RDS) Compliance, Audit, and Payment Error Reduction Activities.

- *Performance Measurement and Technical Assistance for MA and SNPs* - This project funds a variety of oversight and surveillance activities and analysis of MA contracting organizations. Activities include the enhancement of the review of MA plan benefit packages to ensure the offerings represent high value health care and do not discriminate against sick or high-cost beneficiaries, validating accrediting organization oversight of MA plan performance, and developing a quality improvement strategy that focuses on clinical as well as operational outcomes and the development of prescriptive policies that assist the industry with implementing internal quality controls. In addition, quality of care and process improvement deficiencies has surfaced in the Program of All-Inclusive Care for the Elderly (PACE) plans. PACE plans are required to be audited frequently, which is causing a significant expansion in Regional Office and Central Office resources to assure appropriate quality controls in PACE. Another activity is the analysis of Employer Group plan offerings to assure that beneficiaries are receiving benefits equal to or greater than individual market beneficiaries and to assure that beneficiary health care services are in parity with what is available in the general MA market. Furthermore, providing expert statistical and consultative services to improve the rigor of the past performance analysis, assuring the final methodology does not advantage or penalize certain applicants and assisting CMS staff in assembling necessary performance data and briefing/supporting materials are also functions of this activity.
- *MA and Part D Audits* – Sections 1857 (d) (1) and 1860D-12 (b) (3) (C) of the Social Security Act require the Secretary to provide for the annual audit of financial records (including data relating to Medicare utilization, costs, and computation of the bids) of at least one-third of MA organizations and Part D sponsors. Auditors review costs associated with the MA and Prescription Drug programs, identify internal control deficiencies, and make recommendations for compliance with Medicare regulations and accurate reporting to CMS. Some of the specific areas of review include plans’ solvency; related party transactions; administrative costs; direct medical costs; and Part D costs and payments, including direct and indirect remuneration and true out-of-pocket costs. CMS audits over 250 MA organizations and Part D sponsors per year to meet the one-third audit requirement.
- *Risk Adjustment Data Validation* – In compliance with the Improper Payment Information Act (IPIA), as amended by the IPERA, CMS has enhanced its efforts to address improper payments. This activity is focused on ensuring the accuracy of annual MA risk adjusted payments. Diagnosis data submitted by plans is validated to check for incorrect reporting of diagnoses which can lead to overpayments and underpayments. This payment validation process involves conducting medical record reviews on approximately 15,000 records and estimating contract level payment errors with the intent of conducting payment recovery and then implementing an appeals process.
- *Retiree Drug Subsidy (RDS) Compliance, Audit, and Payment Error Reduction Activities* - The regulations require that RDS plans maintain and furnish to CMS, upon request, all

documentation of costs incurred and other relevant information used to calculate the amounts of subsidy payments CMS made. CMS audited enrollment files, claims, and other payment-related data to help ensure appropriate payment of RDS subsidy amounts.

D. Program Integrity Special Initiatives²²

1. DME Stop Gap Initiative

In FY 2009, CMS began its Medicare DME Stop Gap initiative in the seven states with highest volume DME billing, expenditures, and growth rates (FL, CA, TX, NY, MI, IL and NC). The Stop Gap Plan focused on high risk DME suppliers and ordering physicians as well as the beneficiaries receiving equipment supplied by or ordered by them and the items of equipment which appear vulnerable to “gaming.”

Under this project, CMS and its contractors identify and conduct site visits to the highest-paid and elevated-risk DME suppliers, ordering physicians, and interview beneficiaries. Based on the findings, CMS initiated administrative actions as appropriate. The second year of the project concluded on September 30, 2011, and the results to date include on-site interviews and reviews of 5,230 providers, suppliers, and beneficiaries; implementation of 15,409 claims processing edits to prevent improper payment (with associated \$34.9 million in denied claims); \$66.2 million in requested overpayments; 1,200 new investigations opened; and 469 suppliers revoked or deactivated. Based on the results of the DME Stop Gap project, CMS plans to incorporate this work into the statement of work for all ZPICs and the remaining PSCs.

2. Fraud & Abuse Customer Service Initiative

CMS implemented a successful initiative aimed at increasing fraud reporting in South Florida. CMS established a dedicated fraud hotline and a rapid response team to handle all Medicare fraud-related calls in South Florida. Trained, multilingual staff answer and triage telephone calls and provide follow-up to individuals with the written acknowledgment of the receipt of a complaint. A rapid response team investigates the highest priority leads within 48 hours of receipt of the call.

The Florida hotline has received tremendous public interest and has yielded a significant amount of credible information. To support this work, CMS and its partners conducted beneficiary outreach and education on the use of the Medicare Summary Notice to detect and report questionable and suspicious billings. As of September 30, 2011, the hotline has received more than 54,500 calls, leading to 835 new fraud investigations. These investigations led to prepayment review saving \$10.7 million and the identification of \$58.6 million in overpayments.

3. Provider Screening Pilots

In FY 2011, CMS initiated multiple pilots using advanced statistical methodologies and multiple data sources to develop models to identify providers and suppliers that pose an elevated risk of

²²CMS obligated \$33,630,898 for Medicare program special initiatives in FY 2011.

fraud to the Medicare program. The techniques include outlier analysis, behavioral analysis, neural networks, linkage analysis, predictive modeling, and other advanced analytic methods. Traditional data sources (e.g. claims and enrollment) will be linked with new data sources (e.g. complaints and compromised numbers) at a national level to provide more robust and precise scoring.

4. 1-800 Next Generation Desktop

CMS began implementation of an enhanced Next Generation Desktop on September 10, 2011. CMS collaborated with National Government Services (NGS), a MAC, to respond to requests from law enforcement for enhanced views of provider and supplier data, including the ability to match actual fraud complaints against the provider or supplier and display claims associated with a provider or supplier tax ID. This project will improve the access to data for both CMS and law enforcement, including access to a complete view of the beneficiary's Medicare records. CMS and NGS developed tailored training material for law enforcement partners and will provide training classes to law enforcement staff three times a year.

5. Senior Medicare Patrol (Administration on Aging)

Beneficiary involvement is a key component of CMS's anti-fraud efforts. Alert and vigilant beneficiaries, family members, and caretakers are some of our most valuable partners in stopping fraudulent activity. For example, in 2011, over 49,000 calls to 1-800-MEDICARE led to further investigation. CMS partners with the Administration on Aging²³ to operate the Senior Medicare Patrol (SMP) program which promotes increased awareness and understanding of health care programs in seniors. To support this work, \$9 million in grants were provided to SMP projects in 2011 for the second consecutive year. These funds support additional targeted strategies for collaboration, media outreach, and referrals for states identified with high-fraud areas.

To support the mission of the SMPs to encourage fraud reporting, CMS continued its work in FY 2011 to redesign the Medicare Summary Notices (MSN). CMS engaged beneficiaries in focus groups to make the beneficiary explanation of benefits statement easier to understand and detect billing errors and report suspected fraud. The new MSN also highlights the critical information that needs to be verified, and provides beneficiaries with information on how to report potential fraud. The new MSN is now available on www.MyMedicare.gov, and the revised MSN will be mailed to beneficiaries beginning in 2013.

6. Beneficiary Complaint Special Projects

In FY 2011, CMS began testing innovative methods for incorporating beneficiary complaint data and tools into the ZPIC fraud detection efforts. CMS is partnering with the Zone 5 ZPIC, AdvanceMed, to undertake an early complaints study, an enhanced proactive complaints investigation study, a study of 1-800-MEDICARE data and tools, and a Senior Medicare Patrol (SMP) collaboration study. AdvanceMed began its screening of 1-800-MEDICARE complaints on August 11, 2011. Since then, AdvanceMed has screened 3,264 complaints. These complaints

²³The Administration on Aging became part of the Administration for Community Living in April 2012.

resulted in 736 leads that either created new investigations, or supplemented existing investigations.

