2024 REPORT TO CONGRESS

Medicare & Medicaid Program Integrity

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

REPORT TO CONGRESS

Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2024

September 2025

Executive Summary

The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2024 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). Section 1893(i)(2) requires the Centers for Medicare & Medicaid Services (CMS) to report the use of appropriated funds, including funds transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund, and the effectiveness of the use of such funds for Medicare program integrity activities. Section 1936(e)(5) requires CMS to report on the use of appropriated funds and the effectiveness of the use of such funds for Medicaid program integrity activities.[1]

CMS's mission for program integrity is to prevent, detect, and combat fraud, waste, and abuse in the Medicare, Medicaid, and the Federally-facilitated Marketplace programs. CMS achieves this mission by ensuring that it makes the correct payment to the right entity for services covered under CMS programs. CMS also collaborates with providers[2], plan sponsors, states, and other stakeholders to support proper enrollment and accurate billing practices. This work focuses on protecting patients while also minimizing unnecessary burden.

As federal health programs are quickly evolving and improving health outcomes, CMS's program integrity strategy must keep pace to address emerging challenges. To focus its efforts, CMS uses the Government Accountability Office (GAO)[3] Fraud Risk Framework to identify and mitigate program integrity risks in all CMS-administered health care programs. CMS developed a five-pillar program integrity strategy intended to modernize the Agency's approach and protect its programs for future generations. In FY 2024, this strategy focused on stopping bad actors, preventing fraud, mitigating emerging program risks, and reducing provider burden.

Medicare Program Integrity

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

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

[3] All abbreviations are listed in Appendix C.

Medicare processes over one billion Fee-for-Service (FFS) claims annually[4] To do this properly – to "pay it right" – Medicare uses a variety of tools, including provider enrollment, data analysis, investigations, and review of medical records.

In FY 2024, CMS's program integrity activities saved Medicare an estimated $26.3 billion and produced a return on investment (ROI) of $14.6 to 1 (see Table 3 for activity-specific savings).[5] These activities help strengthen the integrity and sustainability of the Medicare program, while promoting quality and the efficient delivery and financing of health care.

In addition to the estimated savings and ROI, CMS's program integrity efforts have contributed to a reduction in the improper payment rate in recent years. The Medicare FFS improper payment rate has decreased from 9.51 percent in 2017 to 7.66 percent in FY 2024.[6]

Medicaid and CHIP Program Integrity

Medicaid and the Children's Health Insurance Program (CHIP) are federal state partnerships, and these partnerships are central to the programs' success. CMS provides the states with guidance, technical assistance including tools and data, federal matching funds for expenditures, and other resources to use in meeting statutory and regulatory requirements. States fund their share of the programs and, within federal and state guidelines, operate their individual programs through various activities, such as setting rates, paying claims, enrolling providers and beneficiaries, contracting with private plans, improving service quality, and claiming expenditures. States and CMS share responsibility for ensuring that state and federal dollars are used to deliver health care services consistent with efficiency, economy, and quality to eligible individuals and are not misspent due to fraud, waste, or abuse. In FY 2024, federal and state collaborative program integrity efforts for Medicaid and CHIP resulted in estimated federal share savings of $1.5 billion (see Table 4 for activity-specific savings).[7]

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[4] Centers for Medicare & Medicaid Services, "CMS Financial Report for the Fiscal Year 2024," November 2024 https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

[5] CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes. CMS notes any such changes in Appendix B.

[6] US Department of Health and Human Services, "FY 2024 HHS Agency Financial Report," November 14, 2024, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html, page 200

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

In 2024, CMS released the FYs 2024-2028 Comprehensive Medicaid Integrity Plan (CMIP). The CMIP seeks to protect taxpayer dollars and is based on the three pillars of flexibility, accountability, and integrity.[8]

[8] Centers for Medicare & Medicaid Services, "Comprehensive Medicaid Plan, FY 2024-FY 2028," Undated https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance

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1 Introduction

The Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2024 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report the use of appropriated funds and the effectiveness of the use of such funds for activities conducted under the Medicare and Medicaid Integrity Programs.

CMS is the agency within the Department of Health and Human Services (HHS) responsible for administering the Medicare program consistent with title XVIII of the Act. CMS is also responsible for providing direction and guidance to, and oversight of, state-operated Medicaid programs and Children's Health Insurance Programs (CHIP), consistent with titles XIX and XXI of the Act, respectively, in addition to other federal health care programs and activities. The Medicare and Medicaid Integrity Programs help protect Medicare and Medicaid against fraud, waste, and abuse. In addition, CMS is responsible for providing direction and guidance to, and oversight of, Federally-facilitated Marketplaces (FFMs)[9] and state-based Marketplaces established pursuant to the Patient Protection and Affordable Care Act (the Affordable Care Act).[10]

Medicare, Medicaid, CHIP, and the Marketplaces provide health care coverage for many Americans. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 68 million beneficiaries in 2024, while Medicaid enrollment has increased from 11 million beneficiaries in 1966 to approximately 73 million beneficiaries in 2024.[11] Over 13 million people are dually eligible for both Medicare and Medicaid.[12] Approximately 21.4 million people selected, or were automatically re-enrolled in, a Marketplace plan during the 2024 Open Enrollment period.[13]

The CMS Center for Program Integrity (CPI) is primarily responsible for implementation of the Medicare and Medicaid Integrity Programs. While other areas of CMS also engage in program

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

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

[11] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

[12] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

[13] Centers for Medicare & Medicaid Services, " Marketplace 2025 Open Enrollment Period Report: National Snapshot, December 4, 2024, https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-0

integrity-related activities,[14] this report focuses on the program integrity activities led, or that had significant involvement, by CPI.

During FY 2024, CMS's comprehensive program integrity efforts resulted in estimated Medicare savings of $26.3 billion and estimated Medicaid and CHIP federal share savings[15] of $1.5 billion. This commitment to fiscal integrity allows CMS to focus on efforts to better serve patients and ensure that providers render high-quality care. Section 1.3 of this report provides activity-specific Medicare, Medicaid, and CHIP savings, and Appendix B provides detailed methodologies for all savings metrics. Achieving meaningful cost savings is essential for extending the Medicare Trust Funds' solvency and supporting the long-term financial stability of Medicare, Medicaid, and CHIP.

CMS Program Integrity Strategy

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

CMS's program integrity strategy focuses on stopping bad actors, preventing fraud, mitigating emerging program risks, and reducing provider burden. To focus its program integrity efforts, CMS uses the GAO Fraud Risk Framework to identify and mitigate program integrity risks in all CMS-administered health care programs. CMS organized this report around these strategic goals, with each section detailing specific aspects of CMS's program integrity efforts. Appendices at the end of this report provide additional information and references.

1.1 Reporting Requirements

As required by sections 1893(i)(2) and 1936(e)(5) of the Act, CMS must report to Congress the use of appropriated funds and the effectiveness of the use of such funds for activities

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

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

conducted under the Medicare and Medicaid Integrity Programs.[16] Section 1893(h)(8) of the Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and the savings to the program.

This report fulfills the reporting requirements with respect to the Medicare and Medicaid Integrity Programs, the Medicare FFS Recovery Audit Contractors (RACs), the Medicare Advantage (MA or Part C) program and Medicare Part D prescription drug benefit (Part D) RACs, and the Medicaid RACs.[17]

1.1.1 Medicare Program Integrity Funding[18]

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)[19] established mandatory funding for the Medicare Integrity Program, which provided a stable funding source for Medicare program integrity activities that is not subject to annual appropriations. The Affordable Care Act increased the base funding level and applied an annual inflationary adjustment to that base funding level. This funding supports program integrity functions performed across CMS, including Cost Report Audits, Medicare Secondary Payer (MSP), Medical Review, Provider Outreach and Education, and Benefit Integrity.

CMS receives additional mandatory funding pursuant to authority established by the Deficit Reduction Act of 2005 (DRA)[20] and the Affordable Care Act, as well as discretionary Health Care Fraud and Abuse Control (HCFAC) program funding, subject to annual appropriation. CMS obligated a total of $1.6 billion in FY 2024 for the Medicare Integrity Program. Additional details can be found in Appendix A.

1.1.2 Medicaid Program Integrity Funding

The DRA established section 1936 in the Act, creating the Medicaid Integrity Program and providing CMS with dedicated funding to operate the program. Under section 1936 of the Act, Congress annually appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. Beginning in FY 2011,

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

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

[18] This report includes activities funded outside of the Medicare or Medicaid Integrity Programs. Activities such as CMS Innovation Center models, the Medicare Shared Savings Program, and the DMEPOS Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity.

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

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

the Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[21] CMS obligated a total of $121.4 million in FY 2024 for the Medicaid Integrity Program. In addition, CMS obligated a total of $129.0 million in FY 2024 for Medicaid program integrity activities using discretionary HCFAC funds. Additional detail can be found in Appendix A.

1.2 Program Integrity in Medicare and Medicaid

CMS is the nation's largest insurer, covering over 160 million Americans through Medicare, Medicaid, CHIP, and the health insurance marketplaces.[22] CMS programs account for approximately 22 percent of federal expenditures.[23] Medicare is comprised of four programs:

Hospital Insurance (Part A), Supplementary Medical Insurance (Part B), Medicare Advantage (MA, also known as Part C), and Medicare Prescription Drug Benefit (Part D). Medicare processes over one billion FFS claims a year.

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

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

[21] 42 U.S.C. 1396u-6(e)(1)(D).

[22] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

[23] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Unified Program Integrity Contractors (UPICs)	Medicare FFS and Medicaid	• Identify and investigate potential fraud, waste, or abuse in Medicare and Medicaid • Conduct medical review for Medicare and Medicaid program integrity purposes • Make referrals to law enforcement for further investigation and potential prosecution • Provide support for ongoing law enforcement investigations • Investigate leads generated by the Fraud Prevention System (FPS) and complaints from beneficiaries and a variety of other sources • Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid • Make recommendations to CMS or states for appropriate provider-related administrative actions (i.e., revocations and payment suspensions) to protect the Medicare Trust Funds and Medicaid dollars • Implement provider-related administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the Medicare Administrative Contractors • Provide feedback and support to CMS to improve the Unified Case Management System • Identify improper payments to be recovered within Medicare and Medicaid
Medicare Administrative Contractors (MACs)	Medicare FFS	• Process claims, determine proper payment amounts, and pay providers and beneficiaries • Perform A/B provider and supplier screening and enrollment (DME supplier enrollment managed by National Provider Enrollment contractors) • Audit the Medicare cost reports upon which CMS bases part of Medicare payments to institutional providers, such as hospitals and skilled nursing facilities • Conduct prepayment and post-payment medical review, and prior authorization

		• Analyze claims data to identify providers with patterns of errors or unusually high volumes of particular claim types • Develop and implement prepayment edits • Deliver provider education, outreach, and technical assistance • Collect overpayment amounts identified through prepayment and post-payment review conducted by the MACs and other review contractors
Supplemental Medical Review Contractor (SMRC)	Medicare FFS	• Conduct nationwide medical review as directed by CMS • Notifies CMS of identified improper payments and noncompliance with documentation requests, quality of care concerns, and matters requiring further analysis of potential fraud, waste, or abuse • Assists CMS with closing recommendations from the Office of Inspector General
Medicare FFS Recovery Audit Contractors (RACs)	Medicare FFS	• Conduct post-payment reviews to identify a wide range of improper payments • Correct improper payments by identifying overpayments to be collected and underpayments to be restored • Make recommendations to CMS about how to reduce improper payments in the Medicare FFS program
Coordination of Benefits & Recovery (COB&R) Contractors	Medicare FFS Secondary Payer	• Identify, develop, and recover Group Health Plan and Non-Group Health Plan debts • Provide customer service to beneficiaries, providers, attorneys, insurers, and employers for coordination of benefits and recovery activities. • Perform data collection and electronic data interchange • Conduct business analysis, quality assurance activities, outreach and education to stakeholders • Provide system development and data center support for all coordination of benefits and recovery information systems • Functions as the national claims' crossover warehouse for Medicare FFS claims.

Plan Program Integrity Medicare Drug Integrity Contractor	Medicare Part C and Part D	• Conduct data analyses of Medicare Part C and Part D issues leading to potential identification of improper payments and regulatory non-compliance • Coordinate Medicare Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement entities • Support enforcement of Medicare Part C and Part D through Program Integrity audits, national audits, and self-audits of plan sponsors.
Investigations Medicare Drug Integrity Contractor (I-MEDIC)	Medicare Part C and Part D	• Conduct complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support • Detect, prevent, and proactively deter fraud, waste, and abuse for high-risk prescribers/pharmacies in Medicare Part C and Part D
Risk Adjustment Data Validation (RADV) Contractors	Medicare Part C	• Perform post-payment review of medical records to validate diagnoses submitted by MA organizations for risk adjustment purposes • Maintain systems that house data and support audit functions • Develop sampling frameworks for audits • Develop supplemental documents to support MA organizations' use of audit systems • Calculate payment errors • Generate audit reports • Support the appeals process
State Medicaid RACs	Medicaid FFS and Managed Care	• Contract with state Medicaid agencies (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers
Marketplace Program Integrity Contractor	Marketplace	• Conduct program integrity oversight of the Federally-facilitated Marketplaces (FFM) • Collaborate with external stakeholders, including state Departments of Insurance (DOI) and federal law enforcement agencies
Marketplace Complaints Review Contractor (MCRC)	Marketplace	• Review and categorize consumer complaints received through the Marketplace Call Center to support CPI's determination of whether an administrative remedy is appropriate

1.3 Measuring Program Integrity Success

1.3.1 Improper Payment Rates

As required by the Payment Integrity Information Act of 2019,[24] CMS estimates the amount of improper payments for Medicare FFS, Medicare Part C, and Part D; Medicaid, CHIP, and the Advance Premium Tax Credit Program (APTC).[25] Table 2 provides the gross improper payment rates (including both overpayments and underpayments) and summarizes trends in the improper payment rates since 2020. Section 4.2 of this report provides specific information on recovery audit program activities.

Table 2: Reported Improper Payment Rates Trend for Reporting Years 2020-2024[26]

Program	2020	2021	2022	2023	2024
Medicare FFS	6.27%	6.26%	7.46%	7.38%	7.66%
Part C[27, 28]	6.78%	10.28%	5.42%	6.01%	5.61%
Part D	1.15%	1.58%	1.54%	3.72%	3.70%
Medicaid	21.36%	21.69%	15.62%	8.58%	5.09%
CHIP	27.00%	31.84%	26.75%	12.81%	6.11%
APTC[29]	N/A	N/A	0.62%	0.58%	1.01%

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

[25] While CMS' improper payments reporting programs are designed to protect the integrity of CMS programs, it is important to keep in mind that not all improper payments represent fraud or abuse. They can be overpayments, underpayments, or payments where insufficient information was provided to determine whether a payment was proper.

[26]Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

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

[28] In FY 2022, CMS finalized a policy regarding treatment of spontaneous "additionals" in the improper payment rate calculation. Diagnoses that were not submitted to CMS for payment have been excluded from the payment error calculation to get a true measure of payment error. In previous years, these potential payments were reflected in the underpayment rate and overall payment error calculation; however, including the spontaneous "additionals" in the gross underpayment portion resulted in an overstatement of the overall improper payment rate. This new policy contributed to a decrease in the projected Part C improper payment rate, representing a new baseline improper payment rate for Part C, and is not directly comparable with prior reporting years. Moreover, FY 2021 also represented a new baseline due to various methodology changes, most significantly, a refined denominator calculation.

[29] The APTC improper payment estimates represent improper payments for the Federally-facilitated Marketplace. CMS continues to develop the improper payment measurement methodology for the State-based Marketplaces.

While this report discusses many of the ways that CMS works to reduce the improper payment rates for Medicare, Medicaid, and CHIP, the FY 2024 HHS Agency Financial Report (AFR) also includes a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2024 to reduce improper payments.[30]

1.3.2 Medicare Program Integrity Savings

In FY 2024, CMS's Medicare program integrity activities saved an estimated $26.3 billion.[31] This represents an ROI of $14.6 to 1.[32] CMS provides activity-specific Medicare program integrity savings in Table 3,[33] programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B. Notably for FY 2024, 35% of CMS's Medicare program integrity savings stemmed from actions on suppliers suspected of problematic urinary catheter billing ($9.3 billion). Cost avoidance from revocations represented 98% of the savings associated with these catheter suppliers.

Table 3: Medicare Savings

Type of Medicare Savings [a]	FY 2024 Savings (in millions)
Automated Actions	
National Correct Coding Initiative (NCCI) Procedure-to-Procedure Edits	$151.1
NCCI Medically Unlikely Edits	$489.9
NCCI Add-On Code Edits	$15.5
Ordering and Referring Edits	$164.4
Orthotics and Prosthetics Licensure Edits	$1.3
Fraud Prevention System Edits	$207.0
MAC Automated Medical Review Edits	$774.8
UPIC Automated Edits	$67.8
Prepayment Review Actions	
Medicare Secondary Payer (MSP)[34] Operations (Prepayment)	$6,926.8

[30] US Department of Health and Human Services, "FY 2024 HHS Agency Financial Report," November 15, 2024, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html

[31] CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes. CMS notes any such changes in Appendix B.

[32] CMS calculates the fiscal year Medicare program integrity ROI by dividing the total Medicare savings by the total Medicare obligations, i.e., the portions of program integrity obligations summarized in Appendix A that represent funding for the Medicare Integrity Program as well as other funding supporting RACs and provider enrollment. In FY 2024, this amount, i.e., the denominator of the ROI calculation, totaled $1.8 billion.

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

[34] Table 3 includes three mutually exclusive categories of MSP-related savings.

Type of Medicare Savings [a]	FY 2024 Savings (in millions)
Prior Authorization Request and Claim Reviews (in DMEPOS)	$52.2
MAC Non-Automated Medical Reviews	$96.1
UPIC Non-Automated Reviews	$8.3
Provider Enrollment Actions	
Revocations	$12,213.9
Deactivations	$155.4
Overpayment Recoveries	
MSP Operations (Recovery)	$2,602.8
MSP Commercial Repayment Center	$281.7
MAC Post-Payment Medical Reviews	$8.8
Medicare FFS RAC Reviews	$227.8
SMRC Reviews	$91.3
UPIC Post-Payment Reviews	$337.8
Medicare Part C and Part D Plan-Identified Risk Adjustment Overpayments	$2.6
Medicare Part D Plan Sponsor Audits	$98.7
Cost Report Payment Accuracy	
Provider Cost Report Reviews and Audits	-$47.8
Cost-Based Plan Audits	-$18.4
Plan Penalties	
Medicare Part C and Part D Program Audits	$0.1
Medicare Part C and Part D One-Third Financial Audits	$0.3
Medical Loss Ratio Requirement	$494.9
Other Actions	
Payment Suspensions	$562.9
Medicare Part D Reconciliation Data Reviews	-$32.2
Qualified Independent Contractor (QIC) Party Status Appeals	$30.3
Law Enforcement Referrals	
UPIC Law Enforcement Referrals	$332.7
I-MEDIC Part C and Part D Law Enforcement Referrals	$27.8
Total Savings [b]	$26,327.1

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

1.3.3 Medicaid and CHIP Program Integrity Savings

States and the federal Government share mutual obligations and accountability for the integrity of Medicaid and CHIP. This includes the application of effective safeguards to ensure the proper and appropriate use of federal and state dollars and the provision of quality care to some of the nation's most vulnerable populations. CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from CMS's Medicaid and CHIP financial oversight and state-reported Medicaid overpayment recoveries due to collaborative

federal-state programs and state-level initiatives. In FY 2024, these efforts resulted in estimated federal share savings of $1.5 billion. CMS provides activity-specific Medicaid and CHIP federal share savings in Table 4,[35] programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

Table 4: Medicaid and CHIP Savings

Type of Medicaid and CHIP Savings [a]	FY 2024 Federal Share Savings (in millions)
Medicaid and CHIP Financial Oversight	
Averted Medicaid and CHIP Federal Financial Participation	$465.5
Recovered Medicaid and CHIP Federal Financial Participation	$454.9
State-Reported Medicaid Overpayment Recoveries	
UPIC Recoveries	$19.3
State Medicaid RAC Recoveries	$176.5
Social Security Act Section 1909 Compliant False Claims Act Recoveries	$35.6
Other State Program Integrity Recoveries	$391.9
Total Savings [b]	$1,543.7

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

2 Stopping Bad Actors

2.1 Major Case Coordination (MCC)

The Major Case Coordination (MCC) activities provide an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after the development of fraud leads. This level of collaboration has contributed to several successful coordinated law enforcement actions and helped CMS to better identify national fraud trends and program vulnerabilities. In FY 2024, CMS reviewed 1,005 cases at Medicare MCC meetings, and law enforcement partners made 465 requests for CMS to refer reviewed cases.

The actions below illustrate CMS' support for the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG) and Department of Justice (DOJ) during FY 2024:

- In June 2024, the U.S. Justice Department announced criminal charges against 193 defendants, including 76 doctors, nurse practitioners, and other licensed medical professionals in 32 federal districts across the United States, for their alleged

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

participation in various health care fraud schemes involving approximately $2.75 billion in intended losses and $1.6 billion in actual losses. CMS also announced that it separately took 127 administrative actions in the previous six months against providers for their alleged involvement in health care fraud schemes.[36]

CMS also includes Medicaid in the MCC process. In FY 2024, CMS reviewed 74 cases at Medicaid MCC meetings, and law enforcement partners made 51 requests for CMS to refer reviewed cases from 18 different states. The level of collaboration resulting from the Medicaid MCC has helped CMS better identify national trends and program vulnerabilities that can lead to fraud and other improper payments.[37] For example, as part of the Medicaid MCC work in 2024, UPICs identified and referred providers that were billing for services not rendered. The collaboration of these cases often included coordination with the state, OIG, and a Medicaid Fraud Control Unit (MFCU).

