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Centers for Medicare & Medicaid Services

Annual Report to Congress on the Medicare and Medicaid Integrity Programs

For Fiscal Years 2013 and 2014

October 1, 2012 through September 30, 2013

October 1, 2013 through September 30, 2014

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Executive Summary

This report describes the Centers for Medicare & Medicaid Services' (CMS) program integrity activities during Fiscal Years (FY) 2013 and 2014. CMS has been required to report its Medicaid program integrity activities since the enactment of the Deficit Reduction Act of 2005.[1] Section 6402(j) of the Patient Protection and Affordable Care Act[2] (hereafter referred to as the Affordable Care Act) established the requirement that CMS report its Medicare program integrity activities. This report responds to both of those requirements.[3]

One of CMS's key responsibilities is to protect the Trust Funds and other public resources against losses from fraud, waste, abuse, and other improper payments and to improve the integrity of the federal health care system. CMS's program integrity strategy is moving beyond the reactive "pay and chase" method toward a more effective, proactive strategy that identifies potential improper payments before they are made, keeps unscrupulous providers and suppliers out of Medicare and Medicaid at the outset, quickly removes wrongdoers from the programs once they are detected, and corrects improper payments as quickly as possible.

Medicare Program Integrity

The effectiveness of CMS's comprehensive strategy is demonstrated by the results of our activities in FY 2013 and FY 2014. CMS estimates that program integrity activities saved Medicare $21.1 billion in FY 2013 and $18.1 billion in FY 2014, for a two-year return on investment of $12.4 to 1.

Prevention of improper payments represented 68.4% ($14.4 billion) of the FY 2013 savings and 73.7% ($13.4 billion) of the FY 2014 savings. Prevention savings activities included Systematic Edits ($738.9 million in FY 2013 and $744.7 million in FY 2014), Provider Revocations ($701.3 million in FY 2013 and $700.7 million in FY 2014), Prepayment Reviews ($12.9 billion in FY 2013 and $11.9 billion in FY 2014), and Payment Suspensions ($43.2 million in FY 2013 and $52.2 million in FY 2014). Prevention of improper payments continues to increase as CMS proceeds with its proactive approach to program integrity.

Recovery of overpayments represented the remaining $6.7 billion in FY 2013 and $4.8 billion in FY 2014. Overpayment recovery savings activities included Reviews and Audits ($2.9 billion in FY 2013 and $2.2 billion in FY 2014), Recovery Auditor Collections ($3.7 billion in FY 2013 and

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1 P.L. 109-171.

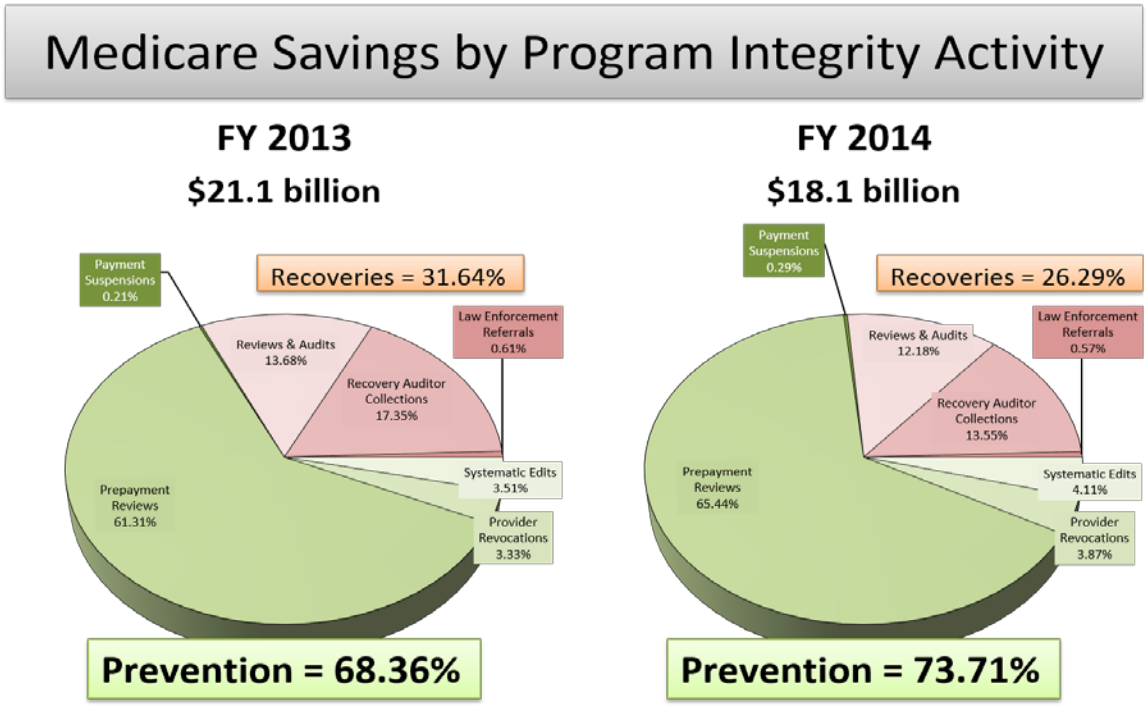
2 P.L. 111-148 and P.L. 111-152, collectively are referred to as the Patient Protection and Affordable Care Act.

3 Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Social Security Act (as amended by the Affordable Care Act) and not all Medicaid program integrity activities are funded under section 1936 of the Social Security Act (which was created by the Deficit Reduction Act of 2005). However, this report includes other Medicare and 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 state program integrity units that enhance the overall integrity of the Medicaid program. Therefore, there also may be some fraud or improper payment initiatives that are not included in this Report to Congress. Where applicable in this report, we have described certain activities funded outside of sections 1893 and 1936 of the Act to provide better context for CMS's anti-fraud programs.

$2.5 billion in FY 2014), and Law Enforcement Referrals ($129.3 million in FY 2013 and $102.7 million in FY 2014).

Type of Medicare Savings	Medicare Savings (in millions)	
	2013	2014
Prevention Savings (Estimated Amounts)		
Systematic Edits	$ 738.9	$ 744.7
Provider Enrollment	$ 701.3	$ 700.7
Prepayment Review	$ 12,913.5	$ 11,859.7
Suspensions	$ 43.2	$ 52.2
Total Prevention Savings	**$ 14,396.9**	**$ 13,357.3**
Post-Payment Recovery Savings (Estimated Amount Recovered after Identifying Overpayments*)		
Reviews and Audits	$ 2,881.9	$ 2,207.1
Recovery Auditors (RA)	$ 3,654.9	$ 2,455.2
Law Enforcement Referrals	$ 129.3	$ 102.7
Total Post-Payment Recovery Savings	**$ 6,666.1**	**$ 4,765.0**
Total Medicare Savings (Prevention and Post-Payment)	**$21,063.0**	**$18,122.3**
*Includes fee-for-service and Part D savings.		

A more detailed list of savings by program integrity activity is included in the full report in Table 3 and throughout Section 1.3 of the report.



During FY 2013, CMS had 484 active payment suspensions. The number of active payment suspensions rose to 507 during FY 2014. The Fraud Prevention System (FPS) resulted in $454.0 million in fraudulent payments being stopped, prevented, or identified during calendar year 2014, the third year of FPS implementation. CMS also saved the Medicare program $694.5 million in FY 2013 and $681.9 million in FY 2014 using National Correct Coding Initiative (NCCI) edits.[4] The NCCI prevents improper payments when incorrect code combinations for Medicare Part B services are reported. In FY 2013, CMS created a major, new technical guidance document for states that compiles, organizes, and integrates CMS requirements for state implementation for the Medicaid NCCI. In addition, the Medicare Fee-for-Service Recovery Audit Program identifies and corrects improper payments and makes recommendations to CMS about how to reduce improper payments in the Medicare program. In FY 2013, the program corrected $3.75 billion in improper payments.[5] The corresponding amount for FY 2014 was $2.57 billion.[6]

Medicaid Program Integrity

Through the Medicaid Integrity Program, CMS directed the activity of the Audit Medicaid Integrity Contractors (MICs), which identified $22.6 million in overpayments in FY 2013 and an additional $24.5 million in overpayments in FY 2014 for recovery by states. Through Audit MIC activities, the states returned the federal share of $2.9 million in FY 2013 and $8.0 million in FY 2014 to the Treasury. Through the State Medicaid Recovery Audit Programs, the states have recovered a total federal and state share combined amount of $135.6 million for FY 2013 and returned the federal share of $81 million to the Treasury. For FY 2014, states reported combined Medicaid Recovery Auditor recoveries of $96.7 million and returned the federal share of $60.8 million to the Treasury. CMS also provided support to state activities through the Medicaid Integrity Program that led to substantial recoveries – including $1.2 billion reported by states for FY 2014. Importantly, CMS has laid the ground work for additional savings with the implementation of innovative technology, and is continuing to refine an approach to measuring the impact of initiatives that achieve cost avoidance.

Coordinated Activities in Program Integrity

CMS also coordinated closely with a variety of partners during FY 2013 and FY 2014. For example, CMS, in partnership with the Healthcare Enforcement and Action Team (HEAT), took administrative actions against 96 Medicare providers and suppliers implicated during those HEAT activities. Another example is the Center for Program Integrity (CPI) Command Center. The Command Center provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and the Federal Bureau of Investigation (FBI), clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads in real time. In FY 2014, the Command Center conducted 40 missions that included participants from CMS and our partners, including the HHS-OIG and FBI that are designed to lead to

[4] These amounts are included in the Systematic Edits total mentioned previously.

[5] CMS Financial Report Fiscal Year 2013 and Recovery Auditing in Medicare for Fiscal Year 2013.

[6] CMS Financial Report Fiscal Year 2014 and Recovery Auditing in Medicare for Fiscal Year 2014.

improvements in the fraud prevention and detection process. Missions are facilitated collaboration sessions that bring together experts from various disciplines to improve the processes for fraud prevention in Medicare and Medicaid. CMS is also working with FBI, HHS-OIG, and other Federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud prevention.

Also, since FY 2012, HHS and DOJ have nurtured a ground-breaking partnership that unites public and private organizations in the fight against health care fraud, known as the Healthcare Fraud Prevention Partnership (HFPP). The voluntary, collaborative partnership includes the federal government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop improper payments from being made. At the end of FY 2014, the HFPP had 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse.

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

Table of Contents

1. Introduction 1

1.1. Reporting Requirements 2

1.2. Program Integrity in Medicare and Medicaid 4

1.3. Measuring Program Integrity Success 8
1.3.1. Improper Payment Rates 8
1.3.2. Medicare Savings 8
1.3.3. Medicaid Savings 11

1.4. OIG and GAO Recommendations Implemented 12

2. Operational Excellence 14

2.1. Address the full spectrum of fraud, waste, and abuse 14
2.1.1. Medicare Program Integrity 14
2.1.2. Provider Cost Report Audits 16
2.1.3. Medicare Secondary Payer 16
2.1.4. Supplemental Medical Review 18
2.1.5. Medicare Fee-For-Service Recovery Audit Program 19
2.1.6. Medicaid Recovery Audit Contractor (RAC) Program 19
2.1.7. Medicaid Special Investigation Projects 21
2.1.8. Medicare-Medicaid Data Match Program (Medi-Medi) 22

2.2. Expand Activities in Medicare Part C and Part D 23
2.2.1. Part C and Part D Program Integrity Oversight 23
2.2.2. Medicare Part C and Part D Recovery Audit Programs 27
2.2.3. Medicare C and D Marketing Oversight 28

2.3. Proactively Manage Provider Screening and Enrollment 30
2.3.1. Provider Enrollment Moratoria 32
2.3.2. Sharing Medicare Provider Information with Medicaid 33
2.3.3. Provider Revalidation 33
2.3.4. PECOS Improvements 34
2.3.5. Medicare Shared Savings Program and Innovation Center Initiatives 35

2.4. Emphasize efficient, focused utilization management and payment oversight 36
2.4.1. Medicare FFS Payment Controls, Including Medical Review 36
2.4.2. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding 37
2.4.3. Demonstrations 37
2.4.4. Medicare National Correct Coding Initiative 39
2.4.5. Medicaid National Correct Coding Initiative 40
2.4.6. National Medicaid Audit Program 40
2.4.7. Annual Upper Payment Limit (UPL) Demonstrations 42
2.4.8. Disproportionate Share Hospital (DSH) Audit and Reporting 42

2.5. Move Swiftly to Administrative Action 43
2.5.1. Fraud Prevention System 43
2.5.2. Command Center 45

3. Leadership and Coordination 46

3.1. Increase Alignment of Medicare and Medicaid 46
3.1.1. Integrated Data Repository (IDR) and the One Program Integrity (One PI) Portal 46
3.1.2. Medicaid and CHIP Business Information Solutions (MACBIS) 46

3.2. Strengthen States' Capacity to Protect Medicaid Program Integrity 49
3.2.1. Medicaid Integrity Institute 49
3.2.2. State Program Integrity Reviews 51
3.2.3. Guidance and Technical Assistance 52
3.2.4. Toolkits to Educate Providers and Beneficiaries 53

3.3. Educate Providers 54
3.3.1. Provider Outreach and Education 54

4. Impacting Cost and Appropriateness of Care 55

4.1. Partnership with Law Enforcement 55
4.1.1. Field Offices and DOJ Support 55
4.1.2. HEAT Strike Force Teams 55

4.2. Partnership with the Private Sector 56
4.2.1. Healthcare Fraud Prevention Partnership 56

4.3. Provide Greater Transparency into Program Integrity Issues 57
4.3.1. Beneficiary Education 57
4.3.2. Open Payments 57
4.3.3. Data Transparency 59
4.3.4. Improper Payment Rate Measurement in the Medicare FFS, Medicaid and CHIP Programs 59
4.3.5. Improper Payment Rate Measurement in the Part C and Part D Programs 61
4.3.6. Probable Fraud Measurement Pilot 62

Appendix A - Table of Program Integrity Actual Obligations 64

Appendix B - Related Reports and Publications 68

Appendix C - Acronyms and Abbreviations 69

Appendix D – Statutes Referenced in this Report 73

List of Figures

Figure 1: Medicaid Program Integrity Collection Trends, 1989-2014 11

Figure 2: Percentage Change in Medicaid Expenditures and Program Integrity Collections, 1989-2014..... 12

Figure 3: Revocation and Deactivation Trend from FY 2008 though FY 2013..... 32

Figure 4. Cumulative Revalidation Notices Sent to Providers and Suppliers 34

List of Tables

Table 1: Program Integrity Contractors 6

Table 2 Reported Improper Payment Rates Trend for Reporting Years 2009-2014 8

Table 3: Medicare Savings 9

Table 4: Savings Identified by ZPICs..... 15

Table 5: Overall Performance Score Ranges and Corresponding Performance Actions.. 29

Table 6: Compliance Actions Taken by Risk Level for Secret Shopping..... 29

1. Introduction

The Centers for Medicare & Medicaid Services (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 Social Security Act and 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, respectively, of the Social Security Act, in addition to other federal health care programs and activities. The Medicare Integrity Program and Medicaid Integrity Program were established to protect the programs against improper payments. Program integrity encompasses all causes of improper payments, including fraud, waste, and abuse. It is important to note that while all payments made as a result of fraud are considered "improper payments," not all improper payments constitute fraud.

The effectiveness of CMS's comprehensive approach to program integrity in Medicare is demonstrated by the results of our activities in Fiscal Years (FYs) 2013 and 2014. CMS's program integrity efforts resulted in $21.1 billion in savings for the Medicare Trust Funds during FY 2013, with an additional $18.1 billion in savings during FY 2014. Starting in FY 2013, CMS improved its ability to measure program success, grounding our revised savings methodology in the Fraud Prevention System methodology, which was certified by the HHS Office of Inspector General (OIG). For the first time in the history of federal health care programs, the OIG certified a methodology to calculate cost avoidance due to removing a provider from the program. This is a critical achievement as moving towards prevention requires a clear measurement of the future costs avoided. In most cases, these savings are conservative because they do not include measures of sentinel effect, or changes in behavior that are made as a result of our focused attention in certain areas.

In Medicaid, CMS actions have contributed to a 360 percent increase in program integrity-related collections since the launch of the Medicaid Integrity Program in 2006. For FY 2013, states reported $1.4 billion in total Medicaid collections. For FY 2014, states reported $1.2 billion in total Medicaid collections.

This report is divided into four major sections, each detailing specific aspects of CMS's program integrity efforts.

The first section provides background information regarding CMS's program integrity activities. This section highlights CMS's statutory authority to establish and report on its program integrity activities, identifies and defines the various program activities, and presents the methods of measuring these activities' success. Finally, improvements in CMS's efforts are detailed, including a description of the implementation of HHS OIG and Government Accountability Office (GAO) recommendations.

The second section outlines CMS's efforts to improve the operational excellence of its program integrity efforts. This section explores the improvements made in several areas of audit and investigation of potential fraud, waste, and abuse based on improved

techniques and information from previous successful efforts (lessons learned). This section also addresses expanding program integrity activities into Medicare Parts C and D and becoming more proactive in preventative activities, such as provider enrollment and payment control through improved utilization management. Finally, the application of swift administrative action as a means to prevent improper payments is addressed.

The third section promotes CMS's role in leading and coordinating improved program integrity for all programs as a means to preserve the benefit for beneficiaries, properly make payment to legitimate providers, and safeguard the Trust Funds and taxpayer resources used for healthcare. This section discusses better alignment of the Medicare and Medicaid programs to promote an effective and efficient sharing of information and best practices in each program. Methods to strengthen the States' capacity to protect the Medicaid programs (and thereby both federal and state funds) and to inform and educate providers about approved and accepted practices in the Medicare and Medicaid programs are examined. A clear understanding of program expectations among providers, States, and CMS is essential to preventing improper payments.

The fourth and final section addresses the need to balance safeguarding program funds with the need to provide appropriate care to the beneficiaries. This section examines the measures CMS uses to gauge the level of improper payments and the communications employed to inform the public, beneficiaries, and providers in an effort to reduce the rate of improper payments. This section also describes the partnerships CMS has with law enforcement agencies that provide a deterrent effect on fraud as a result of their active investigations.

Additional information is provided in four appendices at the end of this report.

1.1. Reporting Requirements

This report describes CMS's program integrity activities during FY 2013 and FY 2014. As required by statute, CMS must report to Congress the use of appropriated funds and the effectiveness of the use of such funds for both Medicare and Medicaid program integrity activities. CMS has been required to report on Medicaid program integrity activities since the enactment of the Deficit Reduction Act of 2005[7] (DRA), which added section 1936 to the Social Security Act[8] (the Act). Section 6402(j) of the Patient Protection and Affordable Care Act[9] (hereafter referred to as the Affordable Care Act) amended section 1893 of the Act and established the requirement that CMS report on

[7] P.L. 109-171

[8] Please note that not all Medicaid program integrity activities are funded under the Medicaid Integrity Program, which was created by the DRA in section 1936 of the Social Security Act. However, this report includes other Medicaid program integrity activities to provide a more complete view of Medicaid program integrity. Where applicable in this report, we have described activities conducted by the state program integrity units that enhance the overall integrity of the Medicaid program.

[9] P.L. 111-148 and P.L. 111-152, collectively are referred to as the Patient Protection and Affordable Care Act.

Medicare program integrity activities.[10] The Affordable Care Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Program under Medicaid and Medicare. While Medicare Part A and Part B Recovery Auditors are discussed in Section 2.1.5, the comprehensive report on the Medicare Fee-for-Service Recovery Audit Program is published separately.[11] This report responds to the requirements with respect to Medicare and Medicaid program integrity, Medicaid Recovery Auditors, and Medicare Part C and Part D Recovery Auditors.[12]

The Health Insurance Portability and Accountability Act of 1996[13] (HIPAA) established mandatory funding for the Medicare Integrity Program that provided a stable funding source for Medicare program integrity activities, not subject to annual appropriations. The amount specified in HIPAA increased for the first few years and then was capped at $720 million per year in FY 2003 and future years. This funding supports the following program integrity functions performed across CMS: Audits, Medicare Secondary Payer, Medical Review, Provider Outreach and Education, Program Integrity, and Provider Enrollment.

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

The DRA added section 1936 to the Act to establish the Medicaid Integrity Program and provided CMS with dedicated funding to operate the program. The Medicaid Integrity Program represents the first comprehensive strategy at the federal level to combat fraud, waste, and abuse in the Medicaid program and is one component in the overall effort to safeguard Medicaid program integrity.

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

[11] The FY 2013 Medicare FFS Recovery Audit Report to Congress can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf, and the FY 2014 Medicare FFS Recovery Audit Report to Congress can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.pdf.

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

[13] Public Law 104-191.

