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

Medicare

Problem: The Government Accountability Office (GAO) has designated Medicare as a high-risk program because its complexity and susceptibility to improper payments, added to its size, have led to serious management challenges. The Medicare program serves approximately 49 million beneficiaries with a total gross benefit expenditure of approximately $569 billion in 2012. Medicare faces increasing financial pressure and it is a critical Administration priority to increase the effectiveness and efficiency of the program. CMS administers Medicare and is responsible for implementing payment methods that encourage efficient service delivery, managing the program to serve beneficiaries and safeguard it from loss, and overseeing patient safety and care. CMS has implemented payment reforms in various parts of the program, such as Medicare Advantage, inpatient hospital, physician, home health, and end-stage renal disease services. The agency has implemented accountable care organizations and begun providing feedback to physicians on their resource use and is developing a value-based payment method for physician services that accounts for the quality and cost of care. CMS has made significant efforts to implement the requirements of recent legislation, guidance, and directives aimed at reducing improper payments. CMS has set key performance measures to reduce improper payments in fee-for-service Medicare, Part C, and Part D. Other recent CMS efforts to safeguard the integrity of the Medicare program include the implementation of predictive analytic technology to identity and prevent fraud in fee-for-service Medicare claims, the revalidation of billing privileges of all currently enrolled providers and suppliers to ensure compliance with CMS requirements, and enhanced coordination between CMS authority to suspend payments and nationwide law enforcement activities.

Goals

- Refining Medicare payment accuracy by reducing improper payments, and improving patient safety and quality of care;
- Improving Medicare program management by enhancing oversight of Medicare contractors, and Medicare Part C and D plans; and
- Enhancing program integrity by increasing the prevention and detection of fraud, waste and abuse.

Planned Actions and Milestones

<u>Refining Medicare Payment Accuracy by Reducing Improper Payments, and Improving Patient Safety and Quality of Care</u>

- ***2013 Home Health Prospective Payment System (HH PPS) Final Rule:*** The overall net impact of the provisions of this rule is an estimated decrease in payments to Home Health Agencies in CY 2013 of 0.01 percent. This estimated impact includes the combined effects of the 1.3 percent HH PPS payment update (home health market basket update of 2.3 percent reduced by 1 percentage point as required under the Affordable Care Act and an updated wage index), as well as a reduction 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 and a decrease in the fixed-dollar loss (FDL) ratio used in outlier payments from 0.67 in CY 2012 to 0.45 in CY 2013 resulting in an estimated net decrease in payments to HHAs of $10 million in CY 2013 compared to HHA payments in CY 2012. The CY 2013 final rule was published on November 8, 2012.

- ***Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding:*** 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. The target implementation date for Round 2 and national mail order contracts and prices is July 1, 2013.

  CMS has also implemented a comprehensive real-time claims monitoring system to track health outcomes and beneficiary access to DMEPOS items paid under the competitive bidding program.

- ***End Stage Renal Disease (ESRD) Prospective Payment System (PPS):*** The ESRD PPS was implemented beginning with services furnished on or after January 1, 2011, and the first payment reductions under the ESRD Quality Incentive Program (QIP) were implemented beginning with services furnished on or after January 1, 2012, as required by statute. On November 9, 2012, CMS published a final rule in the Federal Register updating the ESRD PPS for Calendar Year 2013 and establishing performance measures under the ESRD QIP for payment year (PY) 2015. This final rule added a new measure for anemia management, and it replaced the dialysis adequacy measure with one that includes adult hemodialysis patients, adult peritoneal dialysis patients, and pediatric in-center hemodialysis patients.

  CMS is closely monitoring the results of the program since implementation to ensure that beneficiary access to appropriate supplies and equipment has not been compromised. CMS real-time claims monitoring has found no disruption in access to needed supplies for Medicare beneficiaries. Moreover, there have been no negative health care consequences to beneficiaries as a result of competitive bidding. The QIP Monitoring and Evaluation team has begun sharing anemia management data with the ESRD Networks. The data provides dialysis-facility-level information about key monitoring indicators related to ESRD treatment practices. The ESRD Networks can use these data to identify facilities that may be in need of outreach to facilitate quality improvement efforts to assist in monitoring changes in anemia management practices among facilities within their jurisdiction. The data reveals yearly trends—at the national, Network, state, and facility level—for four anemia management indicators from 2008 to 2012 (as current as possible):

  - Beneficiary hemoglobin levels
  - Percentage of beneficiaries receiving blood transfusions

- Percentage of beneficiaries receiving intravenous (IV) iron
- Percentage of beneficiaries receiving erythropoietin-stimulating agents (ESAs)

- ***2013 Inpatient Hospital Prospective Payment System (IPPS) Final Rule:*** The FY 2013 IPPS Long Term Care Hospital (LTCH) Final Rule implemented the following provisions of the Affordable Care Act:

  - Market Basket Update – applied a market basket adjustment of 2.6 percent for FY 2013; applied a multifactor productivity adjustment of -0.7 percentage points and an additional -0.1 percentage reduction in accordance with section 3401(a) of the Affordable Care Act.

  - Hospital Readmissions Reduction Program – an Affordable Care Act provision that establishes, effective FY 2013, a payment reduction for hospitals with excess Medicare inpatient hospital readmissions in three conditions (heart attack, pneumonia, and congestive heart failure). In addition, CMS established a review and correction process for the readmission rates under the program before they are made publicly available on the Hospital Compare website, as required by the statute.

- ***Selected other issues in the FY 2013 IPPS-LTCH Final Rule unrelated to the Affordable Care Act***:

  - 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 updated the list of quality measures that hospitals must publicly report in order to receive the full annual payment update. Specifically, the Hospital Inpatient Quality Reporting Program finalized measure set is intended to reduce burden on hospitals, create a more streamlined measure set, improve perinatal care, reduce readmissions, and reduce surgical complications associated with hip and knee replacement procedures.