2.2 Provider Enrollment

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

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

2.2.1 Medicare Provider Screening

[36] Department of Justice, "National Health Care Fraud Enforcement Action Results in 193 Defendants Charged and Over $2.75 Billion in False Claims, June 27, 2024, https://www.justice.gov/archives/opa/pr/national-health-care-fraud-enforcement-action-results-193-defendants-charged-and-over-275-0

[37] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

As required by law,[38] CMS utilizes three levels of provider enrollment risk-based screening: "limited", "moderate", "high", and a classification by provider- and supplier-types, subject to upward adjustment in certain circumstances.[39]

Providers designated in the "limited" risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider-specific requirements. Providers designated in the "moderate" risk category are subject to unannounced site visits in addition to all the requirements in the "limited" screening level. Providers in the "high" risk category are subject to fingerprint-based criminal background checks (FCBCs) in addition to all the requirements in the "limited" and "moderate" screening levels. Providers screened in the high-risk category during initial enrollment are lowered to moderate-risk screening for subsequent application submissions, such as revalidations. CMS may also elevate a provider's screening level if they were excluded from Medicare or another Federal Health Care program, terminated from Medicaid, applied for Medicare within 6 months after a temporary moratorium or had a payment suspension, Medicare revocation, or final adverse action in the last 10 years. Of the 2.9 million currently enrolled providers, 90% are designated as "limited," 8% are "moderate" and 2% are "high."

The Advanced Provider Screening (APS) system automatically screens all current and prospective providers against numerous data sources, including provider licensing and criminal records, to identify and highlight potential program integrity issues for proactive investigation by CMS. APS continuously monitors all providers against external licensure and criminal data sources to alert CMS to any actionable changes to licensure information or any criminal flags.

Site visits are a screening mechanism used to prevent questionable providers from enrolling or maintaining enrollment in the Medicare program. The CMS-authorized site visit contractors validate that the provider is operational during these visits.

CMS's provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers from the program. In FY 2024, CMS denied 5,959 enrollments, deactivated 192,636 enrollments, and revoked 3,675 enrollments (927 Individual Practitioners, 179 Institutional Providers, 1,921 DME suppliers and 648 Part B Organizations).

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[38] Sec 6401 of the ACA, Public Law 111-148 (enacted March 23, 2010) and https://www.ssa.gov/OP_Home/ssact/title18/1866.htm

[39] 42 CFR 424.518.

[40] If a provider that's precluded prescribes a part D drug, the pharmacy furnishing the medication will not be paid for the Part D drug

In addition, CMS bulk screens providers using National Provider Identifiers (NPI) data from the National Plan and Provider Enumeration System (NPPES) to identify providers that need to be added to the CMS Preclusion list. The Preclusion List consists of providers and prescribers who are precluded from receiving payment for Medicare Advantage items and services and prescribing covered Medicare Part D drugs[40] to Medicare beneficiaries.

2.3 Provider Revalidation

Generally, Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) suppliers are required to revalidate every three years, and all other providers every five years. However, CMS has the authority to modify the 3- and 5-year cycles if it determines that revalidations should occur more or less frequently. These efforts help ensure that only qualified and legitimate providers can provide health care items and services to Medicare beneficiaries.

Similarly, states are also required to revalidate Medicaid providers at least every five years. States may rely on Medicare revalidation results to meet revalidation requirements for dually participating providers.[41]

3 Preventing Fraud

3.1 Unified Program Integrity Contractors (UPICs)

CMS investigates instances of suspected fraud, waste, and abuse in Medicare and Medicaid using the UPICs. The UPICs develop investigations and take actions to prevent inappropriate payments from being made to Medicare providers. UPICs perform provider and beneficiary interviews and site visits, take appropriate administrative actions (e.g., prepayment edits, payment suspensions, revocations), and conduct program integrity reviews of medical records. While a variety of other contractors also perform medical reviews, UPIC reviews are uniquely focused on fraud detection and investigation. For example, the UPICs look for possible falsification of documents that may be associated with an attempt to defraud the Medicare and Medicaid programs.

Various UPIC administrative actions result in Medicare savings, including automated edit claim denials, non-automated review claim denials, provider revocations and deactivations (as effectuated by CMS based on UPIC investigations), payment suspensions, overpayment recoveries, and law enforcement referrals. Based on the results of all information collected, the UPICs coordinate with CMS and the MACs in taking appropriate administrative action to

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

recover improper Medicare payments and prevent future loss of funds, or the UPICs refer the cases to law enforcement.

UPICs also provide support and assistance to state Medicaid agencies by performing several functions to detect and investigate fraud waste and abuse. Further, UPICs work with states to make recommendations for appropriate administrative action to protect the Medicaid program. When a UPIC investigation or audit results in the identification of an overpayment, a report is issued to the state, and CMS works with the state to ensure the federal share of any overpayment is returned to CMS.

To maximize the impact of our Medicaid program integrity activities, CPI expects the UPICs to prioritize high dollar, high risk investigations. As noted in Section 4.6.5, Transformed-Medicaid Statistical Information System (T-MSIS) data is an important resource for program integrity activities, [42] and 713 [41](90%) of the UPICs' Medicaid investigations initiated in FY 2024 utilized T-MSIS data. Furthermore, the UPICs' FY 2024 Medicaid program integrity efforts focused on audits of Medicaid managed care plans. Additionally, UPICs' work in FY 2024 included investigations initiated in 49 states and the District of Columbia. The most common collaborative investigations and audits were conducted in the areas of hospitals, physicians, clinics, pharmacies and pharmacists, hospices, DME suppliers, and labs.

3.2 Part C and D Program Integrity

3.2.1 Medicare Drug Integrity Contractors

The Plan Program Integrity Medicare Drug Integrity Contractor's (PPI MEDIC) nationwide focus provides oversight of plan sponsor's adherence to the Medicare Part C and Part D program integrity initiatives, including identification of program vulnerabilities, data analysis, plan sponsor audits, outreach and education, and law enforcement support. As part of its work, the PPI MEDIC conducts analyses to identify trends, anomalies, and questionable prescriber and pharmacy practices, including aberrant opioid prescriptions.

The Investigations MEDIC's (I-MEDIC) nationwide focus consists of investigations of prescribers and pharmacies, recommendations for administrative actions, and submission to law enforcement of case referrals.

3.2.2 Medical Loss Ratio Requirement

A medical loss ratio (MLR) represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, as opposed to other expenses that do not directly impact patient care or quality (e.g., marketing, profits, salaries, administrative expenses, and agent commissions). The minimum MLR requirement is intended

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

to create incentives for Medicare Part C and Part D plan sponsors to reduce overhead expenses and ensure that taxpayers and enrolled beneficiaries receive value from Medicare Advantage and Medicare Part D plans. Medicare Part C and Part D plan sponsors must report the MLR for each contract they have with CMS.

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

3.3 Healthcare Fraud Prevention Partnership (HFPP)

The HFPP is a voluntary, public-private partnership consisting of the federal government, state agencies, law enforcement, private health insurance plans, and health care anti-fraud associations. The overall mission of the HFPP is to position itself as a leading body for the health care industry to reduce fraud, waste, and abuse by:

- Providing cross-payer data source, representing the full spectrum of the health care industry, to enable the performance of sophisticated data analytics and information-sharing for the benefit of all partners;
- Achieving meaningful participation by partners and establishing strategic collaborations with diverse stakeholders; and
- Leveraging partnership resources and relationships to generate real-time, comprehensive approaches materially benefiting efforts to reduce health care fraud, waste, and abuse.

In FY 2024, the HFPP reached a total membership level of 307 partner organizations, comprised of: 6 federal agencies, 81 law enforcement agencies, 15 associations, 141 private payers, and 64 state and local partners, of which 50 are state Medicaid agencies.

To achieve its objectives and ensure HIPAA Privacy Rule compliance, the HFPP uses a "Trusted Third Party" (TTP), a CMS contractor, which serves as a common data aggregator. Under this model, the TTP conducts cross-payer data aggregation and analysis services to identify potential fraud across payers, while ensuring that each Partner only has access to its own claims data.

The HFPP uses a diverse variety of approaches to identify vulnerabilities in partner data. These methods include standard searches to detect anomalies that may implicate the existence of fraud, waste, and abuse; scanning of incoming claims information against existing data sets, such as lists of deactivated providers; creation of reference files that list providers that may be

suspect based on known risks; and creation of informational content to support stakeholders in addressing vulnerabilities (e.g., white papers). The HFPP has also expanded its study methodology to collect frequently updated data, including, and consistent with all applicable privacy requirements, personally identifiable information and protected health information. The HFPP is currently using professional, institutional, and pharmacy claims.

Ninety-four of the current partners actively submit claim level data for the purpose of conducting cross-payer analyses. HFPP studies give partners ways to take substantive actions that stop fraudulent and improper payments from going out the door. Examples of studies initiated in FY 2024 include the identification of problematic billing in the following areas:

- Remote Physiologic and Therapeutic Monitoring
- Suspicious Billing of GLP-1 Agonists
- Atherectomies and Other Endovascular Interventions for Peripheral Artery Disease (PAD)
- Customized DMEPOS for Out of State Members
- Allergy Services

The HFPP also continued its efforts to foster collaboration among partners in FY 2024 by hosting two virtual and one hybrid information-sharing sessions. These meetings are used to share fraud schemes and provider alerts, provide updates on law enforcement activities, and strategize on how to broaden the HFPP's impact in the private and public sectors. Of these sessions, one was specifically for state partners with 179 attendees, while the other had 2,323; the hybrid information session drew 879 attendees. These meetings are used to share information about fraud schemes and provider alerts and provide updates on law enforcement activities. In addition, the HFPP holds various focus groups to foster open dialogue on issues and schemes and identify types of studies partners would like the HFPP to conduct.

3.4 Medicare Beneficiary Education

CMS educates people with Medicare about the importance of guarding their personal information against identity theft, protecting themselves and the Medicare Program from becoming victims of fraud, and reporting suspected fraud, waste, or abuse. In FY 2024, CMS included key fraud prevention messages in a variety of beneficiary communication channels, including:

- The *Medicare & You* handbook
- Beneficiary education materials
- 1-800-MEDICARE
- Medicare.gov
- Medicare Summary Notices

- Medicare.gov Message Center
- Social media
- Direct-to-beneficiary emails
- Response letters to beneficiary inquiries

3.5 National Correct Coding Initiative (NCCI)

The NCCI promotes national correct coding methodologies and reduces improper coding that may result in inappropriate payments in Medicare Part B and Medicaid. NCCI Procedure-to-Procedure edits prevent inappropriate payment of services that should not generally be reported together by the same provider for the same beneficiary and date of service, while an NCCI Medically Unlikely Edit is the maximum units of service (UOS) reported for a Healthcare Common Procedural Coding System (HCPCS) and *Current Procedural Terminology (*CPT*)* HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider for the same beneficiary on the same date of service. An Add-On Code (AOC) is a HCPCS/CPT code that describes a service that is performed in conjunction with another primary service by the same practitioner. An AOC is rarely eligible for payment if it is the only procedure reported by a practitioner. AOC edits assure that AOCs are never paid unless a listed primary procedure code is also paid.

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

4 Mitigate Emerging Programmatic Risks

4.1 Improper Payment Rate Measurement

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

The FY 2024 HHS AFR includes a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2024 to reduce improper payments. [43]

4.2 Recovery Audit Programs

4.2.1 Medicare Fee-For-Service (FFS)

Section 1893(h) of the Act requires the establishment of a nationwide Medicare FFS Recovery Audit Program, whose mission is to identify and correct overpayments made on claims for services and items for which payment is made under Part A or B of Title XVIII of the Social Security Act. Recovery Audit Contractors (RACs) also provide information that allows CMS to implement corrective actions to help prevent future improper payments.

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

In FY 2024, the Medicare FFS RAC program identified approximately $486.64 million in overpayments and recovered $382.21 million. [44] Recoveries in FY 2024 exceeded those in FY 2023 as the RACs identified and pursued new vulnerabilities, and review limits for existing RAC review topics were increased, allowing for the review of more claims. During FY 2024, the majority of Medicare FFS RAC collections were from hospital outpatient claim reviews. CMS regularly evaluates the RACs' performance and adherence to program requirements by using an independent validation contractor as well as CMS staff that conduct site visits to observe contractor performance requirements and conduct desk audits on claims to confirm that all aspects of program requirements are performed correctly and completely. Such oversight contributes to the RACs' accurate identification of improper payments and overall program success. Additionally, in FY 2024, the Medicare FFS RACs had a 78.54 percent overpayment recovery rate and continued to make recommendations to CMS to improve program operations and to help prevent improper payments. [45]

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[43] US Department of Health and Human Services, "FY 2024 HHS Agency Financial Report," November 15, 2024, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html

[44] Additional results and analysis of Recovery Audit Program data are available for download at: Centers for Medicare & Medicaid Services, Medicare Fee for Service Recovery Audit Program, Modified September 10, 2024, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program

[45] US Department of Health and Human Services, "FY 2024 HHS Agency Financial Report," November 15, 2024, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html page 232.

Table 5: Amounts Identified in FY 2024 by Fee-for-Service (FFS) RAC Region

FFS RAC Region	Overpayment Amount Identified (in millions)	Underpayment Amount Identified (in millions)	Overpayment Amount Recovered[46] (in millions)
1. Region 1	$79.18	$4.41	$57.14
2. Region 2	$108.17	$6.35	$78.87
3. Region 3	$135.24	$15.92	$100.58
4. Region 4	$117.50	$9.91	$99.04
5. Region 5	$46.55	$0.09	$37.89
6. Other			$8.70
TOTALS	$486.64	$36.68	$382.21

4.2.2 Medicare Part C and Part D

Although the RAC program under section 1893(h) includes Medicare Part C and Part D, and despite the success of RACs in Medicare FFS, RAC vendors have not found the incentives for performing recovery audits of the Medicare Part C program to be viable because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. Instead, CMS has been able to accomplish the same objectives that a Part C RAC would pursue (i.e., identifying, and recouping overpayments) via contract-level Risk Adjustment Data Validation (RADV) audits conducted by non-RAC contractors that perform medical record review, payment error calculations, and other supportive tasks. The contract-level RADV audit program is the primary corrective action to reduce the Part C improper payment rate through the identification and collection of overpayments. Through contract-level RADV audits, medical records are reviewed and MAOs are held financially accountable when the MAO-submitted diagnostic data for risk adjustment purposes does not conform to program rules. CMS published a final rule (CMS-4185-F2) in February 2023 that outlined its audit methodology and related policies for contract-level RADV audits, including that it will extrapolate RADV audit findings beginning with payment year (PY) 2018. In April 2024, CMS finalized an appeals rule (CMS-4205-F), to establish a clear and consistent administrative appeals process for MAOs.

Likewise, with respect to the Medicare Part D program, CMS accomplishes the objectives that a Medicare Part D RAC would pursue (i.e., identifying, and recouping overpayments) via

[46] This amount differs from the savings metric reported in Table 3. Medicare Savings. The savings metric reported in Table 3 is calculated as the amount of Medicare FFS RAC-identified overpayments that Medicare recovered, minus 1) the amount of Medicare FFS RAC-identified underpayments reimbursed to providers and 2) the amount that had been collected on Medicare FFS RAC-identified overpayments overturned on appeal in the fiscal year.

another mechanism, the PPI MEDIC, a non-RAC contractor. The PPI MEDIC's workload is substantially like that which a Medicare Part D RAC would pursue, and the PPI MEDIC has a robust program to identify improper payments. After the PPI MEDIC identifies improper payments, CMS requests that plan sponsors delete prescription drug event (PDE) records that are associated with overpayments. Subsequently, CMS validates that plan sponsors delete such records and do not resubmit them for payment. As noted previously, the PPI MEDIC's responsibilities relate to plan oversight and pertain to specific initiatives like data analysis, health plan audits, outreach and education, and law enforcement support.

4.2.3 Medicaid

Section 1902(a)(42) of the Act requires states to establish Medicaid RAC programs. Each state has the flexibility to tailor its RAC program, where appropriate, with guidance from CMS. Sixteen states currently have operational RAC programs. Federal law provides authority for states to request, and the Secretary to grant, an exception from the Medicaid RAC requirement(s). Such an exception may be a partial exception from a specific program requirement(s) or a full exception from the Medicaid RAC requirements. As of FY 2024, 34 states and the District of Columbia have CMS-approved full exceptions to Medicaid RAC implementation. Such full exceptions are because of state-specific circumstances, including the high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS, or issues related to procuring a contractor. Additionally, 12 states operate their programs with CMS-approved partial exceptions from specific program requirements, including an exception to the requirement of having at least a 1.0 full-time equivalent (FTE) Contractor Medical Director, an exception allowing the state to expand the three-year look-back period, and an exception to the contingency-fee limit. FTE is a standardized measurement unit used to quantify employee workload. This metric is based on the hours typically worked in a standard full-time position. Table 6 below includes additional information about state Medicaid RAC operations.

Table 6: Operational Status of State Medicaid RAC Programs

Program Operations		State
Operational Medicaid RAC with No Exceptions		Arizona, California, New Mexico & North Carolina
Operational Medicaid RAC with Program-Specific Exceptions	*FTE Medical Director Requirement*	Connecticut, Hawaii, Illinois, Minnesota, Nevada, South Carolina, Texas & West Virginia
	3-Year Look-Back Period	Georgia, Minnesota, New York, Oregon, Texas & West Virginia

	Contingency Fee Limit	Colorado, Hawaii & West Virginia
No Operational Medicaid RAC (Full Exception)		Alabama, Alaska, Arkansas, Delaware, District of Columbia, Florida, Idaho, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin & Wyoming

*Note: States can submit state plan amendments at any time requesting a change to their Medicaid RAC programs. The information in this chart is current as of January 2025.

Given the great variability among states' Medicaid programs, resources, and capabilities, CMS believes that the flexibility afforded to states when implementing a Medicaid RAC program is essential to states' program integrity operations. By overseeing the Medicaid RAC program requirements and engaging closely with states on implementation, CMS has identified several promising practices in RAC administration that states can use when determining if and how to administer a Medicaid RAC program. For those states with a high proportion of beneficiaries enrolled in Medicaid managed care compared to FFS or that have issues related to procuring a contractor, a full exception may allow the state to focus its program integrity resources on alternative oversight practices. For those states seeking to enhance their Medicaid RAC programs, such as by offering larger contingency fee rates to incentivize contractor participation, a partial exception provides the necessary flexibility to achieve the state's oversight goals.

4.3 Medicare Fee-for-Service Medical Review

Consistent with sections 1815(a), 1833(e), 1862(a)(1), and 1893 of the Act, CMS is required to protect the Medicare Trust Funds by taking corrective actions to prevent and reduce improper payments. CMS contracts with a variety of medical review contractors, including the MACs and SMRC, to perform medical review for claims paid by the Medicare FFS program.[47] Medical review involves both automated and manual processes to help ensure that only claims for items and services that meet all Medicare coverage, payment, and coding requirements are paid. Medical review activities concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing (CERT) results, and oversight agency findings that indicate questionable billing patterns. CMS incorporates provider feedback processes, such as one-on-one education and detailed medical review results notifications, to encourage proper billing.

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

4.3.1 Targeted Probe and Educate (TPE)

CMS's TPE program helps providers reduce claim denials and appeals through one-on-one education by the MAC. As part of TPE, the MACs focus on providers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Under the TPE strategy, MACs generally conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the conclusion of each round. Providers are also offered individualized education during each round of review to fix simple problems more efficiently. The goal of TPE is to help providers meet Medicare's payment policy requirements. Providers who, based on data analysis, already submit claims generally compliant with Medicare policy do not become subject to TPE, thus minimizing the burden on them and best maximizing CMS's use of its limited resources.[48]

4.3.2 Supplemental Medical Review Contractor (SMRC)

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

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

4.3.3 DMEPOS Prior Authorization

CMS utilizes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization. CMS defines unnecessary utilization as "the furnishing of items that do not comply with one or more of Medicare's coverage, coding, and payment rules."[49] CMS also maintains a list of DMEPOS items that could be subject to prior

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

[49] National Archives, Code of Federal Regulation, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-D/section-414.234

authorization before items or services are provided and payment is made.[50] During FY 2024, CMS expanded prior authorization for six orthoses[51] codes (L0631, L0637, L0639, L1843, L1845, and L1951) and continued nationwide prior authorization of 46 power mobility device (PMD) codes, five pressure reducing support surface codes, six lower limb prosthetic codes, five orthoses codes, and voluntary prior authorization of 53 PMD accessories. Through this process, CMS reviewed 175,577 prior authorization requests in FY 2024 and non-affirmed[5] (denied) 27.1% of those requests because they did not meet applicable Medicare coverage and payment rules. *Table 3. Medicare Savings* reports savings from DMEPOS prior authorization request and claim reviews.

4.3.4 Hospital Outpatient Department Prior Authorization

Using its authority under section 1833(t)(2)(F) of the Social Security Act, CMS established a nationwide prior authorization process and requirements for certain hospital outpatient services that demonstrate significant increases in volume.[53] In FY 2024, CMS continued prior authorization for Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, Vein Ablation, Implanted Spinal Neurostimulators, Cervical Fusion with Disc Removal, and Facet Joint Interventions. Prior authorization of hospital outpatient department services serves as a method for controlling unnecessary increases in the volume of these services as claims must be associated with a provisional affirmative prior authorization decision to be eligible for payment. Through this process, CMS reviewed 423,830 prior authorization requests in FY 2024 and non-affirmed 20.8% of those requests because they did not meet applicable Medicare coverage and payment rules. This resulted in $38 million in savings.[54]

4.4 Medicare Provider Cost Report Audits

Cost report auditing is among CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, skilled nursing facilities (SNFs), and end-stage renal disease dialysis facilities. Many of these providers claims are paid mostly through a prospective (bundled) payment system, but reimbursement of certain items remains on an interim basis that is subject to final payment after a cost reconciliation process. These providers submit an annual Medicare cost report that, after the settlement process, forms the

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[50] Centers for Medicare & Medicaid Services, "Required Prior Authorization List," December 18, 2024, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/DMEPOS/Downloads/DMEPOS_PA_Required-Prior-Authorization-List.pdf

[51] Orthoses are leg, arm, back, and neck braces.

[52] A non-affirmation is a finding that Medicare's coverage, coding, and payment rules were not met.