Under section 1936 of the Act, Congress appropriated funds for the Medicaid Integrity Program beginning in FY 2006 and authorized these funds to remain available until expended. Beginning in FY 2011, the Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.[14] CMS obligated a total of $56.2 million in FY 2013 and $101.0 million in FY 2014 for the Medicaid Integrity Program. The increase from FY 2013 to FY 2014 is largely attributable to obligating previously unobligated and unexpended funds during FY 2014.

Appendix A provides further information on the actual expenditures for Program Integrity for both Medicare and Medicaid.

1.2. Program Integrity in Medicare and Medicaid

In FY 2013, Medicare and Medicaid collectively covered an estimated 109.7 million people. By FY 2014, the estimated number of covered beneficiaries had risen to 118.9 million. The average monthly Medicare enrollment was 52.3 million in FY 2013[15], rising to 54 million in FY 2014.[16] The unduplicated annual enrollment for Medicaid was 72.8 million with an average monthly enrollment of 57.4 million during the course of FY 2013.[17] During FY 2014 these enrollment numbers had risen to 80.6 million and 64.9 million, respectively.[18] CMS directly administers Medicare through contracts with private companies that processed 1.2 billion claims in both FY 2013[19] and FY 2014.[20] This represents an average of 3.325 million claims every day in FY 2013 and 3.323 million every day in FY 2014. Medicaid is administered by states within the bounds of federal law and regulations, and CMS partners with each state Medicaid program to support program integrity efforts. The 56 separately state-run Medicaid programs process claims for services provided to Medicaid beneficiaries. The number of claims processed during FY 2013 and FY 2014 are not readily available. To preserve access to quality health care services, CMS is accountable for the protection of the Medicare Trust Funds and other public resources from fraud, waste, and abuse, and for the reduction of improper payments in Medicare and Medicaid.

CMS applies three key operational principles to guide all of our initiatives focused on the reduction of improper payments. First, we aim to achieve operational excellence in

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14 42 U.S.C. 1396u-6(e)(1)(D).

15 2013 CMS Statistics (CMS Pub. No. 03504), Table I.1, page 6. This publication is available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/2013.html

16 2014 CMS Statistics (CMS Pub. No. 03510), Table I.1, page 6. This publication is available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/2014.html

17 2013 CMS Statistics, Table I.16, page 15.

18 2014 CMS Statistics, Table I.16, page 15.

19 2014 CMS Statistics, Table V.5, page 46.

20 2015 CMS Statistics, Table V.5, page 46. These publications should be consulted for disclosures related to data sources and reliability.

addressing the full spectrum of program integrity causes; in taking swift administrative actions; and in performing audits, investigations, and payment oversight. Second, CMS provides leadership and coordination in program integrity efforts across the federal healthcare system. Finally, we focus on impacting the cost and appropriateness of care across federal healthcare programs. Fraud can inflict real harm to Medicare and Medicaid beneficiaries. When fraudulent providers steal a beneficiary's identity and bill for services or goods never received, the beneficiary may later have difficulty accessing needed and legitimate care. Beneficiaries are at risk when fraudulent or abusive providers and suppliers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity. Our efforts are focused on ensuring that beneficiaries receive appropriate health care services, protecting both beneficiaries and taxpayers from unnecessary costs.

As required by law, CMS procures contractors to conduct certain program integrity activities in the Medicare and Medicaid programs. Each of these contractors has a distinct role and responsibility that are summarized in Table 1 on the next page. Certain contractors assist CMS in combating fraud and identifying improper payments, while others support CMS's fraud fighting efforts as part of their broader responsibilities of claims processing and overpayment recovery.

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Zone Program Integrity Contractors[21] (ZPICs)	Medicare Fee-for-Service	• 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 • Make recommendations to CMS for appropriate administrative actions to protect Medicare Trust Fund dollars (revocations and suspensions) • Implement administrative actions, in coordination with the MAC (payment suspensions, prepayment edits, auto-denial edits) • Conduct medical review for program integrity purposes • Identify and investigate incidents of potential fraud, waste, or abuse that exists within its jurisdiction • Make referrals to law enforcement for potential prosecution • Provide support for ongoing law enforcement investigations • Provide feedback and support to CMS to improve the FPS • Identify improper payments to be recovered
Medicare Administrative Contractors (MACs)	Medicare Fee-for-Service	• Perform provider and supplier screening and enrollment • Audit the Medicare cost reports upon which CMS bases Medicare payments to institutional providers, such as hospitals and skilled nursing facilities • Conduct prepayment and post-payment medical review audits • Perform medical review by analyzing claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims types • Develop and implement prepayment edits • Determine payment amounts for and make payments to providers, suppliers, and individuals • Provide beneficiary, provider, and supplier education, outreach, and technical assistance • Collect overpayment amounts identified through prepayment and post-payment review audits conducted by the MAC and other review contractors

[21] For the purposes of this report, references to the Zone Program Integrity Contractors include legacy Program Safeguard Contractors

Contractor	Program	Program Integrity Responsibilities
Supplemental Medical Review Contractor	Medicare Fee-for-Service	• Conduct nationwide medical review as directed by CMS • Notify CMS and the MACs of identified improper payments and noncompliance with documentation requests
Medicare Fee-For-Service Recovery Audit Program	Medicare Fee-for-Service	• Conducts post-payment audits to identify a wide range of improper payments • Make recommendations to CMS about how to reduce improper payments in the Medicare Fee-For-Service program
Coordination of Benefits & Recovery Contractors	Medicare Fee-for-Service 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 • Perform data collection and electronic data interchange • Conduct business analysis, quality assurance activities, and outreach and education to stakeholders • Provide system development and data center support for all coordination of benefits and recovery information systems
Medicare Drug Integrity Contactors (MEDICs)	Medicare Parts C and D	• Data analyses of national Part C and Part D issues leading to potential identification of improper payments and regulatory improvement • Coordinate all Part C and Part D program integrity outreach activities for all stakeholders, including plan sponsors and law enforcement • Support compliance and fraud audits of Part C and D plan sponsors • Develop educational materials on payment integrity and quality of care issues • Conduct plan sponsor related downstream entities' education and training • Highlight the value of education in preventing fraud, waste, and abuse in Medicare Part C and D
Part D Recovery Audit Program	Medicare Part D	• Conducts post-payment reviews of reconciled Part D Prescription Drug Events (PDE) data to identify a wide range of improper payments
State Medicaid Recovery Auditors	Medicaid Fee-for-Service and managed care	• Contracted by State Medicaid agencies to identify and recover overpayments, and identify underpayments made to Medicaid providers
Review Medicaid Integrity Contractors (MICs)[22]	Medicaid Fee-for-Service	• Design and apply algorithms and data models to analyze Medicaid claims data to identify aberrant claims and potential billing vulnerabilities • Create audit leads for Audit MICs

[22] Review MICs ceased operating in May 2013, with the functions absorbed within CPI.

Contractor	Program	Program Integrity Responsibilities
Audit Medicaid Integrity Contractors (MICs)	Medicaid Fee-for-Service and managed care	• Conduct post-payment audits of all types of Medicaid providers and report identified overpayments to states for recovery • Provide support to states for hearings and appeals of audits conducted under assigned task order(s)
Education Medicaid Integrity Contractors (MICs)	Medicaid Fee-for-Service and managed care	• Develop educational materials on Medicaid payment and program integrity issues • Conduct provider and beneficiary education and training • Focus on the value of education in preventing fraud, waste, and abuse in the Medicaid program

1.3. Measuring Program Integrity Success

1.3.1. Improper Payment Rates

Table 2 summarizes the historical trends in the improper payment rates for the various programs since 2009: Medicare Fee-for-Service, Medicaid, CHIP, Medicare Part C, and Medicare Part D. Specific information on how each program measures improper payments can be found in section 4.3 of this report.

Table 2 Reported Improper Payment Rates Trend for Reporting Years 2009-2014

Program	2009	2010	2011	2012	2013	2014
Medicare FFS	10.8%	10.5%	8.6%	8.5%	10.1%	12.7%
Part C	15.4%	14.1%	11%	11.4%	9.5%	9.0%
Part D	N/A	N/A	3.2%	3.1%	3.7%	3.3%
Medicaid	9.6%	9.4%	8.1%	7.1%	5.8%	6.7%
CHIP[23]	N/A	N/A	N/A	8.2%	7.1%	6.5%
Note: Additional information about previous year's improper payment rates can be found at http://www.paymentaccuracy.gov.						

1.3.2. Medicare Savings

In FYs 2013 and 2014, CMS achieved a positive return on investment in fighting fraud, waste, and abuse in the Medicare program and achieved significant savings through prevention. CMS saved an estimated $21.1 billion in FY 2013 and $18.1 billion in FY

[23] HHS did not report a CHIP improper payment rate in FYs 2009 through 2011 due to a statutory requirement. In FY 2012, HHS reported an improper payment estimate based on one cycle of 17 states; in FY 2013 HHS reported an improper payment rate that represented data from 34 states; and In the FY 2014 Agency Financial Report, HHS reported a baseline for the CHIP improper payment rate based on measuring all 50 states and the District of Columbia.

2014 (see Table 3). This represents a two-year average return on investment of 12.4 to 1 for the period that ended on September 30, 2014.[24] More than 68 percent of the savings in FY 2013 and 73 percent in FY 2014 came from prevention actions, safeguarding Medicare dollars by stopping inappropriate payments before they were made. This continued increase reinforces CMS's proactive policy of prevention of improper payments.

CMS revised many of its savings measures to be more precise in determining the impact to the Medicare Trust Funds. Notably, for the first time, CMS is estimating the impact of revoking providers' billing privileges. By taking swift administrative action to remove providers and suppliers from the program who were no longer qualified to bill Medicare, CMS estimates that in both FY 2013 and FY 2014, it will avoid paying over $700 million dollars to these revoked providers over the three-year period following their revocation.

The new savings measures may not capture the full scope of savings achieved through program integrity activities, and CMS is continuing to develop new methodologies for administrative actions where savings are not currently measured for FY 2013 and FY 2014. In addition, savings from sentinel effects are not measured. A sentinel effect occurs when providers and suppliers improve their billing behavior or come into compliance because of oversight actions. By taking administrative action, CMS deters and reduces fraudulent behavior across the provider population. Because this type of behavior change is difficult to measure and attribute to CMS's specific administrative actions, no dollar value can be assessed at this time to account for sentinel effect savings.

Table 3: Medicare Savings

Type of Medicare Savings	Medicare Savings (in millions)	
	2013	2014
Prevention Savings (Estimated Amounts)		
Systematic Edits		
NCCI - Procedure to Procedure	$ 530.4	$ 452.5
NCCI – MUE Edits	$ 164.1	$ 229.4
FPS Edits	$ 0.0	$ 2.3
ZPIC Edits	$ 42.6	$ 59.5
Field Office Edits	$ 1.8	$ 1.0
Provider Enrollment		
Revocation	$ 701.3	$ 700.7
Prepayment Review		
Medical Review	$ 5,547.1	$ 4,713.1

[24] The return on investment for the Medicare Integrity Program for FY 2013 and FY 2014 is a two-year average. It is calculated by dividing the combined total Medicare savings from FY 2013 and FY 2014 (Table 3) by the combined total Medicare obligations from FY 2013 and FY 2014 (Appendix A). The reader is cautioned that the above amounts include Recovery Auditor findings that are also reported separately in a distinct Report to Congress pertaining to the Medicare Recovery Auditor program.

Type of Medicare Savings	Medicare Savings (in millions)	
	2013	2014
Medicare Secondary Payer	$ 7,285.3	$ 7,088.7
ZPIC-Initiated Review	$ 81.0	$ 57.9
Field Office Reviews	$ 0.1	$ 0.0
Suspensions		
ZPIC-Initiated Suspensions	$ 43.2	$ 52.2
Total Prevention Savings	**$ 14,396.9**	**$ 13,357.3**
Post-Payment Recovery Savings (Estimated Amount Recovered after Identifying Overpayments*)		
Reviews and Audits		
Medicare Secondary Payer	$ 1,640.5	$ 1,111.3
Medical Review	$ 86.4	$ 28.9
Provider Cost Report Audit	$ 865.8	$ 639.7
Risk Adjustment Data Validation	$ 140.0	$ 215.0
MEDICs	$ 9.4	$ 53.8
Appeals Initiatives	$ 1.9	$ 3.6
Compliance Audits	$ 4.4	$ 3.4
Cost Plan Audits	$ 37.9	$ 47.6
ZPIC-Initiated Reviews	$ 95.5	$ 103.4
Retroactive Revocations	$ 0.1	$ 0.4
Recovery Auditors (RA)		
Part A/B RA	$ 3,650.0	$ 2,394.0
Part D RA	$ 1.6	$ 1.9
Medicare Secondary Payer RA	$ 3.3	$ 59.3
Law Enforcement Referrals		
ZPIC Law Enforcement Referrals	$ 22.5	$ 49.3
MEDIC Law Enforcement Referrals	$ 106.8	$ 53.4
Total Post-Payment Recovery Savings	$ 6,666.1	$ 4,765.0
Total Medicare Savings (Prevention and Post-Payment)	**$21,063.0**	**$18,122.3**

*Includes fee-for-service and Part D savings.

Notes: The methodology used to calculate many of the savings measures is grounded in the methodology used to calculate the Fraud Prevention System return-on-investment, which was certified by the Department of Health and Human Services Office of Inspector General. The Fraud Prevention System savings for FY 2013 and FY 2014 are a subset of the measures in the table. The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA).

In FY 2014 the capabilities of the FPS were expanded to automatically reject or deny claims. Thus, the FY 2014 savings measure for NCCI, ZPICs and CPI Field Office, and FPS Edits includes savings from these FPS edits.

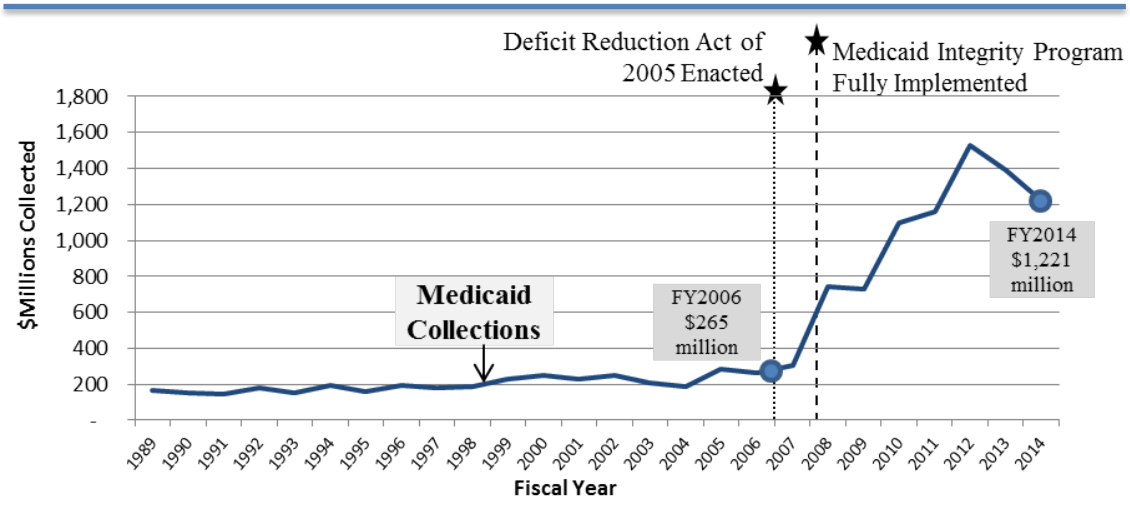
1.3.3. Medicaid Savings

The creation of the Medicaid Integrity Program by, and the funding provided through, the DRA has had a significant impact on the effectiveness of states' efforts to protect the integrity of the Medicaid program against fraud, waste, and abuse. As a result of both federal and state efforts to focus more resources on strengthening states' capacities to protect the integrity of their Medicaid programs, states' collections of Medicaid overpayments increased significantly after the establishment of the Medicaid Integrity Program in 2006. From 1989 until 2006, total state Medicaid program integrity collections were consistently below $300 million each year. In FY 2014, at $1.2 billion, total state Medicaid program integrity collections were approximately 360 percent higher than in FY 2006 (see Figure 1). During the same time period (FY 1989 to FY 2014), Medicaid expenditures overall increased at a steady pace, highlighting the dramatic change in program integrity success after the Medicaid Integrity Program became operational (see Figure 2).[25]

Impact of the Medicaid Integrity Program

By FY 2014, States' recoveries of Medicaid overpayments as a result of program integrity activities have increased by 360% since the Medicaid Integrity Program was established in 2006.

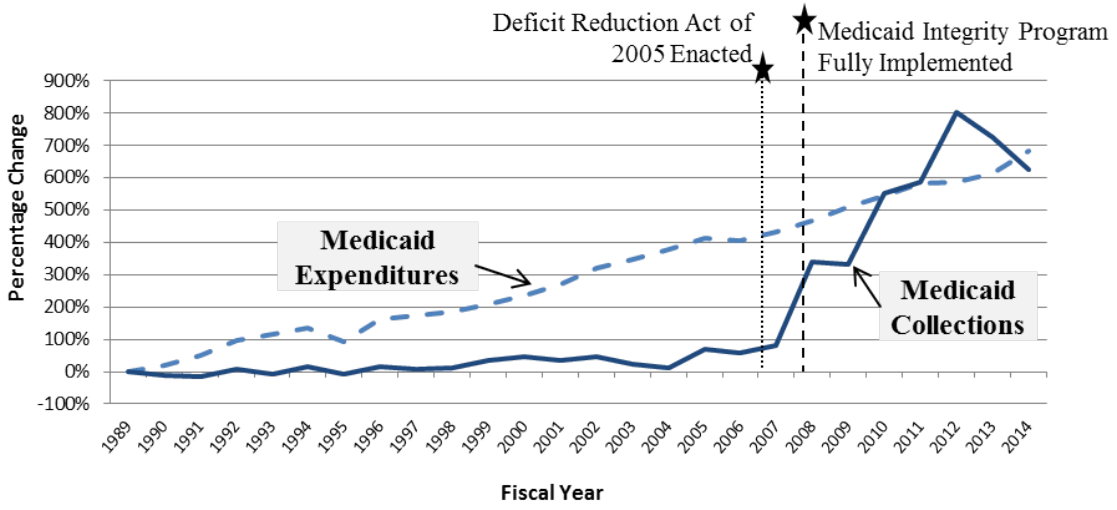
Figure 1: Medicaid Program Integrity Collection Trends, 1989-2014



Source: Form CMS 64, Summary, line 9

[25] In Figure 1 and Figure 2 (on the succeeding page) the term "Medicaid Integrity Program Fully Implemented" refers to that approximate moment in time, after passage of the DRA, that the Medicaid Integrity Program (MIP) reached a level of staffing and engagement of program integrity contractors to adequately address its mandate under the statute. Prior to this time the MIP was in a start-up phase, including hiring staff and conducting surveys and test audits, to better align its activities to the purposes outlined in the DRA.

Figure 2: Percentage Change in Medicaid Expenditures and Program Integrity Collections, 1989-2014



Source: Form CMS 64, Summary, percentage change of lines 6 and 9, normalized to 1989

1.4. OIG and GAO Recommendations Implemented

In FY 2013 and FY 2014, CMS took action to address 11 recommendations from the OIG and GAO on program vulnerabilities. Below are brief descriptions of some of the actions taken in response to OIG and GAO's priority recommendations.

CMS implemented GAO and OIG recommendations in FY 2013 and FY 2014 to strengthen program integrity

- To promote implementation of effective edits based on national policies, GAO recommended the CMS Administrator implement medically unlikely edits (MUEs) that assess all quantities provided to the same beneficiary by the same provider on the same day, so providers cannot avoid claims denials by billing for services on multiple claim lines or multiple claims without including modifiers that reflect a declaration that quantities above the normal limit are reasonable and necessary. CMS updated its quarterly MUE edits to implement this recommendation.
- GAO recommended that to improve the effectiveness of the unpublished MUEs and better prevent improper payments, CMS should examine contractor local edits related to unpublished MUEs to determine whether any of the national unpublished MUE limits should be revised. CMS established a plan to review the national unpublished MUEs.
- Both OIG (OEI-05-10-00210-R1) and GAO (GAO-12-917-R3) recommended in FY 2012 that the National Medicaid Audit Program increase the use of collaborative audits with states. Collaborative audits began in January 2010, and through the end of FY 2012, CMS had developed 218 collaborative audits with 22 states. By the end

of FY 2014, CMS increased state participation in collaborative audits to a total of 40 states representing 87 percent of Medicaid program expenditures by assigning a cumulative total of 691 collaborative audits.