CMS will use the early complaints study to determine whether forwarding beneficiary complaints directly to the ZPIC will result in faster identification of potentially fraudulent providers and an increased cost savings. The 1-800-MEDICARE currently forwards complaints to MACs, which forward complaints of potential fraud to ZPICs. The “enhanced proactive complaints investigation” emphasizes, and aggressively investigates, reports involving compromised beneficiary Medicare numbers.

7. Regional Health Care Fraud Prevention Summits

Regional health care fraud prevention summits have been held across the country in six cities since 2010 to build on the momentum generated by the National Health Care Fraud Summit in January 2010. CMS and OIG collaborated with the Department of Justice (DOJ), and the FBI to convene Regional Health Care Fraud Summits in Miami and Los Angeles in FY 2010, and Brooklyn, Boston, Detroit, and Philadelphia in FY 2011. These summits have brought together federal and state officials, law enforcement experts, private insurers, beneficiaries, caregivers, and health care providers and suppliers to discuss innovative ways to eliminate fraud within the nation’s health care system. These summits have also featured educational panels that discussed best practices for providers, suppliers, beneficiaries, government agencies, and law enforcement in preventing health care fraud.

E. Error Rate Measurement and Reduction Activities

1. Comprehensive Error Rate Testing Program (CERT) – Medicare FFS²⁴

CMS developed the CERT 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 CERT 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.

²⁴CMS obligated \$59,519,840 for Medicare fee-for-service Error Rate Measurement in FY 2011.

The FY 2011 Medicare FFS improper payment rate was 8.6 percent. CMS reviews claims according to a significantly revised and improved methodology as implemented in 2009. The revisions to the claims review methodology were discussed with the OIG before implementation. The methodology was further refined in 2011 to reflect the impact that late documentation and the result of appeals activities have on the improper payment rate. The unadjusted rate (before factoring in appeals and receipt of additional documentation) for 2011 was 9.9 percent. The adjusted error rate more accurately reflects the estimated improper payment rate for the Medicare FFS program.

Additionally, in FY 2011, the Medicare FFS Recovery Audit program identified approximately \$939 million in total improper payments, including recovering \$797.4 million in overpayments and returned \$141.9 million in underpayments.²⁵ The Recovery Auditors focused their reviews on short hospital stays and claims for durable medical equipment.

Throughout FY 2011, CMS developed several demonstration projects to reduce improper payments in Medicare. In November, 2011, CMS announced plans for these demonstration projects (using separate demonstration funds) to strengthen Medicare by aiming to eliminate fraud, waste, and abuse. Reductions in improper payments will help ensure the sustainability of the Medicare Trust Funds and protect beneficiaries who depend upon the Medicare program. These demonstrations address errors associated with hospital outpatient services billed inappropriately as inpatient services, power mobility devices, and other high error areas in Medicare.

- **Part A to Part B Rebilling:** Allows participating hospitals to re-bill for 90 percent of the allowable Part B (outpatient) payment when a Part A inpatient short stay claim is denied as not reasonable and necessary due to the wrong setting (outpatient vs. inpatient). Currently, when outpatient services are billed as inpatient services, the claim is denied in full, and hospitals are allowed to re-bill for certain Part B ancillary services only. This demonstration was limited to a representative sample of 380 qualifying hospitals nationwide that volunteered to be part of the program. This demonstration is expected to lower the Medicare Fee-For-Service appeals 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 will no longer be considered in error. Participating hospitals are not permitted to charge beneficiaries for any additional co-pay or out-of-pocket costs.
- **RAC Prepayment Review:** Allows Medicare FFS Recovery Auditors to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The Recovery Auditors 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 will also help lower the error

²⁵The cost of 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.

rate by preventing improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur.

- **Prior Authorization of Power Mobility Devices (PMDs):** Implements Prior Authorization for PMDs 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 will implement prior authorization, a tool used by private-sector health care payers to prevent improper payments and deter fraud.

In addition to the demonstration projects, CMS has other ongoing Medicare Integrity Program-funded efforts to reduce improper payments. These efforts include:

- Increasing prepayment medical review at the MACs to prevent improper payments and helps inform the provider community about proper billing practices.
- Developing comparative billing reports (CBRs) to help Medicare contractors and providers analyze administrative claims data. CBRs compare a provider's billing pattern for various procedures or services to their peers on a state and national level. CMS also utilizes the Program for Evaluating Payment Patterns Electronic Report (PEPPER). The PEPPER also allows Medicare inpatient hospitals to analyze their billing patterns through a comparison to other providers in their state and in the nation.
- Increasing and refining educational contacts with providers found to be billing in error.
- Issuing Quarterly Provider Compliance newsletters to physicians, providers, and suppliers. These materials are designed to provide education on how to address common billing errors and other erroneous activities when dealing with the Medicare program.
- Commencing DME and A/B MAC task forces that consist of contractor medical review professionals that meet regularly to develop and implement strategies for provider education in error prone areas.
- Implementing the Electronic Submission of Medical Documentation (esMD) into the CERT review process will create greater program efficiencies, allow a quicker response time to documentation requests, and provide better communication between the provider, the CERT contractors, and CMS.
- Developing a Program Vulnerability Tracking System (PVTS) that will track vulnerabilities identified by internal and external sources. CMS will use the PVTS to inventory and prioritize vulnerabilities, and track corrective actions. Currently, CMS tracks improper payment vulnerabilities using different systems. The PVTS will consolidate and centralize the vulnerability tracking into one system.

2. Provider Education and Outreach

The primary goal of provider education and outreach is to reduce the Medicare error rate by giving Medicare providers the timely and accurate information they need to bill correctly. The Medicare fee-for-service claims processing contractors (MACs, fiscal intermediaries [FIs] and carriers) 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 CERT. Medicare contractors use a variety of strategies and communication channels to offer Medicare providers 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 undertook a significant provider education and outreach effort on the provider enrollment revalidation project, which began in September 2011. Given that the scope of the project is the revalidation of all 1.5 million Medicare providers and suppliers, CMS implemented an aggressive and proactive approach to revalidation information and outreach activities. CMS held individual conversations with the American Medical Association and Medical Group Management Association. CMS conducted face-to-face meetings and telephone conference calls with other medical and professional associations' representatives. In FY 2011, CMS held 43 calls and presentations specific to the revalidation effort. In addition to participating in several of CMS general Open Door Forums to discuss revalidations, CMS also conducted a Special Open Door Forum call on revalidation on October 27, 2011 that was attended by over 7,000 providers, suppliers, and other stakeholders.

3. Medicare Advantage and Part D Error Rate

In compliance with the IPIA, as amended by 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, which 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 2011 (based on payment year 2009) is 11.0 percent, or \$12.4 billion. This is a reduction from the FY 2010 payment error estimate of 14.1 percent. However, the MA program is non-compliant with IPIA as amended by IPERA because the improper payment (i.e., error rate) rate exceeds 10 percent. This reduction to 11.0 percent meets and exceeds the target error rate established for FY 2011 in the FY 2010 Agency Financial Report. The FY 2011 Medicare Advantage payment error estimate presents the combined impact on MA payments of two sources of error: MA payment system error and the Risk Adjustment Error.

The improvement in the error rate can be attributed to the Administration's emphasis on contract-level risk adjustment data validation (RADV) audits designed to recover overpayments to Part C plans. In February 2012, CMS announced that it is moving forward with a revised methodology for the RADV audits that will further reduce the payment error rate for the Medicare Advantage program and will recover an estimated \$370 million in overpayments for the first audit year.

