

# **CMS GAO High Risk Program Report**

## CMS –Plan to Address GAO High Risk Items

### Centers for Medicare & Medicaid Services Summary of Plan for Improvement in the GAO High Risk Area

#### Medicare

**Problem:** The Medicare program is the second-largest social insurance program in the U.S. with 48.5 million beneficiaries and total gross benefit expenditures of approximately \$548 billion in 2011. Medicare faces increasing financial pressure and it is a critical Administration priority to increase the effectiveness and efficiency of the program. To achieve these goals, CMS continues to update and strengthen our payment systems, minimize vulnerabilities and improve information control weaknesses in IT management and security, ensure Medicare/Medicaid dual eligible population enrollment into and coverage by Medicare prescription drug plans, and improve quality of care and efficiency while restraining costs.

#### Goals:

- Refine Medicare payments to ensure they are appropriate, improve program integrity, and reduce improper payments
- Improve Medicare program management
- Strengthen oversight to improve patient safety and quality care

#### Challenges/Actions

##### Refining Medicare payments to ensure they are appropriate, improving program integrity, and reducing improper payments

- **CY 2012 Home Health Prospective Payment System Final Rule:** The overall net impact of the provisions of this rule is an estimated decrease in payments to Home Health Agencies (HHAs) in CY 2012 by a negative 2.31 percent. This estimated impact includes the combined effects of the 1.4 percent HH PPS payment update (home health market basket update of 2.4 percent reduced by 1 percentage point as required under the Affordable Care Act) and an updated wage index (a \$290 million increase), as well as reductions to the HH PPS rates to account for increases in aggregate case-mix that are not related to changes in the health status of patients (a \$720 million decrease) resulting in an estimated net decrease in payments to HHAs of \$430 million in CY 2012 compared to HHA payments in CY 2011. This rule also finalized structural changes to the HH PPS by removing two hypertension codes from the case-mix system, lowering payments for high therapy episodes and recalibrating the HH PPS case-mix weights to ensure that these changes result in the same aggregate payments. Finally, this rule added flexibility to satisfy the face-to-face encounter requirement by allowing physicians who attend to a home health patient in an acute or post-acute setting to inform the certifying physician of their encounters with the patient. The CY 2012 final rule was published on November 4, 2011.
- **Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding:** On July 1, 2010, CMS announced the single payment amounts for the Round 1 re-bid of the Competitive Bidding program. On November 3, 2010, CMS announced the contract

suppliers. The contracts and payment amounts for the Round 1 re-bid became effective on January 1, 2011. CMS started the supplier competition for Round 2 of the program when bidder registration opened on December 5, 2011. Round 2 covers an additional 91 metropolitan statistical areas. CMS is conducting a national mail order competition for diabetic testing suppliers at the same time as Round 2. Round 2 and national mail order contracts and prices are scheduled to become effective on July 1, 2013. CMS is required to implement competitive bidding or payment rate adjustments using competitively bid rates in all areas of the country by January 1, 2016.

- **End Stage Renal Disease (ESRD) Prospective Payment System (PPS):** On November 10, 2011, CMS published a final rule updating the ESRD PPS for Calendar Year 2012 and establishing performance measures under the Quality Incentive Program (QIP) for payment years (PY) 2013 and 2014. The effective date of the final rule is January 1, 2012. The ESRD PPS was implemented beginning with services furnished on or after January 1, 2011, and the first payment reductions under the QIP will be implemented beginning with services furnished on or after January 1, 2012, as required by statute.
- **2012 Inpatient Hospital Prospective Payment System (IPPS) Final Rule:** Both the FYs 2011 and 2012 IPPS Final Rule implemented several provisions of the Affordable Care Act. These include:
  - Reducing the hospital market basket update by 0.1 percentage points and for a multifactor productivity adjustment of 1.0 percentage points.
  - Providing additional payments totaling \$250 million for FY 2012 to certain IPPS hospitals located in a county that ranks within the lowest quartile of counties in the United States in per enrollee Medicare spending under parts A and B, adjusted for age, sex, and race.
  - Additionally, the law modified the prior low-volume adjustment for certain Medicare hospitals for FYs 2011 and 2012, ranging from a 25 percent adjustment for hospitals with 200 or fewer Medicare discharges to no payment adjustment for hospitals with 1,600 or greater Medicare discharges. These modifications expire at the end of FY 2012.
  - Requiring CMS to adopt protections for frontier States by implementing hospital wage index that is not less than 1.0 for hospitals located in frontier states, beginning in FY 2011. Frontier States are defined in the law as States where at least 50 percent of the counties have a population density of less than six people per square mile. CMS will update this determination of frontier State status periodically as more recent data – such as data from the 2010 Census-- become available.
- **Issues Not Included in the ACA: Non – Affordable Care Act (ACA) Issue:** CMS will continue to no longer pay hospitals a higher Medicare Severity Diagnosis Related Groups (MS-DRGs) amount when selected conditions (including selected infections) are acquired during the hospitalization and are the sole reason why the hospital would otherwise receive a higher MS-DRG based payment amount for the discharge. CMS also expanded the list of quality measures that hospitals must publicly report in order to receive the full market basket update. In addition, we are making a net adjustment to FY 2012 IPPS rates of 2.0 percent to account for prior increasing

in spending that is due to changes in hospital documentation and coding practices and not an increase in patient severity of illness.