- GAO recommended in FY 2013 (GAO-13-50) that CMS merge the functions of the federal review and audit contractors within a state or geographic region and use the knowledge gained from comprehensive reviews of state program integrity activities as a criterion for focusing audit resources towards states that have structural or data analysis vulnerabilities. CMS redesigned the Medicaid Audit Program, eliminating the review contractor function, leveraging up-to-date state claims data, and increasing collaborative audits in states with structural or data analysis vulnerabilities.
- GAO recommended that CMS discontinue the annual State Program Integrity Assessment (SPIA) to avoid duplication of effort with other CMS activities. As a result, CMS indefinitely suspended the SPIA data collection in early FY 2013.
- OIG recommended that CMS improve oversight of supplier data to ensure accurate and consistent information. CMS implemented enhancements to the enrollment system to address this recommendation.
- OIG recommended that CMS develop a system to track revocation recommendations and improve revocation communication with contractors. CMS implemented a system to track revocation recommendations.
- OIG recommended that CMS establish additional contractor performance standards for high-risk home health providers in fraud-prone areas. CMS issued guidance to contractors to address this recommendation.
- OIG recommended that CMS should consider using measures of questionable billing in sleep study services to identify providers for further investigation. CMS launched a model in the FPS to identify aberrant billing patterns related to this service area.
- OIG recommended that CMS require Medicare Administrative Contractors (MACs) to implement program integrity safeguards for Medicare provider enrollment as established in the Program Integrity Manual (PIM). CMS required the MACs to implement program integrity safeguards as established in the PIM.

2. Operational Excellence

2.1. Address the full spectrum of fraud, waste, and abuse

2.1.1. Medicare Program Integrity

One way CMS investigates instances of suspected fraud, waste, and abuse is through the activities of the Zone Program Integrity Contractors (ZPICs). The ZPICs develop investigations and take a variety of actions to prevent Medicare Trust Fund monies from being inappropriately paid to Medicare providers. They also identify improper payments that are to be recovered by the MAC.

Zone Program Integrity Contractor Goals

- *Protect the Medicare Trust Fund by taking action to prevent payments for fraudulent billing and recover any inappropriate payments*
- *Identify and develop cases of suspected fraud*

The ZPICs take a variety of actions to detect and deter fraud, waste, and abuse in the Medicare Program, which includes conducting interviews and site visits, implementing appropriate administrative actions (e.g., prepayment edits, payment suspension, revocation), and performing program integrity review of medical records and documentation. While the MACs and other contractors also perform medical review to make coverage or coding determinations, when the ZPICs perform program integrity-directed medical review, their focus is different. For example, the ZPICs look for possible falsification of documents that may lead to identification of provider or supplier overpayments. This type of program integrity medical review may lead the ZPIC to request that the MAC implement a prepayment edit, auto-denial edit, or payment suspension to prevent the loss of future funds.

In FY 2013, the ZPICs saved an estimated $455.7 million in potentially improper payments by taking appropriate action to initiate collection, prevent payment to Medicare providers and suppliers, or refer cases to law enforcement (see Table 4). Of this total amount, the ZPIC investigations resulted in revoking billing privileges that avoided an estimated $169 million in improper payments. The ZPICs worked with the MACs to implement automatic denials or prepayment reviews on the providers' and suppliers' billing that stopped an estimated $125.5 million from being inappropriately paid to these Medicare providers and suppliers. CMS estimates that the ZPICs saved the Medicare Trust Funds another $43.2 million by implementing payment suspensions.

In FY 2014, the corresponding savings for potentially improper payments was an estimated $466 million. Of this total amount, the ZPIC investigations resulted in revoking billing privileges that avoided an estimated $142.8 million in improper payments. The ZPICs worked with the MACs to implement automatic denials or prepayment reviews on the providers' and suppliers' billing that stopped an estimated

$118.4 million from being inappropriately paid to these Medicare providers and suppliers. CMS estimates that the ZPICs saved the Medicare Trust Funds another $52.2 million by implementing payment suspensions.

Table 4: Savings Identified by ZPICs

Type of Savings	Savings (in millions)	
	2013	2014
Prevention Savings		
Estimated Amount Avoided Due to Revocation of Billing Privileges	**169.0**	**142.8**
Estimated Amount Prevented by Automatically Denying Claims	**44.4**	**60.5**
Estimated Amount Prevented by Denying Claims After Prepayment Review	**81.1**	**57.9**
Amount Held in Escrow Due to Payment Suspensions	**43.2**	**52.2**
Post-Payment Recovery Savings		
Estimated Amount Recovered after Identifying Overpayments	**95.5**	**103.4**
Estimated Amount Saved through Referrals to Law Enforcement	**22.5**	**49.3**
Total Savings	**$455.7**	**466.0**

Notes: The methodology used to calculate many of the savings measures is grounded in the methodology used to calculate the Fraud Prevention System return-on-investment, which was certified by the Department of Health and Human Services Office of Inspector General. The Fraud Prevention System savings for FY 2013 is a subset of the measures in the table. The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010 (SBJA). The savings values listed above also include administrative actions submitted by the CMS Field Offices (FOs), as CMS transitioned to having the FOs submit their administrative actions through the ZPICs in FY 2014 and 2015.

Zone Program Integrity Contractor Investigation

As a result of a ZPIC investigation in 2013, the owner of a Miami medical clinic was indicted for conspiracy to commit healthcare fraud and pleaded guilty in January 2014. The owner and co-conspirators provided fraudulent home health and therapy prescriptions and other medical documentation to home health care agencies in return for kickbacks and bribes. The provider acknowledged involvement in fraudulent billing in excess of $20 million and is now out of business. The owner was sentenced to serve 108 months in prison and three years of supervised release, and ordered to pay $8,437,393 in restitution.

2.1.2. Provider Cost Report Audits

Auditing is one of CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, nursing homes, and end-stage renal dialysis facilities whose costs are settled through the submission of an annual Medicare cost report. Although many providers have their claims paid through a prospective payment system (PPS), several items continue to be paid on an interim basis, with the final payment being made through the cost report reconciliation process. This cost report review, audit, and settlement process provides a method to detect improper payments and identify the reasons these improper payments have occurred. Once identified, the reasons for the improper payments provide insight to potential payment vulnerabilities that can be used to strengthen and focus the program integrity response. The cost report includes calculations of the final payment amount for items such as direct graduate medical education (GME) and indirect medical education (IME), disproportionate share hospital (DSH) payments, and Medicare bad debts. Some providers, such as critical access hospitals and cancer hospitals, are paid based on costs reported on their cost reports. For example, in FY 2013, Medicare paid in excess of $24 billion in DSH payments, $19 billion in Medical Education payments (GME and IME), and $4 billion in payment for bad debt. In FY 2014, the corresponding amounts were $11 billion in DSH payments, $8 billion in GME and IME, and $3 billion for bad debt.

The audit process includes the timely receipt and acceptance of provider cost reports, desk review, and audit of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines that providers are paid properly, in accordance with CMS regulations and instructions. CMS contracts with the MACs to provide these audit services. During FY 2013, approximately 46,000 Medicare cost reports were received and accepted by the MACs. This includes initial cost report filings as well as amended filings. When combined with the cost reports deemed acceptable during the end of 2012, tentative settlements were completed for approximately 23,000 cost reports. In addition, approximately 18,000 cost reports were desk reviewed and around 2,400 cost report audits were completed. The corresponding workload in FY 2014 consisted of approximately 47,000 Medicare cost reports received and accepted and when combined with the cost reports deemed acceptable during the end of 2013, approximately 23,000 cost reports were issued a tentative settlement. In addition, approximately 18,000 cost reports were desk reviewed and around 2,000 cost report audits were completed. The MACs that perform this audit work are reviewed annually to ensure the accuracy of their work. CMS works closely with its contractors to increase efficiencies and to develop ways to improve the audit process.

2.1.3. Medicare Secondary Payer

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

conditionally once it is established that another individual or entity is responsible for primary payment.

Implementation of the mandatory insurer reporting requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007[26] resulted in a significant increase in new MSP information reported to CMS from group health plans and other insurers. The number of MSP records posted to CMS's systems grew from 6.6 million in 2008 to 16 million in 2013.

As CMS continues to implement Title II of the Medicare IVIG [intravenous immune globulin] Access and Strengthening Medicare and Repaying Taxpayers Act of 2012 (SMART Act)[27] several milestones have been achieved. CMS has developed a web portal and applications that, when fully implemented, will effect quicker resolution of Medicare's claim in recovery situations. In 2014, CMS also evaluated and set a new reporting and recovery threshold where the total settlement amount of the physical trauma-based injury is $1,000 or less. Finally, CMS implemented a new process that allows MSP reporting entities the option of reporting less than a full SSN to CMS when the Health Insurance Claim Number (HICN) is otherwise not available. CMS continues work toward implementing all other requirements in the SMART Act, including development of an Applicable Plan Appeals Regulation and a Civil Monetary Penalty (CMP) Regulation under the insurer reporting requirements of Section 111 of MMSEA.

CMS continues to leverage technology in its MSP program to make Medicare information directly accessible to beneficiaries, their representatives, and the industry. We have expanded the MyMedicare.gov website to provide specific beneficiary information regarding MSP in a secure and readily accessible way. Through www.MyMedicare.gov, a beneficiary can access eligibility and enrollment information, learn about coverage options, review Medicare claims, and view MSP information. Beneficiaries can go to the My MSP page of www.MyMedicare.gov to see the Medicare reimbursement amount for their individual case, including information on associated claims. They can request and receive updates for newly processed claims within 48 hours. Authorized representatives for a beneficiary can access the portal by using www.cob.cms.hhs.gov/msprp. These improved processes not only provide more timely data to beneficiaries and their representatives, but also allow them to better manage their case.

In an effort to increase efficiency of its MSP program, CMS implemented a new MSP contracting strategy to restructure its prepayment coordination of benefits activities and MSP debt recovery activities. Implementation activities included the transition of all Group Health Plan debts established under the Medicare Secondary Payer Recovery Contractor (MSPRC) to the MSP Commercial Repayment Center (CRC) and the start of new recovery case development by the MSP CRC. This program is now referred to as the Commercial Repayment Center Recovery Auditor (CRC RA) program. In addition, CMS awarded a Benefits Coordination and Recovery Contract (BCRC). The BCRC

[26] Public Law 110-173.

[27] Public Law 112-242.

became fully operational February 1, 2014, marking the final transition to the new MSP contract structure. CMS has already consolidated MSP information, providing stakeholders with one central point of contact and one single website for all aspects of MSP policy and operations.

As a result of these changes, MSP operations saved $8.2 billion in FY 2014. This includes indirect recoveries of $582 million. Significant enhancements continue to be implemented to take advantage of combined MSP operations.

Commercial Repayment Center Recovery Auditors

In FY 2013, CMS finalized the award of a new CRC RA specifically tasked with the recovery of Part A and Part B payments mistakenly made when a beneficiary has coverage through an employer-sponsored Group Health Plan (GHP). These amounts are typically recovered from employers. Implementation activities included the transition of all GHP debts established under the MSPRC to the CRC RA and start of new recovery case development by the CRC RA. The CRC RA began full operations at the end of FY 2013.

The CRC RA is also developing enhancements to the GHP recovery process that will modernize and streamline the current paper processes. These enhancements are designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program. In FY 2014, CRC RA identified $234.2 million in mistaken payments and posted net collections of $59.3 million.

2.1.4. Supplemental Medical Review

In FY 2013, CMS continued to enhance medical review while closely monitoring the decisions made by these contractors. CMS established a Supplemental Medical Review Contractor (SMRC), which operates at the direction of CMS, to provide support for a variety of tasks aimed at lowering the improper payment rate by enhancing medical review efficiencies. One of the SMRC's primary tasks is evaluating medical records and related documents to determine whether claims were billed in compliance with Medicare's coverage, coding, and payment rules, including those claims identified by the Office of Inspector General and/or Government Accountability Office. CMS expects savings from this program to increase significantly as other medical review projects are initiated in the future.

2.1.5. Medicare Fee-For-Service Recovery Audit Program[28]

In FY 2013, the Medicare FFS Recovery Audit program corrected $3.75 billion in improper payments, including recovering $3.65 billion in overpayments. This represents an increase in recoveries of 59 percent over FY 2012.

We also continued to expand the use of Recovery Auditors in the Medicare FFS program. In FY 2013, Recovery Auditors started reviewing under a demonstration project certain error-prone claims before they are paid (known as prepayment review), thereby preventing improper payments from being made. This demonstration project began for claims submitted on or after September 2012 in 11 states.[29] Through this prepayment demonstration, CMS prevented an estimated $22.3 million in erroneous payments.

During FY 2013[30], the Recovery Auditors focused their reviews on short hospital stays and claims for Durable Medical Equipment. These areas have a history of improper payments. CMS expects that implementation of certain corrective actions for such services will lower collections in the future because they will prevent future improper payments from being made. CMS continues to monitor and make continuous enhancements to the Recovery Audit Program. In addition to using the Medicare FFS Recovery Auditors to correct improper payments, CMS also uses Recovery Auditor findings to prevent future improper payments. For example, in FY 2013, CMS released four Quarterly Provider Compliance Newsletters that provided detailed information on 30 findings identified by the Recovery Auditors.

In FY 2014[31], Recovery Auditors corrected $2.57 billion in improper payments. This includes $2.39 billion in overpayments collected and $173.1 million in underpayments repaid to providers and suppliers. CMS attributes this decrease in overpayments collected from FY 2013 to FY 2014 to the statutory prohibition on Recovery Auditors from conducting inpatient hospital patient status reviews and the limited amount of reviews that took place during the contract close-out process, as part of the procurement for the next round of Recovery Auditors contracts.

2.1.6. Medicaid Recovery Audit Contractor (RAC) Program

State Medicaid agencies contract with Medicaid Recovery Audit Contractors (RACs) to identify and recover overpayments and identify underpayments made to Medicaid

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[28] For more information on the Medicare Fee-For-Service Recovery Audit Program the reader should consult https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/

[29] The 11 states include Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri

[30] A more detailed review can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY-2013-Report-To-Congress.pdf

[31] A more detailed review can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-RTC-FY2014.pdf

providers. CMS implemented section 6411(a) of the Affordable Care Act in a final rule published on September 16, 2011, adding a new subpart F to 42 C.F.R. Part 455 and requiring states to implement Medicaid RAC Programs by January 1, 2012. Pursuant to 42 C.F.R. § 455.516, states may request exceptions to the regulatory requirements by submitting a State Plan Amendment for CMS review and approval.

As of September 30, 2014, 47 states and the District of Columbia had implemented Medicaid RAC Programs, and CMS had granted five U.S. Territories complete exceptions from implementing RAC Programs because they did not have the necessary Medicaid claims data infrastructure to support a Recovery Audit Program. Additionally, CMS granted three states time-limited exceptions from implementing Medicaid RAC Programs during FY 2013 and FY 2014, due to either high rates of Medicaid managed care penetration (one state) or small Medicaid beneficiary population (two states).

State Medicaid Recovery Auditor Recoveries

In the first full fiscal year of operation, 19 states reported total Medicaid Recovery Audit Contractor recoveries of $135.6 million in FY 2013, from which the federal share of $81 million was returned to the Treasury.

As a measure of effectiveness of the Medicaid RAC Program for FY 2013, 19 states reported a total combined federal and state share amount of Medicaid RAC recoveries of $135.6 million. The federal share of $81 million was returned to the Treasury. For FY 2014, 28 states reported a combined federal and state share amount of Medicaid RAC recoveries of $96.7 million. The federal share of $60.8 million was returned to the Treasury.[32, 33]

Expenditures related to the Medicaid RAC Program arise from administrative costs and fees paid to contractors. As provided in section 6411(a) of the Affordable Care Act, state and federal governments share administrative costs equally: amounts spent by the state to carry out the administration of the program are reimbursed at the 50 percent administrative claiming rate. As implemented in the final rule published on September 16, 2011, section 6411(a) of the Affordable Care Act also provides that payments to Medicaid RACs are to be made only from amounts "recovered" on a contingent-fee basis for collecting overpayments and in amounts specified by the state for identifying underpayments. CMS does not dictate contingency fee rates for states, but establishes a maximum contingency rate for which Federal Financial Participation (FFP) will be available unless a state has been granted a waiver. The maximum contingency rate for

[32] Recovery Audit Contractor recoveries include overpayments collected, adjusted, and refunded to CMS, as reported by states on the CMS-64.

[33] FY 2013 was the first full federal fiscal year of the Medicaid RAC program, and 36 states had implemented Medicaid RACs by the beginning of FY 2013. However, due to startup time, time to complete audits, and the one year period allowed for recovering overpayments, several states may not have recovered overpayments during FY 2013 or FY 2014.

Medicaid RACs effective for FY 2013 and FY 2014 was 17.5 percent for durable medical equipment claims and 12.5 percent for all other types of claims.[34]

CMS's role with the State Medicaid RAC Program is to provide guidance to states as they implement their RAC Programs, collect state reports on the progress of those programs, and encourage states to make their Medicaid RAC Programs as transparent as possible. During FY 2012, CMS facilitated transparency through the public State Medicaid RACs-At-A-Glance website, where states provide information on their State Medicaid RAC Programs, including contact information for the state program integrity director, the name of each Recovery Audit Contractor and medical director, contingency fee rates for the identification and recovery of overpayments, and fee structures for the identification of underpayments.[35] CMS launched a secure online portal in April 2013 for states to report information on their State Medicaid RAC Programs. CMS also provided training webinars on how to report performance data on the portal in May 2013 and June 2014.

Although not required to do so, six states have elected to include managed care in their RAC Programs by the end of FY 2014. The largest numbers of RAC audits completed during FY 2013 and FY 2014 were performed in the service areas of dental care, inpatient care, long-term care, and physician services. The largest total overpayments were identified in inpatient care, outpatient care, physician services, nursing homes, and home health services. The most common service areas where RAC audits identified underpayments in FY 2013 and FY 2014 were inpatient care and long-term care.

2.1.7. Medicaid Special Investigation Projects

CMS also partners with states to provide personnel and other resources to carry out antifraud field investigations in high risk areas in cooperation with state Medicaid staff. During FY 2013 and FY 2014, CMS staff participated in six field investigation projects with states. Five of these investigations involved assistance provided to the Florida Agency for Health Care Administration (AHCA) on high-risk providers in the Florida Medicaid program. During FY 2013, CMS and AHCA staff conducted three investigations involving 123 onsite reviews of group homes for the developmentally disabled and assisted living facilities. The projects resulted in over 80 provider sanctions and $373,500 in fines being levied for various violations. In addition, based on a state analysis of provider payments for the 12 months preceding and following the field work, these initiatives were responsible for a total cost savings of $839,188.[36]

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[34] 77 Fed. Reg. 11127, February 24, 2012.

[35] The public State Medicaid RACs-At-A-Glance website is available at: http://www.medicaid-rac.com/medicaid-rac-activity/

[36] Data on the Florida field projects comes from the AHCA publication, *The State's Efforts to Control Medicaid Fraud and Abuse, FY 2012-2013*, page 34, available at http://ahca.myflorida.com/Executive/Inspector_General/docs/FraudReports/FraudReport2012-13.pdf.

In FY 2014, CMS participated in two field projects with the State of Florida. The first Florida project took place in January 2014, and involved site visits to 30 providers of various types in Monroe County. The visits cited violations which resulted in provider sanctions including fines, referrals to other agencies, and placement on manual prepayment review. The second Florida review took place in April and May 2014, and involved site visits to 50 of the top-billing group homes for the developmentally disabled in a tri-county area north of Miami. This field project identified compliance deficiencies, imposed provider sanctions (including $17,000 in fines), and made disciplinary referrals to other agencies.

Medicaid Investigation Teams Rescue Group Home Residents

In early FY 2013, CMS staff joined Florida Medicaid officials to conduct unannounced inspections of 39 Assisted Living Facilities and Adult Family Care Homes in the greater Jacksonville area. In one Assisted Living Facility, an investigative team found 14 beneficiaries living in such unsafe conditions that they summoned a fire safety inspector who discovered 19 fire code violations, including a nonworking fire sprinkler system. The Fire Marshall issued a Cease and Desist Order to immediately shut down the facility and remove all residents. At another adult care facility, investigators found a resident living in poor conditions without adequate supervision, air conditioning, or sufficient food stores and immediately contacted the Department of Children and Families to remove the resident to a suitable facility before the inspection team departed.

Another FY 2013 field project involved a street-level investigation of non-emergency medical transportation vehicles in New York City. CMS staff assisted the New York State Office of the Medicaid Inspector General and the New York City Taxi and Limousine Commission in a one day sweep designed to identify unlicensed or improperly licensed paratransit vehicles, primarily ambulettes, serving disabled Medicaid beneficiaries. This project resulted in the seizure of 4 vans and 18 summonses being issued by the New York City Taxi and Limousine Commission with fines totaling $11,450.[37]

2.1.8. Medicare-Medicaid Data Match Program (Medi-Medi)

CMS is also working with state Medicaid data in the Medicare-Medicaid Data Match program (Medi-Medi program). CMS designed the program to collaborate with participating state Medicaid agencies on billing trends across the Medicare and Medicaid programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. In 2001, the Medi-Medi program began as a pilot project in California and grew to 20 states in FY 2013. During FY 2013, CMS partnered with states that account for most of the expenditures in Medicaid. Participating

[37] Data from website of NY State Office of the Medicaid Inspector General at: http://omig.ny.gov/latest-news/678-omigtlc2.

states include: Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa, Mississippi, Michigan, Missouri, Nebraska, New York, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, and Utah.

Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the program an important tool in identifying and preventing fraud across the programs. The Medi-Medi program promotes collaboration among state Medicaid agencies, CMS, and law enforcement by targeting resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse.

In FY 2014, CMS implemented many refinements to the program, and is currently assessing ways the program can be improved and be more beneficial to states. CMS is sharing lessons learned from states that have made successful referrals and recovered overpayments in the Medicaid program. CMS is also exploring opportunities to collaborate with states participating in the Medi-Medi program to improve access to timely and robust Medicaid data for Medicaid program integrity activities, as well as specific collaborative projects.

Throughout FY 2014, the program grew to 21 states. Participating states include: Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa, Louisiana, Mississippi, Missouri, Nebraska, New York, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Texas, West Virginia, and Wyoming. Program participation is optional for the states; however, CMS works diligently to encourage each individual state's participation. Through the Medi-Medi refinements, CMS plans to further enhance the Federal-State collaboration in identifying program vulnerabilities and increasing cost avoidance and recoupments on claims identified as potentially fraudulent, wasteful, or abusive.

2.2. Expand Activities in Medicare Part C and Part D

2.2.1. Part C and Part D Program Integrity Oversight

In FY 2013 and FY 2014, CMS continued to invest Health Care Fraud and Abuse Control (HCFAC) program discretionary funds to strengthen Medicare Part C and Part D oversight. CMS enhanced its data analysis and improved coordination with law enforcement to provide a more comprehensive assessment of program integrity activities in the Medicare Advantage (MA; also referred to as Part C) and Part D programs. An example is the use of Risk Adjustment Data Validation (RADV) contract-level audits to recover overpayments. A more detailed explanation of these audits is included in Section 4.3.5 *Improper Payment Rate Measurement in the Part C and Part D Programs*. All MA and Part D plan sponsors are required to have a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse. This plan consists of written policies, procedures, and standards that articulate the organization's commitment to comply with all applicable federal and state standards related to fraud and abuse. Plan sponsors must have a properly trained, effective compliance officer and provisions for internal monitoring and

auditing, as well as other requirements. These requirements help ensure plan sponsors track and identify potential beneficiary or provider abuse. CMS issued Compliance Program Guidelines in Chapter 9 of the *Prescription Drug Benefit Manual* and Chapter 21 of the *Medicare Managed Care Manual*. Both chapters are identical, and apply equally to Medicare Advantage Plans and Prescription Drug Plans. As part of the program integrity oversight of Parts C and D, CMS evaluates plan sponsors' operations for compliance with federal regulations and guidance.

National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)

CMS also contracts with the NBI MEDIC to assist CMS in managing audit, oversight, and anti-fraud efforts in the Medicare Part C and Part D programs. The NBI MEDIC's main functions include the following activities:

- Managing all incoming complaints about Part C and Part D fraud, waste, and abuse;
- Utilizing new and innovative techniques to monitor and analyze information to identify potential fraud, waste, and abuse;
- Investigating potential fraud and abuse in the Part C and Part D programs;
- Developing cases for referral to law enforcement agencies and managing requests for information;
- Working with law enforcement, MA and prescription drug plans, consumer groups, and other key partners to protect beneficiaries and to enforce Medicare's rules;
- Providing basic tips for beneficiaries on how to protect themselves from potential scams; and
- Identifying and reporting program vulnerabilities.

In FY 2013, the NBI MEDIC received an average of 554 actionable complaints per month, processed 38 requests for information from law enforcement per month, and referred 34 cases to law enforcement per month. The NBI MEDIC's referrals to law enforcement resulted in $106.8 million in recoveries in FY 2013.

In FY 2014, the NBI MEDIC received an of average 662 actionable complaints per month, processed 39 requests for information from law enforcement per month, and referred 40 cases to law enforcement per month. NBI MEDIC referrals resulted in $53.4 million in recoveries in FY 2014, including restitution of $33.6 million, forfeitures of $14.9 million, $2.8 million in fines, and $2.0 million in civil settlements.

The NBI MEDIC was responsible for assisting the HHS-OIG and DOJ through data analysis and investigative case development in achieving 67 convictions, 33 arrests, and 47 indictments during FY 2014.

Doctor Sentenced to 25 Years

The NBI MEDIC identified a "pill mill" through outlier analysis for prescribing a high volume of controlled substances. The investigation and prosecution resulted in a prison sentence for the physician for distribution of a controlled substance resulting in death.

One prescription fraud case referred to law enforcement by the NBI MEDIC resulted in the arrest, indictment, and conviction of a Pennsylvania physician, a pharmacist, and more than 50 other individuals—including office staff, pseudo-patients, Medicare patients, and drug dealers in a large prescription drug conspiracy. The physician was sentenced in 2013 to 25 years in prison for distribution of a controlled substance resulting in death and over 300 other counts stemming from his pill mill operation. The pharmacist was sentenced to 72 months of imprisonment and three years of probation. Through outlier analyses, the NBI MEDIC identified the physician for prescribing a high volume of controlled substances. He prescribed over 46,800 units of controlled substances, which equaled 84 percent of his total prescribed medications. The investigation revealed the physician worked with drug traffickers who recruited large numbers of pseudo-patients. With the help of his office staff, those "patients" were transported to his medical office for cursory examinations and paid an office visit fee, after which the physician wrote prescriptions allowing them to obtain oxycodone-based drugs without a legitimate medical purpose. The patients were driven to a particular pharmacy to have their prescriptions filled. The drugs were then turned over to a network of drug dealers who resold the drugs on the street.

Another investigation initiated by the NBI MEDIC resulted in the sentencing of a West Philadelphia physician who owned and operated a family medical clinic. This case was initiated as an internal proactive investigation resulting from a liaison meeting with the Drug Enforcement Administration (DEA). Allegations against the physician included employing unlicensed individuals in the clinic who performed examinations and administered drugs. The physician admitted to prescribing OxyContin to patients "for pain and also their emotional well-being," and admitted that many patients picked up controlled substance prescriptions for others and sold their prescriptions. He was sentenced in 2013 to 30 years in federal prison and ordered to pay a $50,000 fine. He was also ordered to forfeit $200,000 linked to prescription trafficking.

Outreach and Education (O&E) MEDIC

In FY 2014, the Outreach and Education (O&E) MEDIC facilitated the CMS Parts C & D Fraud Waste and Abuse (FWA) training sessions that offer Medicare Advantage Organizations (MAOs) and Prescription Drug plans an opportunity to collaborate and discuss techniques on how to prevent and detect fraud, waste, and abuse in the Medicare Advantage and Part D programs. These FWA training sessions are designed to educate MAO and Prescription Drug plan staff through enhanced collaboration, information sharing, data analytics, and communication. FWA training session stakeholders include plan sponsors, Pharmacy Benefit Managers (PBMs), representatives from law enforcement agencies—including HHS-OIG, U.S. DOJ, and other state and local law

enforcement entities. These FWA training sessions provide a forum for stakeholders to learn about the most recent fraud schemes and fraud prevention best practices to assist in developing effective fraud prevention programs.

The O&E MEDIC is also responsible for many other outreach activities in 2014. In March, the CMS Center for Program Integrity released its most comprehensive fraud fighting tools to date, the Medicare Advantage and Part D Fraud Handbook: Practical Techniques and Approaches on Detecting and Preventing Fraud, and an Online Training Module for MAOs and Part D sponsors. The handbook is a modular online reference providing MAOs and Part D sponsors with industry best practices regarding processes, methods, and resources to support fraud prevention, detection, corrective action, preliminary investigation, and referral activities. The training is an online presentation covering each chapter of the Fraud Handbook in an on-demand webcast format.

Part D Prescriber Validation

Over the past few years, CMS has been working to strengthen federal regulations and procedures to ensure that Medicare pays only for covered prescriptions written by qualified Medicare prescribers with valid prescriber identifiers on the prescription drug claim. Since 2011, CMS has been taking steps to verify that only valid prescriber identifiers accompany Part D claims, and that the NBI MEDIC and plan sponsors are carefully monitoring pharmacy billing patterns. In collaboration with the DEA, CMS directed Part D sponsors to submit only active and valid prescriber identifiers on a Prescription Drug Event (PDE) record, and we began validating the format of all prescriber identifiers that were coded as a NPI and excluded from payment reconciliation PDEs with invalid NPIs.

In April 2012, CMS published a final rule requiring that Part D sponsors must submit to CMS only PDE records that contain active and valid individual prescriber NPIs beginning January 1, 2013.[38] CMS, through the annual Medicare "Dear Doctor" letter, explained the NPI requirement to prescribers. CMS began to deny any PDE without an active and valid individual NPI beginning on May 6, 2013. We continued to assess each sponsor's performance regarding NPI use and validity of submitted NPIs and notified sponsors of their performance in preparation for this deadline. Based on this assessment, we found that 99.6 percent of the 2013 PDEs received during the first quarter of the coverage year reported the prescriber's NPI, and all but 0.002 percent (or 1 in 50,000) of the reported NPIs were valid and currently active, or active within a year of the date of service. We also examined the taxonomy codes, which are self-reported by the providers to identify their specialty. Because we found that a small percentage of these taxonomy codes would be unreasonable for a prescriber, we have initiated a review of the corresponding PDEs to determine what drugs were prescribed, if any are controlled substances, and if the prescribers have valid individual DEA numbers.

To ensure that Part D drugs are prescribed only by individuals qualified to do so under state law and under the requirements of the Medicare program, CMS published a final

[38] 77 FR 22072 (April 12, 2012)

rule in May 2014 that will require that physicians and eligible professionals who write prescriptions for covered Part D drugs must be enrolled in Medicare, or have a valid record of opting out of Medicare for their prescriptions to be covered under Part D.[39]

2.2.2. Medicare Part C and Part D Recovery Audit Programs

Section 6411(b) of the Affordable Care Act expanded the use of Recovery Auditors to Medicare Part C and Part D. CMS awarded a Part D Recovery Auditor contract with national jurisdiction in January 2011. The primary function of the Part D Recovery Auditor is to conduct post-payment reviews to identify improper payments made to Part D plan sponsors, which provide prescription drug benefits to Medicare beneficiaries. The Part D Recovery Auditor also provides information to CMS to help prevent future improper payments. Results from the Recovery Auditor reviews help CMS identify vulnerabilities in the Part D program that can lead to implementing preventive actions by focusing resources more effectively on new fraud, waste, or abuse issues as they emerge.

The Part D Recovery Auditor uses a CMS-approved audit methodology to identify potential improper payments in PDE records submitted by Part D plan sponsors. The Recovery Auditor works with a data validation contractor to confirm the results, obtaining additional documentation from plan sponsors when needed. Once the findings are finalized, the Recovery Auditor sends Notifications of Improper Payments to plan sponsors, which can then appeal the Recovery Auditor's findings. After all potential appeals are considered and final decisions are made, CMS collects any overpayments from or repays any underpayments to plan sponsors. The Recovery Auditor is paid a contingency fee based on a percentage of improper payments corrected, as required by law.

Measures of the effectiveness of the Part D Recovery Auditors include the amount of improper payments identified and corrected in each fiscal year. Due to the length of appeal processes, recoveries of overpayments may occur in the fiscal year following the year in which the improper payments were identified. During FY 2013, CMS recovered $1.6 million in overpayments identified by the Part D Recovery Auditor in its FY 2012 review of PDEs resulting from prescriptions written by OIG-excluded providers during the 2007 contract year. Also in FY 2013, the Part D Recovery Auditor reviewed PDEs resulting from the actions of excluded prescribers for the 2008 through 2011 contract years, and sent Notifications of Improper Payments totaling $3.4 million to Part D plan sponsors: after appeals, CMS recovered $1.9 million in overpayments from this review during FY 2014.

[39] To ensure that Part D drugs are prescribed only by individuals qualified to do so under state law and under the requirements of the Medicare program, CMS published a final rule in May 2014 that will require that physicians and eligible professionals who write prescriptions for covered Part D drugs must be enrolled in Medicare, or have a valid record of opting out of Medicare for their prescriptions to be covered under Part D. 79 FR 29843 (May 23, 2014), later revised in interim final rule 80 FR 25958 (May 6, 2015).

The Part D Recovery Auditor also completed a new project during FY 2014 by reviewing PDEs resulting from prescriptions written by unauthorized prescribers who do not have the authority to prescribe drugs for beneficiaries under Medicare Part D, such as veterinarians or dieticians. As a result of its review of unauthorized prescribers for the 2009 through 2012 contract years, the Part D Recovery Auditor sent Notifications of Improper Payments to Part D plan sponsors totaling $5.3 million during FY 2014. Following appeals, recoveries of overpayments resulting from prescriptions written by unauthorized prescribers will occur in FY 2015.

In FY 2013, CMS developed a procurement strategy for the Part C Recovery Auditor after reviewing implementation options. The Part C Recovery Auditor will identify improper payments related to services provided under Medicare managed care and provide information to CMS to help prevent future improper payments. CMS had posted a Request for Information in December 2012 and a Sources Sought Notice in April 2013 related to this procurement. More recently, a Request for Quote was posted in June 2014; however, no responses were received as a result of that solicitation. CMS has continued its implementation efforts to secure a Part C Recovery Auditor.[40]

2.2.3. Medicare C and D Marketing Oversight

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

Secret Shopping

Secret shopping provides undercover surveillance of formal MA, MA-PD, and Prescription Drug Plans (PDP) marketing events. CMS and its contractors identify a sample of events to secret shop from Plan sponsors' reported formal sales/marketing events. Shoppers used a CMS-developed tool to facilitate and electronically record their evaluations of marketing events' compliance with CMS requirements. The tool is designed to capture whether the representatives' or agents' presentations, actions and provided materials are compliant. Additionally, it collects general information, such as the number of attendees, the type of venue, and the language in which the agent presented.

For the 2013 Annual Enrollment Period (AEP), CMS completed 1,781 secret shopping events, of which 45 (2.5 percent) were presented in a language other than English.

Of the total events shopped, 1,176 (65.7 percent) had no validated deficiencies and were considered entirely compliant with Medicare regulations. Of the 114 parent organizations shopped, 23 (or 20.2 percent) had no validated deficiencies noted. These

[40] A Request for Information (RFI) was posted on December 22, 2015 to solicit feedback from industry related to expanding the Recovery Auditor Program to Medicare Part C to identify underpayments and overpayments associated with diagnosis data submitted to CMS by Medicare Advantage Organizations.

23 parent organizations represented 605 shops or approximately 33 percent of the total completed shops.

For the 2014 Annual Enrollment Period (AEP), CMS completed 1,320 secret shopping events. Of the events shopped, 1,133 (85.5 percent) had no validated deficiencies and were considered entirely compliant with Medicare regulations. Of the 101 parent organizations shopped, 42 (or 41.6 percent) had no validated deficiencies noted. These 42 parent organizations represented 211 shops or approximately 16 percent of the total completed shops.

Compliance for Secret Shopping Deficiencies

CMS takes compliance actions against sponsors who have had deficiencies identified during our secret shopping activities. To determine the appropriate compliance action for deficiencies identified by secret shopping, CMS developed a data-driven and performance-based model, which automated the review process, and accounted for the seriousness of each. The types of compliance actions taken by CMS are described and detailed in Tables 5 & 6 on the next page.

Table 5: Overall Performance Score Ranges and Corresponding Performance Actions

$\frac{\text{Total \# of deficiency points for all shops in a plan}}{\text{Total number of shops conducted for the plan}}$ = OPS	
Overall Shopping Performance Score Range	**Compliance Action Taken**
0.01 – 1.49	Technical Assistance Letter
1.50 – 3.49	Notice of Non-Compliance
3.50 – 6.99	Warning Letter with Business Plan
7.00 +	Ad-hoc Corrective Action Plans

Table 6: Compliance Actions Taken by Risk Level for Secret Shopping

Action	High[41]	Medium	Low	Total
Technical Assistance Letter	105	72	13	183
Notice of Non-Compliance	2	1	1	4
Warning Letter	2	0	0	2
Total Letters Issued	109	73	14	189

Unreported Marketing Events

The unreported marketing events initiative was an effort to determine if plan sponsors appropriately reported and represented their sales events activity to CMS. The CMS contractor reviewed daily and weekly print publications in U.S. domestic markets nationwide, including several non-English languages. CMS conducted reviews of 4,846

[41] CMS performed a risk assessment to determine how many events to shop for each sponsor. High risk sponsors were shopped more than medium or low risk sponsors.

Medicare advertisements representing 8,699 total advertised events. These advertisements represented events hosted by 36 plan sponsors.

Of those advertisements reviewed, CMS identified 406 marketing events (4.7 percent) that were unreported, indicating a deficiency for each plan sponsor that had failed to submit a marketing event. Based on the results, CMS issued 18 Technical Assistance Letters and four Notices of Non-Compliance (NONCs) to plan sponsors related to unreported marketing events. NONCs were issued to plan sponsors that incurred deficiency rates of 5 percent or higher.

2.3. Proactively Manage Provider Screening and Enrollment

Provider enrollment is the gateway to the Medicare and Medicaid programs and is the key to preventing ineligible providers and suppliers from entering either program. Accordingly, CMS is committed to maintaining operational excellence in its provider enrollment screening process. CMS implemented the Affordable Care Act's additional screening provisions through a final rule[42] published by the agency on February 2, 2011. There are three levels of provider and supplier enrollment risk-based screening: "limited"; "moderate"; and "high," and each provider and supplier specialty category is assigned to one of these three screening levels. Providers and suppliers designated in the "limited" risk category undergo verification of licensure and a wide range of database checks to ensure compliance with all provider- or supplier-specific requirements. Providers and suppliers designated in the "moderate" risk category are subject to all the requirements in the "limited" screening level, in addition to unannounced site visits. Providers and suppliers in the high risk category are subject to all of the requirements in the "limited" and "moderate" screening levels, in addition to possible fingerprint-based criminal background checks. For Medicare, CMS implemented the fingerprinting requirements on August 6, 2014.

Site visits are a screening mechanism used to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The visits are conducted by a CMS-authorized contractor who validates that the provider or supplier is in compliance with Medicare enrollment requirements.

CMS's role in the provider enrollment process is different in the Medicare and Medicaid programs. CMS directly administers Medicare and oversees the provider enrollment and screening process for providers and suppliers participating in the Medicare FFS program. CMS uses provider enrollment information in a variety of ways, such as claims payment, fraud prevention programs, and the sharing of data through its Healthcare Fraud Prevention Partnership. In Medicaid, states directly oversee the provider screening and enrollment process for their own Medicaid programs, and CMS provides regulatory guidance and technical assistance to states.

State Medicaid agencies may rely on the screening completed by CMS for dually-enrolling providers to assist them in complying with their Medicaid screening

[42] 76 FR 5862 (Feb. 2, 2011)

requirements so that they do not have to re-screen such applicants. States may use Medicare screening data including revalidation, site visits, payment of application fees, fingerprint-based criminal background checks, and revocations. For Medicaid-only fee-for-service providers, state Medicaid agencies must follow the same risk-based screening procedures followed by CMS or its contractors when enrolling Medicare providers and suppliers.

State Medicaid programs must terminate any provider that has been terminated by Medicare or another state Medicaid program or CHIP "for cause."[43] Additionally, CMS has the discretionary authority to revoke Medicare billing privileges where a state has terminated a provider's or supplier's Medicaid billing privileges for cause. CMS has established a voluntary process and system for states to report and share information about Medicaid terminations. States may report to CMS all "for cause" Medicaid terminations of providers who have exhausted all applicable appeal rights or the timeline for appeal has expired for inclusion in the CMS provider termination system.

CMS's provider screening and enrollment initiatives in Medicare have had a significant impact on removing ineligible providers from the program. Site visits, which are performed to verify information on record and prevent questionable providers and suppliers from enrolling in the Medicare program, and the revalidation initiative, which requires providers and suppliers to resubmit and recertify the accuracy of their enrollment information to maintain their Medicare billing privileges and be reevaluated under new screening guidelines, has contributed to the deactivation[44] and revocation[45] of more than 568,000 enrollment records since CMS started implementing the requirements of the Affordable Care Act (Figure 3). CMS deactivated 106,269 enrollments, and revoked 4,143 enrollments in FY 2013 and in FY 2014 CMS deactivated 166,487 enrollments and revoked 7,278 enrollments.[46] By removing these providers and suppliers from the Medicare program in FY 2013, CMS estimates that more than $700 million has been saved.