CMS is reporting for the first time a payment error estimate for the Part D program. The Part D payment error estimate reported for FY 2011 (based on payment year 2009) is 3.2 percent, or

\$1.7 billion. The FY 2011 Part D error estimate presents the combined impact on Part D payments of five sources of error:

1. Part D payment system error;
2. payment error related to low income subsidy status;
3. payment error related to incorrect Medicaid status;
4. payment error related to prescription drug event data validation; and
5. payment error related to direct and indirect remuneration.

Most of the Part D payment error is driven by errors related to prescription drug event data validation (PEPV). The FY 2011 PEPV rate of 2.18 percent represents a decrease of approximately 10 percentage points from the FY 2010 PEPV rate of 12.7 percent. This decrease is due largely to the Administration's efforts to provide plans with additional guidance to improve their collection of prescription documentation from pharmacies.

F. Program Support and Administration²⁶

1. Staffing (Salaries and Indirect Costs)

In FY 2011, CMS had 126 full-time employees dedicated to Medicare program integrity activities, of which 78 are funded by mandatory Medicare integrity program funds. CMS has hired staff with the skill sets required to perform detailed analytic work, provide contractor oversight, and develop policy. These staff support the FPS and APS, and the collaborative approach of working with law enforcement and other agencies. The indirect costs include associated administrative costs.

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 contractors and 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.

²⁶CMS obligated \$23,602,074 for Medicare integrity program support and administration in FY 2011.

SECTION III – THE MEDICAID INTEGRITY PROGRAM

Use of Medicaid Funds

The Deficit Reduction Act (DRA) of 2005²⁷ (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. CMS works with partner agencies at the federal, state, and local levels to detect and deter those individuals and organizations that would abuse or defraud the Medicaid program. Prior to enactment of the DRA, the federal Medicaid PI effort consisted of fewer than six full-time equivalent (FTE) employees and limited funding; states performed the majority of program integrity oversight in the Medicaid program. Within CPI, Medicaid Integrity Group (MIG) is responsible for operating the Medicaid Integrity Program.

Under section 1936 of the Act, Congress appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. 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.²⁸ In FY 2011, the appropriation for the Medicaid Integrity program was \$76.275 million. In addition, CMS allotted \$16.8 million in carry-over funds from previous fiscal year appropriations, for a total of \$93.1 million available for spending in FY 2011. Of these funds, CMS obligated a total of \$75,701,811 in FY 2011, leaving \$17.4 million of carry-over funds for FY 2012.

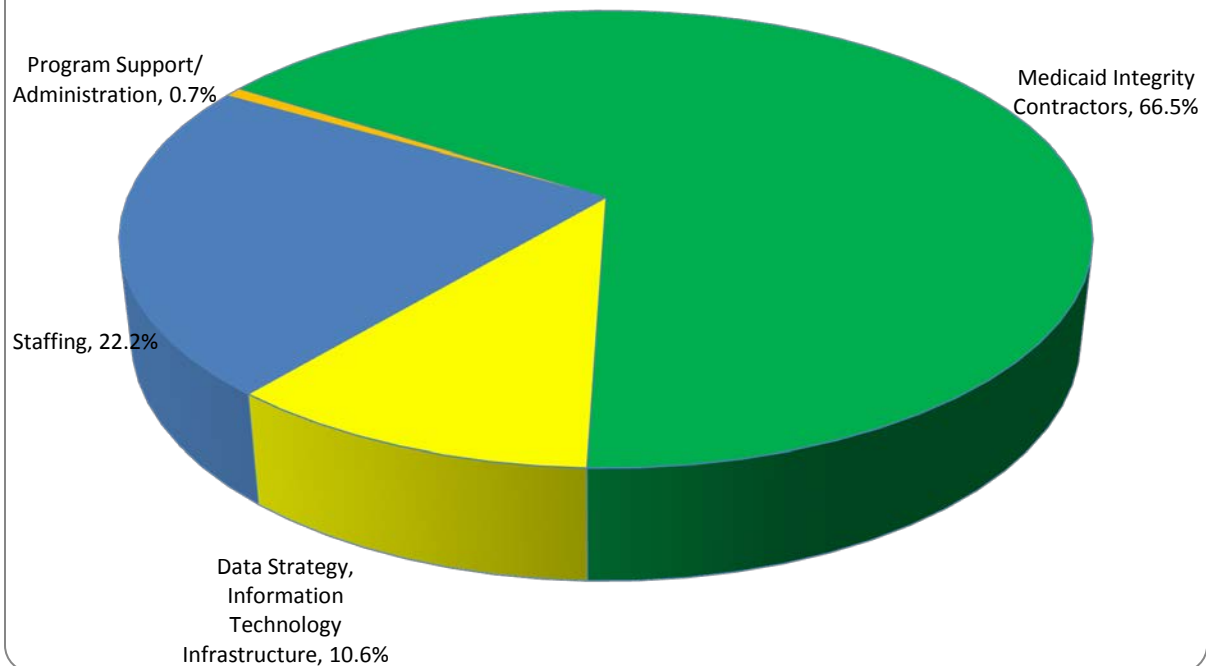
This section of the report focuses on the direct efforts of the Medicaid Integrity Program within CPI. It is important to note that there are other significant Medicaid program integrity activities and initiatives, notably within the Center for Medicaid and CHIP Services (CMCS), which intersect with those within CPI.

The chart below summarizes the use of funds for the Medicaid Integrity Program during FY 2011 and a narrative description of this information is provided on the pages that follow.

²⁷Public Law 109-171.

²⁸42 U.S.C. 1396u-6(e)(1)(D).

FY 2011 Medicaid Integrity Program Obligations



A. Medicaid Integrity Contractors (MICs)²⁹

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers, audit providers' claims, identify overpayments, and educate providers and others on Medicaid program integrity issues. There are three categories of MICs: Review of Provider (Review) MICs, Audit of Provider and Identification of Overpayment (Audit) MICs, and Education MICs. CMS completed the solicitation process in 2009 and awarded Indefinite Quantity/ Indefinite Delivery (IDIQ) contracts to vendors for each category of MIC. The selected contractors are qualified to compete for specific task orders under each IDIQ. The task orders for the Review and Audit MICs are based on a geographic region, whereas the Education MIC task orders are based on specific activities. Task orders are renewed annually. Tables 3 through 5 below depict the date of initial task order award and the most recent date the task order was renewed.

CMS provides contract management and oversight of the MICs by monitoring contractor performance, providing technical direction and ensuring the contractors comply with the terms

²⁹CMS obligated \$50,258,805 for Medicaid integrity contractors in FY 2011. An additional \$48,203 was obligated for a contractor to conduct webinars related to implementation of section 6411(a) of the Affordable Care Act (State Medicaid Recovery Audit Contractor Program). This resulted in a total of \$50,307,008 obligated for all Medicaid program integrity contractors during FY 2011 (see Appendix II).

and conditions of the contracts. Additionally, CMS conducts annual performance assessments and makes recommendations on all award fee contracts as a result of performance.

1. National Medicaid Audit Program

The design of the National Medicaid Audit Program includes both Review and Audit MICs. In FY 2011, CMS renewed the task orders for the Review and Audit MICs in all the jurisdictions (see Tables 3 and 4). A total of \$4.6 million in estimated overpayments was identified as a result of the National Medicaid Audit Program during FY 2011.

a. Review MICs

The Review MICs apply algorithms and data models to Medicaid claims data to identify anomalies. The results from these analyses identify Medicaid providers with suspicious billing practices. These providers are reviewed by CMS and those for whom an audit appears to be appropriate are assigned to the Audit MIC.