- **2012 Hospital Outpatient Prospective Payment System (OPPS) Final Rule:** Regarding CMS' continuing efforts to update and strengthen its payment systems and improve quality of care and efficiency while restraining costs, the 2012 OPPS Final Rule implemented several provisions to advance these goals including the following:
  - Paying for partial hospitalization (PHP) services in hospital-based PHPs and community mental health centers (CMHCs) based on the unique cost-structures of each type of program (i.e., payment rates based on the median costs calculated using the most recent claims data for each provider type).
  - Hospital Outpatient Quality Reporting Program -- Increasing the number of measures for reporting for purposes of the CY 2014 and CY 2015 payment determinations, and modifying the process for selecting hospitals for validating reported chart-abstracted measures that was adopted for CY 2012 in the CY 2011 OPPS rule.
  - Establishing a quality reporting program for ambulatory surgical centers (ASCs) that adopts five quality measures, including four outcome measures and one surgical infection control measure, with data collection, beginning in CY 2012 for the CY 2014 payment determination. The final rule with comment period retained these five measures and added two structural measures for reporting beginning in CY 2013 for the CY 2015 payment determination – one for safe surgery checklist use, and one for ASC facility volume data on selected ASC surgical procedures. Additionally, it retained the seven measures adopted for the CY 2015 payment determination and added one measure of healthcare personnel influenza vaccination for the CY 2016 payment determination.
  - Hospital Value-Based Purchasing (as required by section 3001(a) of the Affordable Care Act) -- The final rule adopted one additional chart-abstracted measure for the FY 2012 program, as well as outlined other program requirements for the FY 2014 program. These requirements include: establishing the weighting for the clinical process, patient experience, and outcomes measures for FY 2014.
  
- **2012 Physician Fee Schedule (PFS) Final Rule:** The CY 2012 PFS Final Rule with comment period implemented several changes to the fee schedule that continue to ensure appropriate and efficient Medicare payments while improving quality. Specifically:
  - The potentially misvalued code initiative was expanded to focus on the codes billed by physicians in each specialty that result in the highest Medicare expenditures under the PFS to determine whether these codes are over-valued. In the past, specific codes were targeted for review that may have affected a few procedural specialties like cardiology, radiology or nuclear medicine; but this review had not taken a look at the highest expenditure codes across all specialties.

- The multiple procedure payment reduction policy was expanded to include the professional interpretation of advanced imaging services in order to recognize the overlapping activities that go into valuing these services.
  - The payment adjustment for geographic variation has been refined in several ways to better account for differences in the cost of practice. The Affordable Care Act and the Medicare and Medicaid Extenders Act of 2010 made some temporary adjustments that were in place for two years while CMS and the Institute of Medicine (IOM) began to comprehensively study these issues. As part of this initiative, some of the data sources for costs were replaced to improve accuracy —such as using data from the American Community Survey (ACS) in place of the Department of Housing and Urban Development (HUD) rental data and also using ACS data in place of the data currently used for non-physician employee compensation. In addition, for CY 2012 Medicare now adjusts local payments for the full range of occupations employed in physicians' offices.
  - The list of services that can be furnished through telehealth was expanded to include smoking cessation services. In addition, beginning with the CY 2013 PFS, the criteria for adding services to the telehealth list will focus on the clinical benefit of making the service available through telehealth.
  - The final rule implemented the third year of a 4-year transition to updated practice expense relative value units, based on data from the Physician Practice Information Survey that was adopted in the PFS CY 2010 final rule.
  - Physician incentive programs including the Physician Quality Reporting System, the ePrescribing Incentive Program and the Electronic Health Records Incentive Program were all either updated or modified.
  - Quality and cost measures were published for a new value-based modifier that will be developed to adjust physician payments based on whether they are providing higher quality and more efficient care.
- ***FY 2012 Skilled Nursing Facility (SNF) PPS Final Rule:*** This FY 2012 final rule corrects for an unintended spike in FY 2011 payment levels by reducing such payments in FY 2012 by \$4.47 billion, or 12.6 percent (which was partially offset by a positive market basket update of \$600 million, or 1.7 percent), for a net reduction of \$3.87 billion (or 11.1 percent), thereby restoring Medicare SNF payments to their intended levels on a prospective basis. This adjustment to SNF payments is to correct an earlier parity adjustment made in FY 2011 to the case-mix indexes (CMIs) when transitioning from the previous classification system to the new classification system (Resource Utilization Groups Version 4 (RUG-IV) and to better align Medicare payments with costs. Because the FY 2012 adjustment serves to remove an unintended spike in payments in one year rather than decrease an otherwise appropriate payment amount, we do not expect it to affect facilities, beneficiaries, or quality of care adversely. Even with this adjustment, the FY 2012 payment rates still represent an actual increase of 3.4 percent over the rates established for FY 2010, the period immediately preceding the unintended spike in payment levels.