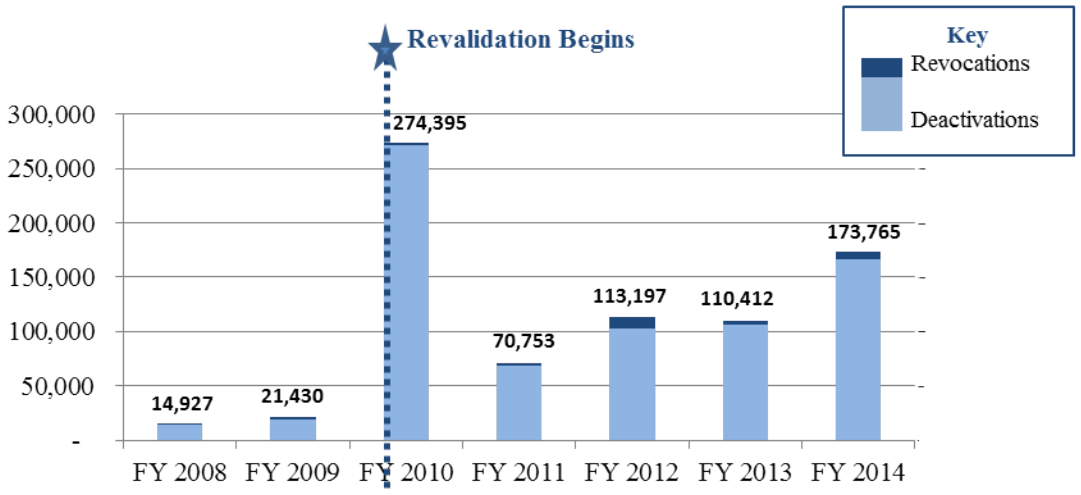
[43] Medicare denial of enrollment is covered at 42 CFR 424.530. Medicare revocation of enrollment is covered at 42 CFR 424.535. Medicaid denial or revocation of enrollment is covered at 42 CFR 455.416.

[44] Deactivation means the provider's or supplier's billing privileges were stopped, but can be restored upon the submission of updated information. See 42 CFR 424.540.

[45] Revocation means the provider's or supplier's billing privileges are terminated. See 42 CFR 424.535.

[46] We note that the first and second phase revalidation results are preliminary results as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

Figure 3: Medicare Revocation and Deactivation Trend from FY 2008 though FY 2013



Notes: Revocation means the provider's or supplier's billing privileges have been terminated. Deactivation means the provider's or supplier's billing privileges were stopped, and can be restored upon the submission of updated information. Deactivation also occurs when a provider is deceased or voluntarily withdraws from the Medicare program.

Provider Enrollment Regulatory Improvements

The success of our provider enrollment and screening efforts demonstrates the importance of permitting only legitimate providers and suppliers to serve our beneficiaries. In April 2013, CMS issued a proposed rule[47] that provides CMS with additional authority to remove providers and suppliers from the Medicare program who pose a risk of fraud or abuse. CMS proposed to permit denial of an enrollment application of a provider or supplier affiliated with a defunct provider or supplier with an outstanding Medicare debt, revoke a provider or supplier for a pattern or practice of submitting claims for services that fail to meet Medicare requirements, and clarify the list of felony convictions that may result in a denial of enrollment or revocation of Medicare billing privileges. CMS published its final regulation in December 2014 and this rule became effective on February 3, 2015.[48]

2.3.1. Provider Enrollment Moratoria

Continuing its commitment to operational excellence, CMS has used the authority provided to the Secretary in the Affordable Care Act to temporarily prevent the enrollment of new Medicare, Medicaid, and CHIP providers and suppliers, including categories of providers and suppliers, where the Secretary has determined such moratoria are necessary to combat fraud, waste, or abuse. In July 2013, CMS announced temporary moratoria on the enrollment of new Home Health Agencies (HHAs) and ground

[47] 78 FR 25013 (April 29, 2013).

[48] 79 FR 72500 (December 5, 2014)

ambulance suppliers in Medicare, Medicaid, and CHIP in three "fraud hot spot" metropolitan areas of the country: HHAs and HHA Sub-units in and around Miami, Florida and Chicago, Illinois, and Part B ground-based ambulance suppliers in and around Houston, Texas. CMS has extended these moratoria in six month increments and subsequently issued additional moratoria on the enrollment of HHAs in another area near Miami, and in areas surrounding Dallas and Houston, Texas and Detroit, Michigan and on ambulance suppliers in and around Philadelphia, Pennsylvania.

In each moratorium area, CMS prohibited the new enrollment of HHAs and ground ambulance suppliers while we took administrative actions, such as payment suspensions and revocations of HHAs and ground ambulance companies, as well as worked with law enforcement to support investigations and prosecutions. Beneficiary access to care in Medicare, Medicaid, and CHIP is of critical importance to CMS and its state partners. Prior to imposing these moratoria, CMS reviewed Medicare data for these areas and consulted with the appropriate State Medicaid Agencies and State Departments of Emergency Medical Services to determine if the moratoria would create access to care concerns for Medicaid and CHIP beneficiaries in the targeted locations and surrounding counties. All of CMS' state partners were supportive of CMS' analysis and proposals, and together with CMS, determined that these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries.

2.3.2. Sharing Medicare Provider Information with Medicaid

To increase efficiency across the Medicare and Medicaid programs, CMS also began providing key Medicare enrollment information to State Medicaid agencies in FY 2013 via direct downloadable files outside of the Provider Enrollment, Chain and Ownership System (PECOS) application. This method allows State agencies the opportunity to reduce the effort associated with manual review of PECOS, and rely on systematic matching and evaluation of information. As previously mentioned, State Medicaid agencies are able to rely on the Medicare screening in place of re-screening an applicant that participates as a provider in both programs.

In addition to sharing provider enrollment data with the states, CMS initiated a project to share Medicare claims data with State Medicaid agencies for use in their program integrity activities. The project was unveiled in September 2014 via webinar, which states were invited to attend.[49]

2.3.3. Provider Revalidation

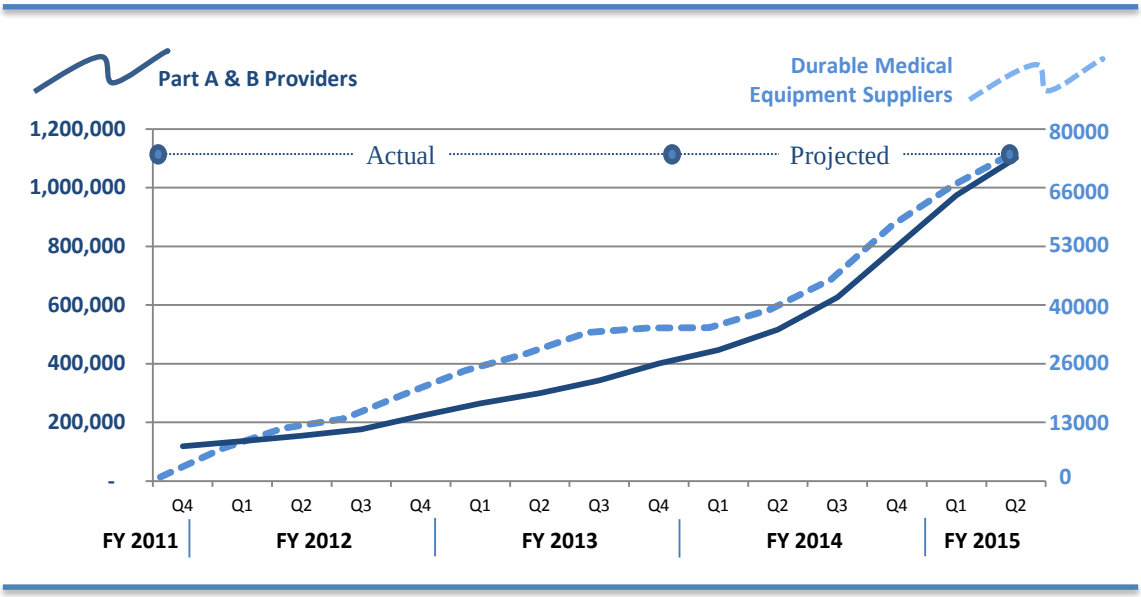
In FY 2013, CMS continued its ambitious project to revalidate the enrollments of all existing 1.5 million Medicare providers and suppliers by March 2015 under the new Affordable Care Act screening requirements. These efforts ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare

[49] For more information see the State Data Resource Center website at http://www.statedataresourcecenter.com/

beneficiaries. Similarly, States are also required to revalidate Medicaid providers at least every five years, pursuant to the Affordable Care Act and 42 CFR 455.414.

In FY 2013 and FY 2014, CMS revalidated the enrollment information for 178,190 and 313,268 providers and suppliers, respectively. The revalidation activity was completed in 2015 (Figure 4). CMS has enrolled or revalidated enrollment information for approximately 535,860 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act.

Figure 4. Cumulative Revalidation Notices Sent to Providers and Suppliers



2.3.4. PECOS Improvements

The PECOS is the internet-based system that providers and suppliers use to enroll, revalidate, or make changes to their enrollment information in the Medicare fee-for-service program. CMS made significant improvements to the system to make it easier for providers and suppliers to access and use the system. CMS engaged providers and suppliers regularly in FY 2013 to better understand the challenges users face and prioritized the improvements based upon the information learned through:

- Sponsoring quarterly focus groups with providers and suppliers,
- Attending sponsored outreach events (e.g. Decision Health),
- Sponsoring quarterly calls with associations (e.g. Medical Group Management Association (MGMA) and American Medical Association (AMA)),
- Holding Open Door Forums with providers and suppliers, and
- Conducting education and outreach through listservs, CMS.gov, PECOS homepage, MLN Matters Articles, change requests and national provider calls.

In FY 2013, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including the following changes:

- Implemented a simple and secure way for providers and suppliers to authorize individuals or groups of individuals to act on their behalf in PECOS through the PECOS Identity & Access Management System (known as the I&A or Surrogacy process).
- Allowed registered users to manage and reset their user ID and password online without calling the CMS Help Desk.

Provider Community Feedback on PECOS Improvements

"Seeing the collaboration provided much needed and long overdue encouragement for those who have become frustrated and discouraged with the issues faced on a daily basis. I hope this is the beginning of a long relationship that will engage CMS, contractors and providers in a coordinated effort."

- Allowed providers and suppliers to initiate a reassignment with an individual or organization with whom they wish to establish a reassignment of benefits arrangement, display a count of active and pending reassignment applications with the ability to view and manage the reassignment data and designate a primary and/or secondary practice location where the practitioner renders services from a drop down box identifying all the organization's practice locations.
- Allowed providers and suppliers to manage the collection of required signatures for electronic documents (i.e., certification statements, electronic funds transfer (EFT) agreements) or documents requiring their signature prior to submission of their web application.
- Provided an easier way for providers and suppliers to view their enrollment information (e.g., approved enrollment record, submitted application or new/in-progress application) in HTML view. The information can be saved and/or printed by the provider or supplier and maintained for their records.

2.3.5. Medicare Shared Savings Program and Innovation Center Initiatives

Programs for Accountable Care Organizations (ACOs) and ACO Participants

To enhance program integrity efforts for new programs, with a particular focus on Accountable Care Organizations (ACOs) and certain innovative payment models being tested by the Innovation Center, CMS developed a streamlined provider screening process that relies in part on safeguards associated with Medicare FFS enrollment. Provider screening conducted by CMS for organizations applying to the Medicare Shared Savings Program and Innovation Center ACO Models is facilitated by the electronic capture and exchange of provider information including, but not limited to: enrollment status, reassignment details, current/previous Medicare Exclusion Database (MED) sanctions, payment suspensions, and Fraud Prevention System (FPS) alerts. In addition, CMS also consults with OIG, DOJ, and the Federal Bureau of Investigation (FBI).

Medicaid Innovation Challenge

On May 30, 2012, CMS launched the "CMS Provider Screening Innovator Challenge" (Challenge). This Challenge addresses our goals of improving our abilities to streamline

operations, screen providers, and reduce fraud and abuse. Specifically, the Challenge is an innovation competition to develop a multi-state, multi-program provider screening software application that would be capable of risk scoring, credentialing validation, identity authentication, and sanction checks, while lowering burden on providers and reducing administrative and infrastructure expenses for state and federal programs. The Challenge ended in January 2014 with two states working on an interactive implementation for FY 2015. Further information about the Challenge is available at https://www.medicaid.gov/State-Resource-Center/Events-and-Announcements/Provider-Screening-Innovator-Challenge.html.

2.4. Emphasize efficient, focused utilization management and payment oversight

2.4.1. Medicare FFS Payment Controls, Including Medical Review

CMS performs education, prepayment, and post-payment activities to ensure that payments are made properly and accurately. CMS has designed its claims processing systems to detect anomalies on the face of the claims whenever possible. The MACs have initiated innovative projects, including additional educational and prepayment review efforts. CMS will continue to provide additional funding in future years to focus on prepayment review of claims that have historically resulted in high rates of improper payments. This will assist with reducing the number of improper payments, and as a result, reducing the improper payment rate, by stopping improper payments before the claims are paid. The MACs reported that medical review resulted in $5.6 billion in savings for FY 2013 and $4.7 billion in FY 2014.

CMS uses ZPICs to investigate providers and suppliers suspected of fraud, waste, and abuse. The ZPICs conduct investigations and take administrative actions to prevent Medicare Trust Fund monies from being inappropriately paid. They also identify improper payments to be corrected by the MAC. The ZPICs may review medical records and documentation, conduct interviews and site visits, and identify providers and suppliers for a potential revocation action. The MACs and other review contractors also perform medical review to make coverage or coding determinations. However, when the ZPICs perform program integrity-directed medical review, their focus is different, for example looking for possible falsification of documents. As a result of medical review, in addition to identifying overpayments, the ZPIC may request the MAC install a prepayment edit, auto-denial edit, or payment suspension to prevent the loss of future funds. In FY 2013, the CMS prevented $192.3 million, and in FY 2014, prevented $117.4 million, in improper payments by denying claims through prepayment and auto-denial edits that the ZPICs recommended to automatically stop improper claims before they are paid.

2.4.2. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding[50]

The Medicare DMEPOS Competitive Bidding Program has saved more than $580 million in nine markets at the end of the Round 1 rebid's 3-year contract period (January 1, 2011 through December 31, 2013) due to lower payments and decreased unnecessary utilization. The expansion of the Competitive Bidding Program – Round 2 and the national mail-order re-compete program – saved approximately $2 billion in its first year (July 2013- July 2014).[51] Based on the FY 2014 President's Budget, the CMS Office of the Actuary (OACT) estimates that the program will save the Medicare Part B Trust Fund $25.7 billion over 10 years[52] and beneficiaries are expected to save an estimated $17.2 billion during the same 10 year period due to the reduction in coinsurance and reduced premiums.

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

CMS implemented an active surveillance and monitoring program to identify any issues and has found no disruption in access or identified negative health consequences for Medicare beneficiaries. In addition, there have been routine beneficiary or caregiver inquiries on the program with only minimal complaints.

2.4.3. Demonstrations

CMS conducts demonstration projects that aim to strengthen Medicare by eliminating fraud, waste, and abuse and reducing improper payments. Reductions in improper payments will help ensure the sustainability of the Medicare Trust Funds and protect

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[50] The DMEPOS Competitive Bidding Program is a CMS administrative program and is neither a specific program integrity activity nor is it funded from program integrity obligations. The program is mentioned in this report because it represents CMS's proactive approach to preventing improper payments.

[51] The DMEPOS competitive bidding program was initially required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) [Public Law 108-173], modified by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) [Public Law 110-275], and expanded by The Patient Protection and Affordable Care Act (ACA) [Public Law 111-148].

[52] These savings are based on the FY 2014 budget (which covers FY 2014 to FY 2023). The most recent savings estimate from the FY 2017 budget (which covers FY 2017 to FY 2026) is $33 billion.

beneficiaries who depend upon the Medicare program. The status of each demonstration conducted in FY 2013 and FY 2014 is detailed below.

Prior Authorization of Power Mobility Device Demonstration

In FY 2012, CMS implemented the Prior Authorization of Power Mobility Device demonstration for Medicare beneficiaries who reside in seven states where historically there has been extensive evidence of fraud or improper payments (CA, FL, IL, MI, NY, NC, and TX). The demonstration implemented prior authorization, a tool used by private-sector health care payers to prevent improper payments and deter fraud before the service is provided and the claim is submitted for payment. The demonstration began for orders written on or after September 1, 2012. In FY 2014, CMS announced the expansion of the prior authorization demonstration to an additional 12 states (AZ, GA, IN, KY, LA, MD, MO, NJ, OH, PA, TN, and WA) to begin on October 1, 2014. Based on initial data, spending per month on power mobility devices in the 19 demonstration states, as well as in the non-demonstration states, has decreased since September 2012.[53] CMS also extended the demonstration to August 31, 2018 in FY 2015.

Part A to Part B Rebilling Demonstration[54]

CMS implemented the Part A to Part B Rebilling demonstration on January 1, 2012. The demonstration allowed participating hospitals to re-bill for 90 percent of the allowable Part B payment when a Medicare contractor denied a Part A inpatient short stay claim on the basis that the inpatient admission was not reasonable and necessary. Participation in this demonstration was limited to a representative sample of 380 qualifying hospitals nationwide that volunteered to be part of the program. This demonstration was expected to lower the appeals rate, which would protect the Trust Funds and reduce hospital burden. As a result, these claims would no longer be considered improper. The demonstration was terminated in March 2013 when a CMS ruling became effective, which ended the demonstration. The ruling was intended as an interim measure until we finalized a policy to address this issue. A proposed rule was published in the Federal Register to revise Medicare Part B billing policies when a Part A claim for an hospital inpatient admission is denied as not medically reasonable and necessary.[55] The proposed rule became final and effective on October 1, 2013.[56]

Recovery Audit Prepayment Review Demonstration

CMS implemented the Recovery Audit Prepayment Review demonstration in August 2012. This demonstration allowed Medicare Recovery Auditors to review claims before they are paid to determine if the provider complied with all Medicare coverage and

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[53] These demonstration data can be found at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Prior-Authorization-of-PMDs-Demonstration-Status-Update-.html

[54] For more information see https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Part_A_to_Part_B_Rebilling_Demonstration.html

[55] 78 FR 16632

[56] 78 FR 50496

billing rules. In FY 2013, the Recovery Auditors conducted prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews have focused on seven states with high incidences of fraud and improper payments (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration sought to develop improved methods to investigate and prosecute fraud to protect the Medicare Trust Funds from fraudulent actions and the resulting improper payments. Through this effort, in FY 2014, CMS prevented approximately $51.8 million in improper payments. As part of the close-out process for the existing Recovery Auditor contracts while CMS worked to procure new contractors, the prepayment demonstration was paused. The demonstration continues to remain on hold while CMS assesses its options regarding the procurement of the next Recovery Auditor contracts.

2.4.4. Medicare National Correct Coding Initiative

Due to the volume of claims processed by Medicare each day and the significant cost associated with conducting medical review of an individual claim, CMS heavily relies on automated edits to identify inappropriate claims. CMS has developed the National Correct Coding Initiative (NCCI), which consists of edits designed to reduce the Medicare Part B and Medicaid improper payment rates. This program was originally implemented in the Medicare program in January 1996 with procedure-to-procedure edits to ensure accurate coding and reporting of services by physicians. Procedure-to-procedure edits stop payment for claims billing for two procedures that could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations.

In addition to procedure-to-procedure edits, CMS established the Medically Unlikely Edit (MUE) program to reduce the paid claims error rate for Medicare Part B claims as part of the NCCI program. MUEs stop payment for claims that are beyond the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. The first MUE edits were implemented January 1, 2007. NCCI edits are updated quarterly and, prior to implementation, edits are reviewed by national healthcare organizations and their recommendations are taken into consideration before implementation.

Since October 2008, all procedure-to-procedure edits and the majority of MUEs have been made public and posted on the CMS website. Certain edits are not published to protect against use or manipulation by fraudulent or abusive individuals and entities. The use of procedure-to-procedure edits developed through the NCCI saved the Medicare program $530 million in FY 2013 and $452 million in FY 2014. In addition, MUE edits within Medicare Part B saved the Medicare program $164.1 million in FY 2013 and $229.4 million in FY 2014.[57]

[57] Savings for Medicare Part A and Durable Medicare Equipment are not yet available.

2.4.5. Medicaid National Correct Coding Initiative

Section 6507 of the Affordable Care Act requires CMS to notify states which NCCI methodologies are compatible with claims filed with Medicaid and requires states to use these methodologies to process applicable Medicaid claims filed on or after October 1, 2010.[58] CMS has worked closely with state Medicaid agencies to implement the NCCI methodologies in their Medicaid programs. Fully and correctly implementing the NCCI methodologies in state Medicaid programs will be a long-term undertaking by both CMS and the states. However, use of the Medicaid NCCI methodologies in adjudicating Medicaid claims is producing significant savings in federal and state Medicaid program expenditures due to reductions in improper payments for Medicaid claims with improper coding, as has occurred in the Medicare program.