The four Review MICs are:

- ACS Healthcare Analytics, Inc.
- AdvanceMed Corporation
- IMS Government Solutions
- Thomson Reuters

The duties of the Review MICs are to:

- 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.

b. Audit MICs

The five Audit MICs are:

- Booz Allen Hamilton
- Cognosante, LLC (formerly Fox Systems, Inc.)
- Health Integrity, LLC
- IntegriGuard, LLC (formerly Health Management Systems [HMS])
- Island Peer Review Organization (IPRO)

The duties of the Audit MICs are to:

- Conduct post-payment audits of all types of Medicaid providers;
- Where appropriate, advise states of overpayments made to these providers; and
- Provide support to states for hearings and appeals of audits conducted under assigned task order(s).

Table 3 - Review MIC Task Order Status

MIC JURISDICTION	CONTRACTOR	INITIAL AWARD DATE	RENEWAL DATE
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CMS Regions III & IV (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN)	Thomson Reuters	April 2008	April 2011
CMS Regions V & VII (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE)	AdvanceMed	May 2009	May 2011
CMS Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, Puerto Rico, U.S. Virgin Islands)	Thomson Reuters	August 2009	August 2011
CMS Regions VI & VIII (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY)	AdvanceMed	September 2008	September 2011
CMS Regions IX & X (American Samoa, AZ, CA, Guam, HI, NV, Northern Mariana Islands, AK, ID, OR, WA)	AdvanceMed	September 2009	September 2011

Table 4 - Audit MIC Task Order Status

MIC JURISDICTION	CONTRACTOR	INITIAL AWARD DATE	TO RENEWAL DATE
CMS Regions III & IV (original) (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN)	Booz Allen Hamilton	April 2008	N/A
CMS Regions III & IV (re-competed) (DE, MD, PA, VA, DC, WV, AL, FL, GA, KY, MS, NC, SC, TN)	Health Integrity, LLC	September 2009	September 2011
CMS Regions V & VII (IL, IN, MI, MN, OH, WI, IA, KS, MO, NE)	Health Integrity, LLC	September 2009	September 2011
CMS Regions I & II (CT, ME, MA, NH, RI, VT, NJ, NY, Puerto Rico, U.S. Virgin Islands)	IPRO	July 2009	July 2011
CMS Regions VI & VIII (original) (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY)	IntegriGuard, LLC	September 2008	March 2011
CMS Regions VI & VIII (re-competed) (AR, LA, NM, OK, TX, CO, MT, ND, SD, UT, WY)	Health Integrity, LLC	September 2011	N/A
CMS Regions IX & X (American Samoa, AZ, CA, Guam, HI, NV, Northern Mariana Islands, AK, ID, OR, WA)	IntegriGuard, LLC	May 2009	May 2011

As described in the FY 2010 report to Congress, CMS launched an effort to enhance the Medicaid audit program by collaborating with the states on priority PI projects. This new approach was designed to address the limitations of audits based solely on MSIS data. In the collaborative audit approach, the states and CMS agree on various audit issues to review, including specific providers selected for audit. The collaborative approach allows CMS to work alongside states identifying areas that warrant further investigation and to develop the audit

targets. In addition, the corresponding data for the collaborative audits is, in many cases, provided or supplemented by the states, making the data more complete and thus increasing the accuracy of any audit findings.

In FY 2011, CMS incorporated these concepts throughout the National Medicaid Audit Program. Recognizing weaknesses in the results of audits based on analysis conducted using solely MSIS data, CMS discontinued assigning new audit targets in the traditional audit process based solely on MSIS data in February 2011, and focused on additional collaborative audit projects with states. Since March 2011, CMS has worked with contractors and states to develop innovative methods for improving audit target selection and enhancing collaboration and communication between CMS and the states. This gives the Audit MICs more timely and complete Medicaid payment data to identify potential fraud, abuse, and overpayments resulting from an audit. In addition, the collaborative audit projects enable states to augment their own resources through the Audit MICs and to address audit targets that they may not be able to initiate due to resource limitations. Ultimately, these projects allow for greater coordination of data, policies, and audit resources.

During FY 2011, CMS added 24 collaborative audit projects with the following states: Idaho, Maryland, Mississippi, New Jersey, Ohio, and Washington. These projects range from reviewing hospice services, credit balances, and mental health services. CMS also initiated collaborative discussions with the states of Alaska, California, Florida, Georgia, Hawaii, Louisiana, Maine, Missouri, Nebraska, New York, North Dakota, Oregon, Pennsylvania, and Utah.

c. Education MICs

Task orders for the Education MICs were also awarded to initiate the development of fraud, waste, and abuse training materials and an educational curriculum on program integrity and quality of care (See Table 5).

The two Education MICs are:

- Strategic Health Solutions, LLC
- Information Experts

The Education 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. The education effort is divided into two specific task orders with one task order focusing on a targeted provider education program and the other task order focusing on developing materials for a broader audience (providers, beneficiaries, managed care organizations, and others) based on the 14 priority areas that were identified as lacking educational information related to fraud, abuse, and payment. The materials are developed with the expertise of stakeholders from state Medicaid agencies, law enforcement agencies, provider and advocacy organizations, and other relevant groups.

Table 5 - Education MIC Task Order Status

TASK ORDER OVERVIEW	CONTRACTOR	INITIAL AWARD	TO RENEWAL DATE
Conduct gap analysis of existing education and training efforts; develop fraud, waste, and abuse educational materials; educate providers and beneficiaries about Medicaid program integrity and quality of care.	Strategic Health Solutions	August 2009	August 2011
Collaborates with states and other key stakeholders to analyze data and develop program integrity materials in areas with high fraud vulnerability.	Strategic Health Solutions	September 2009	September 2011

In FY 2011, 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. Once fully vetted and approved, these materials will be tested in an education pilot in collaboration with five states.

The Education MIC attended 19 stakeholder conferences in FY 2011 and reached 33,550 persons through staffing exhibit booths and distributing 10,143 educational products including 2,600 fraud reporting postcards. The Education MIC also presented at many of the conferences on PI topics such as 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. To support this goal, an article on Medicaid outreach activities was published in the Senior Medicare Patrol’s national newsletter, *The Sentinel*, in August 2011. The Education MIC also provided Medicaid PI materials to the Federal HHS-DOJ fraud summits in Detroit and Philadelphia in March and June 2011, respectively.

B. Support and Assistance to States

Section 1936 of the Social Security Act requires CMS to provide effective support and assistance to states to combat provider fraud and abuse. Through its expenditures on staffing, contract support, and data management systems, CMS provides technical expertise and training to states. One example of CMS oversight is the triennial comprehensive state program integrity reviews and related activities, described more fully below. As part of its critical support and assistance function, CMS offers PI training and best practices guidance to the states. CMS participation in joint federal-state field projects related to vulnerable programs, such as home health and DME, and other forms of technical assistance augments the efforts of state Medicaid PI nationally.

1. State Program Integrity Reviews

CMS conducts triennial comprehensive reviews of each state's PI activities. One third of the states are reviewed each year. The CMS review team reviews the state's responses to a comprehensive review guide and conducts interviews with staff from the state, contractors, and Medicaid Fraud Control Unit (MFCU). The team also conducts sampling of provider applications, program integrity cases and other primary data. Following the review, CMS conducts follow-up reviews to evaluate the success of the state's corrective actions.

In FY 2011, CMS conducted 16 comprehensive state program integrity reviews in the following states: Georgia, Idaho, Illinois, Minnesota, New Mexico, North Carolina, North Dakota, Oklahoma, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Utah, Vermont, Wisconsin, and Wyoming. For each of the states listed, this was the second 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 2011, CMS had reviewed 26 states twice (Arkansas, Connecticut, Delaware, Iowa, Michigan, Missouri, Nevada, Oregon, Texas, Virginia and those previously mentioned).

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

Most Common Findings:³⁰

- 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 the OIG;
- failure to conduct searches for federally excluded providers; and
- incomplete implementation of key Affordable Care Act PI provisions, e.g., the requirement to suspend payment when there is a credible allegation of fraud.