[53] Federal Register, Volume 48, No. 218, November, 12, 2019, Rules and Regulations, https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf-12/pdf/2019-24138.pdf

[54] CMS is in the process of formalizing a savings methodology for hospital outpatient department prior authorization. When that methodology is finalized, CMS will report associated savings in *Table 3. Medicare Savings* and in the calculation of the Medicare program integrity ROI of future years' reports. For the interim, CMS notes that the above amount is informal and supplemental, since it is based on the MACs' self-reporting.

basis for reconciliation and final payment to the provider. The cost report includes calculations of the final payment amount for categories such as graduate medical education, disproportionate share hospital (DSH) payments, and Medicare bad debts.

The cost report audit process determines whether providers have been paid properly and provides a method to detect both improper payments and potential reasons the improper payments occurred. Discerning the reasons underlying improper payments provides insight into potential payment vulnerabilities, which can then be attacked and eliminated. Cost report auditing includes providers' timely submitting cost reports and their receipt/acceptance by the MACs, and the MACs' cost report desk reviews, audits, and final settlement.

4.5 Medicare Secondary Payer

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

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

4.6 Medicaid and CHIP Program Integrity

The Medicaid and CHIP programs are federal-state partnerships, and these partnerships are central to the programs' success. While states have primary responsibility for direct oversight of their programs, CMS plays a critical role in ensuring that states are compliant with federal

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

statute and regulations. As a result, CMS undertakes a wide array of activities to oversee and support states' Medicaid and CHIP program integrity efforts.

Section 1936(d) of the Act directs the Secretary to establish, on a recurring five fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. In FY 2024, CMS released the FYs 2024-2028 Comprehensive Medicaid Integrity Plan (CMIP), setting forth CMS's Medicaid program integrity strategy. [56]

4.6.1 Eligibility and Payment Integrity

Consistent with previous years a large driver of the Medicaid and CHIP improper payment rates in FY 2024 was state noncompliance with various beneficiary eligibility requirements and processes. Making accurate beneficiary eligibility determinations helps protect the integrity of the Medicaid program and CHIP, as well as taxpayer dollars. To ensure oversight of states' beneficiary eligibility determinations, in FY 2024, CMS conducted several oversight activities, described below.

Payment Error Rate Measurement (PERM) Corrective Action Plan (CAP) Oversight and Monitoring

To address root cause(s) of payment errors identified by the PERM program, [57] CMS provides support and technical assistance to states as they develop and implement their PERM CAPs. CMS also monitors and evaluates each state's CAP effectiveness.

States that have consecutive PERM eligibility improper payment rates exceeding the 3 percent standard described by section 1903(u) of the Act are required to meet more stringent PERM CAP requirements.

In FY 2024, CMS supported states during their CAP development process through routine status calls and work groups. Upon submission of a state's CAP, CMS monitors the state's progress in implementing effective corrective actions by providing training opportunities to ensure compliance with federal policies. For example, in FY 2024, CMS facilitated several workgroup meetings, one of which focused on state supervised, and county administered, beneficiary eligibility determination structures. Workgroups allow states to share promising practices and identify innovative approaches to managing various PERM-related topics.

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[56]Centers for Medicare & Medicaid Services, "Comprehensive Medicaid Plan, FY 2024-FY 2028," Undated, https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance/

[57] CMS uses the PERM program to measure improper payments and produce state and national improper payment rate estimates in Medicaid and CHIP. CMS uses a 17-state cycle for PERM, which means that each state is reviewed once every three years. Each time a group of 17 states is measured, CMS replaces that group's previous findings with its newest findings, so each year's improper payment estimates include measurements from all 50 states and the District of Columbia.

In FY 2024, states continued to successfully develop and submit their PERM CAPs via the Medicaid and CHIP Program Integrity Reporting Portal (MCPIRP). MCPIRP serves as a correspondence and communication platform and data repository that allows CMS the ability to track important milestones as well as synthesize and analyze reports submitted by states. The goal is to reduce state burden while streamlining the PERM CAP process for both states and CMS. CMS continues to encourage states to share lessons learned as they implement their CAPs. This has proven to be helpful to other states as they evaluate their CAPs and beneficial to CMS to identify target areas for future guidance and education for states.

Medicaid Eligibility Quality Control (MEQC) Program

Under the MEQC program, states design and conduct pilots to evaluate processes that determine an individual's eligibility for Medicaid and CHIP benefits.[58] States conduct MEQC pilots during the two-year intervals ("off-years") that occur between their triennial PERM review years, allowing states to implement prospective improvements in eligibility determination processes prior to their next PERM review. Consistent with federal requirements, states have great flexibility in designing pilots to focus on vulnerable or error-prone areas as identified by the PERM program and by the state. In addition, states are required to devote part of their MEQC pilots to reviews of improper denials or terminations, which are not addressed through PERM reviews. For more information regarding the MEQC program, see the FY 2024-2028 Comprehensive Medicaid Integrity Plan.[59]

Similar to PERM, MEQC uses a 17-state rotation cycle where each state is reviewed once every three years.[60] In FY 2024, CMS worked with a subset of states depending on the cycle to submit their MEQC required documents to CMS via MCPIRP.

Audits of Beneficiary Eligibility Determinations

To ensure compliance with eligibility and enrollment requirements, CMS conducts Medicaid and CHIP beneficiary eligibility audits that assess state eligibility policies, processes, and systems. CMS also calculates any amounts states have been inappropriately paid due to improper eligibility determinations. In FY 2024, CMS conducted targeted audits of determinations of ineligibility made during the Medicaid unwinding period for selected states, allowing CMS to oversee state eligibility determinations and, as needed, provide states valuable feedback and technical assistance. The audit results were shared with the states to rectify any inappropriate eligibility determinations in real-time by reinstating beneficiaries who were inappropriately disenrolled.

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[58] US Department of Health and Human Services, "FY 2024 HHS Agency Financial Report," November 15, 2024, https://www.hhs.gov/about/agencies/asfr/finance/financial-policy-library/agency-financial-reports/index.html, page 214

[59] Centers for Medicare & Medicaid Services, Comprehensive Medicaid Integrity Plan for Fiscal Years 2024 - 2028, Undated

[60] This includes the District of Columbia and Puerto Rico.

4.6.2 Reviewing State Program Integrity Activities

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

In addition to focused reviews, CMS also conducts desk reviews of states' program integrity activities to increase the number of states and topics that are assessed each year. In FY 2024, CMS conducted 47 desk reviews related to telehealth services, managed care, non-emergency medical transportation, Medicaid RACs, and program integrity oversight in the Territories.

4.6.3 Medicaid Managed Care MLR Audits

A key component of CMS' Medicaid managed care oversight strategy is conducting targeted audits of states' Medicaid managed care plans' financial reporting. Many states have adopted risk mitigation strategies, such as remittance arrangements based on a minimum MLR, as a standard managed care plans must meet. CMS reviews managed care plan practices to ensure that claims match plans' reported MLRs. These MLR audits include a review of high-risk vulnerabilities.

In FY 2024, CMS:

- Continued its audit of Ohio's six Medicaid managed care plans' MLR reporting for calendar year (CY) 2020
- Conducted an audit of Washington's five Medicaid managed care plans' MLR reporting for CY 2021

Initiated an audit of Arizona's nine Medicaid managed care plans' MLR reporting for the contract year ending 2021. The final audit reports will be released in the future .[61]

4.6.4 State Access to Medicare Data

In FY 24 over 13 million[62] Americans are dually eligible for both Medicare and Medicaid, and providers and managed care plans that serve Medicaid patients often participate in Medicare as well. This overlap means that Medicare program integrity data offers the potential to greatly enhance state Medicaid program integrity efforts. Analyzing both Medicare and Medicaid claims data enables CMS and states to detect duplicate and other improper payments for services billed to both programs. Coordinated information sharing among federal and state investigators about aberrant providers or plans can improve the

[61] Rating periods vary by state implementation: some states align their managed care rating periods with calendar years (January-December), while others follow contract years that may begin at different times throughout the year based on their specific contractual arrangements.

[62] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report

identification of improper billing and optimize investigative resources through targeted collaboration. Through CMS's State Data Resource Center (SDRC), state Medicaid agencies may request Medicare data, free of charge, for individuals who are dually enrolled in Medicare and Medicaid to support care coordination and program integrity functions, such as preventing duplicate payments by Medicare and Medicaid.

4.6.5 Strengthen Medicaid Data Analytics and Audits

Effective data collection and analysis enables CMS to tackle fraud, waste, and abuse. CMS is enhancing data sharing and collaboration to improve Medicare and Medicaid program integrity.

CMS works closely with states to ensure that CMS and other oversight entities have access to the best, most complete, and accurate Medicaid data, not only to support program integrity activities, but also to more broadly improve the monitoring, oversight, and evaluation of Medicaid and CHIP to protect coverage, and drive innovation and whole person care for the programs' beneficiaries. All 50 states, the District of Columbia, Puerto Rico, Guam and the U.S. Virgin Islands submit data on their programs on an ongoing basis to T-MSIS. Each year, CMS partners with states to improve their data quality and holds states accountable for correcting high priority data areas. As a result of optimized data quality improvement efforts, historical T-MSIS data is used for analysis and to inform program integrity.

In FY 2024, CMS released to federal partners and stakeholders a de-identified research version of T-MSIS data called the T-MSIS Analytic Files (TAF), with data for CYs 2014-2023, and released de-identified research files for CYs 2014-2023. CMS also releases the Data Quality Atlas,[63] an interactive, web-based tool that helps policymakers, analysts, researchers, and other stakeholders explore the quality and usability of the TAF to determine whether the data can meet their analytic needs.

4.6.6 Provider Screening and Enrollment

As part of its Medicaid oversight role, CMS works closely with state Medicaid agencies to provide sub-regulatory guidance, technical assistance, and other support with respect to provider screening and enrollment via the Medicaid Provider Enrollment Compendium (MPEC).

Provider Screening Data Sources

CMS has significantly expanded data sources available to states for provider screening and enrollment over the past few years and continues to enhance the usability of these data sources through ongoing work with state partners.

DEX

[63] https://www.medicaid.gov/dq-atlas/welcome

All 50 states, the District of Columbia, and Puerto Rico have access to these databases through an online portal, the Data Exchange (DEX) system. DEX allows CMS to share Medicare revocation data with each state's Medicaid program, which in turn use DEX to share terminated Medicaid and CHIP provider information with CMS and other states. DEX also provides states with access to the Social Security Administration's Death Master File, as well as Medicare Exclusion Database extracts, which contain the HHS-OIG's data regarding individuals and entities excluded from federally funded health care programs. CMS continues to work with states to ensure they adopt DEX, and to determine the need for future enhancements that may benefit states.

Data Compare

State non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments. To reduce states' burden in conducting Medicaid provider new enrollment screening as well as revalidation, CMS allows states to use provider screening results from Medicare or other state Medicaid or CHIP agencies. To assist in this work, CMS currently offers a provider screening data compare service that allows a state to rely on Medicare's screening in lieu of conducting state screening. This service reduces state burden, particularly for provider revalidation, because it allows states to remove dually enrolled providers from their revalidation workload. Via this service, CMS also provides states information on providers with deactivated NPIs or who are deceased, excluded by the HHS OIG, or revoked by Medicare or terminated for cause by another state Medicaid agency, thereby allowing the state or territory to, if appropriate, take deactivation or termination action against a provider.

In FY 2024, 7 states submitted files for the data compare service,[64] while 39 states overall have utilized the service since its inception. CMS will continue to work with states on an ongoing basis to promote the advantages of this service to work toward the goal of expanding use of the service to all states.

Provider Enrollment: Guidance and Technical Assistance

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

> In FY 2024, CMS published updates to the MPEC, a resource of sub-regulatory guidance to assist states in the implementation of provider screening and enrollment requirements, to clarify Medicaid provider enrollment policies and procedures.[65]

[64] To participate in Data Compare, states must submit the Data Compare Intake Template, which is available for download in the 'Files' tab in DEX and can be uploaded using the 'Upload File' option under the same tab.

[65] The current version of the Medicaid Provider Enrollment Compendium, updated on April 24, 2025 is available at: https://www.medicaid.gov/medicaid/program-integrity/downloads/mpec.pdf.

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

4.6.7 Medicaid Integrity Institute (MII)

CMS offers training at no cost to states and their program integrity staff through the Medicaid Integrity Institute (MII). MII has provided both classroom training and virtual learning webinars to enhance the professional qualifications of state Medicaid integrity staff across the nation. Courses at the MII provide opportunities to discuss emerging trends, support new initiatives, and strengthen collaboration among state and federal partners.

In FY 2024, following the end of the COVID-19 public health emergency, CMS resumed in-person learning, while also continuing to offer virtual training that we found was very effective, for a total of five in-person courses and six webinars. FY 2024 MII courses included Medicaid Coding Boot Camps; Medicaid Managed Care Toolkits Overview; CMS Data Experts Symposium; Medicaid Provider Audits & Investigative Skills Symposium; Coding for Non-Coders; HHS-OIG Fraud Schemes & Trends; Program integrity opportunities for the Territories; and Program Integrity in Medicaid Managed Care.

4.7 Demonstrations and Models

CMS conducts innovative demonstrations and models designed to test improved methods for the prevention, identification and prosecution of potential fraud, with the goal of reducing program expenditures while preserving or enhancing the quality of care.[66]

4.7.1 Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967[67] authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of investigation and prosecution of fraud in the provision of care or services provided under the Medicare program.

Review Choice Demonstration for Home Health Services

The Review Choice Demonstration (RCD) for Home Health Services allows participating home health agencies (HHAs) to choose between two documentation submission pathways thus

[66] While these demonstrations and models contribute towards CMS's program integrity objectives, they are not part of the Medicare or Medicaid Integrity Programs. These demonstrations and models are supported by other sources and authorities. CMS provides information about demonstrations and models as a supplement to offer a broader, more complete view of CMS's program integrity activities beyond the requirements of this report.

[67] 42 USC 1395b-1(a)(1)(J).

offering them flexibility and choice, as well as a risk-based path to reward providers who show compliance with Medicare home health policies. Specifically, it offers HHAs the option to submit documentation either before (pre-claim review) or after (post-payment review) claims for reimbursement are submitted. A provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the demonstration.

The RCD assists in developing improved methods to identify, investigate, and prosecute potential fraud to protect the Medicare Trust Funds; improves provider compliance with Medicare rules and requirements; and potentially reduces the rate of improper payments. This demonstration, which began in FY 2019, applies to Home Health and Hospice Medicare Administrative Contractor (HH/H MAC) Jurisdiction M (Palmetto GBA) providers operating in Illinois, Ohio, Texas, North Carolina, Florida, and Oklahoma, with the option to expand to other states in Jurisdiction M.

The RCD was originally set to end in FY 2024, but in FY 2024 CMS announced its extension for an additional 5 years. The demonstration offers providers an initial choice of either pre-claim review or post payment review,

Through this process, CMS reviewed 1,853,354 pre-claim review requests in FY 2024 and non-affirmed 3.2% of those requests because they did not meet applicable Medicare coverage and payment rules, resulting in $6 million in savings.[68]

Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services

On May 15, 2023, CMS announced the start of the demonstration for IRFs located in Alabama, starting August 21, 2023. The Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility (IRF) Services provides flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules. IRFs initially select between two review choices: pre-claim review or post payment review. After a 6-month period, IRFs demonstrating compliance with Medicare rules through their pre-claim review affirmation rate or post payment review approval rate have additional review choices to select from. At that point, IRFs may select from one of three subsequent review choices: continue with pre-claim review, selective post payment review, or spot check prepayment review.

This demonstration provides flexibility and choice for IRFs, as well as a risk-based approach to reduce burden on providers demonstrating compliance with Medicare IRF rules; CMS provides IRFs with operational flexibility while maintaining Medicare compliance standards. The tiered approach allows facilities to progress to less intensive review options based on

[68] This initiative is not supported by funding subject to this report's requirements; thus, these savings are not included in *Table 3. Medicare Savings* or in the calculation of the Medicare program integrity ROI. CMS provides this as supplemental information to offer a broader, more complete view of CMS's program integrity activities. This savings metric is based on the MACs' self-reporting.

their demonstrated compliance performance, ultimately reducing administrative burden for high-performing providers while ensuring program integrity.

The RCD for IRF Services tests improved methods for the identification, investigation, and prosecution of potential Medicare fraud CMS plans to expand the demonstration to IRFs in other states including those that bill to MAC jurisdictions. [69]

Through this process, CMS reviewed 13,641 pre-claim review requests in FY 2024 and non-affirmed (denied) 21.7% of those requests because they did not meet applicable Medicare coverage and payment rules, resulting in $24 million in savings. [70]

4.7.2 Models

Section 1115A of the Act authorizes the Secretary, through the Center for Medicare and Medicaid Innovation, to test innovative payment and service delivery models in order to reduce program expenditures while preserving or enhancing the quality of care furnished to beneficiaries.

Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport

Medicare Part B covers medically necessary repetitive, scheduled non-emergent ambulance transports (RSNAT), most often required with respect to dialysis treatment. On September 22, 2020, CMS announced that it would expand the Medicare Prior Authorization Model for RSNAT nationwide, as the model had met all expansion criteria. [7]

In FY 2024, CMS continued operating the Prior Authorization Model for RSNAT in all states and territories. Through this process, CMS reviewed 28,836 prior authorization requests in FY 2024 and non-affirmed 27.6% of those requests because they did not meet applicable Medicare coverage and payment rules, resulting in $1 million in savings. [72]

4.8 Federally-facilitated Marketplaces

- CMS continued expanding and refining program integrity operations for the FFM during FY 2024 by continuing to work on improving the prevention, detection, and mitigation of fraud, misconduct, and improper payments in the FFM. In FY 2024, the

[69] https://www.cms.gov/files/document/irf-rcd-faqs.pdf

[70] This initiative is not supported by funding subject to this report's requirements; thus, these savings are not included in *Table 3. Medicare Savings* or in the calculation of the Medicare program integrity ROI. CMS provides this as supplemental information to offer a broader, more complete view of CMS's program integrity activities. This savings metric is based on the MACs' self-reporting.

[71] https://www.cms.gov/newsroom/press-releases/cms-expand-successful-ambulance-program-integrity-payment-model-nationwide

[72] This initiative is not supported by funding subject to this report's requirements; thus, these savings are not included in *Table 3. Medicare Savings*, or in the calculation of the Medicare program integrity ROI. CMS provides this as supplemental information to offer a broader, more complete view of CMS's program integrity activities. This savings metric is based on the MACs' self-reporting.

MCRC triaged more than180,000 complaints from consumers who alleged they had been enrolled in FFM insurance policies without their consent, that incorrect information had been submitted on an application by an insurance agent or broker, or that other misconduct had occurred. CMS worked with health insurance issuers to verify and cancel over 119,000 cases of confirmed unauthorized enrollments. CMS and its program integrity contractors continuously analyzed plan enrollments and other types of data to identify trends and early warning signs of fraud, conducted investigations of outlier and high-risk agents, brokers, and web-brokers, and referred cases to the HHS-OIG and states' DOIs.[73] When cases of agent, broker, and web-broker misconduct warranted it, CMS took administrative actions including blocking their access to the FFM to prevent consumer harm. CMS also supported ongoing HHS-OIG and DOI investigations by fulfilling requests for records regarding consumer FFM enrollments and financial assistance, complaints, and results of CMS investigations. CMS also hosted bi-monthly meetings with State-based Marketplaces (SBMs) to share best practices for identifying and deterring fraud and notifying SBMs of specific schemes being investigated within the FFM. In accordance with the Payment Integrity Information Act of 2019, CMS annually prepares an estimate of APTC improper payments for the FFM, identifies root causes of improper payments, and develops corrective actions to mitigate risks of improper payments. Information related to APTC improper payments is reported annually in the HHS AFR.

4.9 Open Payments

The Open Payments program is a statutorily required national disclosure program that promotes transparency and accountability by making information about the financial relationships between the health care industry (reporting entities)[74] and certain health care providers (covered recipients)[75] available to the public.

Open Payments data includes payments and other transfers of value made by reporting entities to covered recipients, along with ownership and investment interests in the reporting entities held by physicians or a physician's immediate family members. Full details on the

[73] State DOIs are notified of suspensions and terminations of agents' agreements as required by 45 CFR 155.220(g)(6). State DOIs have the ability to pursue criminal and civil actions, as well as suspension or revocation of agents' insurance licenses.

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

[75] Covered recipients collectively refers to physicians (excluding medical residents), physician assistants and nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, anesthesiologist assistants, and certified nurse-midwifes who are not employees of the applicable manufacturer that is reporting the payment; or teaching hospitals that receive payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which such information is available.

Open Payments program can be found in the annual Report to Congress on the Open Payments Program.[76]

On June 28, 2024, CMS published Program Year (PY) 2023 data, the tenth full year of data reported to Open Payments. Drug and medical device companies reported 15.64 million records amounting to $12.75 billion in payments or transfers of value to health care providers during 2023. In addition to publishing data in PY 2023, data from PYs 2017 through 2022 was refreshed and republished[77] to reflect any updates made by reporting entities during the 2023 PY cycle, while PY 2016 data was archived.[78]

Reporting entities will submit and attest to their PY 2024 data by March 31, 2025, and this data will be publicly displayed by June 30, 2025.

4.10 The Vulnerability Collaboration Council

To detect and combat fraud, waste, and abuse, CMS utilizes a centralized vulnerability management process to identify, prioritize, track, and mitigate vulnerabilities that affect the integrity of federal health programs. The centralized component of this process, known as the Vulnerability Collaboration Council (VCC), is comprised of subject matter experts who work collaboratively to identify vulnerabilities that lead to fraud, waste, and abuse and develop comprehensive risk strategies to mitigate these vulnerabilities. CMS aligned the VCC's risk-based approach with GAO's Fraud Risk Framework (GAO-15-593SP). By aligning with the GAO framework, CMS standardized the vulnerability management process by focusing on the identification and mitigation of key risk factors through the design and implementation of specific mitigation activities that are regularly evaluated and adapted to adjust to changing circumstances.

In FY 2024, CMS conducted three program integrity risk assessments on topics including nursing facilities and DMEPOS. The VCC also more effectively included improper payment information for Medicare, MA, Medicare Part D, and Medicaid programs into VCC analyses to ensure that comprehensive assessments are completed.[79]

5 Reduce Provider Burden

[76] Centers for Medicare & Medicaid Services, "Report to Congress, Annual Report on Open Payments Program, Fiscal Year 2023", August 2024, https://www.cms.gov/medicare/medicaid-coordination/center-program-integrity/reports-guidance

[77] Refreshed and republished data include data corrections made to reported payments since the initial publication of data submitted by applicable manufacturers and GPOs.