Along with recalibrating and updating the SNF PPS payment rates for FY 2012, this final rule makes a number of additional revisions aimed at enhancing SNF PPS accuracy and integrity. The

final rule modifies the patient assessment windows and grace days to minimize duplication and overlap in observation periods and between assessments. The rule also:

- Clarifies circumstances where SNFs must report breaks of three or more days of therapy.
- Eliminates the distinctions between facilities regularly furnishing therapy services on a 5- or 7-day basis for purposes of setting the date for the End of Therapy (EOT) Other Medicare Required Assessment (OMRA) Streamlines procedures for documenting situations involving a brief interruption in therapy where therapy resumes without any change in the patient's RUG-IV classification level.
- Introduces a new Change of Therapy OMRA to capture those changes in a patient's therapy status that would be sufficient to affect the patient's RUG-IV classification and payment, even though they may not rise to the level of a significant change in clinical status.
- Provides for the allocation of a therapist's time for group therapy (defined in the rule as a single therapist leading four patients simultaneously in similar therapy activities) to ensure that Medicare payments better reflect resource utilization and cost for these services, and specifically that the therapist's time is being appropriately counted and reimbursed.

### **Improving Program Management: Fee-For-Service Contracting Practices and Reform**

- In accordance with section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has initiated Medicare contracting reform, first replacing certain contracting authority under title XVIII of the Social Security Act with the Medicare Administrative Contractor (MAC) authority and then integrating Medicare Parts A and B under the MAC contracts. The use of competitive contract procedures and performance incentives has improved Medicare's administrative services both to beneficiaries and to health care providers, the latter who use the MACs as their primary point-of-contact for conducting all claims-related business and obtaining information for their patients. Many of the recent changes brought about by the Affordable Care Act and the Improper Payments Elimination and Recovery Act of 2010 are implemented by the MACs. For example, as part of the prevention-based approach to attack fraud and abuse, all providers will be revalidated. To reduce improper payments, MACs will conduct additional prepayment reviews. To ensure that the MACs continue to perform at a high level of excellence, every MAC contract is recompeted no later than every five years.
- Initially, CMS anticipated that fifteen A/B MACs and four DME MACs would perform Medicare FFS claims processing administration activities. In October 2010, in order to achieve further efficiencies in program management, CMS revised its strategy to consolidate from the initial fifteen A/B MAC jurisdictions into ten using a phased process that will take several years. As of December 2011;
  - Four Durable Medical Equipment (DME) MAC contracts have been fully implemented;

- Eleven of fifteen A/B MAC contracts have been fully implemented;
  - One A/B MAC contracts, Jurisdiction F (combines former Jurisdictions 2 and 3) is being implemented; and
  - Three A/B MAC contracts (Jurisdictions 6, 8, and the newly formed Jurisdiction H (Jurisdictions 4 and 7)) were awarded and are under temporary stays of performance, and CMS expects resolution of these stays in FY 2012.
- The Government Accountability Office (GAO) issued the temporary stays of performance because of protests received on the contract awards. to when the Agency announced contract awards. The GAO is expected to rule on the Jurisdictions 6 and 8 protests in early February 2012, and then in early March 2012 for Jurisdiction H.

## **Enhancing Program Integrity – Measuring Improper Payments**

### **Fee-for-Service**

CMS continues to enhance our program integrity efforts and improve our improper payment measurement programs. CMS continues to implement and refine Medicare error rate measurement programs that comply with the Improper Payments Elimination and Recovery Act of 2010 (IPERA).

In 2011, Medicare fee-for-service improper payment rate dropped to 8.6 percent or \$28.8 billion in estimated improper payments. This rate was calculated using a refined methodology, after consulting with the Office of the Inspector General, that reflects the impact of late documentation and the results of appeal activities that typically occur after the cut-off date. For consistency and comparison purposes, CMS adjusted the 2010 error rate to 9.1 percent or \$29.7 billion. When comparing the adjusted rates, the 8.6 percent error rate for 2011 represents a 0.5 percentage point reduction in the improper payment rate from 2010.

### **Parts C and D**

CMS is improving payment accuracy and enhancing program integrity in the Part C and Part D programs by developing error rates to measure improper payments in these two programs.