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;
- lack of written PI policies and procedures; and
- inadequate oversight of Medicaid managed care organizations.

CMS uses state program integrity reviews to:

- assess the effectiveness of the state's PI efforts;
- determine if the state's policies, procedures, and practices comply with federal regulations; and
- identify and disseminate best practices.

The review areas include:

- provider enrollment;
- provider disclosures;
- program integrity operations;
- managed care operations; and
- interaction between the state's Medicaid agency and its MFCU.

³⁰ 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.

Upon issuance of final program integrity review reports, CMS requires states to submit corrective action plans (CAPs) within 30 days addressing each finding and vulnerability identified during their review. 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 2011, CMS also issued its FY 2010 Program Integrity Review Annual Summary Report, which includes a compendium of data collected from comprehensive integrity reviews that have 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. CMS publishes this report annually and makes it available to the public on the CMS website:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html/>.

2. Medicaid Integrity Institute

Through an interagency agreement with the U.S. Department of Justice (DOJ), the Medicaid Integrity Institute (MII) is located within DOJ's National Advocacy Center, in Columbia, South Carolina. The first MII course was held in February 2008. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and collaboration among states in a structured learning environment. In 2011, the MII began to develop a credentialing process for state Medicaid program integrity employees to certify professional qualifications.

In FY 2011, the MII provided training to 860 state employees and officials from 50 states, the District of Columbia, and Puerto Rico. From its 2008 inception through FY 2011, CMS trained 2,464 state employees through 58 courses at the MII at no cost to the states. The training in FY 2011 included the following courses:

- Evaluation and Management Boot Camp: an intensive two-day course geared toward both coding and auditing professionals, to show how to evaluate documentation in accordance with national and local guidelines with a strong emphasis on interpreting rules accurately; and how to maximize the results of audits.
- Basic and Specialized Skills and Techniques in Medicaid Fraud Detection: a program to enhance the fundamental investigatory and analytical skills of state Medicaid employees to maximize the effectiveness of program integrity efforts.
- Program Integrity Fundamentals: an orientation to Medicaid PI and how it relates to state Medicaid programs.

- Data Expert Symposium: a program which brought together state Medicaid data experts to exchange ideas, define concepts, and create best practice models to identify fraud, waste, and abuse.
- Emerging Trends in Medicaid Program Integrity: a course to facilitate collaboration and discussion of emerging issues that currently have, or will have, a significant impact on program integrity functions in the future.
- CPT (Current Procedural Terminology) Coding Boot Camp: a comprehensive, five-day course designed to teach the fundamentals of medical coding, assist in preparation for national certification, and provide the framework for applying coding principles in a real-world environment.
- Emerging Trends in Behavioral Health: a course to identify problems, exchange ideas, define concepts, and create best practice models to address fraud, waste, and abuse in behavioral health.
- Program Integrity Directors Conference: a forum for all state program integrity directors to collaborate and discuss issues and emerging trends that may have significant impact on Medicaid program integrity functions.
- CPT Coding Inpatient/Diagnosis-Related Group (DRG) Boot Camp: a comprehensive five-day course on coding and DRG assignment for hospital inpatient facility services.
- Electronic Health Records Symposium: orientation of the Health Information Technology for Economic and Clinical Health Act (HITECH) and PI aspects of the Act.
- ICD-10 Basics Boot Camp: an intensive two-day course which introduces the fundamentals of ICD-10 coding, the differences between ICD-9 and ICD-10 codes, and major changes to official coding guidelines.
- The Reid Technique of Interviewing and Interrogation Program: a three-day course designed to teach the fundamentals of style, appearance, and approach for a successful investigation or audit interview.
- Faculty Development Seminar: explore teaching-learning goals, strategies, methods, styles, and peer review critiquing processes to improve the skills of faculty lecturers, facilitators, and panelists.
- Interactions between Medicaid Fraud Control Units (MFCUs) and Program Integrity Units Symposium: bring together state leaders from the state PI units and MFCUs to exchange ideas on building and maintaining effective relationships between the units. This symposium is the first of its kind to engage both PI and MFCU staff.
- Medicaid Provider Auditing Fundamentals Program: a course to discuss ways to identify overpayments, decrease the payment of inappropriate Medicaid claims, and discuss best

practice models to identify fraud, waste, and abuse through audits, cost avoidance, edits, and terminations.

Overall, the course evaluations have been positive, and as a result state staff from across the country have the opportunity to engage in productive dialogue about the challenges they face combating fraud, waste, and abuse issues unique to their state Medicaid programs. This interaction permits participants to share their success stories, to learn from other's successes, to give their Medicaid programs a wider range of perspectives on available policy options, and to help identify problem providers who attempt to migrate from one state Medicaid program to another. For example, the MII CPT coding classes provided staff in some states with their first opportunity to acquire formal certification in medical coding. State participants have been able to implement ideas gained from the training upon returning to their workplaces.

“I found the wealth of experience and background and time spent with the PIU directors to be particularly effective. I plan to develop new policies and training for MFCU staffers (auditors, investigators).”

–Student commenting on Interactions Between MFCUs and PI Units Symposium

“It was great to hear about how other states are preparing for this process of EHR or that some have already rolled out with this process. I am more informed about EHR – HITECH Act and plan to share everything both verbally and written with my co-workers.”

–Student commenting on Electronic Health Records Symposium

3. State Program Integrity Assessment (SPIA)

The 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 gauge their collective progress in improving the overall integrity of the Medicaid program.

In FY 2011, CMS completed the third national collection of SPIA data representing FY 2009 activity. The self-reported data from the states for FY 2009 showed more than 4,230 PI FTEs were employed by the states and a total of \$393.6 million was expended on PI activities. This represents a 2.5 percent increase in staff and a 13.6 percent increase in funding dedicated to Medicaid PI activities from FY 2008. States reported that they conducted 122,631 audits resulting in the recovery of more than \$1 billion. This was a 15.5 percent increase in audits performed, resulting in a 35.8 percent increase in recoveries from audits and a 10.5 percent increase in overpayments identified by audits.

Overall, in FY 2009, states reported \$2.3 billion in recoveries from all PI-related activities,³¹ an increase of 37 percent from FY 2008 levels. Individual state reports, the complete dataset, and a high-level executive summary of the FY 2007, FY 2008, and FY 2009 results are available on the CMS website at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/SPIA.html>.

At the end of FY 2011, CMS was planning for the fourth consecutive year of SPIA data collection. As these data become available, and as future collections are conducted, statistical trends and indicators should emerge to enable CMS to refine its approach to Medicaid program integrity activities and to provide states with additional information they can use to improve the effectiveness of their PI efforts.

4. Special Fraud Investigation Projects

CMS also provides states assistance with “boots on the ground” for targeted special investigative activities. In 2011, CMS staff assisted Florida Medicaid program integrity officials with two separate multi-day investigations targeting DME suppliers and home and community-based services.

The first of these occurred in March 2011 when CMS staff assisted Florida Medicaid program integrity officials in an investigation of DME suppliers in Miami-Dade County suspected of submitting excessive billings for oxygen concentrators. The multi-day investigation involved visits to 11 DME suppliers and 85 Medicaid beneficiaries. Of the 11 suppliers contacted, 10 were found to have issues resulting in \$24,000 in fines and \$30,255 in paid claims reversals. Additionally, based on preliminary findings, one supplier was referred for a full-scope audit and two were referred for quality oversight.

In September 2011, CMS staff assisted Florida Medicaid PI officials in an investigation of group homes serving the developmentally disabled as part of a Medicaid home and community based services waiver program. This multi-day investigation involved site visits to the top 52 group home billers in three South Florida counties (including Miami-Dade). Its purpose was to determine if residential rehabilitation services were being provided in accordance with Medicaid policy, specifically, if the services were being provided by qualified personnel and if the homes had other quality of care or environmental issues. As of September 30, 2011, the preliminary findings of the investigation resulted in 20 sanctions and \$103,000 in fines, three group homes being placed on prepayment review, 21 facilities being referred to state and federal oversight agencies, and four receiving provider education letters.