[78] When a program year reaches its fifth full year of data publication it is no longer eligible for new data submissions or edits and is not searchable within the Open Payments database. Archived program years are accessible with the full dataset available for download on the Open Payments Archived Datasets Page (https://www.cms.gov/OpenPayments/Archived-Datasets).

[79] Centers for Medicare & Medicaid Services, "CMS Financial Report for Fiscal Year 2024," November 2024, https://www.cms.gov/data-research/statistics-trends-and-reports/cfo-report, page 24

5.1 Outreach & Education – Medicare Fee-for-Service

A major goal of provider outreach and education in the Medicare Fee-for-Service program is to reduce improper payments by ensuring that providers have timely and accurate information they need to bill correctly the first time. The MACs educate providers and their staff about Medicare policies and procedures, including local coverage policies; significant changes to the Medicare program; and issues identified through review of provider inquiries, claim submission errors, medical review data, CERT program data, and other relevant sources. MACs use a variety of strategies and communication channels to offer providers a broad spectrum of information about the Medicare program, including materials developed by CMS and the MACs.

CMS-developed materials include Medicare Learning Network® (MLN) educational content for health care providers. For example, MLN Matters® articles explain national Medicare policies on coverage, billing, and payment rules for specific provider types. MLN products also include fact sheets, booklets, and electronic mailing list messages. MAC-developed materials include education on local coverage policies and electronic mailing list messages tailored to each jurisdiction. CMS receives significant positive feedback from providers on the value of these educational materials.

5.2 Outreach & Education – Medicare Part C & Part D

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

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

5.3 Provider Compliance Focus Groups

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

CMS held two conference groups virtually: one focus group on provider compliance and one on the National Provider Compliance Conference (NPCC) during FY 2024.

The NPCC united CMS with Program Integrity stakeholders, including Medicare Administrative Contractors (MACs) and other experts, to offer support and tools to providers on how to efficiently manage Medicare claims for Parts A and B, Home Health, Hospice, and Durable Medical Equipment (DME).

Appendix A - Program Integrity Obligations[80]

CMS Program Integrity Activity	FY 2024 Actual Obligations (in thousands)
MAC Program Integrity Operations	$427,145
Audits & Appeals	$145,165
Medical Review	$133,323
Medicare Secondary Payer	$93,934
PI Investigation, Systems & Analytics[81]	$386,142
Technical Assistance, Outreach & Education	$93,926
Provider Enrollment & Screening[82]	$116,951
Error Rate Measurement[83]	$90,099
Provider & Plan Oversight	$58,637
Program Support & Administration	$401,136
Recovery Audit Contractors[84]	$128,947
Total	$2,075,404

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

[81] This amount includes Marketplace activities that are funded with discretionary HCFAC resources.

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

[83] This amount includes Marketplace activities that are funded with discretionary HCFAC resources.

[84] The Medicare Recovery Audit Program is not a budget appropriation. RACs receive payment through contingency fees based on the amounts recovered from their audit activity. In addition, RACs receive payment for identifying underpayments.

Appendix B - Program Integrity Savings Methodologies

1 Medicare Savings Methodologies

1.1 Introduction to Medicare Savings Methodologies

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

1.2 Automated Actions in Medicare

Automated actions prevent improper payments to providers[85] generally without the need for manual intervention at every instance. Automated actions occur as the result of edits, or sets of instructions, which are coded into a claims processing system to identify and automatically deny or reject all or part of a claim exhibiting specific errors or inconsistency with Medicare policy. CMS calculates automated action savings from the following edits of Medicare FFS claims:

- National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits
- NCCI Medically Unlikely Edits (MUEs)
- NCCI Add-On Code (AOC) Edits
- Ordering and Referring (O&R) Edits
- Orthotics and Prosthetics Licensure Edits
- Fraud Prevention System (FPS) Edits
- Medicare Administrative Contractor (MAC) Automated Medical Review Edits
- Unified Program Integrity Contractor (UPIC) Automated Edits

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

1.2.1 National Correct Coding Initiative Procedure-to-Procedure Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or reduced in payment due to a PTP edit, accounting for any subsequently paid claim lines.

Data Sources: Multi-Carrier System (MCS) and Fiscal Intermediary Shared System (FISS) claims data in the CMS Integrated Data Repository (IDR)

CMS developed NCCI edits to promote national correct coding practices and reduce inappropriate payments from improper coding in Medicare Part B claims. The coding decisions for these edits are based on Medicare policies including the principles described in the *Medicare NCCI Policy Manual*, Healthcare Common Procedural Coding System (HCPCS) and *Current Procedural Terminology (CPT) Professional* codebook descriptors and guidelines, coding guidelines of national societies, and standards of medical and surgical practice. NCCI edit tables are refined and updated quarterly to address changes in coding guidelines and additions, deletions, and modifications of HCPCS/CPT codes, hereafter referred to as HCPCS codes.[86] NCCI edits apply to services[87] rendered by the same provider for the same beneficiary on the same date of service (DOS).

NCCI PTP edits prevent inappropriate payment when incorrect code combinations are billed for the same provider, beneficiary, and DOS. Each PTP edit applies to a specific pair of HCPCS codes. CMS uses PTP edits for pairs of codes where one code, in general, should not be reported with another code for a variety of reasons; for example, one code may represent a component of a more comprehensive code, or the codes may be mutually exclusive due to anatomic or temporal reasons. One code in each edit pair is defined as eligible for payment. If the two codes of an edit pair are billed for the same provider, beneficiary, and DOS, the edit automatically allows payment for the claim line containing the eligible code and denies payment for the claim line containing the other code.

NCCI PTP edits are used to adjudicate claims for practitioner, ambulatory surgical center, and certain facility services. Practitioner and ambulatory surgical PTP edits occur in MCS, and facility service PTP edits occur in FISS. Facility service PTP edits apply to claims subject to the Outpatient Code Editor (OCE) for the Outpatient Prospective Payment System (OPPS), i.e., outpatient hospital services and other facility services including, but not limited to, Part B SNFs, comprehensive outpatient rehabilitation facilities (CORFs), and certain claims for home health agencies (HHAs). PTP edits occur before claims are sent to the Common Working File (CWF).

For every incoming claim line, PTP edits test for edit code pairs between the reported HCPCS code and all other codes submitted at the same time or in the claims history for the same provider, beneficiary, and

[86] This document uses the term HCPCS code to reference any code contained in the overarching HCPCS coding system, inclusive of its two subsystems, i.e., Level 1 (CPT codes maintained by the American Medical Association that identify medical services and procedures furnished by physicians and other health care professionals) and Level II (codes that identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies when used outside a physician's office). When billing Medicare, health care providers use these codes to define any services/items rendered for patients.

[87] This document uses "service" as a general term referring to any services, procedures, products, supplies, etc. that health care professionals provide for patients.

DOS. Thus, it is possible to trigger an NCCI PTP edit by billing a code after payment of a different code from a PTP edit for the same provider, beneficiary, and DOS. If the code on the current claim line is the non-payable code in the edit pair, it is automatically denied. If the code on the current claim line is the payable code in the edit pair, in most cases, the claims processing system automatically reduces the allowed payment for the payable code by the amount previously allowed for its non-payable code pair (referred to as a cutback in this document).[88]

When justified by clinical circumstances and documented in the medical record, providers may append an NCCI-PTP-associated modifier to some codes to bypass certain PTP edits. If there are no clinical circumstances under which a pair of services should be paid at the same encounter, the PTP edit for that pair cannot be bypassed with any modifiers. After a PTP edit denial/cutback, a provider could resubmit the service with corrected information that makes the claim payable. Providers also have the right to appeal PTP edit denials/cutbacks through the Medicare FFS appeals process.

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

1. Identifying PTP Edit Denials and Cutbacks
System logic in MCS or FISS automatically appends a specific reduction/audit or reason code to claim lines that fail one of the PTP edits. During processing, claim lines may be denied for multiple errors. CMS attributes savings to PTP edits only when a PTP edit code is the system's highest priority reason for denying or reducing payment for a claim line.[89]

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

2. Pricing PTP Edit Denials and Cutbacks
To quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most denied/cutback claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been fully payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims

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

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

processing contractor, locality, place of service, and pricing modifier.[90] For each unique denial, CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.[91, 92] For each unique cutback, CMS first determines the cutback amount by subtracting the allowed payment amount from the system-generated or average price. CMS then multiplies the cutback amount by 80 percent to estimate what Medicare did not have to pay.

- *FISS:* Unlike MCS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each PTP denial based on the applicable pricing mechanism.[9] CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) OPPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from PTP denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/cutback services. Specifically, where there are any subsequently paid claim lines for a previously denied/cutback service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from a) the priced amount of the earliest denial, up to that priced amount, or b) the cutback amount of the earliest cutback, up to that cutback amount. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial/cutback and that share the same claim type code, HCPCS code, provider, beneficiary, and DOS. All amounts used in these steps have the estimated beneficiary coinsurance removed, where appropriate.[94]

For a given PTP denied/cutback claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of PTP edits savings uses claims data captured 90 days after

[90] For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

[91] In the methodology for this and other edits involving Part B services, CMS uses 80 percent as a conservative estimate of what Medicare did not have to pay a provider. There may be denied services for which Medicare would have paid 100 percent or the beneficiary would have paid 100 percent as part of his/her deductible.

[92] In the methodology for this and other edits across MCS, FISS, and the Viable Information Processing Systems (VIPS) Medicare System (VMS), CMS multiplies savings estimates by 98 percent to account for sequestration.

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

[94] In the methodology for this and other edits, CMS also accounts for sequestration payment adjustment as applicable.

the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.[95]

1.2.2 National Correct Coding Initiative Medically Unlikely Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied due to an MUE, accounting for any subsequently paid units of service.

Data Sources: MCS, Viable Information Processing Systems (VIPS) Medicare System (VMS), and FISS claims data in the IDR

NCCI MUEs prevent payment for billing an inappropriate quantity of the same service rendered by the same provider for the same beneficiary on the same DOS. An MUE for a given service defines the maximum units of service (UOS) reported for a HCPCS/CPT code on most appropriately reported claims by the same provider for the same beneficiary on the same DOS. MUEs are adjudicated either as claim line edits or DOS edits, more specifically:

- If the MUE is adjudicated as a claim line edit, the UOS on each claim line are compared to the MUE value for the HCPCS code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied.
- If the MUE is adjudicated as a DOS edit, the MUE value is compared to the sum of all UOS for the same HCPCS code, provider, beneficiary, and DOS on claim lines of the current claim and paid claim lines of previously submitted claims. If the sum of all UOS exceeds the MUE value, all UOS for that HCPCS code and DOS are denied on the current claim.

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

- Practitioner and ambulatory surgical center services. These MUEs are implemented in MCS.
- DMEPOS. These MUEs are implemented in VMS.
- Hospital outpatient services, other Part B hospital services, critical access hospital services, and freestanding non-residential opioid treatment programs.[9] These MUEs are implemented in FISS.

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

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

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

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

1. Identifying MUE Denials

System logic in MCS, VMS, and FISS automatically appends a specific reduction/audit, action, or reason code, respectively, to claim lines that fail an MUE. During processing, claim lines may be denied for multiple errors. CMS attributes savings to MUEs only when an MUE code is the system's highest priority reason for denying a claim line.[97]

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

2. Pricing MUE Denials

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

- *MCS:* In MCS, most denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[9] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, most MUE denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[9] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

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

[98] For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

[99] For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each MUE denial based on the applicable pricing mechanism.[100] CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) OPPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from MUE denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

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

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

1.2.3 National Correct Coding Initiative Add-On Code Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied due to an AOC edit, accounting for any subsequently paid claim lines.

Data Sources: MCS and FISS claims data in the IDR

NCCI AOC edits prevent inappropriate payment for HCPCS codes which are not eligible for payment unless billed with another HCPCS code, the former referred to as an AOC and the latter referred to as the primary code. AOCs reflect supplemental services that are commonly performed alongside the primary service; for example, an AOC may indicate additional time spent with a beneficiary together with an interval established by the primary procedure code, or a further service performed during a surgery already designated by the primary procedure code. Depending on the AOC, the acceptable primary

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

code(s) required for payment of an AOC may be designated by CMS or by the MACs.[101] Exceptions exist, but in general, an AOC and an appropriate primary code must be billed by the same provider for the same beneficiary and same DOS.

AOC edits are used to adjudicate claims for practitioner and non-OPPS institutional provider services. Practitioner AOC edits occur in MCS, and AOC edits for non-OPPS institutional providers occur in FISS, as relevant to claims subject to the integrated OCE. AOC edits occur before claims are sent to CWF.

For every incoming claim line, AOC edits test for edit code pairs between the billed AOC and all other codes submitted at the same time or in the claims history generally for the same provider, beneficiary, and DOS. If the edit does not find one of the CMS- or MAC-designated primary procedure codes for that AOC, the AOC is denied. After an AOC edit denial, a provider could resubmit the AOC with an associated primary code (if both had been rendered), thereby making the AOC payable. Providers generally also have the right to appeal through the Medicare FFS appeals process.

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

1. Identifying AOC Edit Denials
System logic in MCS and FISS automatically appends a specific reduction/audit or reason code, respectively, to claim lines that fail one of the AOC edits. During processing, claim lines may be denied for multiple errors. CMS attributes savings to AOC edits only when an AOC edit code is the system's highest priority reason for denying a claim line.[102]

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

2. Pricing AOC Edit Denials
To quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific to each claims processing system:

- *MCS:* In MCS, most denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been fully payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims

[101] More specifically, there are three types of AOCs: 1) Type 1, wherein CMS alone designates the specific primary code(s) that render a given AOC eligible for payment, 2) Type 2, wherein the MACs develop their own lists of acceptable primary codes, and 3) Type 3, wherein CMS designates some of the acceptable primary codes for a given AOC, and the MACs may designate additional primary codes.

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

processing contractor, locality, place of service, and pricing modifier.[103] For each unique denial, CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each AOC denial based on the applicable pricing mechanism.[104] CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) a prospective payment system (PPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from AOC denied claim lines that were packaged under a PPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

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

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

1.2.4 Ordering and Referring Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claims or claim lines denied or rejected due to an O&R edit, accounting for any subsequently paid claims or claim lines.

Data Sources: MCS, VMS, and FISS claims data in the IDR

Physicians or other eligible professionals must be enrolled in or validly opted out of the Medicare program to order or refer certain items or services for Medicare beneficiaries. In addition, only physicians and certain types of non-physician practitioners are eligible to order or refer such items or services for Medicare beneficiaries. CMS uses O&R edits to validate Part B clinical laboratory and imaging, DMEPOS,

[103] For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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

home health, and hospice claims that require identification of the ordering/referring provider.[105] O&R edits prevent inappropriate payment for items or services when the ordering/referring provider: 1) does not have an approved Medicare enrollment record or a valid opt-out affidavit and a valid NPI or 2) is not eligible to order or refer items or services for Medicare beneficiaries.[106] Part B clinical laboratory and imaging O&R edits occur in MCS, DMEPOS O&R edits in VMS, and home health and hospice O&R edits in FISS, before claims are sent to CWF.

If a claim or claim line does not meet the ordering/referring provider requirements, the O&R edit logic automatically denies or rejects the claim or claim line. This prevents payment to the billing provider, i.e., the provider who furnished the item or service based on the order or referral. CMS regularly updates a public ordering/referring data file containing the NPIs and names of physicians and eligible professionals who have approved Medicare enrollment records or valid opt-out affidavits on file and are of a type/specialty that is eligible to order and refer. Billing providers may reference this information to ensure that the physicians and eligible professionals from whom they accept orders and referrals meet Medicare's criteria.

After an O&R edit denial/rejection, a provider could resubmit the service with corrected information that makes the claim payable. Providers may also have the right to appeal O&R edit denials through the Medicare FFS appeals process.

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

1. Identifying O&R Edit Denials and Rejections
System logic in MCS and VMS automatically appends a specific reduction/audit or action code, respectively, to claim lines that fail an O&R edit. During processing, claim lines may be denied for multiple errors. CMS attributes savings to O&R edits only when an O&R edit code is the system's highest priority reason for denying or rejecting a claim line.

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

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

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

[106] CMS calculates savings from O&R edits implemented in 2014 ("Phase 2" O&R edits), hospice O&R edits implemented in 2024, and a long-standing edit that identifies claims missing the required matching NPI for the ordering/referring provider.

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

2. Pricing O&R Edit Denials and Rejections

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

- *MCS:* In MCS, most denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.[107] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, few O&R edit denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[108] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* FISS does not store the priced amount of denied/rejected claims or claim lines; thus, CMS approximates the price for each O&R denial/rejection by replicating the home health PPS pricing formula or the hospice payment rate, as applicable to the claim or claim line.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/rejected services. Specifically, where there are any subsequently paid claims or claim lines for a previously denied/rejected service, CMS subtracts the allowed payment amount of those subsequently paid claims or claim lines from the priced amount of the earliest denial/rejection, up to that priced

[107] For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

[108] For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

amount. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial/rejection and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial/rejection. In FISS for home health claims, these attributes are the same claim type code, beneficiary, provider, and DOS as the denial/rejection. For hospice claim lines, these attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial/rejection. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

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

1.2.5 Orthotics and Prosthetics Licensure Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied due to orthotics and prosthetics licensure edits, accounting for any subsequently paid claim lines.

Data Source: VMS claims data in the IDR

Currently, 17 states require that suppliers vending custom-fitted and/or custom-fabricated orthotics and/or prosthetics have a licensed orthotist or prosthetist at the establishment, or meet another state-specific licensure requirement, to vend those supplies. In accordance with CMS regulations,[109] all DMEPOS suppliers must meet state licensure requirements to maintain their approved Medicare enrollment and receive Medicare payments. Therefore, orthotics and prosthetics licensure edits aim to prevent inappropriate payment for custom orthotics and prosthetics when suppliers are not appropriately specialized to vend such products in states with such requirements.

If a supplier located in one of these states wishes to vend custom orthotics/prosthetics, the supplier must ensure that its designated CMS DMEPOS enrollment contractor has the appropriate specialty code on file, indicating fulfillment of state licensure requirements. This may require submitting an updated enrollment form and state-specific required documentation to the enrollment contractor. In turn, the enrollment contractor assigns an appropriate specialty code for the supplier in the Provider Enrollment, Chain, and Ownership System (PECOS). The durable medical equipment (DME) MACs reference specialty codes in the functioning of the edits.

Thus, for applicable HCPCS codes and DMEPOS suppliers located in states with licensure requirements,[110] orthotics and prosthetics licensure edits check incoming claim lines to assess if the supplier has one of the required specialty codes associated with its enrollment. If an acceptable specialty code is not on file, the claim line is denied. Providers generally have the right to appeal denials through the Medicare FFS appeals process.

[109] 42 C.F.R § 424.57(c)(1).

[110] As HCPCS codes and state licensure requirements can change, CMS periodically updates orthotics and prosthetics licensure edits to reflect the current lists of applicable HCPCS codes and states, which require a licensed/certified orthotist or prosthetist.

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

1. Identifying Orthotics and Prosthetics Licensure Edit Denials
System logic in VMS automatically appends a specific action code to claim lines that fail an orthotics and prosthetics licensure edit. During processing, claim lines may be denied for multiple errors. CMS attributes savings to a licensure edit only when a licensure edit action code is the system's highest priority reason for denying a claim line.

When a claim line is denied, a supplier might try to submit another claim for that service, thus resulting in multiple denials for the same service, supplier, beneficiary, and DOS in the absence of a required specialty code. CMS only counts savings from the earliest processed licensure edit denial among matching claim lines, i.e., those that share the same HCPCS code, rendering supplier, beneficiary, and DOS.

2. Pricing Orthotics and Prosthetics Licensure Edit Denials
To quantify what Medicare did not have to pay for each denial, CMS uses a pricing approximation methodology, given that VMS does not generate a price (i.e., the Medicare-approved charge if the claim line had been payable) for claim lines denied by orthotics and prosthetics licensure edits. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., items subject to a competitive bidding program, rentals, and new or used equipment, etc.).[111] CMS multiplies the average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the supplier.

3. Accounting for Subsequent Payment
To determine savings, CMS accounts for suppliers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial and that share the same HCPCS code, rendering supplier, beneficiary, and DOS as the denial. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

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

[111] For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

1.2.6 Fraud Prevention System Edits

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or rejected due to an FPS edit, accounting for any subsequently paid claim lines.

Data Sources: 1) FPS and 2) IDR claims data

The FPS can evaluate claims for episodes of care that span different service types or providers (e.g., inpatient care, outpatient and practitioner services, and DMEPOS) as well as those that span multiple visits over time. Because of its integrated potential fraud identification capabilities, CMS implements both edits and analytical models in the FPS to address vulnerabilities for fraud, waste, and abuse on a national level. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if an FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as an FPS model[112] or provider education, are better suited for the issue. CMS continuously develops new FPS edits and updates existing edits.

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

When a claim line is denied or rejected, a provider might try to submit another claim for that service without additional or corrected information necessary to pass the edit logic, thus resulting in multiple denials for the same service, provider, beneficiary, and DOS. CMS only counts savings from the earliest, or unique, FPS denial or rejection of claim lines that share the same HCPCS code, provider, beneficiary, and DOS. For most denied or rejected claim lines, FPS automatically generates the price, i.e., the amount Medicare would have paid for that claim line. The pricing data fields are the Medicare payment amount for Part A claims and the provider reimbursement amount for Part B claims. Both amounts exclude the beneficiary cost share. A small number of claim lines do not have a priced amount and are not included in savings.

To estimate actual costs avoided, CMS subtracts any subsequently paid resubmissions from the priced amount of the earliest denial or rejection, up to that priced amount. Paid resubmissions include paid claim lines that were processed on or after the earliest denial or rejection and that share the same HCPCS code, provider, beneficiary, and DOS.