  - CMS made a permanent prospective adjustment of -1.9 percent to the FY 2013 IPPS rates to offset the effect of changes in hospital documentation and coding practices that did not reflect real changes in case-mix.

- ***2013 Hospital Outpatient Prospective Payment System (OPPS) Final Rule:*** Regarding CMS's continuing efforts to update and strengthen its payment systems and improve quality of care and efficiency while restraining costs, the 2013 OPPS Final Rule implemented several provisions to advance these goals including the following:

- The rule finalized geometric mean costs as the basis for relative payment weights, rather than median costs. Basing the OPPS payments on mean costs better reflects average costs of services and aligns the metric used in rate-setting for the OPPS with the IPPS. Geometric means better encompass the variation in costs that occur when providing a service because, in addition to the individual cost values that are reflected by medians, geometric means reflect the magnitude of the cost measurements, and are thus more sensitive to changes in the data. We believe developing the OPPS relative payment weights based on geometric mean costs better captures the range of costs associated with providing services, including those cases involving high-cost packaged services and those cases where very efficient hospitals have provided services at much lower costs.

- Hospital Outpatient Quality Reporting Program (OQR) – CMS did not add to the previously adopted 25 measures for the CY 2014 and subsequent years payment determinations. CMS, however, confirmed the removal of the measure OP-16, deferred data collection for the measure OP-24, and suspended data collection for the measure OP-19. In addition, CMS finalized a sub-regulatory process for suspending or removing problematic measures based on procedures used in the Inpatient Hospital Quality Reporting Program. The agency also finalized the automatic retention of Hospital OQR Program measures adopted in previous payment determinations for subsequent year payment determinations and changes to an administrative process allowing additional designated hospital personnel to sign CMS payment decision reconsideration request forms.

- Increasing the number of measures for purposes of the CY 2014 and CY 2015 payment determinations, and modifying the process for selecting hospitals for validating reported chart-abstracted measures by adding criteria targeting data quality concerns.

- 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 rule also 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.

- ***Physician Fee Schedule (PFS) Final Rule***: The CY 2013 PFS Final Rule with comment period implemented several changes to the fee schedule that continue to ensure appropriate and efficient Medicare payments. Specifically:

  - CMS has been engaged in a vigorous effort over the past several years to identify potentially misvalued codes and, when codes are found to be misvalued, to revise

the payment accordingly. The final rule adopts coding changes and revisions to relative values for hundreds of services that have been identified as misvalued. In addition, the final rule identifies new areas of potentially misvalued codes, including:

- Harvard-valued codes with annual PFS allowed charges of $10 million or more
- Publically nominated CPT codes
- Services with stand-alone PE procedure time

Codes in these areas will be evaluated in upcoming years.

- An example of codes revised under the misvalued code initiative is payment for *Intensity Modulated Radiation Therapy (IMRT) and Stereotactic Radiation Body Therapy (SBRT)*. These services were identified as potentially misvalued by CMS and the Medicare Payment Advisory Commission. CMS evaluated and proposed changes to relative values for these codes based on evidence indicating that values for certain radiation oncology services were too high. CMS used publicly-available patient education information to help determine how long radiation equipment is typically in use. That information conflicted with the much longer time recommended by the American Medical Association Specialty Society Relative Value Update Committee and the Association for Therapeutic Radiation Oncology. After considering public comments on its proposal, CMS finalized changes to values for IMRT & SBRT to address this difference in times as well as to add to update the equipment involved in furnishing these services.

- CMS revised interest rate assumptions used to establish values for medical equipment used to perform procedures in a physician's office from the previous fixed 11 percent, to the prime rate + either 2.25 percentage points or 2.75 percentage points depending upon the cost of the equipment and its useful life. The new interest rate is based on the Small Business Administration's maximum interest rates for different categories using loan size and maturity. CMS will update the interest rate assumptions in the future at the same time it completes comprehensive pricing updates for other direct cost inputs.

- For CY 2013, CMS expanded its multiple procedure payment reduction (MPPR) policy, which reduces payment for the second and subsequent procedure performed in the same session/same day to the technical component of certain cardiovascular and ophthalmology diagnostic services. CMS will make full payment for the highest paid cardiovascular or ophthalmology diagnostic service and reduce the technical component payment by 25 percent for subsequent cardiovascular diagnostic services, and by 20 percent for subsequent ophthalmology diagnostic services furnished by the same physician or group practice to the same patient on the same day. In addition, CMS will apply an MPPR to certain advanced imaging services beginning in CY 2013 to physicians in the same group practice. This policy was adopted for CY 2012 but was not previously applied to physicians in group practices due to operational issues.

- CMS implemented a new claims-based functional reporting system for therapy services (physical therapy, occupational therapy and speech language pathology) in the final rule. This system will provide additional data on the functional status of beneficiaries who are receiving therapy services and the outcome of the therapy that they receive. This information will assist us in developing an improved payment system for therapy services.

- A series of preventive services were added to the list of services that are paid when provided via telehealth services for CY 2013. These include: annual alcohol misuse screening, brief behavioral counseling for alcohol misuse, annual intensive behavioral therapy for cardiovascular disease, annual depression screening, intensive behavioral therapy for obesity, and high intensity behavioral counseling to prevent sexually transmitted infections. By adding these services to the list of services that can be delivered via telehealth, CMS will extend access to these important services in areas where physicians or non-physician practitioners may be unavailable to provide care in person.

- The final rule implemented the final year of a 4-year transition to revised practice expense relative value units that are based on data from the Physician Practice Information Survey. The revised practice expense relative value units were adopted in the PFS CY 2010 final rule with comment period.