Florida has not yet calculated cost avoidance for the above FY 2011 investigations. However, in six field investigations during FY 2008-2010 involving home health agencies and DME suppliers in which CMS staff also assisted Florida program integrity officials, the state estimated that providers submitted \$38.2 million less in Medicaid billings after the projects, compared to similar time periods before the projects. We anticipate that the two FY 2011 investigations will prove to have had a similar sentinel effect on problem providers and facilities.

³¹Program integrity-related activities include desk audits, field audits, investigations, data mining, provider enrollment activities, provider education and communication, and managed care oversight.

5. Other Support and Assistance Activities

In FY 2011, CMS completed several hundred requests for technical assistance from 44 states and numerous other providers and stakeholders. The other stakeholders included 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: hosting regional state program integrity director conference calls to discuss program integrity issues and best practices, making presentations and answering questions on monthly Medicaid Fraud and Abuse Technical Advisory Group calls, issuing general advisories to states on use of the Drug Enforcement Administration's Controlled Substance Registration Files and "Strategies for Reducing Prescription Drug Diversion in Medicaid," and holding three Open Door Forums (stakeholder meetings) on the Medicaid RACs.

C. Data Management, Information Technology Infrastructure³²

CMS's fraud research and detection activities focus on the use of state Medicaid claims and statistical data to identify potential high-risk areas for overpayments. Using data analytics, CMS and the Review MICs collaborate on the development and refinement of algorithms and other data-mining techniques to help identify providers with billing patterns that may warrant audits by the Audit MICs. In 2011, CMS re-evaluated its process for conducting data analytics and audit target selection which had been in place since 2008. The results showed that the approach was not leading to a high rate of success for audits. In particular, the findings that had been anticipated based upon data analysis conducted by the Review MICs rarely produced positive results. The principal confounding factor was reliance on analysis of data from the Medicaid Statistical Information System (MSIS), the main Medicaid data source available at the federal level. MSIS data proved to be incomplete and not timely, producing inaccurate leads for audits.

Based on its internal evaluation, CMS identified areas for improvement and began implementing ways to overcome the MSIS data limitations. Our approaches to dealing with the MSIS limitations are discussed in detail in the following section. In addition, CMS sought to enhance business processes for analytics including revising the template for Review MICs' Algorithm Findings Reports to include more explicit directions to recommend next steps to recover potential overpayments and improve future algorithms, as well as to identify potential audit leads and increasing the collaboration among the Review MICs and Audit MICs with a focus on recommending audit leads.

1. Information Technology Infrastructure³³

³²CMS obligated \$8,019,228 for Medicaid program integrity data management and information technology infrastructure in FY 2011.

³³The Information Technology Infrastructure was previously referred to as the MIG Data Engine.

In April 2008, CMS began developing its information technology infrastructure comprised of a central data repository and analytical tools which were to be key components of the Medicaid integrity program data strategy. Before the development of the system, there was no analytical database of Medicaid claims available for program integrity purposes. The system became operational in January 2009 and the original data model for the system relied on MSIS data, the only national source of Medicaid claims data. MSIS is a subset of the eligibility and claims data from all 50 states and the District of Columbia that CMS receives on a quarterly basis.

As noted in the previous section, the limitations of the MSIS data resulted in CMS investigating ways to improve MSIS and to identify other sources of Medicaid data for the system. In FY 2011, CMS began storing specific Medicaid data files related to certain service types (e.g., pharmacy) received directly from several states and data from a CMS Medi-Medi contractor in order to improve and supplement the data used to conduct analysis and develop audits targets. In FY 2011, there were approximately 265 users of the system, including CMS and MIC analysts and auditors.

Within the IT Infrastructure, CMS applies defined methods of data analytics to identify potential fraud, waste, or abuse payments. Methods include using algorithms, a rule based technique, to compare claims data and state policy to identify potential overpayments. An additional method, modeling, uses statistical techniques to identify trends and patterns associated with aberrant billing and servicing behaviors related to fraudulent, wasteful, or abusive claims that may warrant further investigation. In FY 2011, CMS began applying these methodologies to conduct state, regional, and national analytic projects.

2. Data Analysis

In FY 2011, CMS met with the Review MICs to review lessons learned and focus on improving data analysis and algorithm development. As a result of the meetings, CMS identified a need to improve communication and collaboration between CMS, Review MICs, and Audit MICs. CMS implemented workgroups for each of the regions consisting of participants from CMS, the Review MICs, and the Audit MICs. The workgroups have three main areas of focus:

- 1) discuss and recommend potential areas for data analysis;
- 2) review and recommend next steps for the results of data analysis projects; and
- 3) discuss improvements to data analysis based on lessons learned from audit outcomes.

The workgroups provide an essential feedback loop for the National Medicaid Audit Program.

During FY 2011, CMS developed new algorithm concepts for the identification and analysis of potential overpayments. The factors used to consider a new algorithm concept include: past experience, referrals from authoritative sources (e.g., Review MICs, Audit MICs, OIG, or DOJ), state collaboration, fraud, waste, and abuse issues identified in Medicare, and news media sources. The analysis and development of algorithm concepts is based on the availability and quality of data, industry trends, and proof-of-concept data mining and analytical results. A new concept will be evaluated by CMS to determine whether it overlaps or complements existing analysis, the level of effort involved in developing the new concept, and the relevance to the Medicaid program on a state, regional, and national level.

Validated new concepts are prioritized based on criteria including: public risk, potential return-on-investment, complexity, legal defensibility, data availability, and analysis limitations. A technical specification describing the algorithm and its selection logic and analytical results is developed and summarized in an Algorithm Findings Report. The algorithm and its results are reviewed through an independent peer review process, which provides a detailed analysis of the data, coding, and test results.

At the end of FY 2011, CMS tasked the Review MICs with developing trend analysis projects that could be conducted on a state, regional, or national level to identify aberrant patterns in the MSIS data that warrant further investigation. The results of the trend analysis projects should assist CMS and states to identify collaborative audit projects. While we acknowledge the limitations associated with the MSIS data, it is currently the only national source of Medicaid data available to conduct cross state, region, or national analytics. We believe the data can be used to identify aberrant trends or patterns which can then be validated using MMIS or other state data.

3. Data Strategy

CMS is taking a multifaceted approach to addressing and overcoming Medicaid data limitations and to build the necessary infrastructure and tools to enhance our data analytics capabilities. Improving the quality of Medicaid data, including the accuracy, timeliness, and completeness of the data, is vital to program integrity efforts. In FY 2011, there were various projects underway to improve the quality of Medicaid data, with the Medicaid and CHIP Business Information and Solutions Council (MACBIS) leading the overall effort.

The MACBIS was established as an internal CMS governance body to provide leadership and guidance for a more robust and comprehensive information management strategy for Medicaid, CHIP, and state health programs. Led by CMCS, the Council's strategy includes:

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

The primary responsibilities of the MACBIS include: data planning (e.g. identifying inventory data needs and performing gap analysis), governing ongoing projects, outreach and education, and information product development. Committee and workgroup members meet bi-weekly and monthly.

The MACBIS is directing a series of projects that will lead to the development and deployment of enterprise wide improvements in data quality and availability for Medicaid program administration, program oversight, and PI. One such project is the TMSIS pilot that began in FY 2011. The TMSIS pilot is a proof of concept pilot with 11 representative states to prove the ability to efficiently extract data, in a consolidated format, which contains the information necessary to satisfy multiple federal information reporting requirements and support fraud and abuse activities. This pilot is anticipated to result in a reduction of the present burden on states

for data submissions through a single CMS data feed, an improvement in the quality of data through highly automated quality review processes, an improvement to the timeliness of data submitted, and provision of a common platform for both federal and state data analytics. The results and lessons learned from this pilot will be used as the basis for potential national implementation in 2014. As projects like this mature, CMS and state users will be able to take advantage of CMS's technical infrastructure and business intelligence tools for program integrity oversight, including analytics, algorithms, and queries.