CMS reported a payment error rate that was below the established target for the Medicare Advantage program (Part C) in the FY 2011 Agency Financial Report (AFR). For the Medicare Prescription Drug program (Part D), CMS reported for the first time a payment error rate in the FY 2011 AFR.

Unlike Medicare FFS, CMS makes prospective, monthly per-capita payments to Medicare Advantage Part C organizations and Medicare Part D plan sponsors. Each per-person payment is based on a bid amount, approved by CMS, that reflects the plan's estimate of average costs to provide benefit coverage to enrollees. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status. In addition, certain Part D prospective payments are reconciled against actual costs, and risk-sharing rules set in law are applied to further mitigate plan risk.

The FY 2011 Part C error rate presents the combined impact on Part C payments of two sources of error: the Part C payment system error rate and the payment error related to risk adjustment. Most of the Part C payment error is driven by errors in risk adjustment data (clinical diagnosis data) submitted by

Part C plans to CMS for payment purposes. Specifically, the payment error related to risk adjustment reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

The improvement in the FY 2011 Part C error rate over FY 2010 can be attributed to the Administration's emphasis on contract-specific Risk Adjustment Data Validation (RADV) audits designed to recover overpayments to Part C plans, and to outreach and education to plans. CMS conducts contract-specific RADV audits for the purpose of estimating risk adjustment error specific to Part C organizations. The RADV audits have created a sentinel effect in the industry. Part C organizations are more aware of the importance of properly documenting the clinical diagnoses they submit to CMS that can lead to enhanced Medicare payments. Further, Part C organizations are now aware that failure to have proper documentation will result in CMS' identification of overpayments for payment recovery purposes. In addition to the RADV audits, CMS has also initiated outreach and education efforts for physicians/providers for FY 2012.

CMS is reporting for the first time a baseline payment error rate for the Medicare Prescription Drug program (based on payment year 2009), which will be used to monitor and correct improper payments. The FY 2011 Part D error rate presents the combined impact on Part D payments of five sources of error: the Part D payment system error; payment error related to low income subsidy status; payment error related to incorrect Medicaid status; payment error related to prescription drug event data validation; and payment error related to direct and indirect remuneration. The fifth measure, a payment error rate related to direct and indirect remuneration (DIR), is being reported for the first time this year. CMS has reported error rates for the other four measures in prior years.

The largest driver of the Part D error rate is the FY 2011 payment error related to prescription drug event data validation, which substantially decreased from the FY 2010 rate. This improvement is due largely to the Administration's efforts to provide plans with additional guidance to improve their collection of prescription documentation from pharmacies.

### **Enhancing Program Integrity – Reducing Medicare Fee-for-Service Improper Payments**

Reducing the incidence of improper payments is a high priority for CMS. CMS is working on multiple fronts in order 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 CMS Recovery Auditors.

Beginning in 2012, CMS plans to conduct the following demonstration projects to strengthen Medicare by aiming at eliminating 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:** This demonstration allows participating hospitals to re-bill for 90 percent of the allowable Part B payment when a Medicare contractor denies a Part A inpatient short stay claim on the basis that the inpatient admission was not reasonable and necessary. Currently, such claims are denied in full. Hospitals are allowed to rebill for certain Part B ancillary services only. This demonstration is limited to a representative sample of 380 qualifying hospitals nationwide that volunteered to be part of the program. This demonstration allows hospitals to resubmit claims for covered services for 90 percent of the allowable Part B payment when a Medicare Administrative Contractor, Recovery Auditor, or the Comprehensive Error Rate Testing Contractor finds that services would have been considered reasonable and necessary if they had been provided to a registered outpatient in the outpatient setting. 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. This demonstration began on January 1, 2012.

**Recovery Audit Prepayment Review:** Will allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs 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 populations of fraud and error-prone providers (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 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):** Will implement Prior Authorization for power mobility devices for all people with Medicare who reside in seven States where historically there has been extensive evidence of fraud (CA, FL, IL, MI, NY, NC and TX). This demonstration seeks to develop improved methods for the investigation and prosecution of fraud to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments. The demonstration will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on power mobility device claims. The second phase, for the remainder of this three-year 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 efforts to reduce improper payments. These efforts include:

- Developed 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;

- Milestones:
  - Issued the first CBRs for certain providers beginning in August 2010. CBRs released on an ongoing basis. Distributed CBRs to over 50,000 providers on physical therapy services, chiropractic services, ambulance services, hospice care, podiatry, sleep studies, diabetic supplies and spinal orthotics.
  - Issue PEPPER reports on an ongoing basis.
- Increasing and refining educational contacts with providers found to be billing in error. Issued 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. In addition, commenced 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;
  - Milestones:
    - Issued Quarterly Provider Compliance Newsletters beginning in October 2010. Issue quarterly on an ongoing basis.
    - The DME and A/B MAC task forces continue to meet on an ongoing basis.
- 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;
  - Milestone:
    - Began implementation of phase one of the esMD pilot in the first quarter of FY 2012.
  - Developing a Provider 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. Milestone:
    - Implement Provider Vulnerability Tracking System (pVTS) in the 3rdquarter FY 2012.