- The Physician Quality Reporting System and the e-Prescribing Incentive Program were updated.

- Quality and cost measures were established for the new value-based modifier that will be used starting in 2015 to adjust physician payments for physician groups of 100 or more eligible professionals based on whether they are providing higher quality and more efficient care.

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

Milestones

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 changes brought about by the Affordable Care Act and the Improper Payments Elimination and Recovery Act of 2010 (IPERA) are implemented by the MACs. For example, as part of the prevention-based approach to eliminate fraud and abuse, all currently enrolled providers and suppliers will have their enrollment record revalidated by 2015. To reduce improper payments, MACs will have conducted additional prepayment reviews. To ensure that the MACs continue to perform at a

high level of excellence, their contracts include performance requirements that must be met before their contracts may be renewed each year. The contractors' past performance also is taken into account should they be an offeror in the competitions for the follow-on contracts every five years.

Planned Actions and Challenges

- 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 2012:

    - Four Durable Medical Equipment (DME) MAC jurisdictions have been fully implemented;

      Twelve of thirteen A/B MAC jurisdictions have been fully implemented (four of the original fifteen A/B MAC jurisdictions have been consolidated into two); and

    - One A/B MAC contract for Jurisdiction 6 was awarded and after undergoing corrective action due to protests is awaiting a decision from the GAO that is expected in January 2013.

Improving Program Management – Measuring Improper Payments in 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).

The Medicare FFS error rate for FY 2012 was 8.5 percent, or $29.6 billion, an improvement from the FY 2011 estimate of 8.6 percent. The FY 2012 net error rate was 7.8 percent, or $27.4 billion. The net improper payment rate was calculated by subtracting the sample's underpayments from overpayments and dividing by the total dollar value of the sample, thus reflecting the overall estimated monetary loss to the program. In FY 2011, CMS refined the Medicare FFS improper payment measurement methodology to reflect activity related to the receipt of additional documentation and the outcome of appeal decisions that routinely occur after the cut-off date for agency financial report (AFR) publication. This refinement applied an adjustment factor that was an estimate, based on the actual historical data from prior years, of the impact of the additional documentation and appeals decisions, and was only used in FY 2011. In FY 2012, we adjusted the measurement methodology by moving the measurement period back 6 months. This allows the error rate to reflect the actual impact that late documentation and appeals has on errors and is a better measure of the true errors, thus no longer necessitating the adjustment factor that was used in FY 2011.

In addition, under current Medicare policy, hospitals that submit a claim for Part A inpatient services that should have been provided on an outpatient basis under Part B are not permitted to re-submit a claim for such payment. These hospitals can only bill for a limited set of ancillary services that were provided to the patient, such as diagnostic laboratory and X-ray tests. Because of this policy, any claim that was inappropriately submitted as inpatient was counted as an error for the total amount billed under Part A. In the past year, the Administrative Law Judges (ALJs) and the Departmental Appeal Board (DAB), which represent the third and fourth levels of Medicare claim appeals (respectively), have concluded that, contrary to CMS's longstanding policy and interpretation of certain Medicare manuals, policy statements in the manuals support Part B rebilling in these circumstances. As a result, the ALJs and the DAB have directed Medicare to pay hospitals under Part B for all of the services provided (not just the ancillary services) after a Part A inpatient claim is denied. CMS refined the improper payment methodology to account for the impact of rebilling of denied Part A inpatient claims for allowable Part B services. This decision does not reflect a change in CMS policy with respect to rebilling in these circumstances but rather was undertaken to properly reflect the practical impact of the Medicare claim appeals.

These two modifications will produce a more accurate portrayal of the actual incidence of improper payments in the Medicare FFS program and will be incorporated into future improper payment reporting.

Improving Program Management: Measuring Improper Payments in Part C

Milestones

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. For the Medicare Advantage Program (Part C), CMS reported a payment error rate or 11.0 percent in the FY 2011 AFR, and 11.4 percent in the FY 2012 AFR. The composite payment error estimate remained relatively constant between FY 2011 and FY 2012. For the Medicare Prescription Drug program (Part D), CMS reported a payment error rate of 3.1 percent in the FY 2012 AFR, which was an improvement from the FY 2011 error rate of 3.2 percent.

Unlike Medicare FFS, CMS makes prospective, monthly per-capita payments to Medicare 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 2012 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.

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

Planned Actions and Challenges

On February 24, 2012, HHS released the *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits*. The notice clarifies the final audit methodology that will be implemented for audited contracts going forward. Payment year 2011 is the first year that CMS will conduct payment recovery based on extrapolated estimates. CMS expects to audit about 30 MA contracts each year. Also, it should be noted that CY 2007 RADV audits are in the final stages. In FY 2012, CMS conducted payment recovery (at the beneficiary level) from five of the contracts involved in the CY 2007 RADV pilot audits totaling $3.5 million.

In addition to the RADV audits, CMS has focused on outreach and education efforts to Medicare Advantage organizations. CMS conducts national training sessions for MA organizations that provide comprehensive information on submitting accurate risk adjustment data. CMS has also developed a method for identifying risk adjustment diagnoses that are more likely to be associated with payment error. This initiative has been and will continue to examine the reasons these diagnoses are error prone. CMS has used and will continue to use these findings to provide guidance to MA organizations.

Regarding educating physicians/providers, CMS enhances physician understanding of the way CMS pays MA organizations and the impact of medical record documentation on payment accuracy. The focus of this effort is to improve medical record documentation prepared by physicians to support risk adjustment diagnoses.

Improving Program Management: Measuring Improper Payments in Part D

Milestones

In FY 2012, CMS reported a payment error rate of 3.1 percent for the Medicare Prescription Drug program (based on payment year 2010), which will be used to monitor and correct improper payments. The FY 2012 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 composite payment error estimate remained relatively constant between FY 2011 and FY 2012, though the error rate did decrease from 3.2 percent to 3.1 percent.

Planned Actions and Challenges

CMS has implemented actions to address the Part D error rate. CMS will continue national training sessions for Part D sponsors on Part D payment and data submission. Additionally, CMS will continue to provide plans with additional guidance to improve their collections of prescription documentation from pharmacies as well as continue to routinely implement payment controls in the Part D payment system. The low income subsidy (LIS) status error will be addressed by providing additional guidance to Part D sponsors to update beneficiary LIS statuses prior to reconciliation.

Enhancing Program Integrity: Reducing Medicare Fee-for-Service Improper Payments

Milestones

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.

CMS's ongoing efforts to reduce improper payments include:

- ***Developed comparative billing reports (CBRs)***. CBRs help Medicare contractors and providers analyze administrative claims data. CBRs compare a provider's or supplier'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.

  CMS issued the first CBRs for certain providers and suppliers beginning in August 2010. CBRs are released on an ongoing basis. On average, CMS issues over 50,000 CBRs a year on subjects such as physical therapy services, chiropractic services, ambulance services, hospice care, podiatry, sleep studies, diabetic supplies and spinal orthotics to providers. CMS also issues PEPPER reports on an ongoing basis.

- ***Increasing and refining educational contacts with providers found to be billing in error***. CMS began issuing Quarterly Provider Compliance Newsletters to physicians, providers and suppliers in October 2010, and is an ongoing activity. 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, CMS 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.

- ***Implementing the Electronic Submission of Medical Documentation (esMD)***. Applying esMD into the comprehensive error rate testing (CERT) review process will

create greater program efficiencies, allow a quicker response time to documentation requests, and provide better communication between the provider or supplier, the CERT contractors, and CMS. CMS began implementation of phase one of the esMD pilot in the first quarter of FY 2012, which provides the ability to accept medical records electronically.

- ***Developing a Provider Vulnerability Tracking System (PVTS) that will track vulnerabilities identified by internal and external sources***. Currently, CMS tracks improper payment vulnerabilities using different systems. CMS will use the PVTS to inventory and prioritize vulnerabilities, and track corrective actions. The PVTS will consolidate and centralize the vulnerability tracking into one system. CMS began implementation of a Provider Vulnerability Tracking System (PVTS) in the third quarter FY 2012.

Planned Actions and Challenges

In 2012, CMS initiated the following demonstration projects to strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments 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 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. Participation in this demonstration is 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 error rate as payments that would be allowable under Part B if the patient was originally treated as an outpatient rather than admitted as an inpatient 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:*** Allows Medicare Recovery Auditor Contractors (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 seeks to develop improved methods to investigate and prosecute fraud in order to protect the Medicare Trust Fund from fraudulent actions and the resulting improper payments. This demonstration will also help lower the error rate by preventing

improper payments rather than the traditional "pay and chase" methods of looking for improper payments after they occur. This demonstration began on August 27, 2012.

- ***Prior Authorization of Power Mobility Devices (PMDs):*** Implemented a prior authorization process for scooters and power wheelchairs for people with Medicare who reside in seven states with high populations of fraud and error-prone providers (CA, IL, MI, NY, NC, FL and TX) beginning with orders written on or after September 1, 2012. This demonstration seeks to develop improved methods for the investigation and prosecution of fraud. In addition to the benefits mentioned above this demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. This demonstration began on September 1, 2012.

Enhancing Program Integrity Through the Prevention and Detection of Fraud, Waste and Abuse

Milestones

CMS has implemented many of the new anti-fraud authorities provided in the Affordable Care Act (P.L. 111-148 and P.L. 111-152) and the Small Business Jobs Act of 2010 (P.L.111-240) to strategically combat fraud, waste, and abuse, and combined with additional tools, has developed a comprehensive strategy to prevent and detect fraud and abuse. The strategy requires CMS to work closely with States, our law enforcement partners, the private sector, and health care providers.

The "Twin Pillar" Approach: CMS's twin pillar approach to fraud prevention in Medicare complements the traditional program integrity efforts to detect and prevent fraud. The first pillar is the Fraud Prevention System (FPS) that applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system that is designed to identify ineligible providers or suppliers prior to their initial enrollment or revalidation. Together these innovative new approaches are growing in their capacity to protect patients and taxpayers from those providers intent on defrauding our programs. These pillars represent an integrated approach to program integrity – preventing fraud before payments are made, keeping bad providers and suppliers out of Medicare in the first place, and quickly removing wrongdoers from the program once they are detected.

The First Pillar – The Fraud Prevention System*:* The FPS is the predictive analytic technology required under the Small Business Jobs Act that has been running predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service, including DMEPOS claims, prior to payment. Since June 30, 2011, all claims - more than one billion - have been screened and the fraud detection computer models within the FPS are growing in sophistication. CMS has implemented the predictive analytic technology consistent with practices used by private insurers to detect health care fraud. CMS is also using the advanced technology to shift how potential fraud is identified and investigated as part of our comprehensive fraud preventions strategy.

CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. The system generates alerts that identify egregious, suspect, or aberrant activity that program integrity analysts further investigate. CMS and Zone Program Integrity Contractors (ZPICs) use the FPS to prevent and detect improper payments using all available administrative tools and actions, including claim denials, payment suspensions, revocation of Medicare billing privileges, and referrals to law enforcement. CMS's Center for Program Integrity (CPI) directs the ZPICs to:

- Develop investigative leads generated by the FPS and perform data analysis to identify cases of suspected fraud, waste, and abuse;

- Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars;

- Make referrals to law enforcement for potential prosecution and provide support for ongoing investigations; and

- Identify improper payments to be recovered.

In the first implementation year of the FPS, 1047 active ZPIC investigations have been supported by leads generated by the FPS. Specifically, the FPS generated leads for 536 new fraud investigations, provided new information for 511 pre-existing investigations, and triggered thousands of provider, supplier, and beneficiary interviews to verify that legitimate items and services were provided to Medicare beneficiaries. While CMS continues to refine the methodology for estimating the value of fraud prevention, the FPS has achieved early results that prove the value of this innovative approach to fraud prevention. In the first year of the system, we have stopped, prevented, or identified an estimated $115 million in fraudulent payments. This comes out to an estimated $3 in savings for every $1 spent, a positive return for the first year.

Additionally, the FPS has led to 617 direct interviews with providers and suppliers suspected of participating in fraudulent activity, and over 1,642 interviews with beneficiaries to confirm whether they received services for which the Medicare program had been billed. These numbers are increasing every day. The beneficiary interviews are similar to the inquiries credit card companies make to cardholders when a suspicious purchase is flagged. CMS uses the information learned from these beneficiary interviews along with historical claims data to identify the characteristics of potentially bad actors and then builds that information into the FPS's predictive algorithms and other sophisticated analytics. Additionally, CMS incorporates beneficiary complaints about potentially fraudulent providers and suppliers submitted via 1-800-MEDICARE directly into the FPS to further refine our analytics.

The Second Pillar: Enhanced Provider Enrollment and Automated Provider Screening:

The second pillar of CMS's program integrity strategy is enhanced enrollment and screening requirements for providers and suppliers seeking to enroll or revalidate their enrollment in Medicare. This innovative approach is designed to leverage the increased scrutiny applied to

bad actors while simultaneously making it easier and more efficient for legitimate providers and suppliers to enroll or re-enroll in the Medicare program. CMS launched the APS technology on December 31, 2011. Medicare Administrative Contractors (MACs) and the National Supplier Clearinghouse (NSC) for DMEPOS enrollment are responsible for provider and supplier enrollment. Currently, the MACs and the NSC process paper applications and crosscheck information manually against various databases to verify provider and supplier enrollment requirements such as licensure status. The new APS technology will conduct routine and automated screening checks of providers and suppliers against thousands of private and public databases to more efficiently identify and remove ineligible providers and suppliers from Medicare. CMS used the APS to verify the licenses of all enrolled physicians and identified 35,000 physicians with potential license issues. As a result, 7,608 have had their billing privileges revoked as of September 2012.

Provider enrollment is the gateway to the Medicare program, and CMS has made significant improvements that are changing the way providers and suppliers interact with CMS. The Provider Enrollment, Chain, and Ownership System (PECOS) maintains the official record of information for all providers, suppliers, and associated groups enrolled in Medicare. Provider enrollment data is used for claims payment, fraud prevention initiatives, and law enforcement activities. A key strategy for improving the process for honest providers and suppliers, while clamping down on bad actors, is the creation of an all-digital process for web-based PECOS. CMS has already implemented the web-based payment of the application fee and now permits the use of electronic signatures on applications. The availability of the electronic signature option eliminates the requirement that providers and suppliers mail a paper signature at the end of the application process. As a result, CMS has seen a significant increase in the submission of web applications, especially for institutional providers, group practices, and DMEPOS suppliers.

Categories of providers and suppliers in the "moderate" level of risk are now required to undergo an on-site visit prior to enrolling or upon revalidation of their Medicare billing privileges. This new requirement expanded on-site visits to many providers and suppliers that were previously not subject to such site visits as a requirement for enrolling in the Medicare program. In addition to announced and unannounced site visits, regulations require providers and suppliers that are assigned to "high" level screening based on their risk of fraud to be subject to fingerprint-based criminal background checks. CMS is currently working on the procurement of a fingerprint contractor and expects to implement this requirement by Q4 FY 2013. As a result of the new Affordable Care Act screening requirements, CMS estimates that approximately 50,000 additional site visits will be conducted between March 2011 and March 2015 to ensure providers and suppliers are operational and meet enrollment requirements.

CMS completed the procurement of a national site visit contractor to increase efficiency and standardization of the site visits. The National Site Visit Contractor (NSVC) began performing site visits on all Medicare providers and suppliers except for DME in late January 2012. As of September 30, 2012 the NSVC completed 23,988 site visits; of those completed, the NSVC determined 534 sites to be nonoperational. If further investigation by the MAC determines those facilities have not submitted a change of address or are otherwise not in

compliance with all enrollment requirements, they may either be denied or revoked as deemed appropriate. Additionally, CMS completed site visits on over 30,000 DME suppliers in FY 2012. As a result of these visits, CMS revoked billing privileges from 381 providers and suppliers and denied 185 enrollment applications for new billing privileges.

CMS has embarked on an ambitious project to revalidate the enrollments of all existing 1.5 million Medicare suppliers and providers by 2015 under the new Affordable Care Act screening requirements. Since March 2011, CMS enrolled or revalidated enrollment information for nearly 410,000 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act. As a result of revalidation and other proactive initiatives, CMS has deactivated 136,682 enrollments and revoked 12,447 enrollments nationwide.

The Integrated Data Repository (IDR) and One Program Integrity (One PI)*:* The IDR contains a comprehensive set of Medicare provider, beneficiary and claims data for Medicare Parts A, B, and D back to January 2006. The IDR is used in conjunction with One PI, CMS's centralized portal that provides CMS contractors and law enforcement with a single access point to Medicare data as well as analytic tools to review and analyze the data. One PI improves CMS's ability to detect fraud, waste, and abuse by providing a rich data source and ready access to consistent, reliable, and timely analytic tools.

Over the last 12 months, CMS has also expanded the IDR to include shared systems data, providing access to Part B and Part B-DME claims data from both before and after final payment has been made. This change enables ZPIC and CMS modelers to test pre-payment analytics on historical data for the development of FPS models. With shared systems history going back to FY 2006, ZPICs and CMS modelers are also able to improve their analytics for post-payment detection of fraud, waste, and abuse. Part A data from the shared systems will be added in by the first quarter of calendar year 2013. CMS is also working to incorporate State Medicaid data into the IDR, while also working with States to improve the quality and consistency of the data reported to the Federal government from each State.

Beginning in July of 2012, CMS further strengthened One PI by providing ZPICs onsite training. This training is scheduled to occur at one ZPIC each month into calendar year 2013.

Planned Actions and Challenges

In the FPS's second year of operation, CMS plans to build on its first-year progress. CMS will enhance the integration of the FPS and the Medicare claims processing system. The agency also plans to more than double the number of models currently in the FPS and will continue to enhance models, making them more sophisticated and incorporating more and better data.

We are working to enhance the program though strong partnerships with our law enforcement partners. The HHS Office of Inspector General (OIG) Office of Investigations (OI) and the Federal Bureau of Investigation (FBI) are already using the FPS to develop cases against fraudulent providers and suppliers. Sixteen OIG and FBI personnel have direct access to the FPS.

Further, both the OIG and the FBI have actively participated in the development of new analytic models to effectively find fraud. The OIG and the FBI have embedded staff onsite at CMS to facilitate active engagement with the CMS Center for Program Integrity and the FPS.

CMS is also working to calculate cost savings for the Fraud Prevention System. Never before has CMS been asked to establish measures of cost savings from a fraud tool and report this to Congress. CMS recognizes that there are inherent challenges that the Agency faces in measuring and reporting cost savings. First, there are conceptual issues about how to measure the costs avoided when specific actions result in preventing fraud from taking place. Second, there are practical data collection issues that are beyond FPS, such as in tracing the actual dollars recovered from providers to the original source of an overpayment identification. The paradigm shift to fraud prevention poses new challenges in moving away from measuring success solely through funds actually recovered, and requires new thinking about how to measure the value of preventing fraudulent payments in the future. CMS plans to form an inter-Agency workgroup to address the challenges inherent in development of an appropriate measure of cost savings.

Enhancing Program Integrity in Parts C and D

Milestones

The National Benefit Integrity Medicare Drug Integrity Contractor (MEDIC) performs Part C and Part D program integrity activities, including proactive data analysis, law enforcement support, referrals to law enforcement, complaint intake, identification of program vulnerabilities, and investigation of Part C and Part D fraud, waste and abuse. CMS uses the Outreach and Education MEDIC to provide Part C and D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups.

The Affordable Care Act requires CMS to implement Recovery Audit Contractor (RAC) provisions in Parts C and D. On January 13, 2011, CMS signed a contract to implement a Part D RAC. The Part D RAC is dedicated to identifying improper payments previously paid to providers in reconciled Medicare claims and to provide information to CMS to help prevent future improper payments. Initial areas of focus for the RAC include payments to plans for drugs prescribed by excluded prescribers, underpayments and overpayments. In June 2012, the Part D RAC notified Part D Plan Sponsors of identified overpayments related to a review of 2007 PDE data to identify excluded individuals and entities, and recoupment began in November 2012. The Part C RAC will identify improper payments related to coordination of benefits in ESRD, Hospice and Medicare Secondary Payer (MSP), and provide information to CMS to help prevent future improper payments. CMS anticipates awarding the Part C RAC contract in July 2013.

Planned Actions and Challenges

CMS plans to re-compete the National Benefit Integrity MEDIC contract in FY 2013. Additionally, the Part D RAC will begin to audit additional years and identify additional issues for review in the spring of 2013.

Improving Program Management – Managing IT and IT Security

Milestones

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.

Planned Actions and Challenges

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 HHS's Computer Security Incident Response Team (CSIRT), the CMS SOC is detecting and protecting the CMS IT Enterprise for various types of Cyber security 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's initiative for modernizing CMS computer and data systems to support improvements in care delivery.

Program Integrity – Improving the Medicare Secondary Payer Program

CMS is striving to strike the appropriate balance between protecting the Medicare Trust Funds and promoting the well-being of Medicare beneficiaries, while working to improve the MSP process. To that end, CMS has taken steps to improve and streamline the MSP program. CMS has provided educational materials to the industry in the form of free computer-based training modules, posted guidance in a downloadable format on our website, and provided technical assistance through contracted technical representatives. Also, CMS is working to consolidate MSP information through a new contracting strategy that will provide stakeholders with one central point of contact and one single website for all aspects of MSP policy and operations. CMS has already implemented two recovery thresholds, and will continue to monitor and evaluate the data received from recently implemented mandatory insurer ("Section 111") reporting to determine if these thresholds should be adjusted and whether additional thresholds can be implemented. CMS has also revised recovery correspondence that is issued to beneficiaries to ensure that rights and responsibilities are more clearly communicated. In October 2011, CMS streamlined the Rights and Responsibilities and Conditional Payment Notification Letters. CMS plans to continue revising MSP correspondence so it can be easily understood by Medicare beneficiaries.

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

Medicaid

Problem: Over the past several years GAO has taken issue with state financing arrangements for the Medicaid program that it believes are improper and/or 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 could better incorporate the use of key Medicaid data systems into its oversight of state claims and could clarify and communicate its policies in several areas, including supplemental payment arrangements.

Goals:

- 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.

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

The CMS has taken steps to strengthen the fiscal accountability of the Medicaid program. We have developed a financial management strategic plan for Medicaid, and incorporated the use of key Medicaid data systems into its oversight of states' claims, and clarified or communicated its policies in several high risk areas, including supplemental payment arrangements.

Milestones

- **Strengthen the Fiscal Accountability of the Medicaid program. (GAO-07-214):** On May 29, 2007, CMS promulgated the final rule, Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of the Federal-State Financial Partnership (CMS-2362-F), to clarify the appropriate Medicaid state financing sources, including 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 Cost Limit for Providers rule 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 upheld a Congressional moratorium on rulemaking and invalidated the Cost Limit for Providers rule. *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 (2008). On November 30, 2010 CMS removed the 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 in a report to Congress and CMS on the policy and financial impact of certain proposed and final Medicaid regulations placed under moratorium by Congress. This report is titled *Analysis of Impact and Issues Related to Four Medicaid Regulations*, and 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 process to monitor and collect information to assure state financing arrangements are consistent with Medicaid payment principles. CMS 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.

CMS will be issuing guidance letters that promote accountability through data review strategies and upper payment limit monitoring. These letters will reinforce states' and CMS's responsibilities to actively monitor Medicaid fiscal accountability for overall efficiency and compliance with federal regulations.

Further Enhance Data Analysis Capabilities (GAO-06-705)

In response to the priorities set by the Medicaid and CHIP Business Information Solutions (MACBIS) Council, CMS is working to streamline the current data and systems environment to minimize the data requests, align data definitions and standards, and create an enhanced operational IT environment to store and to support the use of Medicaid and CHIP data. Data and systems reform are being addressed for four types of data: 1) operations data including fee-for-service claims, encounters, and beneficiary and provider eligibility and enrollment; 2) program data comprised of program characteristics about eligibility structure, benefit structure, and payments; 3) performance data around the business functions of timely determinations and payment; and 4) quality data about the quality of care.

The Medicaid Statistical Information System (MSIS) is the primary vehicle for collection of operations data from states today. Going forward, the Transformed MSIS (T-MSIS) will collect the data that are most needed to support program oversight, administration, and program integrity in a more timely, accurate, and complete submission. Following the successful completion of the 10-state pilot, we have initiated steps with all states to begin TMSIS data submission in 2013. (Before completion of the 10-state pilot, an eleventh state joined the pilot, providing even more data for analysis.) In addition to evaluating enhanced data sets, the 10-State Pilot also tested assumptions concerning the platform, the transactions and the automation

of validation that will be used in the creation of the permanent IT solution for Medicaid and CHIP data. CMS is hosting national webinars and providing one-on-one state assessments and consultations to help the states successfully implement T-MSIS.

Concurrently, CMS is preparing to launch a new system for the collection of Medicaid and CHIP Program (MACPro) information. MACPro will be a web based system to receive and adjudicate state program changes. The system will be released in phases and is scheduled to be available to states to put in priority actions for health care reform early in 2013. CMS is currently soliciting states to register approved users within the MACPro System.

Both of these new systems have been mapped to a Medicaid and CHIP data model resulting in a much higher degree of standardization across state systems. CMS has developed a high-level multi-year plan for system integration and retirement that will streamline data feeds and set up a single source for Medicaid and CHIP data. Business intelligence tools are being designed to layer on top of the data streams, thereby enabling integrated analysis and reporting for both CMS and the states.

Ensure Waiver Programs Are Financed Appropriately (GAO-08-87)

- **CMS has made efforts to review Section 1115 Demonstrations in accordance with program objectives and mitigate budget neutrality risk.** The Secretary of HHS 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 continues to provide states with technical assistance in accordance with budget neutrality principles and will continue to 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 and expects that the 2012 goal will be met.

Improve Fiscal Integrity and Financial Management (GAO-09-628T)

- **CMS has worked to 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.

  MIP encompasses a wide variety of CMS activities to support states' efforts to prevent improper payments and fraud in their Medicaid programs. In 2010, the Center for Program Integrity was formed to integrate Medicaid and Medicare program integrity (PI) efforts and has allowed for a centralized approach that enables CMS to develop more strategic and coordinated initiatives for fighting fraud and abuse.

In FY 2012, CMS redesigned the National Medicaid Audit Program, continued the implementation of program integrity provisions of the Affordable Care Act, and supported states' efforts to reduce improper payments as required by Executive Order 13520.

To fulfill the requirement in Section 1936 of the SSA to provide support and assistance to state Medicaid program integrity efforts, CMS has conducted triennial comprehensive reviews of state program integrity operations to identify problems that warranted improvement or correction in state operations. In the reviews, CMS also highlights noteworthy state best practices. With the completion of 18 comprehensive reviews of state program integrity operations in FY 2012, CMS has performed a review of every state, Puerto Rico and the District of Columbia at least once and 44 states have been reviewed twice.

The Medicaid Integrity Institute (MII) provides training tailored to meet the needs of state Medicaid Program Integrity employees, with the goal of raising national program integrity performance standards and professionalism. The MII is widely acclaimed by state officials, and has trained 3,383 state employees through 82 courses from its inception in 2008 through September 30, 2012. CMS plans to enhance the educational opportunities provided through MII in FY 2012 by expanding course offerings, providing distance learning through webinars to train even more state program integrity staff, and initiating the Certified Program Integrity Professional designation for state program integrity staff who successfully complete certification requirements.

Planned Actions and Challenges

CMS is fundamentally changing the design and operation of the Medicaid Integrity Program, and in particular the National Medicaid Audit Program, to improve overall and to better support states' efforts to combat Medicaid fraud, waste, and abuse. CMS is incorporating lessons learned from early implementation efforts and initial successes with collaborative audits. We have also taken into consideration recommendations from the HHS OIG, GAO, National Association of Medicaid Directors, and the Medicaid and CHIP Payment and Access Commission. CMS is implementing the program redesign as a phased approach that involves piloting new concepts and sharing best practices with states.

An important part of the redesign of the National Medicaid Audit Program is working collaboratively with states to identify issues and providers for audit and to obtain more accurate claims data from state systems. The collaborative process improves audit target selection, streamlines communication to ensure correct application of state policies, and provides more accurate and up-to-date Medicaid claims data for federal contractors. Collaborative audits have proven to be an effective way to coordinate federal and state audit efforts and resources to better meet states' needs resulting in more timely and accurate audits. Through FY 2012, CMS had developed 218 collaborative audits with 22 states that represent approximately 60 percent of all Medicaid expenditures. CMS expects to have collaborative projects with 30 states by the end of FY 2013.

In FY 2013, CMS plans to conduct 14 comprehensive reviews of state program integrity operations as part of its transition to a quadrennial review cycle. With input from states and the OIG, CMS has designed a new review model to better identify opportunities for technical support and to reduce burden on the states. CMS hosted conference calls to discuss Medicaid program integrity issues, best practices and issued guidance on policy and regulatory issues. CMS is also working with states to assess their program integrity vulnerabilities and design appropriate strategies for improvement by:

- Evaluating states with identified vulnerabilities for participation in collaborative audit projects and joint "boots-on-the-ground" site visits to investigate appropriate provider targets and help train state staff;
- Supporting states use of corrective action plans to address vulnerabilities identified by program integrity reviews;
- Providing technical assistance to improve states' program integrity capabilities; and
- Expanding capabilities to support states with their PI oversight of managed care and other payment arrangements.

Support States' Efforts to Reduce Medicaid Improper Payments

Milestones

- In collaboration with the states, CMS is working to address improper payments. CMS measures improper payments annually through the Payment Error Rate Measurement (PERM) program, 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 to its error rate measurement activities, CMS is 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 MII, 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.

  CMS has also implemented Executive Order 13520, Reducing Improper Payments, which requires that certain federal programs - including Medicaid - that already report an annual measurement of improper payments develop supplemental measures of payment error. CMS has initiated Medicaid supplemental measurement projects to more accurately reflect performance and improvement in reducing Medicaid improper payments. For example, CMS has implemented a payment accuracy improvement project in the area of pharmacy education that will measure the extent to which education targeted at physicians with aberrant prescribing practices can reduce the number of prescriptions that exceed recommended dosages. The Education MIC prepared educational materials

designed to reduce overprescribing for five therapeutic drug classes that have been identified as having the highest potential improper payment rates. The educational intervention has been completed in three states, which are expected to submit results beginning in March 2013.

The FY 2012 Medicaid improper payment error rate is 7.1 percent, totaling $19.2 billion in improper payments. This represents a drop in the improper payment rate from FY 2011 (8.1 percent or $21.9 billion). In addition, CMS has devoted significant effort and resources to implementing the Medicaid program integrity provisions of the Affordable Care Act. CMS has issued 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 was effective on January 1, 2012, and 36 States had implemented Medicaid RAC programs as of September 30, 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- topics include sharing lessons learned from the Medicare Recovery Audit program.

Planned Action and Challenges

- A key component of the CMS strategy to address fraud, waste, and abuse has been to educate Medicaid service providers, managed care entities, Medicaid beneficiaries, and other stakeholders about issues of Medicaid program integrity and quality of care. Specifically, CMS's Education MIC collaborates with states, conducts research, performs outreach, and provides training sessions on identified topics to the targeted Medicaid audiences as approved by CMS. By mid-December 2012, program integrity staff from 51 Medicaid programs had attended at least one of the webinars on drug diversion prevention, dental professional compliance, managed care plan compliance, and beneficiary card sharing. Staff from 20 states attended all four webinars. Topics for upcoming educational initiatives include personal care services, hospice services, non-emergency medical transportation, and other outpatient services. In addition to webinars, CMS has created educational products that states can customize and distribute to providers, beneficiaries, and other key stakeholders to enhance awareness of program integrity issues.

  To implement the Medicaid program integrity program integrity provisions of the Affordable Care Act, CMS continues to provide assistance to states and issue guidance as needed to assist states in the implementation of their own state-based RAC programs as well as facilitate state compliance with the final rule. CMS is also implementing other program integrity provisions of the Affordable Care Act, including 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. For example, to facilitate states' compliance with Section 6501 of the Affordable Care Act, CMS established a secure web-based application that allows

states to share information regarding terminated providers beginning on January 1, 2011. A total of 49 states have registered for access to the database which contains data on more than 4,380 terminated providers: 31 states have imported data into the database and 25 states have exported data on terminated providers. These activities, combined with the other efforts of the MIP, represent a comprehensive approach to combat provider fraud and abuse.

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

Milestones

- **CMS has worked to ensure Nursing home resident health and safety:** In the 10th statement of work, 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 18th 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.

Ensuring that Medicaid Beneficiaries Obtain Adequate Access to Medical Care (GAO-12-946/ GAO 13-55)

Although this report noted that over two-thirds of states reported challenges to ensuring access to dental and specialty care, the report found Medicaid access to care generally comparable to that of private insurance. About four percent of beneficiaries who had Medicaid coverage reported difficulty obtaining necessary care compared with three percent of the privately insured. To attract new providers, over half the states are taking actions to simplify administrative requirements for provider participation or increase provider payment rates. GAO found that most states are increasing beneficiary services rather than limiting them.

Generally, this report offers good news for CMS and HHS. The report did not issue any specific recommendations. CMS, however, is engaged in a number of efforts, through the collection and reporting on core measures and the supporting Technical Assistance contractor, to monitor access and quality of care for Medicaid beneficiaries. We also have launched two nationwide improvement efforts (one in oral health and the other in maternal and infant health) to support state efforts in improving access and quality in those areas.