In addition to the projects led by MACBIS, CMS is also working to improve access to better quality Medicaid data by leveraging the data available through the Medicare-Medicaid Data Match Project (Medi-Medi) and its participating states. Currently, 15 states participate in the Medi-Medi program. CMS is also working directly with certain states to get more complete data sets from the states' MMIS for specific Medicaid audit collaborative projects.

Lastly, an integral part in CMS's data strategy is also to include Medicaid data into the IDR. The IDR ensures a consistent, reliable, secure, enterprise-wide view of data supporting CMS and its partners. The IDR provides broader and easier access to data and the enhanced data integration that will be achieved when both Medicare and Medicaid data are incorporated into the IDR. This will strengthen and support CMS' analytical capabilities and enhance the detection of improper payments associated with fraud, waste, and abuse.

D. Communication, Collaboration, and Transparency

CMS is committed to coordinating its activities with internal and external partners in order to combat provider fraud, waste, and abuse. CMS is taking numerous steps to ensure that its efforts are developed in collaboration with other federal PI partners as well as with state PI units and federal and state law enforcement agencies.

1. Comprehensive Medicaid Integrity Plan

Section 1936 of the Act requires the Comprehensive Medicaid Integrity Plan (CMIP) be revised every five years;³⁴ however, CMS has reviewed and updated the five-year plan more frequently in the past.

CMS last issued its CMIP, covering FYs 2009–2013, in July 2009. CMS is working on a revised CMIP, and will have completed the five-year CMIP applicable to FYs 2014 through 2018 by the time the current CMIP expires. As required by statute, the plan was developed in consultation with various stakeholders, including the U.S. Attorney General, the Director of the FBI, the Comptroller General of the U.S., the HHS Inspector General, and state Medicaid PI officials. It includes information on CMS's planned activities for the five-year period in the areas of planning and program management, ensuring accountability, communication and collaboration, information management and research, Medicaid integrity contracting, and state PI operations.

2. Program Integrity Support & Assistance

³⁴Section 1936(d)(1) of the Act

In addition to ongoing methods of providing technical assistance and support, such as the SPIA surveys and state program integrity reviews, CMS supports states and other stakeholders in additional ways. These include the following initiatives:

- Development of protocols for evaluating the effectiveness of state PERM corrective action plans (CAPs), and the creation of a CPI team to review PERM CAPs in consultation with OFM's Division of Error Rate Measurement. In FY 2011, CMS staff evaluated 17 states' PERM CAPs.
- Evaluation of state fraud and abuse detection systems as a part of the certification or recertification process for state MMIS. States must go through a rigorous federal approval process in order to get their system certified for enhanced Federal Financial Participation. This is being done in consultation with the Division of State Systems in CMCS. CPI staff took part in five MMIS certification reviews in FY 2011.
- Sharing data and information obtained in the course of conducting comprehensive PI reviews with OIG. This process has successfully leveraged resources and reduced the burden of information requests on state Medicaid agencies.
- Establishment of a National Medicaid Fraud Alert System in FY 2010 to quickly and effectively disseminate information, as appropriate, to federal and state partners as well as stakeholders in PI. The first alert on a problem provider was issued early in FY 2011. Two additional alerts were subsequently issued, including a March 2011 advisory to states on use of the Drug Enforcement Administration's Controlled Substance Registration Files and an August 2011 alert on the problem of drug diversion in the Medicaid program.
- Provision of technical assistance to the Vaccine for Children's Program (VFC), operated by the Centers for Disease Control and Prevention. In FY 2011, CMS staff reviewed VFC policies and procedures for reporting cases of suspected fraud and abuse by participating providers and assisted the VFC in developing streamlined procedures for funneling fraud referrals to state Medicaid programs via CMS. Eight referrals were successfully conveyed and investigations launched using the new procedures in FY 2011.
- Modification of a secure website through the MII to allow states to communicate and exchange sensitive information confidentially in November 2011 by replacing the existing website with the Resource Information Sharing System (RISS) which is operated under the auspices of DOJ's Bureau of Justice Assistance.

E. Outreach to Program Integrity Partners and Stakeholders

Outreach to Medicaid program integrity partners was a significant activity in 2011 with CMS leadership conducting 14 presentations in person and via webinar at provider association and other stakeholder meetings across the country. Venues included:

- CMS Industry Day
- American Nurses Association & International Council of Nurses meeting
- National Association of State Medicaid Directors fall meeting
- Three meetings with national leadership of the Administration on Aging and Senior Medicare Patrol
- American Hospital Association Issues Forum
- Health Care Compliance Association compliance conference & National Compliance Institute workshop
- American Health Law Association conference
- CMS Region V Home Health and Hospice Association
- CMS Region V Hospital Association
- Connecticut Hospital Association
- Meeting of the U.S. Health Resources and Services Administration
- U.S. Virgin Islands Health Symposium
- National Association of Medicaid Directors spring meeting
- CMS Region II Semi-Annual Medicaid-Medicare Program Integrity Conference
- National Association of Medicaid Program Integrity Annual Meeting (multiple presentations)
- Annual Medicare-Medicaid Statistical Conference

In addition to the above in-person and webinar meetings, CMS conducted three open door forum calls and webinars for state Medicaid staff on the new Medicaid RAC program, one all-state call on the National Medicaid Audit Program, and presented at all-state webinar on “Teamwork in Program Integrity: Partnership with States.” CMS also arranged for a subject matter expert presentation at an MII webinar for states on “Auditing for the Medicaid Electronic Health Record Incentive Program.” The leadership also briefed the Senate Finance Committee on the Medicaid RAC program and produced and distributed an educational DVD on the RAC program for states.

CMS representatives served as faculty in seven MII courses in FY 2011, and CMS staff conducted the following routine conference calls throughout the fiscal year:

- Quarterly conference calls with PI Directors in each region.
- Monthly calls with the Medicaid Fraud and Abuse Technical Advisory Group (TAG).
- Monthly calls with the PI Directors of small states to discuss unique PI issues.

Information on the Medicaid Integrity Program is available at: www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Program-Integrity/Program-Integrity.html.

F. Staffing and Program Support and Administration³⁵

Staffing (Salaries and Indirect Costs)

³⁵ CMS obligated \$17,375,575 for Medicaid program integrity staffing and program support and administration in FY 2011, including \$514,018 in Program Support Contracts.

The 100 FTE employees authorized by the DRA are allocated between two operational components within CMS. At the end of FY 2011, CMS filled 81 of the 100 FTEs allocated for the Medicaid Integrity Program, 79 in the MIG and 2 in the Office of Acquisitions and Grants Management. The MIG recruits and engages staff to assure Medicaid program integrity.

The indirect cost associated with these FTEs consists of staff support, budget, accounting, IT, procurement, regulation development, and legal consultation (provided through HHS's Office of the General Counsel). The other indirect operating expenses include rent, utilities, guard services, furniture, human resources, and telecommunications.

Report Conclusion

FY 2011 marked a year of significant program integrity accomplishments for CMS. Using new authorities and resources from the Affordable Care Act, CMS implemented many new anti-fraud tools such as new provider screening rules, enhanced payment suspension authority, and other enrollment safeguards. CMS also took significant steps toward a more prevention-focused strategy to fight fraud in its programs. For example, CMS implemented the Fraud Prevention System (FPS) ahead of schedule in 2011, on June 30, 2011, screening all nationwide Part A, B, and DME claims to detect fraudulent providers based on predictive analytic algorithms. This system is designed to work in conjunction with other data tools such as the Automated Provider Screening (APS) system to help provide better data for administrative actions and referrals to law enforcement. The APS will screen provider applicants to ensure they meet our qualifications and help to identify those existing providers who need to be revoked or placed under closer scrutiny.