In FY 2013, CMS created a major, new technical guidance document for states that compiles, organizes, and integrates CMS requirements for state implementation for the Medicaid NCCI methodologies. This document is continually updated as new implementation issues are decided. In addition, many new Medicaid NCCI edits were added to the quarterly Medicaid NCCI edit files and even more Medicaid-only NCCI edits were developed.

2.4.6. National Medicaid Audit Program

Section 1936 of the Act requires CMS to contract with eligible entities to review the actions of Medicaid providers and audit providers' claims to identify overpayments. The first audit assignments were made to Audit Medicaid Integrity Contractors (MICs) in September 2008, and CMS has continuously reviewed the results of the audit program to monitor its performance. As a result of these reviews, CMS has focused since FY 2011 on conducting collaborative projects with states, based primarily on states' up-to-date Medicaid claims data. Collaborative audits have proven to be an effective way to augment states' own program integrity audit capacity by leveraging the resources of CMS and its Audit MICs, resulting in more timely and accurate audits. By the end of FY 2013, CMS exceeded its goal of expanding collaborative audits to 30 states by assigning a cumulative total of 516 collaborative audits with 32 states. The total Medicaid program expenditures of these 32 states represents approximately 72 percent of total Medicaid program expenditures nationwide. CMS further increased state participation in collaborative audits to a total of 40 states representing 87 percent of Medicaid program expenditures by assigning a cumulative total of 691 collaborative audits by the end of FY 2014.

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

As a result of these improvements in the audit program, CMS identified $22.6 million[59] in overpayments in FY 2013, or a 75 percent increase from FY 2012. In FY 2014, CMS sustained this increased audit performance by identifying an additional $24.5 million in overpayments sent to states for collection. States are responsible for collecting overpayments identified by Audit MICs, and are permitted one year from the date of the final audit report to return the federal share (42 CFR 433.312). During FY 2013, states reported a total federal and state share combined amount of MIC audit recoveries of $4.7 million and returned the federal share of $2.9 million to the Treasury.[60] In FY 2014, states reported a total federal and state share combined amount of MIC audit recoveries of $11.5 million and returned the federal share of $7.8 million to the Treasury.

In addition, during FY 2013, CMS continued to re-evaluate options to consolidate the work of contractors into a more effective structure. As a first step, CMS determined that the nature and volume of collaborative audits did not require the same Review MIC capacity for provider data review. As a result, CMS did not renew the Review MIC contracts as they expired over the period from August 2012 to May 2013.

During FY 2013 and FY 2014, CMS continued its focus on working jointly with states to develop collaborative audits. These audits combine the resources of CMS and the MICs to assist states in addressing suspicious payments including algorithm development, data mining, auditors, and medical review staff. Through this process, this promising approach more effectively uses resources in support of states in their program integrity efforts. The collaborative process includes a discussion between the state and CMS regarding potential audit issues and the states' provision of MMIS data for data mining. The state, together with CMS, determines the audit processes the Audit MICs follow during the collaborative audit. In some instances, the Audit MICs conduct the entire audit. In other cases, the Audit MICs supplement state resources by providing medical review staff and other resources. In addition to collaboration with states, CMS also assisted federal law enforcement agencies such as the HHS-OIG and the FBI through audit work.

Some examples of collaborative audits include the following:

- Audits of Medicaid credit balances for inpatient and outpatient services that hospitals should have returned to the Medicaid Program were expanded to six states in FY 2013.
- Audits of hospice providers that consistently placed beneficiaries in inappropriate hospice care were expanded to 21 states by the end of FY 2014.

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[59] One additional final audit report for $2.8 million was accepted by CMS at the end of FY 2012, but not released to the state until June 2013, due to a pending fraud referral to law enforcement. Because this audit was included in the total identified overpayments reported in the FY 2012 Report to Congress, it is not included in the FY 2013 figure reported here.

[60] MIC audit recoveries include overpayments collected, adjusted, or refunded to CMS, as reported by states on the CMS-64

- Over 100 audits of emergency services to non-citizens billed to Florida Medicaid were conducted by the end of FY 2013.

2.4.7. Annual Upper Payment Limit (UPL) Demonstrations

The Medicaid statute requires that states set provider payment rates that are consistent with efficiency, economy and quality care. To implement this requirement in part, for certain services, federal regulations set out aggregate upper payment limits (UPL). The UPL for facility benefits such as inpatient and outpatient services provided in hospitals, clinics, nursing facilities, and intermediate care facilities for individuals with developmental disabilities (ICF/IDDs), with the exception of Indian Health Service and tribal facilities, and Federally Qualified Health Centers. The UPL is based on reasonable estimates of the amount that would be paid to the facilities under Medicare payment principles. Demonstrations of the limits are conducted in the aggregate for each Medicaid facility benefit and within the following facility categories: state government owned or operated, non-state government owned or operated and privately owned and operated facilities. Services provided in all other Medicaid inpatient and outpatient facilities are limited to the customary charges of the provider and may not exceed the prevailing charges in the locality for comparable services under comparable circumstances. States are required to submit methodologies and data to CMS to demonstrate that Medicaid payments are in compliance with the applicable limits.

CMS issued a State Medicaid Director's letter on March 18, 2013 (SMDL 13-003), that requires states to submit their UPL demonstrations on an annual basis for all facility benefits. Prior to the issuance of the letter CMS generally reviewed UPL demonstrations only as part of the review procedures for state requests to change provider payment rates. The new annual process will provide CMS with information to understand that states are complying with UPL requirements each year and prior to the start of a state's fiscal year. Beginning in 2013, and annually thereafter, states must provide the methodologies that they use to calculate UPLs and supporting data for inpatient hospital, outpatient hospital and nursing facility services. Beginning in 2014, and annually thereafter, states must provide this information for services provided in clinics, ICF/IDDs, other inpatient and outpatient facilities that provide Medicaid services, and professional services (for states that make target payments up to the average commercial rate for professional services).

CMS is using the new annual process as an opportunity to identify gaps or aberrances in the data the states submit to support UPL demonstrations and factors within states' demonstrations that do not adhere to Medicare principles. With this information, CMS will promote consistent national reviews of state UPL demonstrations, determine additional state needs for technical assistance and guidance, and reinforce our efforts of ensuring program accountability and regulatory oversight.

2.4.8. Disproportionate Share Hospital (DSH) Audit and Reporting

On December 19, 2008, CMS promulgated CMS-2198-F: Medicaid Program: Disproportionate Share Hospital Payments. The final rule implemented section 1001 of

the Medicare Prescription Drug, Improvement, and Modernization Act of 2003[61] (MMA), requiring State audits and reports to ensure the appropriate use of DSH payments. The statute required that States submit the annual independent certified audit and report as a condition of receiving Federal Financial Participation (FFP) for DSH payments.

Audits and reports were required beginning with Medicaid State plan rate year (SPRY) 2005. The final rule established a December 31, 2009 submission deadline for the first two years of audits and reports. Each subsequent audit and report is due on December 31st three years after the completion of the SPRY. The final rule also required audits and reports that meet regulatory requirements as a condition of receiving FFP for DSH payments after the submission deadline. State-specific annual DSH reports are available in the "Annual DSH Reports" section of the CMS Medicaid.gov website.[62]

This process ensures the fiscal integrity of the Medicaid program by making sure that payment adjustments for hospitals that serve a disproportionate share of low-income patients with special needs do not exceed that hospital's eligible uncompensated costs incurred in furnishing inpatient and outpatient hospital services to Medicaid patients and the uninsured.

2.5. Move Swiftly to Administrative Action

2.5.1. Fraud Prevention System

The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010[63] (SBJA). Since June 30, 2011, the FPS has run predictive algorithms and other sophisticated analytics nationwide against all Medicare FFS claims prior to payment in order to identify, prevent, and stop potentially fraudulent claims. For the first time in the history of the program, CMS is using a system to apply advanced analytics against Medicare FFS claims on a continuous, national basis. CMS uses the FPS to target investigative resources to suspect claims and providers and swiftly impose administrative action when warranted. When FPS predictive models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation, which are primarily used by ZPICs. The FPS helps CMS target fraudulent providers and suppliers, reduce the administrative and compliance burdens on legitimate providers and suppliers, and prevent fraud so that funds are not diverted from providing beneficiaries with access to quality health care.

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61 Public Law 108-173.

62 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Medicaid-Disproportionate-Share-Hospital-DSH-Payments.html

63 Public Law 111-240.

CMS released the FPS Report to Congress for the second and third implementation years. The second year report covered FY 2013,[64] while the third year report covered calendar year 2014.[65] As reported, in the second year of the system, CMS stopped, prevented, or identified an estimated $210.7 million in improper payments—this resulted in more than a $5 to $1 return on investment, an increase from the first year's $3 to $1 return on investment. CMS also took administrative action against 938 providers and suppliers due to the FPS. In the third year, CMS increased FPS savings to $454.0 million, resulting in a nearly $10 to $1 return on investment. During this period, CMS took administrative action against 1,093 providers and suppliers due to the FPS. Since CMS implemented the technology in June 2011, the FPS has identified or prevented $820 million in inappropriate payments by identifications of new leads or contribution to existing investigations.

The SBJA requires CMS to evaluate expansion of the use of predictive analytic technologies for identifying and preventing improper payments beyond Medicare to Medicaid and CHIP. The Secretary submitted HHS' recommendations for implementation of this requirement in the Fraud Prevention System, Third Implementation Year Report to Congress, issued in July 2015. After extensive analysis and discussion with states, CMS has determined that it is not feasible at this time to systematically expand predictive analytics technology to all Medicaid and CHIP claims, and it may not be cost effective for all states to adopt predictive analytics individually. However, although Medicaid is administered and organized in a distinctly different way than Medicare, we believe there are opportunities to transfer the knowledge and lessons learned through the FPS and assist states with identifying program integrity risks using predictive analytics technologies in protecting their Medicaid and CHIP programs from fraud, waste, and abuse.

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

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

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64 https://www.cms.gov/About-CMS/Components/CPI/Widgets/Fraud_Prevention_System_2ndYear.pdf.

65 https://www.cms.gov/About-CMS/Components/CPI/Downloads/FPS_Report_to_Congress_and_HHS_OIG_Appendix.zip.

2.5.2. Command Center

The CMS Program Integrity Command Center, which opened in FY 2013, focuses on driving innovation and improvement in reducing fraud and improper payments in the Medicare and Medicaid programs by providing a collaborative environment for multi-disciplinary teams to develop consistent approaches for investigation and action. CMS first tested the value of the concept in a pilot Command Center and found that the time needed for making decisions on administrative actions, such as payment suspensions, can be reduced significantly. The Command Center opened in July 2012 and provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials from OIG and FBI, clinicians, and CMS fraud investigators to collaborate before, during, and after the development of fraud leads in real time.

In FY 2014, the Command Center conducted 40 missions that included participants from CMS and our partners, including the HHS-OIG and FBI that are designed to lead to improvements in the fraud prevention and detection process. Missions are facilitated collaboration sessions that bring together experts from various disciplines to improve the processes for fraud prevention in Medicare and Medicaid. CMS is also working with FBI, HHS-OIG, and other Federal agencies in the Command Center to pool resources to tackle cross-cutting issues surrounding fraud prevention.

3. Leadership and Coordination

3.1. Increase Alignment of Medicare and Medicaid

3.1.1. Integrated Data Repository (IDR) and the One Program Integrity (One PI) Portal

CMS continues to augment the data available in the Integrated Data Repository (IDR) to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and drug information. CMS is using the IDR to provide broader and easier access to data and enhanced data integration while strengthening and supporting CMS's analytical capabilities. The IDR is currently populated with Medicare Parts A, B, and D and Part B-DME paid claims back to January 2006 both before and after final payment has been made. This permits prepayment analytics on historical data that can be used to develop analytic models that can be used in the Fraud Prevention System. In FY 2013, CMS has expanded the IDR to include shared systems data.

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

CMS uses the One Program Integrity (One PI) web-based portal with the IDR to facilitate data sharing with program integrity contractors and law enforcement. The portal provides a single access point to the data within the IDR, as well as analytic tools to review the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. In FY 2013, CMS offered mobile, on-site training on One PI for program integrity contractors, enabling the training of large groups of contractor staff while reducing travel costs related to this training.

3.1.2. Medicaid and CHIP Business Information Solutions (MACBIS)

The Medicaid and CHIP Business Information Solutions (MACBIS) is a CMS enterprise-wide initiative to modernize and transform the information and data exchanges with States and other key stakeholders to ensure high performing Medicaid and CHIP programs. This initiative creates a more robust and comprehensive information management strategy for Medicaid and CHIP. We have designed a "transformed data state," for the first time, to integrate Medicaid and CHIP program, operational, quality, and performance data. The data will also be used to support detection of fraudulent patterns in State Medicaid programs, as well as comparative analytics across state lines and between the Medicare and Medicaid programs. States will be able to analyze their own program data along with other information in the CMS data repositories, including Medicare data, in order to identify potential anomalies for further investigation. As

appropriate, CMS will take action to incorporate T-MSIS data, as it is received from states, into both Medicaid-specific and multi-program analytics.

The Medicaid Statistical Information System (MSIS) data is the primary data source for Medicaid statistical data, and is a subset of Medicaid eligibility and claims data from all 50 states and the District of Columbia. To improve the quality of the MSIS data, and Medicaid data in general, CMS established the MACBIS Council. This Council provides leadership and guidance in support of efforts to create a more robust and comprehensive information management strategy for Medicaid and CHIP. The council's strategy includes:

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

The MACBIS initiative is comprised of four key areas of improvement to help prevent fraud, waste, and abuse: program data, operational data, quality data, and performance data. Implementation of the Transformed-Medicaid Statistical Information System (T-MSIS) by states will be on a rolling basis starting July 1, 2014 with a goal of all states submitting data in 2016. T-MSIS is an expansion of the existing CMS MSIS data and extract process. The new T-MSIS extract format is expected to further CMS and State's goals for improved timeliness, reliability, and more robust data analysis process through monthly updates and an increase in the amount of data provided. The Medicaid and CHIP Program (MACPro) will collect program data to automate State Plan Amendments (SPA) review and approvals and assist enterprise level considerations. The MACBIS projects will lead to the development and deployment of improvements in data quality and availability for Medicaid program administration, oversight, and program integrity.

During 2014, CMS has invested significant resources in the development, implementation, and integration of two primary systems: the Transformed Medicaid and CHIP Statistical Information System (T-MSIS), and Medicaid and CHIP program (MACPro). Quality and performance data requirements are being identified and documented and will be collected through T-MSIS and MACPro.

The following milestones have been achieved in 2013 to support MACBIS:

- T-MSIS – Awarded the Baltimore Data Center and Virtual Data Center Contract that will provide the infrastructure to accept, validate, and house T-MSIS data from states from a short term and long term perspective. Awarded the Development and Testing contracts that will develop and test the receipt and control of the submitted T-MSIS files, validation routines for ensuring data quality and storage capacity for the T-MSIS data. In addition, provided project management and technical assistance to states during the on-boarding process for migrating from MSIS to T-MSIS;
- Planned and began implementing the T-MSIS National Rollout that is the result of the 10-state pilot;

- Developed and implemented a change control process for the MACBIS program, of which MACPro and T-MSIS are the two main projects. The change control process will coordinate and manages change across both projects that provide efficiencies and eliminates duplication;
- Created a data analytic workspace in the MSIS environment that is allowing analysts more accessibility when running advanced analytics on current MSIS data;
- Provided technical assistance to states for on-boarding, project management, and subject matter expertise for data mapping from the State Medicaid and CHIP MMIS systems into the T-MSIS format;
- MACPro – While MACPro is being designed and developed, we implemented an interim technology solution to support the data collection of Medicaid and CHIP and Alternative Benefit Plan State Plan Amendments for meeting the October 1, 2013 Affordable Care Act mandates.

The following milestones have been achieved in 2014 to support MACBIS:

- Implemented a change management process for managing change for T-MSIS and MACPro requirements and other Medicaid and CHIP IT Systems;
- Continued to build infrastructure to house both T-MSIS and MACPRO data from states in the Virtual Data Center (VDC);
- Began the migration of MACPro into the VDC;
- Established a Help Desk for supporting MACPro and T-MSIS;
- Developed and implemented the T-MSIS production application including file and data validation and receipt and control;
- Continued to maintain the T-MSIS data dictionary;
- Continued to provide data administration support and continue to maintain and enhance the data environment.
- Developed and test a database to support data analysis and reporting with submitted data;
- Continue to provide database, portal, data mart, messaging and rules engine administration for T-MSIS and MACPro;
- Completed the initial development of the T-MSIS data repositories in support of the T-MSIS applications development;
- Developed, tested and implemented the initial data submission controls (file and data validation) which ensures data quality and receipt of state operational data;
- Developed the plan for converting data between MSIS and T-MSIS;
- Enhanced data templates for collecting state plan (program) data;
- Developed and tested initial analytical reports;
- Continue to support and enhance Adult Quality and Home Health measures and reports;
- Continue to identify, document and maintain new and existing requirements;
- Provided training to CMS Regional Offices and Central Office users of MACPro.
- Continued to provide technical assistance to states for on-boarding, project management, and subject matter expertise for data mapping from the State Medicaid and CHIP MMIS systems into the T-MSIS format

3.2. Strengthen States' Capacity to Protect Medicaid Program Integrity

Using funds provided under the Deficit Reduction Act (DRA) of 2005, CMS promotes state Medicaid integrity efforts by providing state agencies with guidance and oversight, education and technical assistance, program assessment and feedback, and federal resources for augmenting states' capacity for auditing Medicaid service providers. In Section 2, *Operational Excellence*, of this report, we describe how CMS augments states' program integrity audit capacity by leveraging the resources of CMS audit contractors in collaborative audits with states and through states' participation in the Medi-Medi program. DRA funding also supports the preparation and dissemination of educational toolkits for states to use to enhance awareness of Medicaid fraud, waste, and abuse among providers, beneficiaries, managed care organizations, and others.

In this section, we describe CMS's activities during FY 2013 and FY 2014 to assess and provide feedback on states' Medicaid program integrity activities, to train state program integrity staff through the Medicaid Integrity Institute, and to provide technical assistance and educational toolkits to state Medicaid agencies. CMS carries out its obligations to states while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk.

3.2.1. Medicaid Integrity Institute

Established through an interagency agreement with the DOJ in 2007, the Medicaid Integrity Institute (MII) is located within the DOJ's National Advocacy Center, in Columbia, South Carolina. As the first national Medicaid program integrity training program, the MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and collaboration among states in a structured learning environment to meet, in part, CMS's statutory obligation to provide support and assistance to help states combat provider fraud and abuse. In addition to training in the fundamentals of program integrity activities, the MII regularly refreshes course offerings to focus on emerging program integrity issues in areas, such as Medicaid managed care, home health and personal care services, pharmacy audits, and predictive analytics in Medicaid.

State Attendees Apply Lessons from MII Managed Care Course

"I directly used the presentations and copies of rules and policies from other states to develop internal policies for our state as well as to recommend future changes for our contracts with the MCOs. One-on-one conversations with participants and faculty from other states helped me gain an understanding of all the factors influencing managed care"

- *MII Participant*

From the first course in 2008 through FY 2014, the MII has provided training to state

employees and officials from 50 states, the District of Columbia, and Puerto Rico through 5,189 enrollments in 114 courses and 8 workgroups at no cost to the states. In addition, in FY 2013, the MII implemented its own professional accreditation program for the first time. The MII established the designation of Certified Program Integrity Professional (CPIP) for state employees who complete a rigorous curriculum of three courses covering Basic Skills and Techniques in Medicaid Fraud Detection, Program Integrity Fundamentals, and Specialized Skills and Techniques in Medicaid Fraud Detection. As of September 30, 2014, 154 state employees from 41 states have received the CPIP credential.

In FY 2014, the MII provided onsite training with 909 enrolled in the following courses:

- Basic Skills and Techniques in Medicaid Fraud Detection – CPIP course (2 courses)
- Specialized Skills and Techniques in Medicaid Fraud Detection – CPIP course (2 courses)
- Coding for Non-Coders (2 courses)
- CPT Outpatient Coding Boot Camp (2 courses)
- Medicaid Provider Enrollment Seminar (2 courses)
- CPT Inpatient Coding Boot Camp
- Emerging Trends in Medicaid Program Integrity
- Identifying and Preventing Fraudulent Medicaid Drug Claims Symposium
- Program Integrity Fundamentals Seminar – CPIP course
- Program Integrity Leadership Forum
- Program Integrity Partnership in Medicaid Managed Care Symposium
- New Adult Group Medicaid Expenditure Claiming & Program Integrity Reporting Seminar
- Evaluation & Management Boot Camp
- Data Expert Symposium
- MII Advisory Group Meeting – workgroup
- Predictive Analytics Workgroup Meeting – workgroup

The distance learning sessions provided in FY 2014 included:

- Sampling for Compliance and Control
- Sampling for Recoupment and Prevention
- Program Integrity Data Analysis, Sampling, and Extrapolation
- Sampling and Extrapolation in Program Integrity – A Legal History
- Beneficiary Eligibility, Enrollment and Fraud/Waste/Abuse Issues Session I: Beneficiary Application and Enrollment – Background and Overview
- Beneficiary Eligibility, Enrollment and Fraud/Waste/Abuse Issues Session II: The Application Process, Verification Requirements, and Guidance for Using Rules-Based Systems to Determine Eligibility
- Beneficiary Eligibility, Enrollment and Fraud/Waste/Abuse Issues Session III: What are the implications of the Affordable Care Act for Program Integrity?

- Beneficiary Eligibility, Enrollment and Fraud/Waste/Abuse Issues Session IV: Identifying Outliers; Testing for Accuracy In-House and Identifying A Verification Plan of Action
- Behavioral Health Under Medicaid Expansion
- Behavioral Health (two-part series)

CMS Training Leads to Alaska Fraud Discovery

As a result of learning a fraud "sweep" technique at the MII in January 2013, staff from the Alaska Medicaid program integrity unit and the state's MFCU conducted a joint sweep that led to filing charges against 29 personal care assistants in July 2013 for billing for services not rendered. Overall, fraudulent billing by these 29 providers exceeded $362,000 and included cases where caregivers were billing for over 24 hours a day, or for hours when they were out of the country or working another job. In some cases, caregivers harassed or intimidated Medicaid recipients to pressure them to sign up for services. All 29 personal care assistants who were charged have been barred from any further billing of Medicaid.

3.2.2. State Program Integrity Reviews

To fulfill the statutory requirement to provide effective support and assistance to states to combat provider fraud and abuse, CMS conducted comprehensive, regulation-based reviews of each state's program integrity activities since FY 2007 on a triennial basis. The reviews served to equip states with information to improve program integrity operations and performance. The reviews also served to provide CMS with opportunities to raise state awareness of Medicaid program integrity and promote best practices and collaboration among the states.

Between FY 2007 and FY 2013, CMS completed 110 comprehensive state program integrity reviews. These reviews assessed the operations of each state's program integrity unit, the provider enrollment and disclosure processes, managed care program integrity operations, and the interaction between the state's Medicaid agency and its Medicaid Fraud Control Unit (MFCU). State program integrity reviews have provided a framework for CMS oversight to determine if states' policies and practices comply with federal regulations, identify program vulnerabilities that may not rise to the level of regulatory compliance issues, identify states' best practices in program integrity, and monitor state corrective action plans.

As part of a process of continuous improvement, in FY 2013, CMS completed a redesign of the state program integrity review guide from a focus based primarily on regulatory compliance to one that assesses overall program effectiveness and risks. Other primary goals of the redesign were to reduce the burden of the reviews on the states and identify more opportunities for technical assistance to the states. To test the new approach, CMS

performed pilot program integrity reviews using the new review guide in six states in FY 2013.

CMS conducted 14 comprehensive state program integrity reviews in FY 2013. Eight reviews of the traditional, focused model were conducted in Montana, Alaska, New York, Kansas, South Dakota, Hawaii, Ohio, and Indiana. Six broader pilot reviews were conducted in Arkansas, Iowa, North Dakota, Georgia, Michigan, and Oregon. With the completion of the FY 2013 review cycle, all states, including the District of Columbia and Puerto Rico, have had at least two comprehensive program integrity reviews, and six states have had their third program integrity review by CMS since 2007.

In FY 2014, instead of beginning a third cycle of comprehensive reviews, CMS conducted focused reviews of high-risk program integrity areas concentrated primarily in selected expansion states. The ten states selected for FY 2014 focused reviews were California, Illinois, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, New York, Ohio, and the District of Columbia. The FY 2014 focused reviews were directed toward three areas: operations of the special investigations unit of managed care entities, state implementation of provider enrollment and screening provisions of the Affordable Care Act, and program integrity oversight of personal care services. CMS plans to conduct focused reviews in 10 additional states during FY 2015 with an emphasis on program integrity in Medicaid managed care, as well as non-emergency medical transportation or personal care services in certain states.

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

3.2.3. Guidance and Technical Assistance

CMS responded to 1025 requests for technical assistance on program integrity from 43 states and numerous other providers and stakeholders during FY 2013 and FY 2014. The other stakeholders included CMS contractors, the DOJ including U.S. Attorneys' Offices and the FBI, the HHS OIG, state MFCUs, and other HHS agencies. The most common topics included requests for statistical assistance related to criminal and civil court actions, policy and regulatory requirements governing disclosures, provider exclusions and enrollment, the National Medicaid Audit Program, and specific fraud referrals.

CMS provided additional assistance to states through regular teleconferences with state program integrity directors, Medicaid Fraud & Abuse Technical Advisory Group meetings, and outreach activities as described below:

- CMS staff host quarterly calls of regional program integrity directors and a monthly call in which the program integrity directors of the 14 smallest Medicaid programs participate.

- CMS leadership and staff work with the CMS Medicaid Fraud & Abuse Technical Advisory Group on a variety of policies and issues in Medicaid program integrity.
- In FY 2013 and FY 2014, CMS's New York field office for Medicaid program integrity hosted semi-annual regional meetings of program integrity stakeholders from Medicaid, Medicare, and law enforcement agencies to discuss current fraud issues and recent cases.
- CMS provided essential support and sponsored presenters at the fraud awareness symposia in Atlanta and St. Petersburg in 2013 and in New York City in 2014. The fraud awareness events took place in close collaboration with state provider associations and as well as other federal and state program integrity stakeholders.
- In addition to distance learning provided through the MII, CMS hosted webinars for state Medicaid program integrity staff on topics such as reporting on State Medicaid Recovery Auditor performance and technical training on the use of the CMS Fraud Investigation Database (FID) during FY 2013 and FY 2014.

3.2.4. Toolkits to Educate Providers and Beneficiaries

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

CMS maintains an online resource[66] for Medicaid program integrity education which provides public access to educational toolkits covering topics on dental compliance, managed care compliance, drug diversion, medical identity theft, beneficiary card sharing, and fraud awareness and reporting.[67] These toolkits include print and electronic media, train-the-trainer guides, webinars, videos, and other innovative strategies for promoting best practices and enhancing awareness of Medicaid fraud, waste, and abuse. The Medicaid Integrity Program education contractor conducted two train-the-trainer sessions for states using educational toolkits during FY 2013, and attended four stakeholder conferences where 2,847 educational products were distributed. During FY

[66] https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html

[67] CMS's new online resource for Medicaid program integrity education is available at: http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html.

2014, the Medicaid Integrity Program education contractor also conducted five train-the-trainer sessions for states and developed eight educational toolkits.

3.3. Educate Providers

3.3.1. Provider Outreach and Education

One of the goals of provider education and outreach is to reduce the Medicare improper payment rate by giving Medicare FFS providers the timely and accurate information they need to bill correctly the first time. The Medicare FFS claims processing contractors, known as Medicare Administrative Contractors (MACs), educate Medicare 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, and Comprehensive Error Rate Testing program data. Medicare contractors use a variety of strategies and communication channels to offer Medicare providers and suppliers a broad spectrum of information about the Medicare program, including CMS-developed materials and contractor-developed materials. CMS-developed materials include Medicare Learning Network® (MLN) educational products, information, and resources for the health care professional community. Specifically, Medicare contractors use MLN Matters, which are national education articles prepared in consultation with clinicians, billing experts, and CMS subject matter experts and tailored, by content and language, to specific provider type(s), that explain the latest changes to CMS programs. Medicare contractors also use other MLN products in their education and outreach programs, such as webinars and fact sheets, and disseminate CMS developed listserv messages. Contractor-developed materials include education on local coverage policies and listserv messages tailored to the contractor's jurisdiction. CMS receives significant positive feedback from providers on the value of these educational materials.

CMS uses the Outreach and Education MEDIC to provide Part C and D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups.

In FY 2014, CMS hosted four Medicare Parts C & D Fraud Waste and Abuse (FWA) Trainings, two as in-person events and two as virtual training webinars. Program integrity professionals from plan sponsors, pharmacy benefit managers (PBMs), law enforcement, CMS, and CMS's contractors from across the nation attended these events. More than 130 individuals attended each in-person training, and over 600 individuals attended each webinar. Through these events, CMS provided program integrity training to more than 1,550 anti-FWA professionals. These trainings provide valuable information about Medicare Advantage and Prescription Drug fraud schemes and anti-FWA activities and initiatives. Additionally, during in-person trainings, attendees share data and leads on suspected potential fraud that they take back to their organizations for further investigation. CMS also provides outreach and educational materials to program integrity stakeholders through the CMS O&E MEDIC website, which had more than 2,670 vetted members at the close of FY 2014.

4. Impacting Cost and Appropriateness of Care

4.1. Partnership with Law Enforcement

4.1.1. Field Offices and DOJ Support

CMS maintained three Medicare program integrity field offices in high vulnerability areas of the country (New York City, Los Angeles, and Miami) that provide an on-the-ground presence in known fraud "hot zones" and work closely with the joint HHS and DOJ Health Care Fraud Prevention and Enforcement Action Team known as "HEAT." In addition to CMS's commitment to collaboration, HEAT's sustained success demonstrates the effectiveness of the Cabinet-level commitment between HHS and DOJ to prevent and prosecute health care fraud. Since its creation in May 2009, HEAT has played a critical role in identifying new enforcement initiatives and expanding data sharing to a cross-government health care fraud, waste, and abuse data intelligence sharing workgroup. A key component of HEAT is the Medicare Strike Force Teams, interagency teams of analysts, investigators, and prosecutors, who target emerging or migrating fraud schemes such as criminals masquerading as healthcare providers or suppliers. All three field offices have staff designated as HEAT Strike Force liaisons that coordinate with law enforcement, facilitate data analyses, and expedite payment suspension requests.

Many special projects originate from the field offices and these projects produce significant savings. The field offices conduct data analysis to identify local vulnerabilities and coordinate special projects with Medicare contractors and state and local agencies on issues that have a national or regional impact.

Miami Field Office Special Project

The Miami Field Office has implemented a comprehensive multipronged approach to address all aspects of healthcare fraud in South Florida and has served as a testing ground for the efforts that has expanded to a national level. Based on their comprehensive approach and sharing of this investigative technique with the Zone Program Integrity Contractors (ZPIC), the Miami Field Office was able to work with Zone Program Integrity Contractors to detect many home health and DMEPOS program vulnerabilities across the nation through FPS to stop improper payments and revoke the billing privileges of numerous fraudulent providers.

4.1.2. HEAT Strike Force Teams

In May 2013, a nationwide takedown by Medicare Fraud Strike Force operations in eight cities resulted in charges against 89 individuals, including doctors, nurses and other

licensed medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $223 million in false billings. The defendants charged were accused of various health care fraud-related crimes, including conspiracy to commit health care fraud, violations of the anti-kickback statute, and money laundering. The charges were based on a variety of alleged fraud schemes involving various medical treatments and services, primarily home health care, but also including mental health services, psychotherapy, physical and occupational therapy, durable medical equipment (DME), and ambulance services. This coordinated takedown was the sixth national Medicare fraud takedown in Strike Force history.

In the six and a half years since its inception,[68] Strike Force prosecutors have filed more than 788 cases charging more than 1,727 defendants who collectively billed the Medicare program more than $5.5 billion; 1,137 defendants pleaded guilty and 148 others were convicted in jury trials; 1,087 defendants were sentenced to imprisonment for an average term of about 47 months.

This collaborative effort is having a measurable impact on Medicare payments for certain medical services that have been targeted by the Medicare Strike Force. For instance, Medicare payments for DME in Miami have been subject to both an overwhelming law enforcement response and an aggressive and multifaceted strategy by CMS to address the epidemic of fraud. Since 2006, when payments hit an all-time high, exceeding $73 million in one quarter, these payments have decreased to $15 million a quarter. Similarly, Strike Force and CMS activity targeting fraud in Community Mental Health Centers began in 2008 and accelerated in 2010, ultimately leading to a payment decrease from the peak in 2008 of $70 million a quarter to a decline to $10 million per quarter. These dramatic decreases are due, in part, to the program integrity activities conducted by the Medicare Strike Force.

4.2. Partnership with the Private Sector

4.2.1. Healthcare Fraud Prevention Partnership

In July 2012, the Secretary of HHS and the US Attorney General announced a ground-breaking partnership with the private sector to fight fraud, waste, and abuse across the health care system. The Healthcare Fraud Prevention Partnership (HFPP) is authorized under Section 1128C(a)(2) of the Social Security Act (42 USC §1320a-7c(a)(2)). Pursuant to this authority, CMS is required to consult with, and arrange for, the collection of data from, and sharing of data with, representatives of health plans under the Health Care Fraud and Abuse Control Program [Section 1128C of the Social Security Act].

The HFPP is a platform for sharing skills, assets, and data among partners in accordance with applicable laws to address fraud issues of mutual concern. The HFPP provides visibility into the larger universe of healthcare claims and claimants beyond those encountered by any single partner. The ultimate goal of the HFPP is to exchange facts

[68] Specifically, the period from May 7, 2007, through September 30, 2013.

and information to identify trends and patterns that will uncover fraud, waste, and abuse that may not otherwise be identified. At the end of FY 2014, the HFPP had 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In FY 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop improper payments from going out the door.

4.3. Provide Greater Transparency into Program Integrity Issues

4.3.1. Beneficiary Education

In FY 2013, CMS worked with the Assistant Secretary for Public Affairs to expand the Fraud Prevention Campaign, which was launched in January 2010 to increase public awareness about Medicare's fight against fraud. Outreach included a national television campaign featuring a "cracking-down" on fraud advertisement, print, and digital advertising as well as targeted advertising in various languages ("in-language" advertising). Such advertising included print and radio advertising in Russian in New York, Armenian in Los Angeles, and Spanish in Miami. The national television advertising delivered an estimated 140,580,420 views. The digital advertising delivered an additional 11.1 million views of the "cracking-down" spot.

In FY 2013, CMS began mailing a redesigned statement that informs Medicare beneficiaries about their claims for Medicare services and benefits. The redesigned statement, known as the Medicare Summary Notice (MSN), became available online in March 2012. This MSN redesign is part of a new initiative, "Your Medicare Information: Clearer, Simpler, At Your Fingertips," which aims to make Medicare information clearer, more accessible, and easier for beneficiaries and their caregivers to understand. The redesigned notice will make it easier for people with Medicare to understand their benefits, file an appeal if a claim is denied, and spot claims for services they never received. Medicare beneficiaries and caregivers are critical partners in the fight against fraud, and CMS screens every complaint from a Medicare beneficiary or caregiver, an employee, or a concerned citizen received at its national 1-800-MEDICARE Contact Centers for information indicating suspicious behavior or potential fraud. In FY 2013, nearly 45,000 complaints of potential fraud reported by beneficiaries and others to 1-800-MEDICARE passed initial screening and were evaluated further.

4.3.2. Open Payments

Open Payments is a national disclosure program that promotes transparency by publishing data on the financial relationships between the health care industry (applicable manufacturers and group purchasing organizations, or GPOs) and health care providers (physicians and teaching hospitals). In FY 2014, CMS published 4.45 million payment records, transfers of value, or instances of ownership/investment interest that occurred over the last five months of 2013. These financial transactions totaled nearly $3.7 billion.

The Affordable Care Act requires the Secretary to collect and publicly display information on payments and other transfers of value and ownership/investment interest annually. CMS published information for the first reporting year on its public website, and will update the website annually with a full year of data. This public website is designed to increase access to, and knowledge about, the relationships between the health care industry and health care providers, and provide the public with information to enable them to make informed decisions. Disclosure of the financial relationships between the health care industry and health care providers is not intended to signify an inappropriate relationship, and Open Payments does not prohibit such transactions. The public can search, download, and evaluate the reported data. The payments and transfers of value and ownership/investment interest displayed on the Open Payments website are self-reported by applicable manufacturers and GPOs.

Partner engagement and outreach efforts are a priority for CMS. Open Payments stakeholders, including medical college faculty, teaching hospital employees, industry professional groups, physicians, attorneys, and compliance professionals, received Open Payments outreach throughout the past year. CMS hosts monthly discussions to share program updates and obtain feedback directly from stakeholders. CMS continues to improve the usability of the public website.

Beginning in FY 2015 with the reporting of 2014 calendar year data, all data publications will be performed annually and will include a full calendar year of payment data. CMS published FY 2014 financial data as of June 30, 2015, as well as updated 2013 data. In addition, every year, CMS will update the Open Payments data at least once after its initial publication. The refreshed data will include updates to data disputes and other data corrections made since the initial publication of this data that were submitted by applicable manufacturers and GPOs.

Summary of 2013 Program Year Data
August – December, 2013[1]

	Identified[3]	De-Identified[4]	Total Published	Total Not Published[5]
Number of Records[2]	2.7 million	1.8 million	4.45 million	190,000
Value of payments	$1.4 billion	$2.3 billion	$3.7 billion	$551 million

[1] Figures are reflective of the December 19, 2013 published data refresh.
[2] A record is defined as a single row in a dataset that was reported by an applicable manufacturer or GPO.
[3] An identified record contains identifying information about the recipient of each payment.
[4] Some records could not be matched by CMS to a single doctor or teaching hospital due to missing or inconsistent information within the submitted record. In an effort to maximize data transparency, CMS published these records as de-identified, with all identifying information about the physician or teaching hospital recipient masked.
[5] The Open Payments final rule §403.910 provides applicable manufacturers and GPOs the opportunity to request a delay in publication pursuant to certain research payments or under a product research or development agreement for a period not to exceed four calendar years after the date the payment or other transfer of value was made, or upon the approval, licensure or clearance of the covered drug, device, biological, or medical supply by the FDA.

More information can be found about the program in the Open Payments Program Report to Congress (https://www.cms.gov/OpenPayments/Downloads/Open-Payments-April-2015-Report-to-Congress.pdf).

4.3.3. Data Transparency

On June 3, 2013, CMS released new data, including county level data on Medicare spending and utilization for the first time, as well as selected data on hospital outpatient charges. These data and tools are intended to help researchers and consumers take advantage of health information. CMS released both the average charges for the 100 most common inpatient procedures, and hospital outpatient data that includes estimates for average charges for 30 types of hospital outpatient procedures from hospitals across the country, such as clinic visits, echocardiograms, and endoscopies. Data sets on the county level include Medicare spending and chronic conditions that enable researchers, data innovators, and the public to better understand Medicare spending and service use, spurring innovation and increasing transparency, while protecting the privacy of beneficiaries.

4.3.4. Improper Payment Rate Measurement in the Medicare FFS, Medicaid and CHIP Programs

The Improper Payments Information Act (IPIA) of 2002, as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA)[69] requires each agency to periodically review programs it administers, identify programs that may be susceptible to significant improper payments, estimate the amount of improper payments, submit those estimates to Congress, and report on actions the Agency is taking to reduce improper payments.

Comprehensive Error Rate Testing Program

The Medicare FFS program has been identified as at risk for significant improper payments. To comply with the IPIA, CMS established the Comprehensive Error Rate Testing program to estimate improper payment rates in the Medicare FFS program. The program requires independent reviewers to periodically review a stratified random sample of claims that were either paid or denied by MACs. These sampled claims are then tracked through the system to the final disposition. The independent reviewers perform medical review on the sample of claims to ensure that the payment was appropriately paid or denied under Medicare coverage, coding, and billing rules. CMS publishes the national Medicare FFS improper payment rate in the HHS Agency Financial Report on an annual basis.

While all payments made as a result of fraud are considered “improper payments,” not all improper payments constitute fraud. Many improper payments result from errors in billing, insufficient documentation of medical necessity, lack of certifying signatures on claims, and other non-fraudulent errors. In order to reduce improper payments, CMS is working on multiple fronts to meet our improper payment reduction goals, including increased prepayment medical review, enhanced analytics, expanded education and

[69] Public Law 107-300, Public Law 111-204, and Public Law 112-248, respectively.

outreach to the provider and supplier communities, and expanded reviews by the Medicare FFS Recovery Auditors.

The Medicare FFS improper payment rate for FY 2013 was 10.1 percent, representing $36.0 billion in improper payments, and for FY 2014 was 12.7 percent, representing $45.8 billion in improper payments. Additional information on the Medicare FFS improper payment methodology can be found in the HHS Agency Financial Report on page 165-168 (FY 2013 report) and on page 167-172 (FY 2014 report).

Payment Error Rate Measurement Program

The Medicaid program and CHIP have been identified as at risk for significant improper payments. To comply with the IPIA, CMS established the Payment Error Rate Measurement (PERM) Program to estimate improper payment rates in Medicaid and CHIP. The improper payment rates are based on reviews of the FFS, managed care, and eligibility components of Medicaid and CHIP in the fiscal year under review. CMS uses federal contractors to measure Medicaid and CHIP improper payment rates using a 17-state rotation so that each state is reviewed every three years.

HHS calculated the national Medicaid improper payment rate based on measurements that were conducted in fiscal years 2011, 2012, and 2013, and reported the improper payment rate in the FY 2013 Agency Financial Report. The national Medicaid improper payment rate for FY 2013 was 5.8 percent, representing a projected $24.9 billion in improper payments including both the federal and state share. This was a decrease in the national improper payment rate from FY 2012 (7.1 percent). The national Medicaid component improper payment rates were as follows: Medicaid FFS, 3.6 percent; Medicaid managed care, 0.3 percent; and Medicaid eligibility, 3.3 percent.

The national Medicaid improper payment rate based on measurements that were conducted in fiscal years 2012, 2013, and 2014 was calculated and reported in the FY 2014 Agency Financial Report. The national Medicaid improper payment rate for FY 2014 was 6.7 percent; representing a projected $29.3 billion in improper payments including both the federal and state share. This was an increase in the improper payment rate from FY 2013 due to state difficulties getting systems into compliance with new requirements. These new statutory requirements include:

- all referring or ordering providers must be enrolled in Medicaid,
- states must screen providers under a risk-based screening process prior to enrollment, and
- attending providers must include their National Provider Identifier (NPI) on all electronically filed institutional claims.

While these requirements will ultimately strengthen Medicaid's integrity, they require systems changes that many states had not fully implemented. The national Medicaid component improper payment rates were as follows: Medicaid FFS, 5.1 percent; Medicaid managed care, 0.2 percent; and Medicaid eligibility, 3.1 percent.

Section 601 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) prohibited HHS from calculating or publishing any national or state-specific improper payment rates for CHIP until six months after a new PERM final rule was effective. In addition, Section 205(c) of the Medicare and Medicaid Extenders Act of 2010 exempted HHS from completing a 2011 CHIP improper payment rate. On August 11, 2010, as part of enhanced efforts to reduce improper payments in federal programs, HHS issued the final regulations that fully implemented improvements to the PERM program. Consequently, HHS reinstituted CHIP improper payment rate measurement in 2011. For FY 2013, only two cycles of States had been measured for CHIP. The FY 2013 national CHIP improper payment rate, based on measurements that were reported in FYs 2012 and 2013, was 7.1 percent or $0.9 billion in estimated improper payments, including both the federal and state share.

The FY 2014 national CHIP improper payment rate, based on measurements that were conducted in 2012, 2013, and 2014, was 6.5 percent or $0.9 billion in estimated improper payments, including both the federal and state share. This is the first baseline improper payment rate for CHIP reflecting the measurement of all states. The national CHIP component improper payment rates were as follows: CHIP FFS, 6.2 percent; CHIP managed care, 0.2 percent; and CHIP eligibility, 4.2 percent.

4.3.5. Improper Payment Rate Measurement in the Part C and Part D Programs

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

The Part C payment error estimate reported for FY 2013 (based on payment year 2011) was 9.5 percent, or $11.8 billion, and the payment error estimate reported for FY 2014 (based on payment year 2012) was 9.0 percent or $12.2 billion. The Part C payment error rate is driven by errors in risk adjustment data (clinical diagnosis data) submitted by Part C plans to CMS for payment purposes. Specifically, the estimate reflects the extent to which diagnoses that plans report to CMS are not supported by medical record documentation.

CMS has implemented two key corrective actions to address the Part C improper payment rate: contract-level audits and regulatory provisions.

- **Contract-Level Audits:** CMS has proceeded with Risk Adjustment Data Validation (RADV) contract-level audits to recover overpayments. RADV verifies, through medical record review, the accuracy of enrollee diagnoses submitted by MA

organizations for risk adjusted payment. RADV audits are CMS's primary corrective action to recoup overpayments in MA. For FY 2013 and FY 2014, the RADV methodology included: a selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in calendar year 2012, where the strata are high, medium, and low risk scores; medical record review of the diagnoses submitted by plans for the sampled beneficiaries; calculation of beneficiary-level payment error for the sample; and an extrapolation of the sample payment error to the population subject to risk adjustment, resulting in a Part C gross payment error amount. CMS expects that payment recovery will have a sentinel effect on the quality of risk adjustment data submitted in the future by plans for payment. RADV audits of payment year 2011 will be the first CMS reviews to recoup funds based on extrapolated estimates. CMS has conducted payment recovery at the beneficiary (not extrapolated) level for the 2007 RADV audits in the amount of $13.7 million.

- **Regulatory Provisions:** In CMS-4159-F, "Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Program" (79 FR 100), CMS codified the Affordable Care Act requirement that MA organizations must report and return overpayments that they identify. In CMS-1613-F, "The Calendar Year 2015 OPPS/ASC Rule" (79 FR 66769), CMS also established a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by an MA organization.

The Part D payment error estimate reported for FY 2013 (based on payment year 2011) was 3.7 percent, or $2.1 billion, and the payment error estimate reported for FY 2014 (based on payment year 2012) was 3.3 percent or $1.9 billion. The Part D payment error estimate presents the combined impact on Part D payments of four sources of error: payment error related to low income subsidy status; payment error related to incorrect Medicaid status; payment error related to prescription drug event data validation; and payment error related to direct and indirect remuneration.

4.3.6. Probable Fraud Measurement Pilot

While CMS calculates improper payment rates in Medicare and Medicaid as described above, there is no reliable estimate of the amount of fraud in the Medicare program. Documenting the baseline amount of fraud in Medicare is of critical importance, as it allows officials to evaluate the success of ongoing fraud prevention activities. In collaboration with the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), CMS developed the methodology for the first nationally representative estimate of the extent of probable fraud in the Medicare FFS program, and CMS also developed the interview tools to be used for the pilot. These instruments have been approved by the Office of Management and Budget (OMB).[70]

This project will estimate probable fraud within the area of home health agencies to pilot test the measurement approach and calculate a service-specific estimate. This service

[70] CMS awarded a contract in September 2015 to conduct the pilot. CMS began collecting data on probable fraud to establish an estimate of probable fraud within HHAs in 2015.

area was chosen because home health is defined as a high categorical risk. A review panel of experienced health care analysts, clinicians, policy experts, and fraud investigators will review all collected data and determine if there is sufficient evidence to warrant a referral to law enforcement. After the completion of this pilot, CMS will assess the value of expanding the pilot nationwide.

CMS Program Integrity Obligations[71]	Actual Amounts (in 000's)	
	FY 2013	FY 2014
I. The Medicare Integrity Program		
A. Program Integrity Activities in Medicare Advantage and Medicare Part D		
i. Medicare Drug Integrity Contractors (MEDICs)	$ 22,044	$ 22,873
ii. Part C & D Contract/Plan Oversight	$ 23,753	$ 17,112
iii. Monitoring, Performance Assessment, and Surveillance	$ 58,757	$ 49,478
iv. Program Audit	$ 35,151	$ 30,083
v. Compliance/Enforcement	$ 20,059	$ 16,950
Subtotal - Program Integrity Activities in Medicare Advantage and Medicare Part D	$ 159,764	$ 136,496
B. Program Support & Administration		
i. Field Offices/Rapid Response/Oversight Staffing & Support	$ 54,611	$ 51,039
Subtotal - Program Support & Administration	$ 54,611	$ 51,039
C. Program Integrity Initiatives		
i. Automated Provider Screening[72]	$ 14,394	$ 14,542
ii. 1-800-Medicare Integration	$ 446	$ 919
iii. Case Management System	$ 579	$ 5,300
iv. Technology and Strategic Decision Support	$ 808	$ 0
v. IT Shared Services	$ 4,272	$ 8,828
Subtotal - Program Integrity Initiatives	$ 20,499	$ 29,589
D. Prevent Excessive Payments		
i. Fraud System Enhancements	$ 16,140	$ 1,850

[71] The chart represents total obligations for the CMS Center for Program Integrity, Medicare Integrity Program and Medicaid Integrity Program for Fiscal Year 2013 (10/1/2012 through 9/30/2013, inclusive) and Fiscal Year 2014 (10/1/2013 through 9/30/2014, inclusive).

[72] In FY 2013, CMS made significant advancements to automate program integrity and screening checks performed during the enrollment process. In FY 2014, CMS performed data analysis, expanded monitoring of licensure, identity management, and government exclusion information. APS expanded efforts to do additional screening assessments for criminal background checks and CMS expanded the use of the APS monitoring to all Medicare Administrative Contractors (MACs). For more information see Section 2.3. *Proactively Manage Provider Screening and Enrollment.*

CMS Program Integrity Obligations[71]	Actual Amounts (in 000's)	
	FY 2013	FY 2014
ii. Command Center	$ 1,988	$ 794
iii. Benefits Integrity	$ 134,857	$ 136,761
iv. Provider Audit	$ 151,129	$ 159,117
v. Medicare Secondary Payer (MSP)	$ 161,785	$ 151,986
vi. Medical Review/Utilization Review (MR/UR)	$ 166,748	$ 178,227
vii. Medicare & Medicaid Data match (Medi-Medi)	$ 37,875	$ 48,306
viii. Fraud Prevention System	$ 0	$ 10,137
Subtotal - Prevent Excessive Payments	$ 670,522	$ 687,178
E. Program Integrity Oversight Efforts		
i. Overpayment/Payment Suspension Screening	$ 325	$ 0
ii. DME Initiatives	$ 7,000	$ 0
iii. Compromised Number Checklist	$ 1,962	$ 1,253
iv. National Supplier Clearinghouse	$ 8,671	$ 27,386
v. Provider Enrollment and Chain Ownership System (PECOS)	$ 23,055	$ 25,697
vi. One PI Data Analysis	$ 14,108	$ 16,978
vii. Fraud & Abuse Customer Service Initiative	$ 2,976	$ 636
viii. HEAT Support/Strike Force Team	$ 139	$ 961
ix. Appeals Initiative	$ 1,058	$ 2,268
x. Fraud Prevention Partnership	$ 4,342	$ 14,324
xi. Probable Fraud Measurement Pilot	$ 0	$ 0
Subtotal - Program Integrity Oversight Efforts	$ 63,636	$ 89,503
F. Error Rate Measurement and Reduction Activities		
i. Comprehensive Error Rate Testing Program (CERT) -- Medicare FFS	$ 19,672	$ 21,000
ii. Provider Education and Outreach	$ 34,733	$ 35,977

CMS Program Integrity Obligations[71]	Actual Amounts (in 000's) FY 2013	FY 2014
iii. Medicare Recovery Audit Program[73]	$ 457,405	$ 471,371
Subtotal - Error Rate Measurement and Reduction Activities[74]	$ 511,810	$ 528,348
G. Affordable Care Act		
i. Section 6002 Transparency Reports and Reporting of. Physician Ownership or Investment Interests	$ 15,085	$ 27,414
ii. Section 6401 Provider Screening/Other Enrollment	$ 2,343	$ 0
iii. Section 6402 Enhanced Medicare and Medicaid Program Integrity	$ 8,482	$ 7,600
Subtotal - Affordable Care Act	$ 25,910	$ 35,014
H. ACA Section 6401 Provider Screening/Enrollment Fees		
i. Provider Screening Application Fee Obligations	$ 16,425	$ 38,382
Subtotal - ACA Section 6401 Provider Screening/Enrollment Fees	$ 16,425	$ 38,382
I. Small Business Jobs Act of 2010 (P.L. 111-240)		
i. Predictive Modeling Activities	$ 21,904	$ 11,583
Subtotal - Small Business Jobs Act of 2010 (P.L. 111-240)	$ 21,904	$ 11,583
TOTAL – Medicare Integrity Program Obligations[75]	**$ 1,545,081**	**$ 1,607,132**
II. The Medicaid Integrity Program		
A. Deficit Reduction Act Funds		
i. Medicaid Program Integrity Staffing and Administration	$ 16,992	$ 16,399
ii. Program Support Contracts	$ 403	$ 415

[73] The Medicare Recovery Audit Program is not funded through a budget appropriation. The Recovery Auditors are funded and paid through contingency fees calculated on the basis of the amounts recovered as a result of their audit activity. Medicare Integrity Program funds included in this line are to initiate new RAC programs in Part C and D of Medicare.

[74] This Subtotal includes amounts for the Medicare Recovery Audit Program on line F.iii., which are not obligations under the budget authority. This amount is in addition to the Error Rate Measurement and Reduction Activities Obligations which total $54,405,000 in FY 2013 and $56,977,000 in FY 2014.

[75] This total includes amounts for the Medicare Recovery Audit Program on line F.iii., which are not obligations under the budget authority. This amount is in addition to the Medicare Integrity Program Obligations which total $1,087,676,000 in FY 2013 and 1,135,761,000 in FY 2014.

CMS Program Integrity Obligations[71]	Actual Amounts (in 000's) FY 2013	FY 2014
iii. Medicaid Integrity Contracts	$ 24,616	$ 43,972
iv. Support and Assistance to States	$ 3,555	$ 7,445
v. Medicaid IT Projects	$ 10,563	$ 32,797
Subtotal - Deficit Reduction Act Funds	$ 56,129	$ 101,028[76]
B. HCFAC Discretionary Medicaid		
i. Payment Error Rate Measurement (PERM)	$ 12,699	$ 15,746
ii. Correct Coding Initiative	$ 752	$ 774
iii. State Readiness, Enrollment and Eligibility	$ 4,300	$ 0
iv. Medicaid and CHIP Business Information Solutions (MACBIS)	$ 13,721	$ 0
v. Open Payments (Physician Transparency)	$ 3,000	$ 3,500
vi. Automated Provider Screening[77]	$ 0	$ 1,931
vii. IT Shared Services[78]	$ 7,839	$ 1,541
Subtotal - HCFAC Discretionary Medicaid	$ 42,311	$ 23,492
TOTAL - Medicaid Integrity Program Obligations	**$ 98,440**	**$ 124,520**
Total CMS Program Integrity Obligations[79]	**$1,643,521**	**$1,731,652**

[76] This increase is largely attributable to obligating previously unobligated and unexpended funds during FY 2014.

[77] In FY 2013, CMS made significant advancements to automate program integrity and screening checks performed during the enrollment process. In FY 2014, CMS performed data analysis, expanded monitoring of licensure, identity management, and government exclusion information. APS expanded efforts to do additional screening assessments for criminal background checks and CMS expanded the use of the APS monitoring to support extension of provider enrollment activities to the Medicaid program. For more information see Section 2.3. *Proactively Manage Provider Screening and Enrollment.*

[78] In FY 2013 this also includes $1,273,000 in Medicaid and Children's Health Insurance Program State Information Sharing System (MCSIS) funding.

[79] This total includes amounts for the Medicare Recovery Audit Program on line F.iii., which are not obligations under the budget authority. This amount is in addition to the CMS Program Integrity Obligations which total $1,186,116,000 in FY 2013 and 1,260,281,000 in FY 2014.

Report	Issued	Availability
Comprehensive Medicaid Integrity Plan of the Medicaid Integrity Program FYs 2014-2018	2014	http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf
The Health Care Fraud and Abuse Control Program Annual Report	FY 2014	http://oig.hhs.gov/publications/docs/hcfac/FY2014-hcfac.pdf
Annual Summary Report of Comprehensive Program Integrity Reviews (includes Medicaid Integrity Program Best Practices)	June 2014	http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html
Comprehensive State Program Integrity Review Reports	FY 2014	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html
Annual Summary Report of Medicaid Integrity Institute and Related Educational Activities	July 2014	https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/mii-annualrpt-fy13.pdf
The CMS Financial Report	FY 2014	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/CMS-Financial-Report-for-Fiscal-Year-2014.pdf
FY 2014 CMS Budget Justification	FY 2014	https://www.cms.gov/about-cms/agency-information/performancebudget/downloads/fy2014-cj-final.pdf
The Comprehensive Error Rate Testing Annual Report (Medicare Fee-For-Service)	FY 2014	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/MedicareFeeforService2014ImproperPaymentsReport.pdf
The Payment Error Rate Measurement Program Annual Report (Medicaid)	FY 2014	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/PERM/Downloads/2014MedicaidandCHIPAnnualErrorRateReport1.pdf
Report to Congress, Fraud Prevention System, Second Implementation Year	June 2014	http://www.stopmedicarefraud.gov/fraud-rtc06242014.pdf

ACA	Affordable Care Act
ACO	Accountable Care Organization
AEP	Annual Enrollment Period
AHCA	[Florida] Agency for Health Care Administration
AMA	American Medical Association
APS	Automated Provider Screening System
ASPE	Assistant Secretary for Planning and Evaluation
BCRC	Benefits Coordination and Recovery Contract
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMP	Civil Monetary Penalty
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
CPI-U	Consumer Price Index for all urban consumers
CPIP	Certified Program Integrity Professional
CPT	Common Procedural Terminology
CRC RA	Commercial Repayment Center Recovery Auditor
DEA	Drug Enforcement Agency
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EFT	Electronic Funds Transfer
FBI	Federal Bureau of Investigation
FFP	Federal Financial Participation
FFS	Fee-for-Service
FID	Fraud Investigation Database
FO	[CMS] Field Office
FPS	Fraud Prevention System
FTE	Full-Time Equivalent
FWA	Fraud, Waste, and Abuse

FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
GME	[Direct] Graduate Medical Education
HCFAC	Health Care Fraud and Abuse Control Program
HEAT	Healthcare Enforcement and Action Team
HFPP	Healthcare Fraud Prevention Partnership
HHH	Hubert H Humphrey Building
HHS	Department of Health & Human Services
HICN	Health Insurance Claim Number
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICF/IDD	Intermediate Care Facilities for Individuals with Developmental Disabilities
ID	Identification
IDR	Integrated Data Repository
IME	Indirect Medical Education
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPIA	Improper Payments Information Act of 2002
IT	Information Technology
IVIG	Intravenous Immune Globulin
MAO	Medicare Advantage organization
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
MCSIS	Medicaid and Children's Health Insurance Program State Information Sharing System
MED	Medicare Exclusion Database
MEDIC	Medicare Drug Integrity Contractor
MFCU	Medicaid Fraud Control Unit
MGMA	Medical Group Management Association
MIC	Medicaid Integrity Contractor
MII	Medicaid Integrity Institute
MIP	Medicare Integrity Program / Medicaid Integrity Program
MLN	Medicare Learning Network®
MMIS	Medicaid Management Information System

MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MSIS	Medicaid Statistical Information System
MSN	Medicare Summary Notice
MSP	Medicare Secondary Payer
MSPRC	Medicare Secondary Payer Recovery Contractor
MUE	Medically Unlikely Edit
NBI	National Benefit Integrity
NCCI	National Correct Coding Initiative
NSC	National Supplier Clearinghouse
OACT	[CMS] Office of the Actuary
OEOCR	Office of Equal Employment Opportunity & Civil Rights
OIG	Office of Inspector General
OMB	Office of Management and Budget
One PI	One Program Integrity
OPS	Overall Performance Score
PDE	Prescription Drug Event
PDP	Prescription Drug Plans
PECOS	Provider Enrollment Chain and Ownership System
PERM	Payment Error Rate Measurement
PI	Program Integrity
PIM	Program Integrity Manual
PPS	Prospective Payment System
PSC	Program Safeguard Contractor
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
ROI	Return on Investment
SBJA	Small Business Jobs Act of 2010
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
SMDL	State Medicaid Director's Letter
SMRC	Supplemental Medical review Contractor
SPA	State Plan Amendments
SPIA	State Program Integrity Assessment

SPRY	[Medicaid] State Plan Rate Year
SSN	Social Security Number
T-MSIS	Transformed-Medicaid Statistical Information System
TDD	Telecommunication Device for the Deaf
TTY	Text Telephone
UPL	Upper Payment Limit
US	United States
USC	United States Code
VDC	Virtual Data Center
ZPIC	Zone Program Integrity Contractor

Public Law	Title	Short Title
104-191	Health Insurance Portability and Accountability Act of 1996	HIPAA
107-300	Improper Payments Information Act of 2002	IPIA
108-173	Medicare Prescription Drug, Improvement, and Modernization Act of 2003	MMA
109-171	Deficit Reduction Act of 2005	DRA
110-173	Medicare, Medicaid and SCHIP Extension Act of 2007	MMSEA
110-275	Medicare Improvements for Patients and Providers Act of 2008	MIPPA
111-3	Children's Health Insurance Program Reauthorization Act of 2009	CHIPRA
111-148	Patient Protection and Affordable Care Act	ACA
111-152	Health Care and Education Reconciliation Act of 2010	
111-204	Improper Payments Elimination and Recovery Act of 2010	IPERA
111-240	Small Business Jobs Act of 2010	SBJA
111-309	Medicare and Medicaid Extenders Act of 2010	
112-242	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers (SMART) Act of 2012	SMART Act
112-248	Improper Payments Elimination and Recovery Improvement Act of 2012	IPERIA