For a given FPS denied or rejected claim line, CMS reports savings in the fiscal year during which the claim line was processed. The calculation of FPS edits savings uses claims data captured 90 days after the end of the fiscal year to allow time for appeals.

[112] FPS models look for aberrant billing patterns in post-payment claims data. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation by UPICs.

1.2.7 Medicare Administrative Contractor Automated Medical Review Edits

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by MAC automated medical review edits, accounting for subsequently paid claims or claim lines.

Data Sources: MCS, VMS, and FISS claims data in the IDR

The MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. CMS awards a geographic jurisdiction to each MAC to process and pay Medicare Part A and Part B medical claims[113] or DMEPOS claims. The MACs perform a variety of operational functions, but this document focuses on MAC activities in support of program integrity.

CMS collaborates with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program,[114] GAO, HHS-OIG, Medicare FFS RACs, and other sources. The MACs' medical review efforts focus on reducing payment errors; thus, the MACs refer cases of potential fraud to UPICs. The MACs conduct most of their medical review activities prior to payment using both automated and non-automated, or manual, methods (see Appendix B, Section 1.3.3 for non-automated medical reviews that occur prior to payment and Appendix B, Section 1.5.3 for post-payment medical reviews).

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

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

1. Identifying MAC Automated Medical Review Edit Denials
System logic in MCS and VMS automatically appends a specific Program Integrity Management Reporting (PIMR) activity code[115] to claim lines that fail an automated medical review edit. In MCS, CMS

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

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

[115] CMS previously maintained a PIMR system, which interfaced with the claims processing systems and provided system-generated reports of cost, savings, and workload data related to each MAC's medical review unit. Although CMS retired the PIMR system in 2012, it retained the PIMR data fields in the claims processing systems for the MACs' continued use.

identifies automated medical review denials as those denied claim lines tagged with the MAC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies automated medical review denials as those denied claim lines with a combination of the MAC-specific automated PIMR activity code and a medical review edit code in the automated range provided by each MAC.[116]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of automated review.[117] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[118] or claim line level.[119]

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

2. Pricing MAC Automated Medical Review Edit Denials

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

- *MCS:* In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-

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

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

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

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

generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[120] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, some MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[121] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated medical review denial based on the applicable pricing mechanism.[122] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

[120] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

[121] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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

beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

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

1.2.8 Unified Program Integrity Contractor Automated Edits

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by UPIC-initiated automated edits, accounting for subsequently paid claims or claim lines.

Data Sources: MCS, VMS, and FISS claims data in the IDR

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

During investigations, UPICs may request and review medical records from providers; analyze data; conduct interviews with beneficiaries, providers, or other medical personnel; and conduct onsite visits to provider locations. Based on the findings and CMS's approval, UPICs initiate appropriate administrative actions, such as denying or suspending payment that should not be made to a provider due to reliable evidence of fraud or abuse.[123]

Automated edits are among the administrative actions a UPIC may initiate. A UPIC may request that the MAC within its jurisdiction implement automated edits[124] to address program integrity issues and prevent the loss of future Medicare funds. In most cases, the MACs must comply with UPICs' requests to install automated edits in the relevant local claims processing system. Depending on the issue, these UPIC-initiated edits may automatically deny payment for 1) non-covered, incorrectly coded, or inappropriately billed services, 2) services submitted by suspicious providers, or 3) certain types of services for beneficiaries identified as part of a fraud scheme. Another type of UPIC automated edit denies claim lines that had been suspended for non-automated review, but the provider did not respond in a timely manner to an ADR. Providers have the right to appeal UPIC automated edit denials through

[123] The administrative actions that may result from UPIC investigations in Medicare include automated edits, non-automated reviews (Appendix B, Section 1.3.4) provider enrollment revocations and deactivations (Appendix B, Section 1.4), payment suspensions (Appendix B, Section 1.8.1), post-payment reviews (Appendix B, Section 1.5.6), and referrals to law enforcement (Appendix B, Section 1.9.1).

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

the Medicare FFS appeals process.

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

1. Identifying UPIC Automated Edit Denials
System logic in MCS and VMS automatically appends a specific PIMR activity code to claim lines that fail an automated edit. In MCS, CMS identifies UPIC automated edit denials as those denied claim lines tagged with the UPIC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies automated edit denials as those denied claim lines with the UPIC-specific automated PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.[125]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC automated denials as those denied claims or claim lines with a UPIC-specific code as the denial reason and a UPIC-specific edit reason code or PIMR code indicative of automated review.[126] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[127] or claim line level.[128]

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

2. Pricing UPIC Automated Edit Denials
To quantify what Medicare did not have to pay for each denial, CMS uses pricing methodologies specific

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

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

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

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

to each claims processing system:

- *MCS:* In MCS, most UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[129] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, the majority of the UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[130] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated denial based on the applicable pricing mechanism.[131] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

[129] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

[130] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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

from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claims or claim lines include those that were processed on or after the date of the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same HCPCS code, rendering provider, beneficiary, and DOS as the denial. In FISS, claim-level attributes are the same claim type code, beneficiary, provider, and DOS or admission date as the denial, and the claim-line-level attributes are the same claim type code, beneficiary, provider, HCPCS code, and DOS as the denial. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.

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

1.3 Prepayment Review Actions in Medicare

CMS undertakes activities that subject some claims (or claim precursors) to prepayment manual examination to ensure that providers complied with Medicare policy. This document uses the broad category of prepayment review actions to describe program integrity activities involving manual processing prior to an initial claim determination. CMS calculates prepayment review action savings from the following activities in Medicare FFS:

- Medicare Secondary Payer (MSP) Operations [132]
- Prior Authorization Request and Claim Reviews [133]
- MAC Non-Automated Medical Reviews
- UPIC Non-Automated Reviews

1.3.1 Medicare Secondary Payer Operations

Savings: The amount Medicare FFS would have paid as the primary payer, minus Medicare's secondary payment (as applicable), for all instances of MSP records available during prepayment claims processing.

Data Sources: 1) Contractor Reporting of Operational and Workload Data (CROWD) system and 2) CMS records of Workers' Compensation Medicare Set-Aside Agreements (WCMSAs)

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

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

[133] These prior authorization activities involve the manual review of DMEPOS prior authorization requests and automated editing of claims with DMEPOS HCPCS codes subject to prior authorization.

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

- Group health plan (GHP) [134]
- Liability insurance (including self-insurance) [135]
- No-fault insurance [136]
- Workers' compensation (WC) [137]

In situations when Medicare is not the primary payer, providers must bill the primary payer(s) before billing Medicare. If services are not covered in full by the primary payer(s), Medicare may make secondary payments for the services, as Medicare coverage allows. When a beneficiary does not have other health insurance or coverage for a claim, Medicare remains the primary payer.

CMS's MSP operations involve prevention of erroneous primary payments as well as recovery of mistaken or conditional payments made by Medicare (see Appendix B, sections 1.5.1 and 1.5.2 for additional information about recovery efforts). CMS collects information about Medicare beneficiaries' other health insurance or coverage through a variety of methods. These methods include mandatory reporting by other insurers regarding covered Medicare beneficiaries, beneficiary self-reporting of other coverage, and claims investigations. In addition, Medicare providers must ask Medicare beneficiaries about other coverage and submit that information with Medicare claims.

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

Some MSP-related claims may require manual intervention by the MACs. A claims examiner reviews the claim and information about other coverage. Depending on the findings regarding payment responsibility, the claim may be adjusted such that Medicare only makes a secondary payment, or the

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[134] A GHP is a health insurance plan offered by an employer or other plan sponsor (e.g., union or employee health and welfare fund). A Medicare beneficiary may be eligible for GHP employee/family coverage if he/she or a spouse is currently working, or for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Specific situations, including employer size and the beneficiary's status (e.g., age 65 or older, disabled, and/or end-stage renal disease), determine whether Medicare or the GHP has primary payment responsibility. Some Medicare beneficiaries have retiree GHP coverage through a former employer. For these beneficiaries, Medicare is always the primary payer, and the retiree GHP is the secondary payer.

[135] Liability insurance may pay for medical expenses resulting from negligence, such as inappropriate action or inaction that causes injury. Examples of liability insurance types include automobile, uninsured/underinsured motorist, homeowner, product, and malpractice.

[136] No-fault insurance may pay for medical expenses resulting from injury in an accident, regardless of who is at fault for causing the accident. Examples of no-fault insurance types include automobile, homeowner, and commercial.

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

claim may be rejected or denied. The MACs then attribute costs avoided to the associated MSP records.[138]

Providers may appeal or resubmit a denied/rejected claim and provide additional information to support receiving payment. If the primary payer is not expected to promptly pay the claim, a provider may receive a conditional payment from Medicare (see Appendix B, Section 1.5.1). If the primary payer denies the claim or makes an exhausted benefits determination, a provider may bill Medicare and include documentation of the primary payer's denial or determination. Medicare may make a payment, as Medicare coverage allows.

To determine savings, the amount Medicare would have paid as the primary payer is based on the Medicare fee schedule and Medicare coverage of items and services. What Medicare pays as the secondary payer is subtracted from this amount. In general, CMS reports savings in the fiscal year during which the dates of service or dates of discharge for the applicable claims occurred.[139] For WCMSAs,[140] CMS reports the full amount set aside in the fiscal year during which the agreement is set up. Because Medicare does not receive ongoing WC claims, CMS cannot determine yearly savings due to a given WCMSA.

1.3.2 Prior Authorization Request and Claim Reviews

CMS uses prior authorization to help ensure compliance with Medicare rules. The services that CMS selects for prior authorization have been susceptible to unnecessary utilization in the past. CMS may add or discontinue prior authorization initiatives depending on operational considerations and ongoing assessment of vulnerabilities to the Medicare Trust Funds.[141] For this report, CMS estimates prior authorization request and claim review savings from its DMEPOS initiative, which is program-integrity-funded.[142] Under this initiative, CMS requires prior authorization for selected HCPCS codes in the categories of power mobility devices, orthoses, lower limb prosthetics, and pressure-reducing support

[138] The MACs' MSP-related claims processing efforts are not currently included in the MSP program obligations in the annual *Report to Congress on the Medicare and Medicaid Integrity Programs*.

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

[140] A workers' compensation settlement may provide for funds to be set aside to pay for future medical and/or prescription drug expenses related to an injury, illness, or disease. A WCMSA may be set up for using these funds. Medicare will not pay for any medical expenses related to the injury, illness, or disease until all the set-aside funds are used appropriately.

[141] In FY 2024, CMS's initiatives included prior authorization for selected DMEPOS; selected hospital outpatient department services; and repetitive, scheduled non-emergent ambulance transport. CMS also conducted review choice demonstration initiatives for home health and inpatient rehabilitation facility services, one of the choices being pre-claim review, which has similarities with the prior authorization process.

[142] CMS has prior authorization initiatives funded by sources other than those subject to this report's requirements. Because funding for those other initiatives is not part of the denominator of the Medicare program integrity ROI calculation, CMS accordingly does not include savings from those other initiatives in the total Medicare program integrity savings and ROI metrics included in this report.

surfaces.[143] The list of HCPCS codes is subject to change, which CMS announces via Federal Register notices.[144]

In its DMEPOS initiative, CMS realizes savings via the review of prior authorization requests and relevant claims, as described in the following sections. In this report, *Table 3: Medicare Savings* provides the sum of savings from both activities.

1.3.2.1 DMEPOS Prior Authorization Request Reviews

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

Data Source: MAC reports

For a DMEPOS HCPCS code requiring prior authorization, a provider must submit to their MAC a prior authorization request containing supporting medical documentation.[145] The MAC reviews the request and issues the provider a decision either provisionally affirming that a future claim will likely meet Medicare coverage requirements[146] or not affirming coverage.

A provisionally affirmed prior authorization decision is a condition of payment for DMEPOS HCPCS codes subject to required prior authorization. Following non-affirmative decisions, providers may modify requests and are permitted unlimited resubmissions. The MACs create unique tracking numbers (UTNs) for DMEPOS prior authorization decisions, and a provider must include the relevant UTN when submitting a claim for payment. If a UTN is absent or associated with a non-affirmative prior authorization decision, the MAC will deny the claim (see the next section for more information).[147]

To calculate savings attributable to non-affirmative prior authorization decisions, CMS collects data from the DME MACs detailing, for each HCPCS code and state combination, the number of unique prior authorization requests that were submitted during the reporting period and had a non-affirmative

[143] For operational simplicity, CMS allows suppliers to voluntarily request prior authorization for certain DMEPOS accessory items on the same request as for an item requiring prior authorization, such that a decision can be rendered for both the item requiring prior authorization and the associated accessory that does not require prior authorization. CMS's prior authorization savings methodology does not include HCPCS codes for which voluntary prior authorization is allowed.

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

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

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

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

decision status as of the final date of the reporting period. Given that providers are allowed unlimited resubmissions of requests, CMS does not count savings for multiple non-affirmative decisions of the same prior authorization request or if an initially non-affirmed request subsequently receives an affirmative decision during the reporting period.

To quantify the amount that Medicare did not have to pay, CMS estimates what the price would have been for the HCPCS codes represented in non-affirmed prior authorization requests. CMS uses pricing methodologies based on whether an item can be rented or not, and if an item can be rented, whether beneficiaries typically choose to rent or purchase the item. The following categories provide further pricing estimation details:[148]

- *Non-Rental Equipment:* A small number of items subject to prior authorization cannot be rented. The number of non-affirmed prior authorization requests for each of the corresponding HCPCS codes within each state is counted and priced according to whether a HCPCS code has been billed in Competitive Bidding Areas (CBAs),[149] as detailed below. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

    - *CBAs only:* If all claim lines for a given HCPCS code and state combination were paid using the CBA fee schedule, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced by taking the average of the state's CBA fee schedule rates for the given HCPCS code.

    - *Non-CBAs only:* If none of the claim lines for a given HCPCS code and state combination were paid using the CBA fee schedule, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced by taking the average of the rural and non-rural non-CBA fee schedule rates for the given HCPCS code and state combination.

    - *Both CBAs and non-CBAs:* If claim lines for a given HCPCS code and state combination were paid using both the CBA and non-CBA fee schedules, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced using the mean of the state's average CBA fee schedule rate across all regions for the given HCPCS code and the average of the rural and non-rural non-CBA fee schedule rates for the given HCPCS code and state combination.

- *Equipment Typically Purchased, Rather than Rented:* Among items that can be rented or purchased, a HCPCS code is designated as typically purchased within a given state if 50 percent or more of the claim lines billed for that HCPCS code and state combination are identified as purchases (new or used), as assessed for dates of service in the calendar year prior to the

[148] CMS also accounts for sequestration payment adjustment as applicable.

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

calendar year that marks the beginning of the reporting fiscal year.[150] The number of non-affirmed prior authorization requests for each HCPCS code and state combination in this category is counted and priced using the average of the rural and non-rural non-CBA fee schedule rates for new equipment for each HCPCS code. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

- *Equipment Typically Rented, Rather than Purchased:* Among items that can be rented or purchased, a HCPCS code is designated as typically rented within a given state if over 50 percent of the claim lines billed for that HCPCS code and state combination are identified as rentals, as assessed for dates of service in the calendar year prior to the calendar year that marks the beginning of the reporting fiscal year. The average rental length is calculated for each HCPCS code and state combination using the same reference data. CMS determines the price according to whether a HCPCS code has been billed in CBAs, as detailed below. CMS then multiplies the price by 80 percent to remove the beneficiary coinsurance and estimate the amount that Medicare did not have to pay.

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

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

    - *Both CBAs and non-CBAs:* If claim lines for a given HCPCS code and state combination were paid using both the CBA and non-CBA fee schedules, as assessed for dates of service in the reporting fiscal year, then the HCPCS code and state combination is priced using the mean of the state's average CBA fee schedule rate across all regions for the given HCPCS code and the average of the rural and non-rural non-CBA fee schedule rates for the given HCPCS code and state combination. This amount is then multiplied by the average number of rental months for the HCPCS code and state combination, also

[150] For example, the beginning of FY 2024 (10/1/2023) falls in calendar year 2023. Therefore, CMS used data from calendar year 2022 to determine whether a HCPCS code in a given state is typically purchased or rented.

accounting for a 60% (as related to power mobility devices) or 25% (as related to all other rentals) reduction in the payment rate for months four and after if the average number of rental months is four or more.

1.3.2.2 DMEPOS Prior Authorization Automated Edits [151]

Savings: The estimated amount Medicare FFS did not have to pay for all unique claim lines denied due to prior authorization edits that detect no record of a prior authorization request, accounting for any subsequently paid claim lines.

Data Source: VMS claims data in the IDR

As noted in the previous section, a provider must include the relevant UTN when submitting a claim for a DMEPOS HCPCS code requiring prior authorization. The MACs operate multiple types of automated prepayment edits related to DMEPOS prior authorization that check relevant incoming claims. Scenarios subject to automatic denial include 1) a submitted claim associated with a non-affirmative prior authorization decision.[152] and 2) a submitted claim with no record of a prior authorization request.[153] CMS calculates prior authorization automated edit savings only for the second scenario because denials in the first scenario would represent amounts duplicative of savings from prior authorization request reviews (see previous section). Providers generally have the right to appeal prior authorization automated edit denials through the Medicare FFS appeals process.

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

1. Identifying DMEPOS Prior Authorization Automated Edit Denials
System logic in VMS automatically appends a specific action code to claim lines that fail DMEPOS prior authorization automated edits. There are currently two action codes in use for the scenario of a submitted claim line with no record of a prior authorization request, and either action code may be appended to the denied claim line. During processing, claim lines may be denied for multiple errors. CMS attributes savings to a DMEPOS prior authorization edit only when one of the specific action codes is the system's highest priority reason for denying a claim line.

When a claim line is denied, a supplier might try to submit another claim for that service, thus resulting in multiple denials for the same service, supplier, beneficiary, and DOS in the absence of a prior authorization request. CMS only counts savings from the earliest processed DMEPOS prior authorization

[151] FY 2024 was the first year that CMS implemented a savings methodology for DMEPOS prior authorization automated edit denials; however, these edits were in operation prior to that.

[152] As noted in the previous section, there are circumstances in which providers submit claims knowing that Medicare will deny those claims. For example, documentation of Medicare's denial may be required before secondary insurance will pay for a particular service.

[153] If a claim is associated with a UTN representing either an affirmative or non-affirmative decision, providers must include that UTN on the claim for it to process. Thus, CMS can clearly distinguish between scenarios 1 and 2 in the processed claims data.

edit denial among matching claim lines, i.e., those that share the same HCPCS code, rendering supplier, beneficiary, and DOS.

2. Pricing DMEPOS Prior Authorization Automated Edit Denials
To quantify what Medicare did not have to pay for each denial, CMS uses a pricing approximation methodology, given that VMS usually does not generate a price (i.e., the Medicare-approved charge if the claim line had been payable) for claim lines denied by DMEPOS prior authorization automated edits. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., items subject to a competitive bidding program, rentals, and new or used equipment, etc.).[154] CMS multiplies the average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the supplier.[155]

3. Accounting for Subsequent Payment
To determine savings, CMS accounts for suppliers who successfully appeal or resubmit previously denied services. Specifically, where there are any subsequently paid claim lines for a previously denied service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from the priced amount of the earliest denial, up to that priced amount. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial and that share the same HCPCS code, rendering supplier, beneficiary, and DOS as the denial. Amounts used in these steps have the estimated beneficiary coinsurance removed, when applicable.[156]

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

1.3.3 Medicare Administrative Contractor Non-Automated Medical Reviews

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied prior to payment by MAC non-automated medical reviews, accounting for subsequently paid claims or claim lines.

Data Sources: MCS, VMS, and FISS claims data in the IDR

In addition to automated medical review edits (see Appendix B, Section 1.2.7), the MACs conduct non-automated, or manual, medical reviews where there is risk for improper payment. In MCS, VMS, and FISS,

[154] For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

[155] CMS also accounts for sequestration payment adjustment as applicable.

[156] CMS also accounts for sequestration payment adjustment as applicable.

the MACs implement non-automated medical review edits, which suspend all or part of a claim possessing the targeted criteria for review. The MACs may request additional documentation from providers (i.e., through an ADR), and specific time limits apply to providers' submission of documentation and the MACs' completion of reviews. Each MAC has a medical review staff of trained clinicians and claims analysts, who review claims and associated documentation to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, are up- or down-coded for adjusted payment. The MACs also offer providers education to resolve errors and improve future accuracy.[157] Providers have the right to appeal MAC non-automated medical review denials through the Medicare FFS appeals process.

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

1. Identifying MAC Non-Automated Medical Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.[158] In MCS, CMS identifies non-automated medical review denials as those denied claim lines tagged with a MAC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies non-automated medical review denials as those denied claim lines with a combination of a MAC-specific non-automated review PIMR activity code and a medical review edit code in the non-automated ranges provided by each MAC.[159]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC non-automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of non-automated medical review.[160] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For

[157] Effective FY 2018, CMS implemented Targeted Probe and Educate (TPE), a national medical review strategy that focuses on providers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. TPE involves up to three rounds of prepayment or post-payment claim review combined with individualized provider education. See Appendix B, Section 1.5.3 for information about MAC post-payment medical reviews.

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

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

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

services subject to claim-line-level reimbursement, CMS identifies denials at either the claim [161] or claim line level. [162]

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

2. Pricing MAC Non-Automated Medical Review Denials

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

- *MCS:* In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier. [163] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, the majority of the MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.). [164] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

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

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

[163] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

[164] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated medical review denial based on the applicable pricing mechanism.[165] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

3. Accounting for Subsequent Payment

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

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

1.3.4 Unified Program Integrity Contractor Non-Automated Reviews

Savings: The estimated amount Medicare FFS did not have to pay for claims or claim lines denied by UPIC non-automated reviews, accounting for subsequently paid claims or claim lines.

Data Sources: MCS, VMS, and FISS claims data in the IDR

In addition to automated edits (see Appendix B, Section 1.2.8), a UPIC may request that the MAC in their jurisdiction implement non-automated prepayment review edits in the local claims processing system [166] to identify and suspend claims for medical review prior to payment.