### **Enhancing Program Integrity – Combating Fraud and Abuse**

Program integrity includes a wide range of functions that address the causes of improper payments, ranging from fraud, abuse, and waste, to billing or documentation errors. CMS is taking actions to assure that public funds are not diverted from their central purposes.

In 2009, CMS joined forces with DOJ, FBI and HHS OIG on the HHS-DOJ Interagency Health Care Fraud Prevention and Enforcement Action Team (HEAT) Task Force led by Secretary Sebelius and Attorney General Eric Holder. This effort has continued with the expansion of Medicare Strike Forces, National

and Regional summits on health care fraud, and media campaigns to educate Medicare beneficiaries about how to protect themselves against fraud.

Additionally, in 2010, CMS established a Security Operations Center (SOC) to monitor information security at CMS. Using automated analysis tools, the CMS SOC identified potential fraudulent on-line transactions that were successfully pursued by CPI. This cooperation between the CPI and the CMS SOC will support continued improvements in many new PI activities.

To protect the Trust Funds and other public resources against losses from fraud and other improper payments CMS launched the National Fraud Prevention Program (NFPP) in the spring of 2011. The NFPP consists of two concurrent and inter-related approaches to identifying potential fraud in fee-for-service: Predictive Analytics (focus on claims) and Provider Screening (focus on provider enrollment)

#### *Predictive Analytics*

On June 30, 2011, CMS launched the new Fraud Prevention System (FPS) which uses predictive analytic technology to review every fee-for-service (Part A and Part B) claim and durable medical equipment claim prepayment. The FPS was developed under the Small Business Jobs Act of 2010, which stipulated that the Secretary should implement the use of predictive analytics technologies nationwide by January 1, 2014. The FPS was able to roll out ahead of schedule by going nationwide beginning June 30, 2011.

The FPS identifies FFS claims and providers that merit greater scrutiny and law enforcement involvement. The new system alerts CMS to unusual billing patterns and other suspicious behavior while simultaneously prioritizing claims so CMS can strategically target resources for additional review, investigation, and administrative action as necessary. CMS is now able to review claims, investigate providers, make referrals to law enforcement, and take administrative actions against providers more efficiently than before.

#### *Provider Enrollment*

CMS is moving toward a prevention-focused approach to fighting fraud by identifying fraudulent providers before they bill our programs. As of March 25, 2011, CMS began screening newly-enrolling and existing categories of providers and suppliers in based on three levels of fraud risk: limited, moderate, or high under our new authority in the ACA. The risk levels determine the level of the screening for a provider or supplier when initially enrolling in Medicare or Medicaid, adding a new practice location, or revalidating its enrollment information.

CMS has efforts underway to revalidate all providers that were enrolled prior to March 25, 2011. The first phase of this initiative is focused on providers that have been flagged for suspect characteristics and will ensure that all providers are revalidated under the new screening criteria. In conjunction, CMS awarded a Provider Screening Contractor on September 30, 2011, that will automate screening of all providers against a number of external databases and sources. This service will screen providers prior to enrolling in the Medicare program to ensure providers with suspect characteristics undergo additional scrutiny such as site visits. In addition, the screening tool will continuously screen providers after they have enrolled in the Medicare

program to validate that they are meeting the requirements of the Medicare program and are re-evaluated if they are flagged by the screening tool. Implementation is targeted for 2012.

In addition, CMS has contracted with a national site visit contractor to perform physical site visits to verify information of record about Medicare providers and suppliers both for provider enrollment and in support of investigations of potential fraud. CMS will use information provided by the contractor, in conjunction with other data, to determine provider eligibility for Medicare enrollment and participation. CMS issued a request for quote on September 8, 2011. Implementation is targeted for 2012.

The Zone Program Integrity Contractors (ZPICs)/Program Safeguard Contractors (PSCs) will continue to identify overpayments, refer cases to law enforcement, recoup funds from court determined fines, settlements and/or restitutions, and by take an aggressive approach with other administrative actions such as payment suspensions, prepayment edit denials, auto denial edits, and revocations. ZPICs/ PSCs produced a total of \$1.3 billion dollars in savings for Medicare Parts A and B in FY 2010 and \$1.4 billion dollars in FY 2011.