Medicare PI contractors took actions that resulted in the identification and prevention of \$1.3 billion in improper payments for Medicare Parts A and B for FY 2011.

CMS is also effectively using its funds to prevent the range of improper payments. The Medicare Fee-For-Service Recovery Audit Program recovered \$797.4 million in overpayments. CMS implemented the final requirements for a Medicaid RAC program that is projected to save \$2.1 billion over the next five years, of which \$910 million will be returned to the states.

CMS efforts contributed to the successful prosecution of 20 cases that resulted in Medicaid settlements and restitution totaling \$237,327,258. Finally, the Medicaid integrity program has provided direct support to state activities that have led to the recovery of \$2.3 billion in FY 2009, the most recent data available. CMS 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.

CMS is implementing key laws and innovative solutions that are helping move CMS beyond "pay and chase" to fraud prevention, and anticipates increasing results from many of the initiatives that were put in place in FY 2011.

Looking Forward

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

The Administration made a firm commitment to rein in fraud, waste, and abuse. Today, with our new authorities and resources provided by the Congress, we have more tools than ever before to implement important strategic changes to prevent, detect, and pursue fraud, waste, and abuse.

Appendix I: Table of Medicare Integrity Program Obligations

The following chart represents total obligations for the Medicare Integrity Program from October 1, 2010, through September 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).

Total Medicare Integrity Program Obligations		
October 1, 2010 through September 30th, 2011³⁶		
<i>Actual Dollars</i>		
I. New Legislative Authorities and Executive Orders		Total
A. Implementation of Title VI of the Affordable Care Act		
	Section 6401 Provider Screening/Other Enrollment	\$ 7,543,368
	Section 6402 Enhanced Medicare PI	\$ 17,198,726
	Section 6411 Expansion of RAC for Parts C & D	\$ 3,956,275
	Total - Section A	\$ 28,698,369
B. Implementation of the Predictive Analytics Required under Small Business Jobs Act of 2010		
	Predictive Modeling ³⁷	\$ 27,242,007
	Total - Section B	\$ 27,242,007
C. Executive Orders		
	Executive Order - 50% Error Rate Reduction	\$ 28,166,781
	Payment Error Rate Measurement (PERM) non-add ³⁸	\$ 13,471,013
	Total - Section C	\$ 28,166,781
	Total - Section I	\$ 84,107,157
II. The Medicare Integrity Program		
A. Prevent Excessive Payments		
	Zoned Program Integrity Contractors (ZPIC)	\$ 2,473,037
	Benefits Integrity (ZPIC and PSC activity)	\$ 131,353,784
	Medicare & Medicaid Data match (Medi-Medi)	\$

³⁶ This table is based on actual obligations for FY 2011 and includes carry over funds from FY 2010.

³⁷ This activity was funded by the Small Business Jobs Act of 2010.

³⁸ PERM is funded from the HCFAC Discretionary Medicaid Integrity Program. The \$13.47m is not included in the Executive Order: 50 percent Error Rate total for the Medicare Integrity Program Obligations.

		34,362,688
	Provider Cost Report Audit	\$ 169,088,525
	Medicare Secondary Payer (MSP)	\$ 169,530,084
	Medical Review/Utilization Review (MR/UR)	\$ 136,785,482
	Total - Section A	\$ 643,593,600
B. Program Integrity Oversight Efforts		
	Fraud System Enhancements	\$ 7,159,209
	One PI Data Analysis	\$ 16,662,873
	Provider Enrollment and Chain Ownership System (PECOS)	\$ 22,376,557
	Enhanced Provider Oversight	\$ 8,915,734
	National Supplier Clearinghouse	\$ 16,818,923
	Total - Section B	\$ 71,933,296
C. Program Integrity Activities in Medicare Advantage and Medicare Part D		
	Medicare Drug Integrity Contractors (MEDICs)	\$ 22,657,296
	Part C & D Contract/Plan Oversight	\$ 21,457,301
	Monitoring, Performance Assessment, and Surveillance	\$ 45,451,453
	Compliance/Enforcement	\$ 23,867,152
	Program Audit	\$ 29,934,367
	Total - Section C	\$ 143,367,569
D. Program Integrity Special Initiatives		
	DME Initiative	\$ 4,268,475
	Fraud & Abuse Customer Service Initiative	\$ 7,754,507
	Provider Screening Pilots	\$ 12,559,472
	1-800 Next Generation Desktop	\$ 48,444
	Senior Medicare Patrol (AoA)	\$ 9,000,000
	Total - Section D	\$ 33,630,898
E. Error Rate Measurement and Reduction Activities		
	Comprehensive Error Rate Testing Program (CERT) -- Medicare FFS	\$ 21,693,236

	Provider Education and Outreach		\$ 37,826,604
	Medicare FFS Recovery Audit Program non-add ³⁹		\$129,486,932
	Total - Section E		\$ 59,519,840
F.	Program Support and Administration		
	Field Offices/Rapid Response/ and Oversight Staffing		\$ 23,602,074
	Total - Section F		\$ 23,602,074
	Total - Section II		\$ 975,647,277
	Total CMS Program Integrity Obligations		\$ 1,059,754,434

Appendix II: Table of Medicaid Integrity Program Expenditures

Total Medicaid Integrity Program Obligations October 1, 2010 through September 30, 2011 <i>Actual Dollars</i> (as of November 13, 2011)	
Description	Actual Obligations
Staffing & Program Support/Administration:	
Staffing & Program Support/Administration	\$16,861,557
Program Support Contracts	\$514,018
Subtotal – Staffing & Program Support/Administration	\$17,375,575
Medicaid Program Integrity Contracts:	
Audit Medicaid Integrity Contracts	\$26,647,699
Review of Provider Medicaid Integrity Contracts	\$17,302,235
Education Medicaid Integrity Contracts	\$6,308,871
Webinar Training Contract for Implementation of Section 6411(a) of the Affordable Care Act	\$48,203
Subtotal – Medicaid Integrity Contracts	\$50,307,008.00
Data Management, Information Technology Infrastructure:	
Subtotal - Data Management, Information Technology Infrastructure	\$8,019,228
Total Medicaid Program Integrity Obligations	\$75,701,811⁴⁰

³⁹The cost of 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 \$129,486,604 is not included in the Error Rate Measurement and Reduction Activities obligations.

⁴⁰This figure is for new obligations made in FY 2011 and does not take into account adjustments made in prior years."

Appendix III: Related Reports and Publications

REPORT	LAST ISSUED	AVAILABILITY
The 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 2011	http://oig.hhs.gov/reports-and-publications/hcfac/index.asp .
Medicaid Integrity Program Best Practices Annual Summary	June 2011	https://www.cms.gov/FraudAbuseforProfs/Downloads/2011pisummary.pdf .
Comprehensive State program integrity review reports	FY 2011	https://www.cms.gov/FraudAbuseforProfs/PIR/list.asp#TopOfPage .
Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services Report to Congress	FY 2010	https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf .
The CMS Annual Performance Budget	FY 2011	https://www.cms.gov/PerformanceBudget/Downloads/CMSOPAFY2012.pdf .
The HHS Agency Financial Report	FY 2011	http://www.hhs.gov/afr/2011afr.pdf .
The Comprehensive Error Rate Testing Annual Reports	FY 2010	https://www.cms.gov/CERT/CR/list.asp .
Payment Error Rate Measurement Report	FY 2011	www.cms.gov/PERM