To initiate non-automated review, the MAC sends an ADR to the provider under review. The ADR instructs the provider to provide the necessary medical record documentation to the UPIC for further

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

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

review. In accordance with CMS guidance, the provider must submit the necessary documentation to the UPIC within 45 calendar days or the claims are denied.[167] Upon receiving documentation, the UPIC examines the medical records for compliance with Medicare policy while determining if there is evidence of fraud, waste, or abuse. When the medical documentation does not support the services billed by the provider, the UPIC denies or adjusts payment for the claims. Providers have the right to appeal UPIC non-automated review denials through the Medicare FFS appeals process.

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

1. Identifying UPIC Non-Automated Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.[168] In MCS, CMS identifies UPIC non-automated review denials as those denied claim lines tagged with a UPIC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies non-automated review denials as those denied claim lines with a UPIC-specific non-automated review PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.[169]

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC non-automated review denials as those denied claims or claim lines with a UPIC-specific code as the denial reason and a UPIC-specific edit reason code or PIMR code indicative of non-automated review.[170] For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim[171] or claim line level.[172]

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

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[167] CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

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

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

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

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

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

and DOS.

2. Pricing UPIC Non-Automated Review Denials

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

- *MCS:* In MCS, most UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.[173] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS:* In VMS, the majority of UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).[174] CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS:* Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated review denial based on the applicable pricing mechanism.[175] CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

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[173] For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

[174] For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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

3. Accounting for Subsequent Payment

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

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

1.4 Provider Enrollment Actions in Medicare

Providers must enroll in the Medicare FFS program to receive payment for covered services they furnish to Medicare beneficiaries. To enroll, providers must submit a paper CMS-855 or CMS-20134 enrollment application or a corresponding online application through PECOS and then undergo risk-based screening. If a prospective provider does not meet eligibility requirements, CMS denies enrollment. Once enrolled, providers are responsible for keeping their enrollment information (e.g., ownership information, practice location address, adverse legal actions, etc.) up to date. CMS may revoke or deactivate a currently enrolled provider's Medicare billing privileges if the provider's behavior triggers one or more of the 22 revocation reasons or eight deactivation reasons.[176]

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

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

[176] For non-compliance issues that can be remedied by submitting an enrollment-related application form, CMS may impose a stay of enrollment, or a preliminary, interim pause in enrollment. For example, CMS may impose a stay of enrollment if a provider failed to report an address change in a timely manner. The provider can correct this issue by submitting an application with the updated practice location address and subsequently receive Medicare payment for services rendered during the stay. CMS does not calculate savings from stays of enrollment because the intent and outcome is burden reduction, not savings generation.

1.4.1 Revocations

Savings: The projected amount Medicare FFS did not pay fully revoked providers during each provider's re-enrollment bar, as based on each provider's historically paid claims and adjusted to exclude estimated amounts from expected billing by active providers for like services as previously billed by revoked providers for the same beneficiaries.

Data Sources: 1) PECOS, 2) Previous 18 months of CWF claims data for each revoked provider, and 3) Cost avoidance adjustment factor

CMS has 22 regulatory reasons upon which to revoke a provider's Medicare FFS billing privileges. Examples include non-compliance with Medicare enrollment requirements, certain felony convictions, submission of false or misleading application information, determination that the provider is non-operational, abuse of billing privileges, failure to comply with enrollment reporting requirements, and termination of Medicaid billing privileges. Depending on the revocation reason, CMS bars a provider from re-enrolling in Medicare for one to 10 years with the ability to bar re-enrollment for up to 20 years if it revokes a provider for a second time. CMS may also add up to three years to a provider's existing re-enrollment bar if it determines that the provider is attempting to circumvent its existing re-enrollment bar by enrolling in Medicare under a different name, numerical identifier, or business identity.

If the revocation reason is non-compliance with Medicare enrollment requirements, a provider may submit a corrective action plan (CAP) for CMS's consideration. If CMS approves the CAP, it reverses the provider's revocation. If CMS denies the CAP, the provider cannot appeal that CAP decision but may continue through the appeals process, via a reconsideration request, for the revocation determination.

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

CMS calculates costs avoided for fully revoked providers at the professional identifier and provider type level.. [177] CMS uses the NPI as the professional identifier for individual providers and the Employer Identification Number (EIN) as the professional identifier for provider organizations. CMS defines a full revocation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a revocation within the fiscal year. To calculate savings, CMS captures PECOS enrollment data and CWF claims data as of 90 days after the end of the fiscal year to allow time for revocation appeals as well as for claims submission, adjudication, and appeals/resubmission.

CMS estimates the amount that Medicare did not pay fully revoked providers in two steps: 1) projecting costs avoided and 2) accounting for billing picked up by active providers.

[177] For the purpose of calculating savings, CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DMEPOS supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

1. Projecting Costs Avoided

CMS projects what Medicare would have paid a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider's full revocation date.[178] Using the paid claims in this 12-month period and placing higher weights on previous months of billing, CMS calculates the weighted moving average for each month of the revoked provider's re-enrollment bar to project the Medicare payments that provider would have received.[179] The sum of the payment projections for each month represents the costs avoided for the revoked provider during the length of its re-enrollment bar.

2. Accounting for Billing Picked Up by Active Providers

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

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

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

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

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

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[178] CMS uses the earliest 12 months in the 18 months preceding the provider's revocation date because a provider may change its billing practices closer to the revocation date, especially if the provider becomes aware of CMS conducting a review or investigation of its claims. For a given provider, CMS starts the methodological historical payment window with the date of the earliest service that was paid within the 18 months preceding the provider's revocation date. The historical payment window ends 12 months after that start date or on the revocation date, whichever is earlier.

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

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

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

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

1.4.2 Deactivations

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

Data Sources: 1) PECOS, 2) Previous 12 months of CWF claims data for each deactivated provider, 3) Reactivation correction factor, and 4) Cost avoidance adjustment factor

CMS has eight regulatory reasons upon which to deactivate a provider's billing privileges. Examples include failure to report a change in information (e.g., practice location, billing services, or ownership), failure to respond to a CMS notice to submit or certify enrollment information, and noncompliance with enrollment requirements.[181] Unlike revocations, deactivations have no re-enrollment bars. In most cases, a provider can reactivate its enrollment in Medicare at any time by submitting a new enrollment application or recertifying the information on file. For all deactivation reasons, a provider may file a rebuttal to challenge the deactivation. A rebuttal is an opportunity for the provider to demonstrate that it meets all applicable enrollment requirements and that its Medicare billing privileges should remain active. Only one rebuttal request may be submitted per deactivation. Further, a rebuttal decision cannot be appealed.

CMS calculates costs avoided for fully deactivated providers at the professional identifier and provider type level.[182] CMS uses the NPI as the professional identifier for individual providers and the EIN as the professional identifier for provider organizations. CMS defines a full deactivation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a program-integrity-related deactivation within the fiscal year. To calculate savings, CMS captures PECOS enrollment data and CWF claims data as of 90 days after end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

CMS estimates the amount that Medicare did not pay fully deactivated providers in three steps: 1)

[181] In determining savings, CMS excludes deactivation reasons that do not represent active intervention to promote program integrity. E.g., CMS excludes deactivations due to death or voluntary withdrawal from Medicare.

[182] For the purpose of calculating savings, CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DMEPOS supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

projecting costs avoided, 2) accounting for reactivations within 12 months, and 3) accounting for billing picked up by active providers.

1. Projecting Costs Avoided
CMS projects what Medicare would have paid a fully deactivated provider based on the 12 months of claims history preceding the provider's full deactivation date. Using the paid claims in this period and placing higher weights on previous months of billing, CMS calculates the weighted moving average for each month in a future 12-month period to project the Medicare payments that provider would have received. The sum of the payment projections for each month represents the costs avoided for the deactivated provider during a 12-month period.

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

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

CMS developed the provider-type-specific adjustment factors by analyzing the change in service utilization by the beneficiaries of a historical sample of fully-deactivated providers.[183] For each fully-deactivated provider in the sample, CMS identified the beneficiaries and which services they received from that provider in the 180 days before the deactivation became effective. CMS then calculated the following amounts:

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

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

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

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

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

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

1.5 Overpayment Recoveries in Medicare

Given the volume of claims submitted to Medicare, CMS cannot review every claim prior to payment. Thus, CMS conducts a wide range of post-payment activities to identify improper payments and recover overpayments. An overpayment is any amount a provider or plan receives more than amounts properly payable under Medicare statutes and regulations. Overpayments are debts owed to the federal government, and CMS has the authority to recover these amounts. CMS reports savings from the following overpayment[184] recovery activities:

- *Medicare FFS*:
  - MSP Operations
  - MSP Commercial Repayment Center (CRC)
  - MAC Post-Payment Medical Reviews
  - Medicare FFS Recovery Audit Contractor (RAC) Reviews
  - Supplemental Medical Review Contractor (SMRC) Reviews
  - UPIC Post-Payment Reviews

- *Medicare Part C and Part D*: Medicare Part C and Part D Plan-Identified Risk Adjustment Overpayments

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

1.5.1 Medicare Secondary Payer Operations

Savings: The amount of conditional and mistaken payments Medicare FFS recovered from 1) providers, 2) beneficiaries who received settlements from other insurers/WC carriers, and 3) global settlements with liability insurers.

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

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

CMS's MSP operations include the recovery of mistaken and conditional payments made by Medicare when another payer has primary payment responsibility (see Appendix B, Section 1.3.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.[185] Mistaken payments may occur if information about other coverage is unavailable or inaccurate at the time a claim is received. Medicare makes conditional payments for covered services on behalf of beneficiaries when the primary payer is not expected to pay promptly for a claim. For example, Medicare may make a conditional payment in a contested compensation case, when there is a delay between the beneficiary's injury and the primary payer's determination or settlement. The purpose of conditional payments is to ensure continuity of care for Medicare beneficiaries and to avoid financial hardship on providers while awaiting decisions in disputed cases. CMS initiates recovery actions once information about primary coverage becomes available, either through new reporting or settlement of a case.

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

The MACs conduct MSP-related recovery from providers.[186] Activities include identifying claims for recovery, requesting and receiving repayment, and referring unresolved debts to the Department of the Treasury. Most of the MACs' recovery efforts occur through claims processing. The MACs conduct post-payment adjustments for claims that another insurer/entity should have paid in part or full. In cases of duplicate primary payment by Medicare and another insurer/entity—i.e., the provider received a primary payment from both Medicare and another insurer/entity for a given episode of care—the MACs recover Medicare's portion from the provider.

CMS also pursues global recovery of liability cases involving many Medicare beneficiaries. Examples of such cases include mass tort and class action lawsuits. CMS reports the full amount of a global recovery in the fiscal year during which it is reimbursed.

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

[186] The MACs' MSP-related recovery efforts are not currently included in the MSP program obligations in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

1.5.2 Medicare Secondary Payer Commercial Repayment Center

Savings: The amount of mistaken and conditional payments Medicare FFS recovered in cases when GHPs had primary payment responsibility as well as in liability, no-fault, and WC cases when the insurer/WC carrier has ongoing responsibility for medicals (ORM).

Data Source: CROWD system

The CRC is CMS's RAC responsible for MSP cases when an entity such as an insurer, employer, or WC carrier is the identified debtor (see Appendix B, sections 1.3.1 and 1.5.1 for additional information about MSP operations). The CRC recovers Medicare's mistaken primary payments from GHPs (typically from the employer, insurer, claims processing third-party administrator, or other plan sponsor) as well as conditional payments from applicable plans (liability insurers, no-fault insurers, or WC carriers) when the insurer/WC carrier has accepted ORM. CMS pays the CRC on a contingency fee basis, i.e., a percentage of the amount the identified debtor returned to Medicare.

For recovery of conditional payments from applicable plans, the CRC first issues the insurer/entity a notice of the claims conditionally paid by Medicare. The insurer/entity can dispute the claims with supporting documentation. After considering any disputes, the CRC issues a demand letter with the amount owed to Medicare. Applicable plans have the right to appeal all or a portion of the demand amount. For the recovery of mistaken payments from GHPs, the recovery process begins with the demand letter. The identified debtor must reimburse CMS for the identified claims listed in the demand letter. GHPs do not have formal appeal rights but may use the defense process to dispute the amount of the debt. Outstanding debts are referred to the Department of the Treasury for further collection action.

CMS reports recovered Medicare payments in the fiscal year during which they are collected.[187] CMS calculates the CRC savings as the sum of direct payments from debtors and delinquent debt collections from the Department of the Treasury, minus excess collections that were refunded.[188, 189]

1.5.3 Medicare Administrative Contractor Post-Payment Medical Reviews

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

Data Source: Healthcare Integrated General Ledger Accounting System (HIGLAS)

While the MACs primarily focus on preventing improper payments (see Appendix B, sections 1.2.7 and

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

[188] Excess collections may occur if the Department of the Treasury offsets against a payment due to the debtor by another federal program at the same time as a debtor makes a direct payment to the CRC.

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

1.3.3), they may also conduct some post-payment review of claims when there is the likelihood of a sustained or significant level of payment error. When conducting a post-payment review, a MAC may request additional documentation from a provider. The provider must submit documentation within a specified time limit, though the MAC has the discretion to grant extensions. If a provider does not submit the requested documentation in a timely manner, the MAC denies the claims.

The MAC applies Medicare coverage and coding requirements to determine if the provider received improper payments and sends the provider a review results letter. The MAC then adjusts the associated claims in the appropriate shared claims processing systems to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Delinquent debts may be referred to the Department of the Treasury for further collection action. Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

Overpayment recoveries are tracked in HIGLAS for Part A, Part B, and DME receivables.[190] CMS calculates savings as the sum of collections received for Part A, Part B, and DME receivables in the fiscal year during which the collection occurred.[191] Therefore, there may be overpayments identified by a MAC in a prior fiscal year for which collections accrued in the current fiscal year. Offsets or recoupments made on overpayments that are fully or partially overturned on appeal are removed from savings in the fiscal year during which the appeal is processed.

There may be instances when the MAC cannot collect on an identified overpayment. In those instances, the receivable is closed in HIGLAS, and CMS does not include the amounts in the savings metric.

1.5.4 Medicare Fee-for-Service Recovery Audit Contractor Reviews

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

Data Source: RAC Data Warehouse (RACDW)

CMS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.[192] The Medicare FFS RACs' reviews focus on service-specific topics related to national and local Medicare

[190] In FY 2020, CMS transitioned DME overpayments tracking and data from VMS to HIGLAS. While HIGLAS was CMS's primary data source for FY 2024 overpayment collections, CMS also referenced information in VMS about a few transitioned accounts receivable records.

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

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

policy. CMS approves all review concepts before the Medicare FFS RACs begin reviews. The Medicare FFS RACs may submit proposed review topics to CMS on a rolling basis. At times, CMS will also send the Medicare FFS RACs review topics identified by the MACs, UPICs, or external entities (e.g., HHS-OIG and GAO). Each Medicare FFS RAC has the option to accept or decline these topics for review. CMS can also require the RACs to conduct specific reviews.

The Medicare FFS RACs identify overpayments and underpayments through claims data analysis and review of medical records, which they can request through ADR letters. If a provider does not submit the requested documentation in a timely manner, the Medicare FFS RAC denies the claims. CMS imposes limits on the number of ADRs Medicare FFS RACs may send within a specified period. CMS also sets an initial limit on the number of reviews the Medicare FFS RACs may conduct under each approved RAC review topic. Once a Medicare FFS RAC has reached this limit, CMS reassesses the approved topic before allowing the Medicare FFS RAC to conduct additional reviews on the topic. In addition, the Medicare FFS RACs must assess each approved topic every six months, at a minimum, to check for and report any necessary updates to CMS. Medicare FFS RACs are not allowed to identify improper payments more than three years after a claim was originally paid.

After conducting a review, the Medicare FFS RAC sends the provider a review results letter. The provider has a specified time limit to request a discussion with the Medicare FFS RAC regarding any identified improper payments. The discussion period offers the provider the opportunity to submit additional documentation to substantiate the claims and allows the Medicare FFS RAC to review the additional information without the provider having to file an appeal. If warranted, the Medicare FFS RAC can reverse an improper payment finding during the discussion period and not proceed with administrative action.

After the discussion period, if the RAC finding stands, the Medicare FFS RAC refers an identified improper payment to the MAC in the appropriate claims processing jurisdiction. The MAC then adjusts the associated claim(s) to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Providers who disagree with a Medicare FFS RAC's improper payment determination have the right to use the Medicare FFS appeals process.[193]

Both the Medicare FFS RACs and the MACs record information in the RACDW, as related to the claims review and transactional status of RAC-identified improper payments. The Medicare FFS RACs provide CMS with monthly reports of all amounts identified and demanded. The MACs provide CMS with data on all RAC-identified overpayments collected, and all underpayments reimbursed. There may be overpayments that a Medicare FFS RAC identified in a prior fiscal year for which collections occur in the current fiscal year. The MACs also record appeal outcome information in the RACDW. If an overpayment is fully or partially overturned on appeal, any offsets or recoupments that had been made are removed from savings in the fiscal year of the appeal decision. Thus, CMS calculates savings attributed to Medicare

[193] As required by Section 1893(h) of the Social Security Act, CMS pays Medicare FFS RACs on a contingency fee basis. A Medicare FFS RAC must return its contingency fee if an improper payment determination is overturned on appeal. CMS subtracts the amount of returned contingency fees from its program integrity obligations in the fiscal year during which a RAC returns the funds.

FFS RACs as the sum of Medicare FFS RAC-identified overpayment collections received from providers, minus 1) the sum of Medicare FFS RAC-identified underpayments reimbursed to providers and 2) the sum of collections that had been made on Medicare FFS RAC-identified overpayments overturned on appeal during the fiscal year.

1.5.5 Supplemental Medical Review Contractor Reviews

Savings: The amount of SMRC-identified overpayments that Medicare FFS collected minus the amount of adjustments in the fiscal year.

Data Source: SMRC reports

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

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

The SMRC identifies overpayments by evaluating claims data and the associated medical records for compliance with Medicare's coverage, coding, and billing requirements, as related to the assigned project. The SMRC requests the necessary documentation through letters sent to providers. The SMRC does not perform a review for any claim previously reviewed by another review contractor.

The SMRC communicates its medical review findings to a provider in a final review results letter. Depending on the type of SMRC medical review project, providers may have the option to request a discussion and education (D&E) period with the SMRC. The D&E period provides an opportunity for a provider to review nonpayment findings with the SMRC and for the SMRC to educate the provider in improving future billing practices. During this period, a provider may also submit additional information and/or documentation to support payment of the claim(s) initially identified for denial. The provider receives an updated findings letter detailing the outcome of the D&E session.

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

The SMRC provides CMS with quarterly data reports on project-specific amounts of collected

overpayments and adjustments.[194] Adjustments represent previous collections partially or fully overturned on appeal. The MACs generate these reports for the SMRC based on data from HIGLAS. CMS reports collections from SMRC reviews in the fiscal year during which amounts are received. Therefore, there may be overpayments identified by the SMRC in a prior fiscal year for which collections occur in a later fiscal year. CMS reports adjustments as subtractions from collections in the fiscal year that those adjustments occur, regardless of when the initial collection occurred. Adjustments are reported in a given fiscal year according to when that adjustment was recorded in HIGLAS.

1.5.6 Unified Program Integrity Contractor Post-Payment Reviews

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

Data Source: HIGLAS

During an investigation, a UPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a UPIC requests additional documentation from a provider. The provider must submit documentation within a specified time limit, though a UPIC has the discretion to grant extensions.[195] If a provider does not submit the requested documentation in a timely manner, the UPIC denies the claims.

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

Once a post-payment review is complete, the UPIC provides the results of the medical review to the provider[196] and refers the overpayment to the MAC in its jurisdiction for recovery. The MAC then adjusts the Part A, Part B, or DME claims associated with the overpayment in the respective shared claims processing system, and the provider is issued a demand letter requesting repayment of the overpayment. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. The MAC may also recover overpayments from an escrow account when CMS terminates a payment suspension. Delinquent debts may be referred to the Department of the Treasury for further collection action. Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

[194] In FY 2024, CMS implemented system changes to largely automate the process of tracking and reporting adjustments to SMRC-identified overpayments. During the development of these system changes, the SMRC's reporting of adjustments was limited by data availability, which incrementally improved throughout FY 2024. Between FY 2020 and FY 2023, some adjustments to collections were anecdotally reported.

[195] CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

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

Overpayment recoveries are tracked in HIGLAS for Part A, Part B, and DME receivables.[197] CMS calculates savings as the sum of collections received for Part A, Part B, and DME receivables in the fiscal year during which the collection occurred. Therefore, there may be overpayments identified by a UPIC (or a previous Medicare FFS program integrity contractor) in a prior fiscal year for which collections accrued in the current fiscal year. Offsets or recoupments made on overpayments that are fully or partially overturned on appeal are removed from savings in the fiscal year during which the appeal is processed.

There may be instances when the MAC cannot collect on a UPIC-identified overpayment. In those instances, the receivable is closed in HIGLAS, and CMS does not include the amounts in the savings metric.

1.5.7 Medicare Part C and Part D Plan-Identified Risk Adjustment Overpayments[198]

Savings: The amount of risk adjustment overpayments that Medicare recovered from Medicare Part D plan sponsors and MA organizations due to the retrospective elimination of unsupported diagnosis codes in risk-adjusted payments, as identified by the MA organization.

Data Source: Medicare Advantage and Prescription Drug System

CMS makes risk adjusted per capita payments to Medicare Part D plan sponsors, MA organizations, 1833 health care prepayment plans, Section 1876 cost contract plans, Program of All-Inclusive Care for the Elderly (PACE) organizations, and some demonstration plans (hereafter collectively referred to as MA organizations for the purpose of risk adjustment), as required by the Social Security Act. Risk-adjusted payments allow CMS to more accurately pay organizations for their enrollees with different expected costs based on their health status and demographics.

CMS's risk adjustment models[199] generate a risk score for a given beneficiary based on the beneficiary's demographic characteristics for the current payment year[200] and relevant diagnosis codes[201] from

[197] In FY 2020, CMS transitioned DME overpayments tracking and data from VMS to HIGLAS. While HIGLAS was CMS's primary data source for FY 2024 overpayment collections, CMS also referenced information in VMS about a few transitioned accounts receivable records.