- *Program Integrity Contracting in Parts C and D - Accomplishments*

Beginning in FY2011 and continuing through FY2012, CMS will implement a new contracting strategy to support Medicare Advantage and Medicare Part D program integrity activities. There is now one national benefit integrity MEDIC dedicated to Medicare Advantage and Medicare Part D program integrity work in monitoring fraud, waste, and abuse in the Parts C and D programs in all 50 States, the District of Columbia, and U.S. Territories. The new strategy affords CMS more flexibility to manage key parts of program integrity through contracts that are focused on very specific functions and are complementary to each other. This approach will allow CMS to hire contractors with skill sets that are appropriate to the narrow functions outlined by the statement of work rather than the current approach which requires the MEDIC to perform diverse functions.

Beginning in FY2009 and continuing through FY2012, CMS implemented a new contracting strategy to support Medicare Advantage and Medicare Part D program integrity activities. This new strategy is a departure from the Medicare Drug Integrity Contractor (MEDIC) concept as it was established in 2006. One national benefit integrity MEDIC dedicated to Medicare Advantage and Medicare Part D program integrity work is now responsible for monitoring fraud, waste, and abuse in the Parts C and D programs in all 50 states, the District of Columbia, and U.S. Territories.

The ACA requires CMS to implement Recovery Audit Contractor provisions in Parts C and D. On January 13, 2011, CMS signed a contract to implement a Part D RAC. Initial areas of focus for the RAC include payments to excluded providers, underpayments and overpayments.

## **Enhancing Program Management – Managing IT and IT Security**

CMS has established robust investment management policies, procedures and practices in the area of IT Security. The agency has implemented the post-implementation review (PIR) process for major systems implementations. In FY 2010, a survey of all of the systems at CMS was conducted to develop the CMS System Inventory. This Inventory supports information security, records management, continuity of operations (COOP), the OMB Financial Management Systems Inventory, and the IT project management and Investment management in the CMS Investment Lifecycle operational programs, as well as all major IT initiatives such as HITECH, the Agency for Healthcare Research and Quality Comparative Effectiveness Research (CER) Project (and associated CER projects), MACBIS, and the Affordable Care Act. OIS' Enterprise Architecture & Strategy Group, Division of Enterprise Architecture plans on completing an update to the CMS System Inventory by 4QFY 2011.

In accordance with the latest implementation guidance from DHS and OMB, the CMS Office of the Chief Information Security Officer (OCISO) is implementing a comprehensive Risk Management Framework (RMF), Enterprise Vulnerability Management (EVM) and Continuous Monitoring programs to enhance the IT security of the CMS Enterprise. One key aspect of these programs has been the creation of the CMS Security Operations Center (SOC). In conjunction with the Department of Health and Human Services (DHHS) Computer Security Incident Response Team (CSIRT), the CMS SOC is detecting and protecting the CMS IT Enterprise for various types of Cybersecurity attack, malware, and unauthorized usage. In addition, the CMS OCISO RMF initiative is focused on tightly integrating Systems Security into its data management programs as part of CMS' initiative for modernizing CMS computer and data systems to support improvements in care delivery.

**Updated: February 2, 2012**

**Centers for Medicare & Medicaid Services**  
**Summary of Plan for Improvement in the GAO High Risk Area**  
**Medicaid**

**Problem:** GAO over the past several years has taken issue with State financing arrangements for the Medicaid program that they believe are improper and inconsistent with the Federal statute. While GAO acknowledges that CMS has made improvements in this area, GAO believes that further efforts should be undertaken to strengthen the fiscal accountability of the Medicaid program. Additionally, GAO continues to believe CMS has not incorporated the use of key Medicaid data systems into its oversight of States' claim, or clarified and communicated its policies in several areas, including supplemental payment arrangements.

**Goal:**

- Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles;
- Determine what systems projects are needed to further enhance data analysis capabilities;
- Ensure that waiver programs are financed appropriately; and
- Improve fiscal integrity and financial management.

**Challenge 1 – Issue guidance to clarify allowable financing arrangements, consistent with Medicaid payment principles (GAO-07-214)**

**Strengthen the fiscal accountability of the Medicaid program. Develop a financial management strategic plan for Medicaid, and incorporate the use of key Medicaid data systems into its oversight of States' claims, and clarify or communicate its policies in several high risk areas, including supplemental payment arrangements.**

**Action 1 – Strengthen the Fiscal Accountability of the Medicaid program. (GAO-07-214)**

On May 29, 2007, CMS produced a final rule, the Cost Limit for Providers rule, to clarify the appropriate Medicaid State financing sources, including the use of intergovernmental transfers and certified public expenditures. On June 30, 2008, Public Law 110-252, the Supplemental Appropriations Act, 2008, was enacted; this law prevented CMS from finalizing and/or implementing the regulation until after March 31, 2009. Section 5003(d) of Public Law 111-5, the American Recovery and Reinvestment Act of 2009, conveyed Congressional opposition to finalizing several rules, including the Cost Limit for Providers rule.

In addition, on May 23, 2008, the United States District Court for the District of Columbia in *Alameda County Medical Center, et al. v. Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services, et al.*, 559 F. Supp. 2d 1 (May 23, 2008) vacated final regulations published in the Federal Register, titled "Medicaid Program; Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial

Partnership (CMS-2362-F).” On November 30, 2010 CMS removed the vacated regulations from the Code of Federal Regulations and reinstated the prior regulatory language.

As required under section 7001(c)(2) of the Supplemental Appropriations Act, 2008 (Public Law 110-252), CMS retained an independent contractor to provide additional information to Congress and CMS on the policy and financial impact of certain proposed and final Medicaid regulations placed under moratorium by Congress. This report, entitled Analysis of Impact and Issues Related to Four Medicaid Regulations, was published in 2009. In addition, CMS has recommended to the GAO that this recommendation be marked as met and closed.

CMS continues to use the State plan submission to monitor and collect information to assure State financing arrangements are consistent with Medicaid payment principles, and is using the findings from the congressionally mandated report, court decisions and Congressional guidance to guide future regulatory activities.

Finally, in Federal fiscal year 2010, CMS instituted enhanced expenditure reporting capabilities to facilitate improved information on Medicaid supplemental payments. As part of the CMS-64 form, new expenditure reporting lines were added to capture State reported expenditures for inpatient hospital, outpatient hospital, nursing facility, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and physician services. CMS continues to work with States to improve the reporting accuracy of these expenditures.

## **Action 2 – Further Enhance Data Analysis Capabilities (GAO-06-705)**

An analysis conducted as a part of the Medicaid and CHIP Business Information Solution (MACBIS) project identified additional data currently collected by States which could be used to document most of the financial payments made by States. The project also identified data collection efforts for other program reasons which would no longer be necessary if this additional data was collected. As a result, CMS is working with 10 States to pilot the collection of this data and to validate its usefulness in providing better financial oversight, while at the same time reducing the overall data collection burden on the States.

To address previous barriers to accessing data, we have implemented a Web-based statistical summary, Datamart, which will support review of broad payment patterns and trends. This tool is readily available, and new financial management staff receives an introduction to the use of the Datamart tools during their orientation. We are also developing a Medicaid Data Dashboard to be used by policy makers, program integrity administrators, researchers, and program operations managers. The web-based Dashboard displays Medicaid spending, services and beneficiary information in a user friendly and intuitive format and provides a quick and comparative overview of Medicaid programs and their trends. In addition, CMS has recommended to the GAO that this recommendation be marked as met and closed.

## **Challenge 2 – To Ensure Waiver Programs Are Financed Appropriately (GAO-08-87)**

**The GAO has repeatedly criticized section 1115 demonstration practices with respect to budget neutrality. Budget neutrality ensures that approval of Section 1115 demonstrations do not increase Federal financial liability. Therefore, demonstrations that increase Federal financial liability beyond what it would have been without the demonstration should not be approved.**

### **Action 1 – Review Section 1115 Demonstrations in Accordance With Program Objectives and Mitigate Budget Neutrality Risk**

The Secretary of the Department of Health and Human Services has authority to allow States to test new ideas for achieving program objectives. The Department, in conjunction with the Office of Management and Budget, reviews, negotiates, and makes decisions on awarding proposals from States.

CMS will continue to provide States with technical assistance in accordance with budget neutrality principles and seek ways to improve the process to ensure that approved programs are budget neutral.

CMS, in support of a performance measure, implemented an improved program for monitoring budget neutrality, in which the budget neutrality status of all 1115 demonstrations is routinely reviewed. CMS exceeded its goal for completing targeted budget neutrality reviews in FY 2008, 2009, and 2010.

## **Challenge 3 – Improve Fiscal Integrity and Financial Management (GAO-09-628T)**

### **Action 1 – Strengthen Program Integrity**

**The Deficit Reduction Act of 2005 (DRA) created the Medicaid Integrity Program (MIP) and appropriated funds to combat provider fraud and abuse and to provide effective support and assistance to States.**

The MIP has been operational for five years and continues to work to improve the program by honing its National Audit program, implementing program integrity provisions of the Affordable Care Act, and conducting supplemental measures of Medicaid payment error as required by Executive Order 13520 to reduce improper payments. Formation of the Center for Program Integrity to integrate Medicaid and Medicare program integrity (PI) efforts in April 2010 has allowed for a centralized approach that will enable CMS to develop more strategic and coordinated initiatives for fighting fraud and abuse.

CMS continues to work to improve the National Audit Program by focusing on national and regional areas of vulnerability, increasing the proportion of States engaged in collaborative audit projects with CMS, and developing innovative solutions to improve the quality of claims data available to auditors. The Medicaid and CHIP Business Information and Solutions Council (MACBIS) is working to develop a robust and comprehensive information management strategy for CMS with the goal of including managed care encounter claims and an enhanced data set to better detect fraud and abuse. We are

also taking steps to align audit resources more closely with areas of vulnerability identified by CMS' Payment Error Rate Measurement (PERM) program, with the ultimate goal of reducing the national Medicaid error rate. Based on an examination of PERM data, we have identified hospitals, long term care, home health, and pharmacy as areas of vulnerability for focused attention.

To implement Executive Order 13520, CMS has initiated Medicaid supplemental measures to more accurately reflect performance and improvement in reducing Medicaid improper payments, focused on these same areas of vulnerability. For example, one payment accuracy improvement project in the area of pharmacy education will measure the extent to which guidance targeted to physicians with aberrant prescribing practices can reduce the number of prescriptions that exceed recommended dosages.

In collaboration with the States, CMS is working to address improper payments. Through the error rate measurement, CMS identifies and classifies types of errors and shares this information with each State. States then conduct an analysis to determine the root causes for improper payments to specifically identify why the errors occur, which is a necessary precursor to developing and implementing effective corrective actions. CMS works closely with States following each measurement cycle to develop State-specific Corrective Action Plans (CAPs). States, in close coordination with CMS, are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs. In addition, CMS is continuously reviewing the causes of errors and implementing national and State-focused activities to decrease Medicaid and CHIP improper payments. Examples include expanded education and outreach to the provider community, State education through the Medicaid Integrity Institute, and review of paid claims by Medicaid Integrity Contractors (MICs). Together, these efforts will result in more accurate claim payments and a reduction of waste and abuse in the Medicaid program and CHIP.

Provider education has also been a key component of the CMS strategy to reduce inappropriate billing by providers. CMS has engaged an Education MIC to work with a variety of nationwide stakeholders to enhance awareness of Medicaid fraud and abuse among providers, recipients, and managed care organizations. Through the contractor's gap analysis and the PERM findings, we have identified priority areas to be addressed with outreach and training materials to implement provider and beneficiary education to target areas of perceived risk.

For the continuing education of State program integrity employees, the Medicaid Integrity Institute (MII) offers substantive training, leadership, and technical assistance in a structured learning environment. In its three years of existence, the MII has trained over 2,265 State employees at no cost to the States, offering courses including fraud investigation, data analysis, medical record review, diagnosis and procedure coding, and emerging trends in Medicaid fraud. Over time, the MII plans to create a credentialing process to elevate the professional qualifications of State Medicaid program integrity employees.

In addition, CMS has devoted significant effort and resources to implementing the Medicaid program integrity provisions of the Affordable Care Act. We continue to issue guidance to facilitate State implementation and reporting for provisions including the Medicaid Recovery Audit Contractor (RAC)

program. CMS issued its Final Rule governing the Medicaid RAC program on September 16, 2011. The Final Rule is effective on January 1, 2012. CMS has provided technical assistance and support to States to facilitate the implementation of their respective Medicaid RAC programs. For example, CMS has conducted several all-State calls and webinars regarding the Medicaid RAC program, including sharing lessons learned from the Medicare Recovery Audit program. CMS will continue to provide assistance to States and issue guidance as needed to assist States with the development of their own RAC programs as well as facilitate State compliance with the Final Rule. Other program integrity provisions include standard prepayment edits, enhanced provider screening and enrollment, and coordination of provider terminations. Because these provisions require data sharing among States, Federal and State contractors, and CMS, new initiatives have been added to the agency-wide enterprise data strategy. These activities, combined with the other efforts of the MIP represent a comprehensive approach to combat provider fraud and abuse.

#### **Challenge 4 - Overseeing Patient Safety and Care - Nursing Homes (GAO-07-241/GAO-06-117)**

**The GAO assessed CMS's progress in addressing oversight weaknesses in the nursing home survey and certification program by reviewing trends in nursing home quality, evaluating the extent to which CMS's initiatives have addressed survey and oversight problems.**

##### **Action 1 – Ensure Nursing Home Resident Health and Safety**

In the 10<sup>th</sup> SOW, Quality Improvement Organizations (QIOs) will work to reduce Healthcare Acquired Conditions (HACs) by 40 percent in nursing homes. The initial phase of the nursing home work includes QIOs providing direct technical assistance to low performing nursing homes on the reduction of Pressure Ulcers and Physical Restraints. This initial phase lasts the first eighteen months of the QIO contract. At the 18<sup>th</sup> month of the contract, CMS will launch a National Nursing Home Learning and Action Network. The collaborative methodology will be used to assist nursing homes in further expanding their work to incorporate overall Quality Improvement practices while working to reduce high volume, high cost HACs. The identification of those HACs, as well as appropriate measurement, is in the developmental stages.

**Updated: December 21, 2011**