[198] In previous years' (i.e., FY 2016–FY 2019) reports to Congress, this activity was referred to as overpayments related to risk adjustment data. No recoveries occurred during FY 2020–FY 2022 due to a pause in this activity resulting from litigation. In April–June 2022, CMS issued memos to plan sponsors about its intention to resume this activity, and recoveries began to be realized again in FY 2023.

[199] CMS Hierarchical Condition Category (CMS-HCC) Models are used to calculate risk adjusted payments to MA organizations (Part C portion), Section 1876 cost contract plans, Section 1833 health care prepayment plans, PACE, and some demonstration plans, as appropriate. The Prescription Drug HCC (RxHCC) Model is used to calculate risk adjusted payments to MA organizations (Medicare Part D portion) and stand-alone PDPs.

[200] In this document, the terms "payment year," "benefit year," and "contract year" may be used interchangeably for Medicare Part C and Part D. Because most plans operate on a calendar-year basis, these terms usually reference the calendar year.

[201] CMS uses clinically-significant, cost-predictive medical conditions in the risk adjustment process. Examples include diabetes, congestive heart failure, and cancer.

services provided in the previous year (i.e., the base year).[202] Each beneficiary's risk score is multiplied by the appropriate per capita rate, which is determined during an annual bidding process and represents the expected costs for a Medicare beneficiary of average health. Thus, payments are higher for enrollees with higher projected medical costs and lower for those with lower projected medical costs.

All diagnosis codes submitted by MA organizations and used for risk-adjusted payments must be documented in the medical record as a result of a face-to-face visit with an acceptable provider type, namely hospital inpatient facilities, hospital outpatient facilities, or physicians. Starting with payment year 2022, MA organizations only submit diagnosis codes for risk adjustment through CMS's Encounter Data Processing System (EDPS). PACE organizations submit risk adjustment data to the EDS as well as the Risk Adjustment Processing System (RAPS). CMS calculates risk scores using diagnoses submitted by MA organizations and FFS providers, depending on where the beneficiary was enrolled in the data collection year.

MA organizations are responsible for the accuracy of diagnosis codes submitted to CMS. The Social Security Act requires MA organizations to report and return plan-identified overpayments. Overpayments occur when, after the final risk adjustment data submission deadline for a given payment year, MA organizations identify unsupported or invalid diagnosis codes, for example through internal audits and quality assurance activities or because of provider-reported issues. MA organizations must delete unsupported diagnosis codes in RAPS and EDPS, as appropriate.[203] MA organizations are not paid for added diagnosis codes after the final risk adjustment data submission deadline for a given payment year.[204]

CMS re-calculates risk scores for prior payment years for the purpose of recovering plan-identified overpayments. Each calendar year, CMS expects to announce one or more prior payment years subject to re-calculation and payment adjustment.[205] MA organizations return overpayments by deleting unsupported diagnoses. CMS incorporates deletions to re-calculate risk scores and determine what it should have paid MA organizations. The overpayment is the difference between CMS's previous payment to the MA organization and the re-calculated payments for the payment year.[206] CMS generally recoups overpayments by offsetting future payments to MA organizations and notifies MA organizations when payment adjustments will be applied. CMS reports the recoupment of overpayments as savings in the fiscal year during which the offsets occur.

1.5.8 Medicare Part D Plan Sponsor Audits

Medicare Part D Plan Sponsor Audits include the following activities:

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[202] CMS assigns a new enrollee factor to any beneficiary who does not have 12 months of diagnoses to support a risk score.

[203] In rare circumstances, MA organizations can directly report the amount of an overpayment as prescribed by CMS from a period for which the deadline for final reconciliation payments has closed.

[204] Per 42 C.F.R. § 422.310(g)(ii), the risk adjustment data submission deadline is no earlier than January 31 following the payment year.

[205] CMS may re-run risk score data and make payment adjustments multiple times for a given payment year.

[206] FY 2024 recoveries reflect the collection of plan-identified risk adjustment overpayments for payment years 2015–2023.

- Plan Program Integrity (PPI) Medicare Drug Integrity Contractor (MEDIC) Part D National Audits
- Medicare Part D Plan Sponsor Self-Audits

Table 3: Medicare Savings in this report provides the sum of savings from both initiatives.

1.5.8.1 Plan Program Integrity Medicare Drug Integrity Contractor Part D National Audits

Savings: The amount of overpayments that Medicare recovered from Medicare Part D plan sponsors, as related to PPI MEDIC national audits.

Data Source: PPI MEDIC reports

CMS contracts with the PPI MEDIC, a program integrity contractor that assists with detecting and preventing fraud, waste, and abuse in the Medicare Part D program. The PPI MEDIC conducts national audits related to specific Medicare Part D vulnerabilities to identify inappropriate payments. Data sources used to conduct data analysis include PDE records,[207] Medicare FFS claims, plan formularies, and drug prior authorization information.

The PPI MEDIC submits its findings of improper payments to CMS, and once CMS approves, the PPI MEDIC sends letters to the associated Medicare Part D plan sponsors. Each letter contains a summary of the analysis methodology and the PDE records identified as inappropriately paid. Medicare Part D plan sponsors are required to delete the inappropriately paid PDE records, and the PPI MEDIC validates the deletion.

CMS reports PPI MEDIC national audit savings in the fiscal year during which plan sponsors delete the inappropriate PDE records.

1.5.8.2 Medicare Part D Plan Sponsor Self-Audits

Savings: The amount of overpayments that Medicare recovered from Medicare Part D plan sponsors due to self-audits.

Data Sources: Self-audit attestations and close-out letters

CMS uses Medicare Part D plan sponsor self-audits to evaluate the appropriateness of questionable payments for covered Medicare Part D drugs identified through data analysis. CMS contracts with the PPI MEDIC to conduct data analysis that identifies high-risk areas for inappropriate Medicare Part D payments and plan sponsors with potential overpayments for recovery. CMS provides notification to Medicare Part D plan sponsors to conduct a self-audit. Upon completion of the plan sponsor self-audit review, CMS and the PPI MEDIC validate whether plan sponsors have deleted the identified inappropriate

[207] Every time a beneficiary fills a prescription under a Medicare Part D plan, the plan sponsor must submit a PDE summary record to CMS. A PDE record contains information about the beneficiary, prescriber, pharmacy, dispensed drug, drug cost, and payment.

PDE records. CMS reports self-audit savings in the fiscal year during which the PDE records are deleted.

1.6 Cost Report Payment Accuracy in Medicare

Institutional providers and cost-based plans must submit cost reports, which CMS reviews or audits to ensure accurate payments in accordance with Medicare regulations. CMS reports savings from the following cost report activities related to Medicare FFS and cost-based plans, respectively:

- Provider Cost Report Reviews and Audits
- Cost-Based Plan Audits

1.6.1 Provider Cost Report Reviews and Audits

Savings: The difference between as-submitted or revised reimbursable cost requests submitted by providers and the settlement amounts, as determined through audits or desk reviews, for each cost item submitted in Medicare FFS provider cost reports.

Data Sources: System for Tracking for Audit and Reimbursement Reports 104 and 106, as entered by the MACs

CMS determines final payment to the majority of institutional providers through a cost report reconciliation process performed by the MACs. CMS quantifies savings from the settlement of the following Medicare costs:

- Pass-through costs for hospitals paid under a PPS [208]
- All costs for critical access hospitals reimbursed on a cost basis
- All costs for cancer hospitals reimbursed under the Tax Equity and Fiscal Responsibility Act
- Bad debts [209] claimed by all provider types

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

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

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

[209] Bad debt refers to Medicare deductibles and coinsurance amounts that are uncollectible from beneficiaries. In calculating reimbursement, CMS considers a provider's bad debt if it meets specific criteria.

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

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

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

Within 180 days of receiving the NPR, a provider may appeal disputed adjustments if the Medicare reimbursement amount in controversy is at least $1,000. Appeals disputing amounts of at least $1,000 but less than $10,000 are filed with the MAC and the CMS Appeals Support Contractor, as are any appeals filed by organ procurement organizations or histocompatibility laboratories regardless of the amount in controversy. Appeals disputing amounts of $10,000 or more are filed with the Provider Reimbursement Review Board.

In addition, a final settled cost report may be reopened to correct errors, comply with updated policies, or reflect the settlement of a contested liability. A provider may submit a request for reopening, or the MAC may reopen a cost report based on its own motion or at the request of CMS. A reopening is allowed within three years of an original NPR or a revised NPR concerning the same issue for reopening.[210]

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

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

1.6.2 Cost-Based Plan Audits

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

Data Source: CMS tracking of audit reports and originally-filed cost reports

CMS reimburses Medicare cost-based plans based on the reasonable costs incurred for delivering Medicare-covered services to enrollees.[211] Medicare cost-based plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans operated under Section 1876 of the Social Security Act and Health Care Prepayment Plans (HCPPs) established under Section 1833 of the Social Security Act.

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

Based on the reconciliation of the CMS-determined Medicare reimbursable amounts and interim payments to the plan, CMS issues the plan an NPR indicating a balance due to the plan or to CMS. If the plan owes money to CMS, the plan has 30 days to provide payment, otherwise, interest is due. If CMS owes money to the plan, it reimburses the plan in a subsequent monthly payment. Plans may appeal cost report adjustments that are greater than $1,000. Plans have 180 days to submit a formal written appeal.

CMS determines savings from cost-based plan audits by calculating the difference between Medicare reimbursable amounts determined through cost report audits and reimbursable amounts claimed by cost-based plans.[212] CMS attributes savings to the fiscal year in which NPRs are processed. If a plan receives a settlement refund or favorable appeal decision, CMS subtracts the refund or amount overturned on appeal from savings in the fiscal year during which the settlement refund or appeal is processed.

1.7 Plan Penalties in Medicare

CMS has the authority to take enforcement actions when MA organizations or Medicare Part D sponsors fail to comply with program requirements. CMS reports financial penalties collected from Medicare Part C and Part D plan sponsors, due to the following:

[211] Some Medicare cost plans provide Part A and Part B coverage, while others provide only Part B coverage. Some cost plans also provide Medicare Part D coverage. An HCPP operates like a Medicare cost plan but exclusively enrolls Part B only beneficiaries and provides only Part B coverage.

[212] The cost-based plan audits metric quantifies savings as the truing-up of plan payments. Year-over-year savings may fluctuate depending on the number of audited plans, membership size, and contract years of plans subject to audit, plan adherence to payment regulations, settlement decisions, and other factors.

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

1.7.1 Medicare Part C and Part D Program Audits

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

Data Source: CMS enforcement action records

CMS conducts program audits of MA organizations, Medicare Part D plan sponsors, and organizations offering Medicare-Medicaid plans (MMPs), hereafter, collectively referred to as plan sponsors. CMS conducts program audits at the parent organization level; thus, the collected data includes all MA and prescription drug plan (PDP) contracts between CMS and the controlling legal entity. CMS evaluates key provisions related to the delivery of health care services and medications to Medicare enrollees in MA and Medicare Part D plans to assess plan sponsors' compliance with core program requirements and ability to provide enrollees with access to health care services and prescription drugs. CMS relies on a number of factors when selecting plan sponsors for audit, including performance data collected by or reported to CMS, complaints, and other factors that could increase a sponsor's risk of non-compliance (e.g., significant increases in enrollment, a large number of changes to a sponsor's drug formulary for a new plan year, or switching to a new pharmacy benefit manager close to the beginning of a new plan year). Other factors that affect plan sponsor selection include audit referrals from CMS central and/or regional offices and time since last audit. CMS initiates audits of plan sponsors throughout the year.

A program audit evaluates plan sponsor compliance in the following program areas, as applicable to the plan sponsor's operations:

- Compliance program effectiveness
- Medicare Part D formulary and benefit administration
- Medicare Part D coverage determinations, appeals, and grievances
- Medicare Part C organization determinations, appeals, and grievances
- Special needs plans care coordination
- MMP service authorization requests, appeals, and grievances
- MMP care coordination

If audits or other monitoring activities[213] determine compliance violations that adversely affected or have

[213] In addition to program audits, CMS conducts other monitoring activities that may reveal compliance violations and result in CMPs. While the Medicare Integrity Program may not directly fund all of CMS's other monitoring activities, CMS reports on resulting CMPs to comprehensively quantify its efforts to address compliance violations.

the substantial likelihood of adversely affecting enrollees,[214] CMS has the authority to impose CMPs against plan sponsors. Other enforcement actions include intermediate sanctions (e.g., suspension of marketing, enrollment, or payment) and terminations. CMS considers the nature of the violation(s) and history of noncompliance in determining enforcement actions. Plan sponsors may appeal any enforcement actions. Specific to CMPs, the time limit for submitting an appeal is 60 days after receiving a CMP notice.

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

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

1.7.2 Medicare Part C and Part D One-Third Financial Audits

Savings: The sum of CMP amounts collected from MA organizations and Medicare Part D plan sponsors, due to violations determined during one-third financial audits (OFAs).

Data Source: CMS enforcement action records

As statutorily required, CMS annually conducts a financial audit of one-third of MA organizations and Medicare Part D plan sponsors, as well as facilitates resolution of the issues noted in the audit reports. To satisfy these requirements, an OFA aims to assess the selected plans' financial activities with a focus on protection of Medicare beneficiaries and the Medicare trust funds.

An OFA is performed annually by contracted certified public accountant (CPA) firms. The CPA firms must conduct these audits using an auditors' professional judgment, including determining materiality. Specifically, the auditors opine on the following subject matter:

1. Accuracy of PDE and direct and indirect remuneration (DIR) data submitted and used in annual reconciliation.
2. Accuracy of base year data included in the Medicare Part C and/or Part D bid.
3. Sufficiency of the plan's Medicare Part C and/or Part D internal controls.
4. Ensuring the plan meets CMS and state solvency requirements.

[214] Examples of compliance violations that result in enforcement actions include the following: 1) inappropriate delay or denial of beneficiary access to health services or medications, 2) incorrect premiums charged to or unnecessary costs incurred by beneficiaries, and 3) inaccurate or untimely information provided to beneficiaries about health and drug benefits.

After the audit process, plans must submit CAPs as well as revised claim/financial data including PDE and DIR data, as applicable to resolve any audit findings. Plan sponsors have 90 calendar days from the issuance of the final OFA report to submit their CAPs to CMS attesting that findings have been remediated and corrected data has been submitted to CMS, as necessary. Examples of findings requiring corrective action include inappropriate amounts in bids, providing primary payment for claims when Medicare should be the secondary payer, errors in explanation of benefit statements to beneficiaries, late plan-to-plan payments, incorrect drug dispensing fees and quantities, lack of supporting documentation for plan-submitted data, not meeting solvency requirements, etc.

If an OFA discovers violations that adversely affected or have the substantial likelihood of adversely affecting enrollees, CMS has the authority to impose CMPs against plan sponsors. CMS considers the severity of the impact to the beneficiaries and other factors, such as the nature and scope of the violation(s) and history of noncompliance, in determining whether to impose a CMP and the total CMP amount a sponsor receives. Plan sponsors may appeal CMPs within 60 days after receiving a CMP notice.

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

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

1.7.3 Medical Loss Ratio Requirement

Savings: The sum of remittances recovered from MA organizations and Medicare Part D sponsors during the fiscal year, where each remittance equals the revenue of the MA organization or Medicare Part D sponsor contract for the relevant contract year (subject to certain deductions for taxes/fees) multiplied by the difference between 0.85 and the credibility-adjusted (if applicable) MLR for the contract year.

Data Source: MA organizations' and Medicare Part D sponsors' annual data forms provided to CMS

An MLR represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, rather than for such other items as profit or overhead expenses. MA organizations and Medicare Part D sponsors must report the MLR for each contract they have with CMS. A contract must have a minimum MLR of at least 85 percent to avoid financial and other penalties.

Contracts beginning in 2014 or later are subject to this statutory requirement.[215] The minimum MLR requirement is intended to create incentives for MA organizations and Medicare Part D sponsors to reduce amounts retained as profit or spent on overhead expenses, such as marketing, salaries, administrative costs, and agent commissions, thereby helping to ensure that taxpayers and enrolled beneficiaries receive value from Medicare health and drug plans.

An MLR represents the percentage of Medicare contract revenue spent on the following:

- Incurred claims for clinical services (Not applicable to Medicare Part D stand-alone contracts)
- Incurred claims for prescription drugs
- Activities that improve health care quality
- Direct benefits to beneficiaries in the form of reduced Part B premiums (Not applicable to Medicare Part D stand-alone contracts)

Revenue includes enrollee premiums and CMS payments to the MA organization or Medicare Part D sponsor for enrollees. Certain taxes, fees, and community benefit expenditures may be deducted from the revenue portion of the MLR calculation.

If an MA organization or Medicare Part D sponsor has an MLR for a contract year that is less than 85 percent, the MA organization or Medicare Part D sponsor owes a remittance to CMS. CMS deducts the remittance from the regular monthly plan payments to the MA organization or Medicare Part D sponsor. If an MA or Medicare Part D contract fails to meet the minimum MLR requirement for three consecutive contract years, it is subject to enrollment sanctions. If an MA or Medicare Part D contract fails to meet the minimum MLR requirement for five consecutive contract years, it is subject to contract termination.

In general, MA organizations and Medicare Part D sponsors must report a contract's MLR in December following the contract year, and any payment adjustments are implemented the following July. The reporting deadline is earlier in the year for contracts that fail to meet the MLR threshold for two or more consecutive years, so that CMS has time to implement, prior to the open enrollment period, an enrollment sanction for any contract that fails to meet the MLR threshold for three or more consecutive years and contract termination for any contract that fails to meet the MLR threshold for five consecutive years. Once reported and attested by an MA organization or Medicare Part D sponsor and reviewed by CMS, an MLR is considered final and may not be appealed. CMS reports savings in the fiscal year during

[215] MLR requirements apply to all MA organizations and Medicare Part D sponsors offering Part C and/or D coverage, including the following: 1) MA organizations with contract(s) including MA-PD plans (all MA contracts for coordinated care plans, i.e., health maintenance organization and preferred provider organization plans, must include at least one MA-PD plan, while private FFS MA plans are not required and Medical Savings Account MA plans are not permitted to cover Medicare Part D benefits; some contracts may also include MA-only plans); 2) Medicare Part D stand-alone contracts; 3) Employer Group Waiver Plans with contracts offering MA and/or Medicare Part D; 4) Medicare Part D portion of the benefits offered by Cost HMOs/Competitive Medical Plans and employers/unions offering HCPPs; and 5) Dual Eligible Special Needs Plans. MA organizations report one MLR for each contract with MA-PD plans, instead of one MLR for nondrug benefits and another for prescription drug benefits. As discussed in the May 23, 2013, Medicare MLR final rule (78 FR 31284, 31285), CMS waived the MLR requirement for PACE organizations.

which remittances are recovered.[216, 217] A contract's MLR and the amount of any remittance owed to CMS for a contract year are calculated using the rules in effect during, and applicable with respect to, that contract year, unless otherwise specified. As a result, the savings that are reported in a fiscal year, which are based on remittances owed for a specific contract year (e.g., remittances included in FY 2024 savings are based on remittances owed for contract year 2022), will not reflect the impact of any MLR rule changes that did not become applicable until after that contract year.[218] Additional savings related to any plan corrections to MLR reporting for prior contract years would also be reported in the fiscal year during which the revised remittances were recovered (e.g., remittances included in FY 2024 savings include remittances owed for any plan corrections to contract years prior to 2022).

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

1.8 Other Actions in Medicare

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

- *Medicare FFS*:
  - Payment Suspensions
  - Qualified Independent Contractor (QIC) Party Status Appeals

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

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

[217] Remittances for a contract year are typically collected approximately eighteen months after the end of the applicable contract year. Remittances for contract year 2022 were collected in August 2024.

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

1.8.1 Payment Suspensions

Savings: The projected amount Medicare FFS did not pay providers during payment suspension, as based on each provider's historically paid claims and adjusted to exclude the amount of billing adjudicated as payable during the projection period.

Data Sources: 1) Unified Case Management (UCM) system, 2) PECOS, and 3) IDR claims data during the period of, and 12 months prior to payment suspension for each provider

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

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

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

1. Projecting costs avoided
CMS projects what Medicare would have paid a provider on payment suspension based on the 12 months of claims history preceding the payment suspension effectuated date. Using the paid claims in this period, CMS calculates the weighted moving average for each month in a future six-month period to project the Medicare payments that provider would have received.[219] The sum of the payment projections for each month represents the costs avoided for the provider during their six-month payment suspension period.

In the case that a provider's payment suspension is shorter than six months (e.g., the payment suspension has a termination date less than 180 days from effectuated date, or the provider is revoked or

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

deactivated during the payment suspension), CMS adjusts the cost avoidance projection to reflect the length of payment suspension.

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

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

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

1.8.2 Qualified Independent Contractor Party Status Appeals

Savings: The sum of the estimated amounts in controversy related to Medicare FFS appeals, where a QIC participated as a party in the Level 3 appeal, ALJ hearing, and the ALJ ruled to uphold the Level 2 decision or dismissed the case.

Data Source: QIC party status reports supported by Medicare Appeals System (MAS) data

The Medicare FFS appeals process includes five levels: [220]

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

- *Level 2:* Reconsideration by a QIC[221] is an independent review of the initial determination, including the MAC's redetermination. For decisions made as to whether an item or service is reasonable and necessary, a panel of physicians or other health care professionals conducts the review.

[220] Pursuant to statutory requirements, CMS begins recouping overpayment amounts after Level 2. If the appellant receives a favorable decision in a subsequent level of appeal, CMS reimburses the amount collected with interest.

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

- *Level 3:* Hearing before an ALJ or a review of the administrative record by an attorney adjudicator within the HHS Office of Medicare Hearings and Appeals (OMHA).[222] The amount remaining in controversy must meet the threshold requirement for this appeal level.

- *Level 4:* Review by the Medicare Appeals Council within the HHS DAB.[223] There are no requirements regarding the amount remaining in controversy for this appeal level.

- *Level 5:* Judicial review in U.S. District Court. The amount remaining in controversy must meet the threshold requirement for this appeal level.

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

In support of Medicare program integrity efforts, CMS funds QICs' participation as a party in ALJ hearings in accordance with party status appeals regulatory provisions in 42 CFR § 405.1012.[224] In addition to QICs' performance of Level 2 appeals, a QIC may elect to participate in Level 3 appeals, either as a non-party participant in the proceedings on a request for an ALJ hearing, a witness, or as a party to an ALJ hearing. As a non-party participant, a QIC may file position papers and/or submit written testimony to clarify factual or policy issues in a case.[225] As a witness, the QIC's activities are limited to supporting a party in responding to policy or factual issues related to a particular case. As a party to an ALJ hearing, a QIC can better defend the Level 2 decision by filing position papers, submitting evidence, providing testimony to clarify factual or policy issues, calling witnesses, or cross-examining the witnesses of other parties. The additional rights afforded to parties are extremely beneficial to the ALJ hearing and the QIC's ability to successfully defend a claim denial.

Each fiscal year, CMS determines the funding for and number of hearings in which the QICs can participate as a party. The QICs receive the ALJ Notices of Hearing and identify hearings in which they elect to participate as a party. Within ten days of a QIC receiving a hearing notice, a QIC must notify the ALJ, the appellant, and all other parties that it intends to participate as a party.[226] Generally, the QICs elect party status when there are significant amounts in controversy, national policy implications, or particular areas of interest for CMS.

When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully

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[222] OMHA is independent of CMS.

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

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

[225] The QICs may elect non-party participation in accordance with 42 CFR § 405.1010. Non-party participation is incorporated into the QICs' operational activities and is not part of this savings metric.

[226] If multiple entities, i.e., CMS and/or contractors, file an election to be a party to a hearing, the first entity to file its election may participate a party to the hearing (42 CFR § 405.1010).

upholds the prior decision or dismisses the case,[227] CMS considers the estimated amount in controversy for upheld and dismissed cases as savings.[228] Savings are based on the "item original amount" field from the MAS. For both prepayment denials and overpayment determinations, this field represents the billed amount submitted by the provider for claims or claim lines under appeal. CMS reports savings in the fiscal year during which the QIC receives notice of the ALJ or attorney adjudicator's ruling to uphold the prior decision or dismiss the case. CMS does not currently adjust reported savings if the appellant pursues further appeal rights and receives a favorable decision at Level 4 or Level 5.

1.8.3 Medicare Part D Reconciliation Data Reviews

CMS contracts with private health insurance companies and organizations to offer prescription drug benefits for Medicare beneficiaries who choose to enroll in Medicare Part D. Beneficiaries may join a stand-alone PDP or an MA plan with prescription drug coverage. All Medicare Part D plans must provide a minimum set of prescription drug benefits, and Medicare subsidizes these basic benefits using four statutory payment mechanisms: direct subsidy, low-income subsidies, reinsurance subsidy, and risk corridors.

A plan receives monthly prospective payments from CMS for the direct subsidy, the low-income cost-sharing subsidy, and the reinsurance subsidy. During benefit-year-end reconciliation, CMS compares its prospective payments to a plan with the plan's actual cost data, submitted through PDE records and DIR.[229] reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payment.

CMS validates both PDE and DIR data in advance of reconciliation and quantifies savings for each initiative, as described in the following sections. In this report, *Table 3: Medicare Savings* provides the sum of savings from both the PDE data quality review and DIR data review initiatives.

1.8.3.1 Prescription Drug Event Data Quality Review

Savings: The sum of the differences in gross covered drug costs between the initial and corrected versions of PDEs flagged during pre-reconciliation data quality review and subsequently adjusted or deleted by Medicare Part D plan sponsors.

Data Source: PDE records from the IDR, which are flagged and tracked by the data analysis contractor

During the benefit year, CMS conducts data analysis and validation of PDE records to flag data quality issues for Medicare Part D sponsors' review and action. This pre-reconciliation data quality review

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

[228] Due to data system limitations, there may be overlap across fiscal years with other Medicare FFS savings metrics that quantify savings from prepayment denials and overpayment recoveries.

[229] DIR is any price concession or arrangement that serves to decrease the costs incurred by a Medicare Part D sponsor for a drug. Examples of DIR include discounts, rebates, coupons, and free goods contingent on a purchase agreement offered to some or all purchasers, such as manufacturers, pharmacies, and enrollees. Some DIR, namely POS price concession, is already reflected in the drug price reported on the PDE. Plans must report other types of DIR annually to CMS.

initiative promotes accuracy in the plan-reported financial data used in the Medicare Part D year-end payment reconciliation process. CMS's Medicare Part D data analysis contractor receives a weekly data stream from the Drug Data Processing System (DDPS).[230] and analyzes PDE records for outliers or potential errors in the following categories:

- Total gross drug cost
- Per-unit drug price
- Quantity/daily dosage
- Duplicate PDEs.[231]
- MSP issues
- Covered plan-paid and low-income cost-sharing amounts in the catastrophic coverage phase of the benefit

The Medicare Part D data analysis contractor posts reports of flagged PDEs to a PDE analysis website shared with Medicare Part D plan sponsors. Sponsors have specified time limits to review, investigate, and act on the reports by a) providing a written response explaining the validity of a PDE or b) adjusting or deleting a PDE accordingly if the PDE is invalid.[232] The Medicare Part D data analysis contractor stops reviewing and flagging PDEs for a given benefit year when CMS finalizes payment reconciliation, typically in September following the benefit year.

Among the PDEs flagged during pre-reconciliation data quality review, CMS quantifies savings by summing the differences in gross covered drug costs between the initial and corrected versions of PDEs adjusted or deleted by plan sponsors. This metric represents the reduction in drug costs included in the payment reconciliation process.[233] The calculation of data quality review savings typically uses benefit-year data captured in September following the benefit year.[234] For a given benefit year, CMS reports savings in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

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

[231] CMS's data analysis contractor looks for potential duplicate PDEs for the same beneficiary, DOS, and drug, where the PDEs have different values in one or more of other key claim identifiers and thus were not rejected by edits immediately upon submission.

[232] A PDE adjustment is made to the original PDE record, and the record is marked with an "adjustment" indicator. When a PDE record is deleted, the record is marked with a "deletion" indicator. Deleted PDEs are retained as records in the data system but are excluded from the reconciliation process.

[233] The impact of pre-reconciliation data quality review is not currently assessed through a comparative reconciliation simulation; thus, this metric represents aggregate savings potentially realized by Medicare, plans, and beneficiaries, depending on the circumstances.

[234] For PDE adjustments/deletions that occur between plan sponsors' data submission deadline for payment reconciliation (typically the end of June) and September, associated savings are realized in CMS's global reconciliation re-opening, which usually occurs four years after a given payment year.

1.8.3.2 Direct and Indirect Remuneration Data Review

Savings: The sum of the differences in Medicare's reinsurance and risk corridor shares, comparing a reconciliation simulation using the initially-submitted DIR with the actual reconciliation using the reviewed and finalized DIR for each plan.

Data Sources: 1) DIR data reported by Medicare Part D plan sponsors in the Health Plan Management System (HPMS) and 2) Medicare Part D Payment Reconciliation System

Medicare Part D plan sponsors submit benefit-year DIR reports through CMS's HPMS. The summary DIR report contains data at the plan benefit package level. If a sponsor received DIR at the sponsor or contract level, it must apply one of CMS's reasonable allocation methodologies to allocate DIR to the plan benefit package level.[235] Sponsors must also include good faith estimates for DIR that is expected for the applicable contract year but has not yet been received.

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

CMS uses the reviewed and finalized DIR data in the year-end Medicare Part D payment reconciliation process for each plan, specifically to determine the reconciliation amounts for Medicare's reinsurance subsidy and risk corridor payment/recoupment. Holding all other data constant, CMS also runs a reconciliation simulation for each plan using the initially submitted DIR data to calculate what the reinsurance and risk corridor amounts would have been. For each type of payment, CMS subtracts the actual amount from the simulated amount.[236] CMS calculates the impact from the DIR review as the sum of these reinsurance and risk corridor differences across all plans.[237] For a given benefit year, CMS reports the impact in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

1.9 Law Enforcement Referrals in Medicare

UPICs (see Appendix B, sections 1.2.8, 1.3.4, and 1.5.6) and the Investigations MEDIC (I-MEDIC) identify and investigate cases of suspected fraud related to Medicare FFS and Medicare Part C and Part D, respectively. UPIC and I-MEDIC investigations may involve providers, beneficiaries, and/or other entities. Once a UPIC or the I-MEDIC has gathered evidence to substantiate allegations of suspected fraud, CMS requires the contractor to refer such cases to law enforcement (e.g., HHS-OIG or DOJ) for consideration of civil or criminal prosecution.

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[235] Medicare Part D plan sponsors must also report DIR at the 11-digit National Drug Code level, so that CMS can provide annual sales of branded prescription drugs to the Secretary of the Treasury to determine the fee amount to be paid by each manufacturer.

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

[237] PACE plans are excluded from this analysis because PACE plans typically do not receive rebates.

In certain types of cases, UPICs and the I-MEDIC must make an immediate advisement to HHS-OIG without first conducting or completing an investigation. For example, a UPIC or the I-MEDIC must immediately advise HHS-OIG upon receiving allegations of kickbacks, bribes or illegal renumeration. As another example, the I-MEDIC must immediately advise HHS-OIG of fraud allegations made by current or former employees of provider organizations, MA organizations, or Medicare Part D plan sponsors.

When a UPIC or the I-MEDIC refers a case to law enforcement for criminal or civil investigation, it reports the estimated value of the case to CMS, typically based on total paid amounts for the alleged fraudulent activities.[238] If law enforcement accepts the referral, the UPIC or the I-MEDIC remains available to assist and provide information at the request of law enforcement. When cases result in restitution, judgments, fines, and/or settlements, the DOJ routes Medicare recoveries to CMS or the plan sponsor. The following sections describe how CMS reports savings attributable to UPICs' and the I-MEDIC's law enforcement referrals.

1.9.1 Unified Program Integrity Contractor Law Enforcement Referrals

Savings: The estimated amount Medicare expects to recover from UPIC-referred cases accepted by law enforcement, adjusted for historical recovery experience.

Data Sources: 1) UCM system and 2) Law enforcement adjustment factor

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

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

Savings: The estimated amount Medicare expects to recover from I-MEDIC-referred Part C and Part D cases accepted by law enforcement, adjusted for historical recovery experience.

Data Sources: 1) UCM system and 2) Part C/D law enforcement adjustment factors

CMS reports on the value of the I-MEDIC's Part C and Part D referrals accepted by law enforcement during the fiscal year, regardless of when the case concludes. Because the timeline of case resolution varies, CMS estimates the amount Medicare[239] expects to recover by multiplying the value of the referrals by a Medicare Part-C-specific, Medicare Part-D-specific, or combined Medicare Part C and Part D law enforcement adjustment factor depending on the nature of each case. Each factor reflects the

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

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

historical ratio of court-ordered restitutions, judgments, fines, and settlements to the amounts referred by the former NBI MEDIC.

2 Medicaid and Children's Health Insurance Program Savings Methodologies

2.1 Introduction to Medicaid and Children's Health Insurance Program Savings

States and the federal government share the costs for Medicaid and CHIP. To receive federal Medicaid and CHIP funds, states provide an estimated budget of their prospective costs, and the federal government contributes a specific percentage of these costs as a grant to the state. CMS determines the federal contribution amount using the Federal Medical Assistance Percentage (FMAP). States then submit actual expenditure reports,[240] which CMS uses to reconcile grant amounts. States must report their expenditures to CMS within 30 days of the end of each quarter[241] and may adjust their past reporting for up to two years after an expenditure was made.

States and CMS share accountability for Medicaid and CHIP program integrity and ensuring proper use of both federal and state dollars. As such, CMS and the states collaborate to combat improper payments through multiple strategies. In *Table 4: Medicaid and CHIP Savings* of this report, CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from Medicaid and CHIP financial oversight and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. The following sections describe the methodologies CMS uses to calculate the amounts presented in *Table 4: Medicaid and CHIP Savings*.

2.2 Medicaid and CHIP Financial Oversight

CMS financial management staff engage in financial oversight to ensure that state expenditures claimed for federal matching under Medicaid and CHIP are programmatically reasonable, allowable, and allocable in accordance with federal laws, regulations, and policy guidance. The Federal Financial Participation (FFP) represents the federal funds paid to a state. States submit Medicaid and CHIP budget data through the Medicaid and CHIP Financial (MACFin)[242] reporting system and report expenditure data through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES), which applies the appropriate FMAP to each expenditure to determine the FFP. CMS reports Medicaid and CHIP financial oversight savings as improper FFP that was either 1) averted due to financial management staff intervention or 2) recovered following financial management staff review or assistance in response to and resolution of financial issues.

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

[241] 42 CFR § 430.30(c).

[242] The MBES/CBES is being phased out as the new MACFin reporting system is being developed. States report budget data into MACFin and expenditure data into the MBES/CBES.

2.2.1 Averted Medicaid and CHIP Federal Financial Participation

Savings: The total amount of FFP for which states agree to voluntarily 1) enter a credit adjustment on their expenditure report, 2) retract from their expenditure report, or 3) make a prior period credit adjustment on the current or a future expenditure report.

Data Source: CMS's Medicaid and CHIP averted FFP at-risk form

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

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

If at-risk FFP is identified prior to finalizing the quarterly expenditure report, the state may make a credit adjustment on their expenditure report for the amount in question or retract the claim associated with the at-risk FFP. If identified after finalizing the expenditure report, the state agrees in writing and makes a prior period credit adjustment,[243] which retroactively adjusts the claim in question and offsets the at-risk FFP for which the state already received reimbursement. Averted Medicaid and CHIP FFP represents the total dollar amount of at-risk FFP that was prevented or offset due to CMS financial management staff intervention and oversight during the fiscal year.

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

2.2.2 Recovered Medicaid and CHIP Federal Financial Participation

Savings: The total amount of at-risk FFP that the states returned to CMS because of CMS financial oversight activities.

Data Source: CMS's financial performance spreadsheet

CMS financial management staff identify potential improperly paid FFP through:

- Quarterly expenditure report reviews
- Annual financial management reviews
- HHS-OIG audits

If CMS and the state cannot resolve the issue and the state does not agree to return the improperly paid

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

FFP, CMS initiates a disallowance action requiring the state to return the FFP.[244]

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

The total recovered Medicaid and CHIP FFP includes all at-risk FFP that has been recouped or returned to CMS within the fiscal year; thus, some amounts may be associated with financial issues identified in prior fiscal years. The total recovered Medicaid and CHIP FFP does not include any amounts actively under appeal.[245]

2.3 State-Reported Medicaid Overpayment Recoveries

States report Medicaid overpayment recoveries made through collaborative federal-state programs and state-level initiatives, including 1) UPIC activities, 2) state Medicaid RAC activities, 3) Social Security Act Section 1909 compliant false claims acts, and 4) other state program integrity activities.

As states and the federal government share in the cost of Medicaid, so too do the states and federal government share in overpayment recoveries. States have one year to return the federal share of an identified overpayment;[246] thus, some of the recovered amounts reported in the current fiscal year may be related to amounts identified in the previous fiscal year.

2.3.1 Unified Program Integrity Contractor Recoveries

Savings: The total recovered federal share of Medicaid overpayments identified by UPICs.

Data Source: State Medicaid quarterly expenditure reporting, specifically Form CMS 64.9C1, Line 5 and Form CMS 64.9OFWA, Line 5

In collaboration with states, CMS's UPICs conduct post-payment investigations and audits of Medicaid providers throughout the country and report identified overpayments to the states for recovery. CMS and the states collaborate to select issues and providers for audits. Any Medicaid provider, including FFS providers, managed care plans, and managed care network providers, may be subject to audit.[247] After

[244] 42 CFR § 430.42.

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

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

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

the associated states and providers have the opportunity to comment on any identified overpayments, CMS sends the states the final reports documenting total overpayments for recovery. States are responsible for sending demand letters to the appropriate providers, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their state's administrative process.

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

2.3.2 State Medicaid Recovery Audit Contractor Recoveries

Savings: The total recovered federal share of Medicaid overpayments identified by state Medicaid RACs, after subtracting contingency fees.

Data Source: State Medicaid quarterly expenditure reporting, specifically Form CMS 64 Summary, Lines 9E and 10E

Unless CMS grants an exception, states must contract with one or more Medicaid RACs to identify and recover overpayments as well as identify underpayments made to Medicaid providers. States determine the operations and focus areas for Medicaid RAC audits. CMS requires states to have an appeals process for providers seeking review of Medicaid RAC findings.

CMS reports the recovered federal share of Medicaid overpayments identified by Medicaid RACs in the fiscal year during which the recovery occurred. The calculation of the recovered federal share includes 1) the federal share of amounts collected by states within the one-year time limit, plus 2) the federal share of amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit, less 3) the federal share of Medicaid RAC fees.[248] The recovered federal share includes any necessary adjustments to previously-reported federal share amounts. For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

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

2.3.3 Social Security Act Section 1909 Compliant False Claims Act Recoveries

Savings: The net federal share of Medicaid false or fraudulent payments recovered because of state action under a Social Security Act Section 1909 compliant false claims act, after subtracting the state financial incentive.

Data Source: State Medicaid quarterly expenditure reporting, specifically Form CMS 64 Summary, Line 9C2

Many states have false claims acts that establish civil liability to the state for individuals and entities that knowingly submit false or fraudulent claims under the state Medicaid program. If a state obtains a recovery related to false or fraudulent Medicaid claims, the federal government is entitled to a share of the recovery, in the same proportion as the FMAP. To encourage states to pursue civil Medicaid fraud, Section 1909 of the Social Security Act includes a financial incentive for states if their false claims acts meet certain requirements.[249] HHS-OIG, in consultation with the U.S. Attorney General, determines if a state's false claims act qualifies for the incentive, which is a 10-percentage-point increase in a state's share of recovered amounts.

CMS reports the net federal share of Medicaid false or fraudulent payments recovered under states' Section 1909 compliant false claims acts in the fiscal year during which the recoveries occurred. A state's compliance is subject to review before CMS awards a state the financial incentive; thus, the financial incentive does not appear in Form CMS 64 Summary, Line 9C2. Instead, CMS gives states the financial incentive on a finalization grant award. To report savings, CMS conservatively estimates the net federal share of recovered Medicaid false or fraudulent payments by subtracting out the state financial incentive for all states that report in Form CMS 64 Summary, Line 9C2.

2.3.4 Other State Program Integrity Recoveries

Savings: The total recovered federal share of Medicaid overpayments identified through other state-level program integrity activities.

Data Source: State Medicaid quarterly expenditure reporting, specifically Form CMS 64.9C1, Lines 1A, 1B, 1C, 2, 3, 4, 6, and 8 and Form CMS 64.9OFWA, Lines 1A, 1B, 1C, 2, 3, 4, 6, 8, and 9

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

- Provider audits
- MFCU investigations[250]
- Data mining activities conducted by state Medicaid agencies as well as MFCUs

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

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

- Settlements and judgments
- CMPs

CMS reports the recovered federal share of Medicaid overpayments identified through state-level program integrity activities in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit. The recovered federal share includes any necessary adjustments to previously reported federal share amounts.[251] For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

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

Appendix C - Acronyms and Abbreviations

AFR	[HHS] Agency Financial Report
CAP	Corrective Action Plan
CBA	Competitive Bidding Area
CBES	CHIP Budget and Expenditure System
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CHIP	Children's Health Insurance Program
CMIP	Comprehensive Medicaid Integrity Plan
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
CPI	[CMS] Center for Program Integrity
CPT	Common Procedural Terminology
CRC	Commercial Repayment Center [Recovery Auditor]
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
DAB	Departmental Appeals Board
DDPS	Drug Data Processing System
DEX	Data Exchange System
DIR	Direct and Indirect Remuneration
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOI	Department of Insurance
DOJ	Department of Justice
DOS	Date of Service
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EIN	Employee Identification Number
FFM	Federally-facilitated Marketplace
FFP	Federal Financial Participation
FFS	Fee-for-Service

FISS	Fiscal Intermediary Shared System
FMAP	Federal Medical Assistance Percentage
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
GPO	Group Purchasing Organization
HCFAC	Health Care Fraud and Abuse Control Program
HCPCS	Healthcare Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
HHS	Department of Health & Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
IDR	Integrated Data Repository
IME	Indirect Medical Education
MAC	Medicare Administrative Contractor
MA	Medicare Advantage
MACFin	Medicaid and CHIP Financial reporting system
MA-PD	Medicare Advantage Prescription Drug
MAS	Medicare Appeals System
MBES	Medicaid Budget and Expenditure System
MCC	Major Case Coordination
MCRC	Marketplace Complaint Review Contractor
MCS	Multi-Carrier System
MEQC	Medicaid Eligibility Quality Control Program
MFCU	Medicaid Fraud Control Unit
MII	Medicaid Integrity Institute
MLN	Medicare Learning Network®

MLR	Medical Loss Ratio
MMP	Medicare-Medicaid Plans
MPEC	Medicaid Provider Enrollment Compendium
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NCCI	National Correct Coding Initiative
NGHP	Non-Group Health Plan
NPI	National Provider Identifier
NPR	Notice of Program Reimbursement
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
OPPS	Outpatient Prospective Payment System
O&R	Ordering and Referring [Edit]
PACE	Program of All-Inclusive Care for the Elderly
Part C	Medicare Advantage Part C Program
Part D	Medicare Prescription Drug Program
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PIMR	Program Integrity Management Reporting
PPI MEDIC	Plan Program Integrity Medicare Drug Integrity Contract
PPS	Prospective Payment System
PTP	Procedure-to-Procedure [Edit]
QIC	Qualified Independent Contractor
RAC	Recovery Audit Contractor
RACDW	RAC Data Warehouse
RADV	Risk Adjustment Data Validation
ROI	Return on Investment
RSNAT	Repetitive Scheduled Non-Emergent Ambulance Transport
SBM	State-based Marketplace
SMRC	Supplemental Medical Review Contractor

SNF	Skilled Nursing Facility
T-MSIS	Transformed-Medicaid Statistical Information System
TPE	Targeted Probe and Educate
UCM	Unified Case Management [system]
UOS	Unit(s) of Service
UPIC	Unified Program Integrity Contractor
UTN	Unique Tracking Number
VCC	Vulnerability Collaboration Council
VIPS	Viable Information Processing Systems
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement