Department of Health & Human Services

Centers for Medicare & Medicaid Services

Annual Report to Congress on the Medicare and Medicaid Integrity Programs

For Fiscal Year 2015

October 1, 2014 through September 30, 2015

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Executive Summary

This report describes the Centers for Medicare & Medicaid Services' (CMS) program integrity activities during Fiscal Year (FY) 2015. 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) requires that CMS report its Medicare program integrity activities. This report fulfills both of those requirements.[3]

Medicare Program Integrity

CMS estimates that program integrity activities saved Medicare $17.0 billion in FY 2015, for a three-year return on investment of $12.4 to 1 for the period that ended on September 30, 2015.

Prevention of improper payments represented 84.5 percent ($14.4 billion) of the FY 2015 savings. Prevention savings activities included Systematic Edits ($775.1 million), Provider Enrollment Actions ($1.1 billion), Prepayment Reviews ($12.3 billion), and Payment Suspensions ($128.0 million).

Recovery of overpayments represented the remaining $2.6 billion in FY 2015 savings. Overpayment recovery savings activities included Reviews and Audits ($2.2 billion), Recovery Audit Contractor (RAC) Collections ($392.5 million), and Law Enforcement Referrals ($65.4 million).

Type of Medicare Savings	Savings (in millions)		
	2013[a]	2014[a]	2015
Prevention Savings (Estimated Amounts)			
Systematic Edits	$ 758.1	$ 773.5	$ 775.1
Provider Enrollment	$ 975.3	$ 874.2	$ 1,106.4
Prepayment Review	$ 12,913.5	$ 11,859.7	$ 12,346.2
Suspensions	$ 43.2	$ 52.2	$ 128.0
Total Prevention Savings	**$14,690.1**	**$13,559.6**	**$ 14,355.7**

1 Public Law 109-171.

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

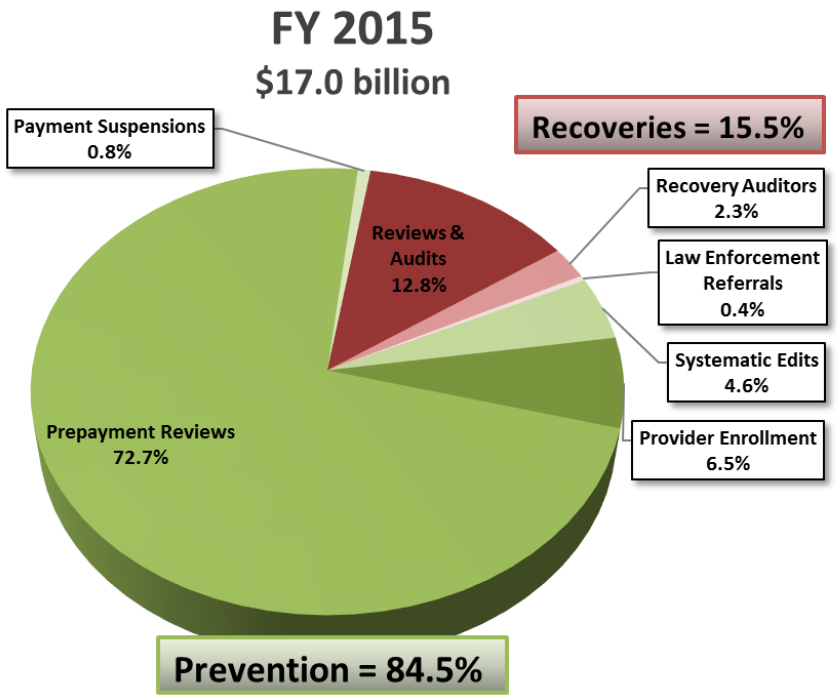
3 Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Social Security Act (as amended by the Affordable Care Act) and not all Medicaid program integrity activities are funded under section 1936 of the Social Security Act (which was created by the 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 Social Security Act to provide better context for CMS's anti-fraud programs.

Type of Medicare Savings	Savings (in millions)		
	2013[a]	2014[a]	2015
Post-Payment Recovery Savings (Estimated Amount Recovered after Identifying Overpayments)[b]			
Reviews and Audits	$ 2,881.9	$ 2,207.1	$ 2,174.1
Recovery Audit Contractors (RACs)	$ 3,496.1	$ 2,126.3	$ 392.5
Law Enforcement Referrals	$ 142.0	$ 105.4	$ 65.4
Total Post-Payment Recovery Savings	**$ 6,520.0**	**$ 4,438.8**	**$ 2,632.0**
Total Savings (Prevention and Post-Payment)	**$21,210.1**	**$17,998.4**	**$16,987.7**

[a] The total savings values for FY 2013 and FY 2014 have changed from the Annual Report to Congress on the Medicare and Medicaid Integrity Programs for FY 2013 and FY 2014. Systematic edits now include a new savings metric for durable medical equipment National Correct Coding Initiative (NCCI) Medically Unlikely Edits (MUEs), and provider enrollment savings include a new savings metric for deactivations. As a result, the savings from systematic edits and provider enrollment for FY 2013 and FY 2014 have been recalculated to include these new savings. In addition, the Part A/B RAC savings methodology was revised in FY 2015, and thus the savings for FY 2013 and FY 2014 were recalculated to reflect the new methodology.

[b] The post-payment recovery savings include fee-for-service, Part D and Part C Law Enforcement Referrals savings.

Medicare Savings by Program Integrity Activity



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.

CMS achieved significant savings in FY 2015 through activities aimed at preventing improper payments before they go out the door. The Fraud Prevention System (FPS) resulted in $604.7 million in fraudulent payments being stopped, prevented, or identified during FY 2015. CMS also saved the Medicare program $700.4 million in FY 2015 using National Correct Coding Initiative (NCCI) edits. The NCCI is intended to promote national correct coding methodologies and control improper coding in Medicare Part A, Part B, and durable medical equipment (DME) claims. In addition, CMS had 435 active payment suspensions during FY 2015.

Medicare Administrative Contractors (MACs) request and review medical documentation from providers and suppliers on a prepayment and post-payment basis. In FY 2015, MAC prepayment medical review resulted in nearly $5.0 billion in improper payments being prevented. These efforts avoid "pay and chase," as well as promote provider compliance.

While Medicare savings from prevention activities increased from FY 2014 ($13.6 billion) to FY 2015 ($14.4 billion), Medicare savings in FY 2015 were overall lower than FY 2014, largely driven by post-payment recovery activities. Savings from RAC Collections were significantly lower than in previous years, declining from $2.1 billion in FY 2014 to $392.5 million in FY

2015.[4] Much of this decrease can be attributed to the prohibition on the Recovery Audit Contractors from performing patient status reviews. Additionally, in FY 2015 CMS began more closely monitoring the type and volume of reviews conducted, while still regularly approving topics for review.

Medicaid Program Integrity

In FY 2015, CMS identified $36.4 million in Medicaid overpayments, which were sent to states for collection. States are responsible for collecting overpayments identified by Audit Medicaid Integrity Contractors (MICs), and are permitted one year from the date of the final audit report to return the federal share. For FY 2015, states reported a total federal and state share combined amount of Audit MIC recoveries of $14.8 million and returned the federal share of $10.1 million to the Treasury.

Through the Medicaid Recovery Audit Programs, the states have recovered a total federal and state share combined amount of $106.4 million for FY 2015 and returned the federal share of $65.5 million to the Treasury. CMS also provided support to state activities through the Medicaid Integrity Program that led to substantial program integrity recoveries – including $852.9 million reported by states for FY 2015. CMS 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 2015. For example, in June 2015, the Medicare Fraud Strike Force conducted a large nationwide health care fraud takedown, which, for the first time, involved non-Strike Force participants and resulted in charges against 243 individuals for approximately $712 million in false Medicare and Medicaid billing. Throughout the year, CMS policy experts and fraud investigators used the Command Center to work with 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 other federal agencies to collaborate before, during, and after the development of fraud leads.

Medicaid is a partnership between the federal government and states, and CMS is committed to maintaining coordination and a strong relationship with states to improve Medicaid program integrity. State program integrity reviews ensure federal oversight of the states' activities, but these reviews also serve as an opportunity for gaining insight into current trends in fraud, waste, and abuse, as well as sharing best practices. Data exchange, such as in provider enrollment and Transformed-Medicaid Statistical Information System (T-MSIS), is another important area where CMS and states rely on each other to promote program integrity.

Also, since FY 2012, HHS and Department of Justice (DOJ) have developed a 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

[4] More information about the Medicare FFS Recovery Audit Program can be found in section 2.13, as well as the FY 2015 Medicare FFS Recovery Audit Program Report to Congress at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/.

includes the federal government, state officials, several leading private health insurance organizations, and other health care anti-fraud groups. In FY 2015, the HFPP completed a number of studies using multiple partner data to address fraud in urine drug screening, pharmacy billing, misused codes, and false storefronts. In addition, the calendar year 2012 public data files were used to identify outlier providers billing impossible days and inappropriate Evaluation and Management (E&M) coding levels in the areas of physical therapy and psychology. Partners participated in the HFPP's first case information sharing session in 2015, resulting in an average of seven new fraud leads per partner. At the end of FY 2015, the HFPP had 43 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse.

Today, with the 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.

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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 (the Act). CMS is also responsible for providing direction and guidance to, and oversight of, state-operated Medicaid programs and Children's Health Insurance Program (CHIP) consistent with titles XIX and XXI, respectively, of the Act, in addition to other federal health care programs and activities. The Medicare Integrity Program and the Medicaid Integrity Program were established to protect the programs against improper payments. 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.

This report focuses on the program integrity activities that are led by or include significant involvement by CMS's Center for Program Integrity (CPI). CPI was created in 2010 to align the program integrity functions of the Medicare and Medicaid programs, and is responsible for implementation of the Medicare Integrity Program and the Medicaid Integrity Program. In September 2014, CPI implemented a reorganization to further move from a program-specific alignment to a functional alignment to better coordinate activities between Medicare and Medicaid and streamline contracting activities.

As part of this reorganization, CPI has developed five strategic objectives that guide our initiatives to reduce improper payments:

1. Address the full spectrum of waste, abuse, and fraud
2. Proactively manage provider screening and enrollment
3. Continue to build states' capacity to protect Medicaid
4. Extend work in Medicare Parts C and D, Medicaid managed care, and the Marketplace
5. Provide greater transparency into program integrity issues

Importantly, in addition to CPI, CMS's comprehensive program integrity activities cut across the agency and are also performed by the Office of Financial Management, the Center for Medicaid and CHIP Services, and the Center for Medicare. For example, the Office of Financial Management oversees the Medicare Secondary Payer program and certain improper payment measurement programs.

The effectiveness of CMS's comprehensive approach to program integrity in Medicare is demonstrated by the results of our activities in Fiscal Year (FY) 2015. CMS's program integrity efforts resulted in $17.0 billion in savings for the Medicare Trust Funds during FY 2015. Starting in FY 2013, CMS improved its ability to measure program success, grounding our revised savings methodology in the methodology used for the Fraud

Prevention System (FPS), 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 was 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. Medicare savings for FY 2015 are discussed in more detail in section 1.3.2.

In Medicaid, CMS actions have contributed to a 222 percent increase in program integrity-related collections since the launch of the Medicaid Integrity Program in 2006. For FY 2015, states reported $852.9 million in total Medicaid program integrity collections.

This report is divided into six 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. This section also includes a description of the implementation of HHS OIG and Government Accountability Office (GAO) recommendations.

The second section describes CMS's efforts to **address the full spectrum of waste, abuse, and fraud**. This includes initiatives that are foundational to protecting program integrity, such as enhancements to our data sharing and analytic capabilities, expansions of our prior authorization programs, and improved coordination of our compliance and investigation activities across the integrity continuum.

The third section outlines CMS's approach to **proactively managing provider screening and enrollment**. CMS requires Medicare and Medicaid providers and suppliers to undergo screening, including enhanced screening for certain high-risk providers and suppliers, and takes action to revoke or terminate those known to be bad actors. This section includes activities such as enhancements to provider screening, temporary provider enrollment moratoria, and our ongoing project to revalidate all existing Medicare providers.

The fourth section promotes CMS's role in **continuing to build states' capacity to protect Medicaid**. CMS provides education, training, technical assistance, and forums to share best practices and lessons learned. Through reviews of state processes and procedures, CMS identifies areas of improvement and works with the states to address vulnerabilities and make their program integrity activities more robust. This section also discusses collaborative audits through the National Medicaid Audit Program.

The fifth section details CMS's efforts to **extend work in Medicare Parts C and D, Medicaid managed care, and the Marketplace**. While CMS is in the early stages of developing program integrity activities around Medicaid managed care, the agency is

implementing a number of activities to address improper payments in Medicare Part C and Part D. This section includes activities such as the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) and marketing oversight.

The sixth and final section discusses CMS's dedication to **providing greater transparency into program integrity issues** through education, outreach, partnership, strategic communications, and data releases. CMS works with its partners and stakeholders to share best practices and lessons learned in program integrity. Linking financial, programmatic, and performance data helps provide transparency and accountability, and ensures program efficiency and effectiveness. This section includes activities such as the Healthcare Fraud Prevention Partnership (HFPP) and improper payment rate measurement.

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 2015. 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[5] (DRA), which added section 1936 to the Act.[6] Section 6402(j) of the Patient Protection and Affordable Care Act[7] (hereafter referred to as the Affordable Care Act) amended section 1893 of the Act and established the requirement that CMS report on Medicare program integrity activities.[8] The Affordable Care Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicaid and Medicare. While Medicare Part A and Part B Recovery Audit Contractors (RACs) are discussed in section 2.13, the comprehensive report on the Medicare Part A and Part B Fee-for-Service (FFS) Recovery Audit Program is published separately.[9] This report fulfills the reporting

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5 Public Law 109-171

6 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 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.

7 Public Law 111-148 and Public Law 111-152, collectively are referred to as the Patient Protection and Affordable Care Act.

8 Please note that not all Medicare program integrity-related activities are funded under section 1893 of the 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.

9 The FY 2015 Medicare FFS Recovery Audit Program 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/.

requirements with respect to Medicare and Medicaid program integrity, Medicaid Recovery Auditors, and Medicare Part C and Part D Recovery Auditors.[10]

The Health Insurance Portability and Accountability Act of 1996[11] (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 between FY 1997 and FY 2003. Then the amount was capped at $720 million from FY 2003 through FY 2010, after which the Affordable Care Act increased the base funding level and also applied an annual inflationary adjustment to that new Medicare Integrity Program funding level. 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 Health Care Fraud and Abuse Control (HCFAC) funding, subject to annual appropriation. CMS obligated a total of $1.2 billion in FY 2015 for the Medicare Integrity Program.

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.

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.[12] CMS obligated a total of $75.2 million in FY 2015 for the Medicaid Integrity Program. In addition, CMS obligated a total of $41.9 million in FY 2015 for Medicaid program integrity activities using discretionary HCFAC funds.

Appendix A provides further information on the actual expenditures for program integrity activities for both Medicare and Medicaid. Please note that this report includes activities

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[10] CMS is subject to other requirements to report to Congress on the use of Health Care Fraud and Abuse Control program funds, Recovery Audit Contractors (RACs), and the implementation of the predictive modeling requirements under the Small Business Jobs Act of 2010 (SBJA). 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.

[11] Public Law 104-191.

[12] 42 U.S.C.

1396u-6(e)(1)(D).

that are funded outside of the Medicaid or Medicare Integrity Programs. Activities such as Innovation Center models, the Recovery Audit Contractor (RAC) programs, and Durable Medical Equipment (DME) Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity.

1.2. Program Integrity in Medicare and Medicaid

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. In FY 2015, Medicare and Medicaid collectively covered an estimated 124.7 million people. During the course of FY 2015, the average monthly Medicare enrollment was 55.8 million,[13] while the average monthly enrollment for Medicaid was 68.9 million.[14] Furthermore, there were more than 10.7 million enrollees in both the Medicare and Medicaid programs.[15] CMS directly administers Medicare through contracts with private companies that processed 1.2 billion FFS claims in FY 2015.[16] This represents an average of 3.325 million claims every day. 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.

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. In fact, improper payments typically do not involve fraud. Instead, improper payments usually are payments for which there is no or insufficient necessary supporting documentation, are payments made for items or services that do not meet Medicare or Medicaid's coverage and medical necessity criteria, or are payments for claims that are incorrectly coded.

As required by law, CMS procures contractors to conduct certain program integrity activities in the Medicare and Medicaid programs. Each contractor has a distinct role and responsibility that is summarized in Table 1 below. 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.

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[13] 2015 CMS Statistics (CMS Pub. No. 03512), 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/2015.html.

[14] 2015 CMS Statistics, Table I.16, page 15.

[15] This data comes from a brief on Medicare-Medicaid dual enrollment from 2006 through 2013. Medicare-Medicaid Coordination Office FY 2015 Report to Congress, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_2015_RTC.pdf.

[16] 2016 CMS Statistics (CMS Pub. No. 03513), Table V.5, page 42. This publication is available online at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/2016.html.

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
Zone Program Integrity Contractors[17] (ZPICs)	Medicare Fee-for-Service	• Investigate leads generated by the 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 their respective jurisdictions • 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 • Analyze 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

[17] 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	• Conducts nationwide medical review as directed by CMS • Notifies CMS and the MACs of identified improper payments and noncompliance with documentation requests
Medicare Fee-For-Service Recovery Audit Contractors (RACs)	Medicare Fee-for-Service	• Conduct 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
National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)	Medicare Parts C and D	• Conducts data analyses of national Part C and Part D issues leading to potential identification of improper payments and regulatory improvement • Coordinates all Part C and Part D program integrity outreach activities for all stakeholders, including plan sponsors and law enforcement • Supports compliance and fraud audits of Part C and Part D plan sponsors • Develops educational materials on payment integrity and quality of care issues • Conducts plan sponsor related downstream entities' education and training • Highlights the value of education in preventing fraud, waste, and abuse in Medicare Part C and Part D
Outreach and Education (O&E) Medicare Drug Integrity Contractor (MEDIC)	Medicare Parts C and D	• Develops educational resources and conducts training on fraud, waste, and abuse activities for Medicare Part C and Part D
Part D Recovery Auditor	Medicare Part D	• Conducts post-payment reviews of reconciled Part D Prescription Drug Events (PDEs) 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 (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers

Contractor	Program	Program Integrity Responsibilities
Audit Medicaid Integrity Contractors (Audit 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 (Education MICs)	Medicaid Fee-for-Service and Managed Care	• Develop educational resources and conduct training on fraud, waste, and abuse activities for Medicaid

1.3. Measuring Program Integrity Success

1.3.1. Improper Payment Rates

To help identify and correct improper payments in Medicare and Medicaid, CMS established an agency-wide Program Integrity Board (PI Board) to identify and prioritize improper, wasteful, abusive, and potentially fraudulent payment vulnerabilities in the Medicare and Medicaid programs. The PI Board is comprised of CMS executive leaders, all of whom share the mutual objective to identify and prevent improper payments. After identifying high-priority vulnerabilities, the PI Board directs corrective actions and tracks issues to resolution. Specifically, the PI Board established an Improper Payment Action Plan workgroup to periodically collect data from improper payment reports and formulate action plans for review by the PI Board.

The PI Board also established smaller working groups—referred to as Integrated Project Teams (IPTs)—to focus on specific projects to address the identified vulnerabilities. For example, in FY 2015, the PI Board approved the Therapy Services IPT, Home Health IPT, and Medicare FFS Integrity Continuum IPT. Each IPT works independently under the directive of the PI Board and provides regular updates.

Table 2 summarizes the historical trends in the improper payment rates for the various programs since 2010: Medicare FFS, Medicaid, CHIP, Medicare Part C, and Medicare Part D. Specific information on how each program measures improper payments can be found in section 6.4 of this report.

Table 2 Reported Improper Payment Rates Trend for Reporting Years 2010-2015

Program	2010	2011	2012	2013	2014	2015
Medicare FFS	10.5%	8.6%	8.5%	10.1%	12.7%	12.1%
Part C	14.1%	11%	11.4%	9.5%	9.0%	9.5%
Part D	N/A	3.2%	3.1%	3.7%	3.3%	3.6%
Medicaid	9.4%	8.1%	7.1%	5.8%	6.7%	9.8%

Program	2010	2011	2012	2013	2014	2015
CHIP	N/A	N/A	8.2%	7.1%	6.5%	6.8%

While this report discusses many of the ways that CMS reduces the improper payment rates for Medicare and Medicaid, please see the HHS FY 2015 Agency Financial Report (AFR)[18] for a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2015.

1.3.2. Medicare Savings

In FY 2015, CMS saved an estimated $17.0 billion in FY 2015 (see Table 3). This represents a three-year average return on investment of $12.4 to 1 for the period that ended on September 30, 2015.[19] More than 84 percent of the savings in FY 2015 came from prevention actions, safeguarding Medicare dollars by stopping inappropriate payments before they were made.

Notably, for the first time, CMS is estimating the impact of deactivating providers' billing privileges. By taking swift administrative action to stop providers' or suppliers' billing privileges, CMS estimates that in FY 2015, it will avoid paying $220.2 million dollars to these deactivated providers and suppliers. CMS also extended its NCCI methodology for Medically Unlikely Edits (MUEs) to include savings from durable medical equipment MUEs. CMS estimates that savings of $288.8 million have been achieved through NCCI MUE edits.

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 2015. 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.

[18] HHS FY 2015 Agency Financial Report, available at http://www.hhs.gov/sites/default/files/afr/fy-2015-hhs-agency-financial-report.pdf.

[19] The return on investment for the Medicare Integrity Program for FY 2013, FY 2014, and FY 2015 is a three-year average. It is calculated by dividing the combined total Medicare savings from FY 2013, FY 2014, and FY 2015 by the combined total Medicare obligations from FY 2013, FY 2014, and FY 2015. The reader is cautioned that the above amounts include RAC findings that are also reported separately in a distinct Report to Congress pertaining to the Medicare FFS Recovery Audit Program.

Table 3: Medicare Savings

Type of Medicare Savings[a]	2015 Savings (in millions)
Prevention Savings (Estimated Amounts)	
Systematic Edits	
NCCI - Procedure to Procedure Edits	$ 411.6
NCCI – MUE Edits[b]	$ 288.8
FPS Edits	$ 11.3
ZPIC Edits[c]	$ 63.4
Provider Enrollment	
Revocation	$ 886.2
Deactivation[d]	$ 220.2
Prepayment Review	
Medical Review	$ 4,969.5
Medicare Secondary Payer	$ 7,316.9
ZPIC-Initiated Review[e]	$ 59.8
Suspensions	
CMS-Initiated Suspensions	$ 128.0
Total Prevention Savings	**$ 14,355.7**
Post-Payment Recovery Savings (Estimated Amount Recovered after Identifying Overpayments*)	
Reviews and Audits	
Medicare Secondary Payer	$ 1,173.9
Medical Review	$ 9.7
Provider Cost Report Audit	$ 133.2
Risk Adjustment Data Validation	$ 515.0
MEDICs	$ 23.5
SMRC	$ 45.1
Appeals Initiatives	$ 1.6
Compliance Audits	$ 5.0
Cost Plan Audits	$ 90.8
ZPIC-Initiated Reviews	$ 175.5
Retroactive Revocations	$ 0.8
Recovery Audit Contractors (RACs)	
Part A/B RAC	$ 237.7
Part D RAC	$ 5.2
Commercial Repayment Center RAC	$ 149.6
Law Enforcement Referrals	
ZPIC Law Enforcement Referrals	$ 6.7

Type of Medicare Savings[a]	2015 Savings (in millions)
MEDIC Part C Law Enforcement Referrals[f]	$ 21.9
MEDIC Part D Law Enforcement Referrals	$ 36.8
Total Post-Payment Recovery Savings	$ 2,632.0
Total Savings (Prevention and Post-Payment)	**$ 16,987.7**

*Includes fee-for-service, Part D and Part C Law Enforcement Referral savings.

[a] The methodology used to calculate many of the savings measures is grounded in the methodology used to calculate the FPS return on investment, which was certified by the HHS-OIG. The FPS savings for FY 2015 are a subset of the measures in the table. The FPS is the predictive analytics technology required under the SBJA.

[b] The savings methodology for NCCI MUEs for FY 2015 has been extended to include savings for durable medical equipment MUEs.

[c] In FY 2015 Field Office Edits have been incorporated into the ZPIC Edits, and as a result have been removed from this table as a separate line.

[d] In FY 2015 CMS began calculating savings related to deactivations.

[e] In FY 2015 Field Office Reviews have been incorporated into the ZPIC-Initiated Review, and as a result have been removed from this table as a separate line.

[f] In FY 2015 CMS began calculating savings related to MEDIC Part C Law Enforcement Referrals.

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 2015, at $852.9 million, total state Medicaid program integrity collections were approximately 222 percent higher than in FY 2006.[20]

1.4. OIG and GAO Recommendations Implemented

In FY 2015, CMS took action to address recommendations from the OIG and GAO on program vulnerabilities. Below are brief descriptions of some of the actions taken, or in response to OIG and GAO's priority recommendations.

- OIG recommended that CMS should implement additional claims processing edits or improve existing edits to ensure that ophthalmology claims are paid appropriately. CMS created a cross-functional workgroup to evaluate limitations

[20] Amounts for Medicaid program integrity collections as reported by states on Form CMS 64, included on line 9.

and opportunities regarding vulnerabilities in ophthalmology claims, including lifetime edits.

- OIG recommended that CMS should follow up on individuals without prescribing authority who ordered prescriptions. CMS initiated the Part D RAC's audit of these individuals after reviewing the analysis completed by the MEDIC. CMS also issued a memorandum to plan sponsors describing best practices on how to ensure that prescribers are authorized to prescribe.
- OIG recommended that CMS review and take appropriate, timely action on RAC referrals of potential fraud. CMS reviewed the identified RAC referrals and forwarded them to ZPICs/Program Safeguard Contractors, as appropriate, for further investigation.
- OIG recommended that CMS provide guidance to its contractors on detecting fraud associated with electronic health records. CMS issued a Technical Direction Letter to its program integrity contractors, and conducted a presentation on electronic health record vulnerabilities at the Medicare Part C & D Fraud, Waste, and Abuse Training.
- OIG recommended that CMS require that state contracts with managed care entities include a method to verify with beneficiaries whether services billed by providers were received. In FY 2015, CMS took steps to implement this recommendation in its Medicaid managed care proposed rule, which included various provisions relating to program integrity.[21]
- GAO recommended that CMS use the knowledge gained from comprehensive state program integrity reviews as a criterion for focusing Medicaid program integrity resources towards states that have structural or data-analysis vulnerabilities. CMS redesigned the comprehensive reviews to shift away from a regulatory compliance framework to a more targeted risk assessment model, which fulfilled the intent of GAO's recommendation.

[21] 80 FR 31097 (June 1, 2015).

2. Address the Full Spectrum of Waste, Abuse, and Fraud

This section describes the wide range of program integrity activities that CMS utilizes to comprehensively address fraud, waste, and abuse. These activities include many different approaches to program integrity, such as data analysis, prior authorization demonstrations, investigations and audits, and recovery actions.

2.1. Fraud Prevention System (FPS)

The Fraud Prevention System (FPS) is the predictive analytics technology required under the Small Business Jobs Act of 2010[22] (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.

The FPS helped identify or prevent $604.7 million in inappropriate payments during FY 2015 through actions taken due to the FPS or through investigations expedited, augmented, or corroborated by the FPS. This resulted in an $11 to 1 return on investment. Since CMS implemented the technology in June 2011, the FPS has identified or prevented more than $1.4 billion in inappropriate payments by identification of new leads or contribution to existing investigations. During FY 2015, the FPS models generated 718 leads that were included in the ZPIC workload. The leads resulted in 492 new investigations and augmented information for 226 existing investigations. During this period, the ZPICs also continued to work leads that were opened during previous implementation years.

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's 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

[22] Public Law 111-240.

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 Medicare physician and beneficiary identification numbers flagged through fraud investigations, security breach reports, and complaints from providers or beneficiaries.

2.2. Medicare and Medicaid National Correct Coding Initiative (NCCI)

Medicare NCCI

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. The National Correct Coding Initiative (NCCI) program consists of edits designed to reduce Medicare Part A and B, Medicare DME, and Medicaid improper payments. 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 MUEs were implemented January 1, 2007, and MUE edits have since been extended to cover Part A and DME. 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 $411.6 million in FY 2015. In addition, MUE edits within Medicare Part B and DME saved the Medicare program $288.8 million in FY 2015.[23]

Medicaid NCCI

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.[24] CMS has worked closely with state Medicaid agencies (SMAs) 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.

2.3. Medicare FFS Medical Review

Consistent with sections 1833(e), 1815(a), and 1862(a)(1) of the Act, CMS is required to protect the Medicare Trust Funds against inappropriate payments that pose the greatest risk to the Trust Funds and take corrective actions. To meet this requirement, CMS contracts with the MACs to perform analysis of FFS claims data to identify atypical billing patterns and perform claims review.[25]

Medical review is the collection of information and clinical review of medical records to ensure that payment is made only for services that meet all Medicare coverage, coding, and medical necessity requirements. Medical review activities are directed toward areas where data analysis, Comprehensive Error Rate Testing (CERT) results, OIG/GAO findings, and RAC findings indicate questionable billing patterns. CMS continues to

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[23] Savings for Medicare Part A are not yet available.

[24] 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.

[25] The Zone Program Integrity Contractors (ZPICs) also perform medical review, as discussed in section 2.6.

enhance medical review efforts and has encouraged MACs to incorporate increased provider feedback processes, such as one-on-one education and more detailed review results notification, in an effort to increase proper billing.

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 nearly $5.0 billion in savings for FY 2015.

Supplemental Medical Review

In FY 2015, CMS continued to enhance medical review while closely monitoring the decisions made by the contractors. The Supplemental Medical Review Contractor (SMRC), which operates at the direction of CMS, provides 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 OIG and/or GAO. In FY 2015, the SMRC saved $45.1 million through post-payment review.

2.4. Demonstrations and Models

CMS conducts demonstration projects and models that aim to strengthen Medicare by eliminating fraud, waste, and abuse and reducing improper payments. The status of each demonstration and model conducted in FY 2015 is detailed below.

Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport Model[26]

In December 2014, CMS implemented a prior authorization model for repetitive, scheduled non-emergent ambulance transport occurring on or after December 15, 2014 in New Jersey, Pennsylvania, and South Carolina. This model was created under section 1115A of the Act, which authorizes the Secretary to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to beneficiaries. Previous analysis shows that non-emergent ambulance transports to and from dialysis facilities have grown noticeably in recent years and represent a large share of non-emergent ambulance claims. The model establishes a prior authorization process for repetitive scheduled non-emergent ambulance transport to reduce utilization of services that do not comply with Medicare policy while maintaining or improving quality of care. Section 515 of the Medicare Access and CHIP

[26] Additional information, including preliminary data, is available on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/AmbulancePriorAuth_Status-Update_040716.pdf.

Reauthorization Act of 2015 (MACRA)[27] expanded the prior authorization model for repetitive, scheduled non-emergent ambulance transports no later than January 1, 2016 to five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia.

Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy Model[28]

In March 2015, CMS implemented a prior authorization model for non-emergent hyperbaric oxygen therapy in Michigan, Illinois, and New Jersey. This model was created under section 1115A of the Act, which authorizes the Secretary to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to beneficiaries. Previous experience indicates that hyperbaric oxygen therapy has a high potential for improper payments and raises concerns about beneficiaries receiving medically unnecessary care. The model establishes a prior authorization process for non-emergent hyperbaric oxygen therapy for certain covered conditions to reduce utilization of services that do not comply with Medicare policy, while maintaining or improving quality of care. Providers in Michigan could begin submitting prior authorization requests on March 1, 2015 for treatments occurring on or after April 13, 2015, and providers in Illinois and New Jersey could begin submitting prior authorization requests on July 15, 2015 for treatments occurring on or after August 1, 2015.

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). Section 402(a)(1)(J) of the Social Security Amendments of 1967[29] authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program. 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

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27 Public Law 114-10.

28 Additional information, including preliminary data, is available on the CMS website at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Prior-Authorization-Initiatives/Downloads/HBOPriorAuth_StatusUpdate_111616.pdf.

29 Public Law 90-248

since September 2012.[30] CMS also extended the demonstration to August 31, 2018 in FY 2015.

Recovery Audit Prepayment Review Demonstration[31]

CMS implemented the Recovery Audit Prepayment Review demonstration in August 2012, and the three-year demonstration ended in August 2015. Section 402(a)(1)(J) of the Social Security Amendments of 1967 authorizes the Secretary to conduct demonstrations designed to develop or demonstrate improved methods of the investigation and prosecution of fraud in the provision of care or services provided under the Medicare program. This demonstration allowed Medicare RACs to review claims before they are paid to determine if the provider complied with all Medicare coverage and billing rules. 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. Due to the close-out process for the existing RAC contracts while CMS worked to procure new contracts, there were no claims reviewed as part of this demonstration in FY 2015. While CMS did see modest savings from this demonstration, system limitations constrained the prepayment review process, and CMS did not extend the demonstration beyond its planned end date.

2.5. Medicare Provider Cost Report Audits

Auditing is one of CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, skilled nursing facilities, 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.

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[30] 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.

[31] Further information on this demonstration can be found in the FY 2015 Medicare FFS Recovery Audit Program Report to Congress, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/.

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 2015, approximately 48,000 Medicare cost reports were received and accepted by the MACs. This includes initial cost report filings as well as amended filings. Tentative settlements were completed for approximately 23,000 cost reports. In addition, approximately 24,000 cost reports were desk reviewed and around 2,500 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.

2.6. Zone Program Integrity Contractors (ZPICs)

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 actions to prevent Medicare Trust Fund monies from being inappropriately paid to Medicare providers. They also identify improper payments that the MAC recovers.

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 suspensions, revocations), 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 2015, the ZPICs saved an estimated $859.6 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 $504.5 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 $123.2 million from being inappropriately paid to these

Medicare providers and suppliers. CMS estimates that the ZPICs saved the Medicare Trust Funds another $49.7 million by implementing payment suspensions.

Table 4: Savings Identified by ZPICs

Type of Savings	Savings (in millions)
	2015
Prevention Savings	
Estimated Amount Avoided Due to Revocation of Billing Privileges	**504.5**
Estimated Amount Prevented by Automatically Denying Claims	**63.4**
Estimated Amount Prevented by Denying Claims After Prepayment Review	**59.8**
Amount Held in Escrow Due to Payment Suspensions	**49.7**
Post-Payment Recovery Savings	
Estimated Amount Recovered after Identifying Overpayments	**175.5**
Estimated Amount Saved through Referrals to Law Enforcement	**6.7**
Total Savings	**$859.6**

Notes: The methodology used to calculate many of the savings measures is grounded in the methodology used to calculate the FPS return on investment, which was certified by the HHS-OIG. The FPS savings for FY 2013 is a subset of the measures in the table. The FPS is the predictive analytics technology required under the SBJA. The savings values listed above also include administrative actions submitted by the CMS Field Offices, as CMS transitioned to having the Field Offices submit their administrative actions through the ZPICs in FYs 2014 and 2015.

2.7. Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding[32]

Prior to the implementation of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Medicare paid for DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the HHS OIG and the GAO have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries were bearing the burden of these excessive payments.

[32] 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.

Under the DMEPOS Competitive Bidding Program,[33] DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding areas. At the end of the Round 1 Rebid's 3-year contract period (January 1, 2011 – December 31, 2013), the program saved more than $580 million in nine markets due to lower payments and decreased unnecessary utilization. Similarly, after the first two years of Round 2 and the national mail-order programs (July 1, 2013 – June 30, 2015), Medicare has saved approximately $3.6 billion. Importantly, the program has maintained beneficiary access to quality products from accredited suppliers in all competitive bidding areas, while at the same time, reducing overutilization of DMEPOS items and services.

2.8. Appeals Initiatives

CMS continues to actively participate in an HHS intra-agency appeals workgroup and is implementing initiatives with the goal of improving the efficiency of the appeals process, reducing the backlog of appeals at the Office of Medicare Hearings and Appeals (OMHA), and mitigating future backlogs by reducing the number of appeals that flow to OMHA, while continuing to protect the integrity of CMS's programs.

2.9. 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, C (encounter), 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 FPS. Claims data in the IDR is sourced from both the National Claims History and shared systems data.

CMS is working to integrate new data sources into the IDR. CMS has recently added shared systems location data for pre-adjudicated claims, claims submitter, and medical review utilization data. CMS is also working to incorporate state Medicaid data into the IDR through standard T-MSIS data formats, while also working with states to improve the quality and consistency of the data from each state.

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

[33] 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 Affordable Care Act.

review the data. CMS has been working closely with our law enforcement colleagues to provide One PI training and support. The One PI team continues to enhance the overall training process by revising manuals and training content. Training now includes virtualized web-based training in combination with on-site instructor led training to reduce training costs and provide better access for law enforcement.

2.10. Medicare Secondary Payer (MSP)

Medicare Secondary Payer (MSP) is an important program that protects both Medicare beneficiaries and the sustainability of the Medicare Trust Funds. The MSP program ensures that when Medicare is 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.

The mandatory insurer reporting requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act (MMSEA) of 2007[34] continues to be the primary source of new MSP information reported to CMS from group health plans and other insurers. The annual number of new MSP records posted to CMS's systems remains more than twice the number posted before section 111 of MMSEA was implemented. MSP operations saved $8.5 billion in FY 2015. This includes approximately $768 million in direct recoveries by MSP specialty contractors and through CMS negotiated global settlements.

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)[35] and several more milestones were achieved in FY 2015. CMS implemented a new process that allows MSP reporting entities the option of reporting less than a full Social Security Number (SSN) to CMS when the Health Insurance Claim Number (HICN) is otherwise not available. In 2015, CMS determined that it would maintain the liability insurance (including self-insurance) reporting and recovery threshold set in 2014, where the total settlement amount of the physical trauma-based injury is $1,000 or less. CMS also implemented a new way to accelerate the claims history retrieval process to support the implementation of the SMART Act. Finally, CMS implemented an Applicable Plan Appeals process so that when Medicare pursues recovery from either a liability insurer, no-fault insurer, or workers' compensation entity, the applicable plan can now appeal Medicare's recovery claim determination.

FY 2015 marked the first full year of operations of CMS's new Coordination of Benefits & Recovery (COB&R) contracting strategy. The COB&R contracts were designed to increase the efficiency of CMS's MSP program prepayment Coordination of Benefits (COB) and MSP debt recovery activities. As part of these operations, CMS is working to consolidate many systems into one Benefits Coordination and Recovery System (BCRS). The BCRS is being implemented to improve efficiency and to provide all stakeholders

[34] Public Law 110-173.

[35] Public Law 112-242.

with more and better COB and recovery related data on a more timely basis. Another major initiative for FY 2015 included the development of processes that will support recovery from liability, workers' compensation, and no-fault insurers that have accepted ongoing responsibility for payment of medical expenses for Medicare beneficiaries.

Commercial Repayment Center (CRC) Recovery Auditors

In FY 2013, CMS finalized the award of a new Commercial Repayment Center (CRC) Recovery Auditor 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. These amounts are typically recovered from employers. In FY 2015, the second full year of the contract, the CRC introduced a new, secure web-based tool designed to provide identified debtors with a way to electronically manage their GHP recovery activities. The CRC Portal is designed to improve customer service, increase efficiency, and ultimately increase recoveries for the program.

In FY 2015, the CRC identified $292.2 million in mistaken payments, representing an increase of almost 25 percent over the $234.2 million identified in FY 2014. The CRC processed net collections of $149.6 million (including interest) on behalf of the Medicare program, which represents an increase of almost 150 percent over the $59.3 million net collections for FY 2014. Collections for the remaining identified debt will continue into future fiscal years as additional overpayments are simultaneously identified and collections initiated.

In FY 2016, the CRC workload will expand to include the recovery of certain conditional payments where either a liability insurer, no-fault insurer, or workers' compensation entity had or has primary payment responsibility. The CRC will recover directly from the applicable plan as the identified debtor when the applicable plan reports that it has Ongoing Responsibility for Medicals or otherwise notifies CMS of its primary payment responsibility.

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

The Medicare-Medicaid Data Match program (Medi-Medi program) is an avenue for supporting the integration of our Medicaid and Medicare investigations and audits where possible. Medi-Medi functionality is carried out by matching Medicaid and Medicare claims and other data to identify improper billing and utilization patterns. Analysis performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making the Medi-Medi program an important tool in identifying and preventing aberrant billing practices across both programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. During FY 2015, CMS partnered with states that account for most of the expenditures in Medicaid. Participating states include: Alabama, Arizona, Arkansas, California, Colorado, Florida, Georgia, Iowa, Louisiana, Mississippi, Michigan, Missouri, Nebraska, New York, New Jersey, North Carolina, Ohio, Oklahoma, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming.

The Medi-Medi program promotes collaboration among SMAs, CMS, and law enforcement by targeting resources on data analyses and investigations that have the greatest potential for uncovering fraud, waste, and abuse. CMS also collaborates with SMAs on conducting audits. Program participation is optional for the states; however, CMS works diligently to encourage each individual state's participation. Each Medi-Medi program operating in a state is designed to accommodate the individual complexity of that state and its program integrity efforts. .

During FY 2015, CMS participated in integrity field projects in both New York and Florida.

- CMS collaborated with the Florida Agency for Health Care Administration (Medicaid), the Florida Department of Health, and the Division of Insurance Fraud within the Florida Department of Financial Services to investigate and take action against problematic Medicaid providers. By combining efforts, the various agencies have been able to identify and use the most effective tools to take action on problematic Medicaid providers. Once one agency has issued a sanction against a provider based on a deficiency within that agency's purview, other agencies are potentially able to take further action against such a provider based on the first agency's sanction. For example, after a joint investigation with CMS, the Florida Department of Health suspended the license of a physician, after which CMS was able to revoke the physician's Medicare billing privileges. Likewise, when Medicare revoked a provider's billing privileges, Florida was able to terminate the physician from the Medicaid program based on the Medicare revocation in accordance with section 6501 of the Affordable Care Act.

- Also in Florida, CMS used a similar collaborative effort between Medicare and the Florida Medicaid program in FY 2015 to take action against Home Health Agencies that were attempting to circumvent a regional moratorium on enrollment by billing for services delivered in areas where they were not licensed.

- In another FY 2015 field investigation, CMS staff assisted the New York State Office of the Medicaid Inspector General in conducting inventory audits of pharmacies. These investigations resulted in fines, referrals to the New York Medicaid Fraud Control Unit, and termination of a pharmacy by the New York State Medicaid agency.

2.12. Command Center

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. 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.

In FY 2015, the Command Center conducted 41 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.

2.13. Recovery Audit Programs (Medicare Fee-For-Service, Medicaid, and Parts C and D)

Medicare FFS[36]

In FY 2015, the Medicare FFS Recovery Audit program identified and corrected 618,996 claims with improper payments that resulted in $440.7 million in improper payments being corrected. The total corrections include $359.7 million in overpayments collected and $81.0 million in underpayments repaid to providers. The Medicare FFS Recovery Audit Program achieved savings of $237.7 million when accounting for overpayments collected, underpayments repaid to providers, and amounts overturned on appeal.

During FY 2015, the RACs focused their reviews on coding for hospital stays and claims for DME. 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 RACs to correct improper payments, CMS also uses RAC findings to prevent future improper payments. For example, in FY 2015, CMS released four Quarterly Provider Compliance Newsletters that provided detailed information on 17 findings identified by the RACs.

Parts C and D

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

[36] For more information on the Medicare FFS Recovery Audit Program, including the FY 2015 Medicare FFS RAC Report to Congress, the reader should consult https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/.

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 2015, CMS recovered $5.2 million in overpayments made as a result of prescriptions written by excluded providers or unauthorized prescribers. Also in FY 2015, the Part D Recovery Auditor identified improper payments for refill errors of Drug Enforcement Agency (DEA) schedule drugs for calendar years 2010 through 2011. Notifications of improper payments totaling $2.76 million were sent to Part D plan sponsors in February 2015, and recoupments are expected to occur in FY 2016.

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. 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.[37] CMS anticipates that a Part C Recovery Auditor contract will be in place in calendar year 2017.

Medicaid

SMAs contract with Medicaid RACs to identify and recover overpayments and identify underpayments made to Medicaid 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 CFR Part 455 and requiring states to implement Medicaid RAC Programs by January 1, 2012. Pursuant to 42 CFR 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, 2015, 47 states and the District of Columbia had implemented Medicaid RAC Programs, but one of these states ended its RAC program when CMS

[37] A Request for Information 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 (MA) organizations.

approved an exception due to high managed care penetration. At the end of FY 2015, four states had CMS-approved exceptions to Medicaid RAC implementation due to either high Medicaid managed care penetration or small Medicaid beneficiary population. Although the RAC Program is applicable to the five U.S. territories,[38] they have been excepted from RAC Program implementation since the program's inception.[39]

As a measure of effectiveness of the State Medicaid RAC Program for FY 2015, 28 states reported a total combined federal and state share amount of Medicaid RAC recoveries of $106.4 million. The federal share of $65.5 million was returned to the Treasury.[40]

Expenditures related to the State 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 Medicaid RACs effective for FY 2015 was 17.5 percent for durable medical equipment claims and 12.5 percent for all other types of claims.[41]

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.

Although not required to do so, six states have elected to include managed care in their RAC Programs by the end of FY 2015. The largest numbers of RAC audits completed during FY 2015 were performed in the service areas of dental care, inpatient care, outpatient care, long-term care, durable medical equipment, and transportation. The largest total overpayments were identified in inpatient care, outpatient care, nursing homes, and home health services. The most common service areas where RAC audits identified underpayments in FY 2015 were inpatient care and outpatient care.

2.14. Medicare Shared Savings Program

To enhance program integrity efforts for new programs, such as the Shared Savings Program that incentivizes Accountable Care Organizations (ACOs), CMS developed a

[38] 42 CFR 455.518.

[39] 76 FR 57808, 57811-812 (September 16, 2011).

[40] State Medicaid RAC recoveries include overpayments collected, adjusted, and refunded to CMS, as reported by states on the CMS-64.

[41] 77 FR 11127 (February 24, 2012).

streamlined provider screening process that relies in part on safeguards associated with Medicare FFS enrollment. Provider screening is conducted by CMS for organizations applying to the Medicare Shared Savings Program, and periodically thereafter for ACOs, ACO participants, and ACO providers/suppliers. These provider screenings are 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 FPS alerts. CMS may deny an application or impose additional safeguards on ACOs, ACO participants or ACO providers/suppliers whose screening reveals a history of program integrity issues or affiliation with individuals or entities that have a history of program integrity issues.

2.15. Partnership with Law Enforcement

Field Offices and Department of Justice (DOJ) Support

CMS maintains four Medicare program integrity field offices in high vulnerability areas of the country (Chicago, 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. CPI's field offices have staff designated as HEAT Medicare 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.

HEAT Strike Force Teams

The first Medicare Fraud Strike Force (Strike Force) was launched in March 2007 as part of the South Florida Initiative, a joint investigative and prosecutorial effort against Medicare fraud and abuse in South Florida. The Strike Force is a key component of HEAT, composed of interagency teams of analysts, investigators, and prosecutors that focus on the worst offenders in regions with the highest known concentration of fraudulent activities. The Strike Force uses advanced data analysis techniques to identify aberrant billing levels in health care fraud "hot spots"—cities with high levels of billing fraud—and target suspicious billing patterns, as well as emerging schemes and schemes that migrate from one community to another. DOJ and HHS have expanded Strike Force operations to a total of nine areas in the United States—Miami, Florida; Los Angeles, California; Detroit, Michigan; Southern Texas; Brooklyn, New York; Southern Louisiana; Tampa, Florida; Chicago, Illinois; and Dallas, Texas.

In the eight and a half years since its inception,[42] the Strike Force prosecutors have filed more than 1,164 cases charging more than 2,536 defendants who collectively billed the Medicare program more than $8 billion; 1,781 defendants pleaded guilty and 243 others were convicted in jury trials; and 1,477 defendants were sentenced to imprisonment for an average term of about 49 months.

[42] Specifically, the period from May 7, 2007, through September 30, 2015.

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. CMS and state Medicaid programs pay providers for furnishing covered services to eligible beneficiaries, including either on a fee-for-service basis or through risk-based managed care arrangements. If CMS or SMAs pay fraudulent providers, either directly or through managed care plans, for services that the providers did not furnish or for services they did furnish to beneficiaries they knew had no need for the services: (1) Medicare and Medicaid funds are diverted from their intended purpose, (2) beneficiaries who need services may not receive them, and (3) beneficiaries who do not need services may be harmed by unnecessary care. Identifying overpayments due to fraud—and recovering those overpayments from providers that engaged in the fraud—is resource-intensive and can take several years. In contrast, keeping ineligible entities and individuals from enrolling as providers in state Medicaid programs and Medicare in the first place allows the programs to avoid paying claims to such parties and then attempting to identify and recover those overpayments. Provider screening allows such parties to be identified before they are able to enroll and start billing.

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.

3.1. Medicare Provider Screening and Site Visits

CMS implemented the Affordable Care Act's additional screening provisions through a final rule[43] 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 fingerprint-based criminal background checks (FCBCs). For Medicare, CMS implemented the fingerprinting requirements on August 6,

[43] 76 FR 5862 (February 2, 2011).

2014. In FY 2015, CMS denied approximately 1,000 enrollments and revoked more than 250 enrollments as a result of the FCBCs.

The Advanced Provider Screening system (APS)[44] automatically screens all current and prospective providers against a number of data sources, including provider licensing and criminal records. APS identifies and highlights potential program integrity issues that are investigated proactively by CMS. In FY 2015, APS resulted in more than 2.5 million screenings. These screenings were composed of more than 20,000 actionable License Continuous Monitoring alerts, and 170 actionable Criminal Continuous Monitoring alerts, which resulted in more than 3,500 revocations.

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. In FY 2015, the initiative resulted in 23,979 site visits conducted by the National Site Visit Contractor (NSVC) and 35,404 conducted by the National Supplier Clearinghouse (NSC). This has resulted in 398 revocations due to non-operational site visit determinations for all providers and suppliers.

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 (discussed in section 3.2), 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[45] and revocation[46] of more than 652,000 enrollment records since CMS started implementing the requirements of the Affordable Care Act (Figure 1). In FY 2015, CMS deactivated 236,018 enrollments, and revoked 16,702 enrollments;[47] CMS estimates that $1.1 billion was or will be prevented in payments to revoked or deactivated providers and suppliers ($886.2 million for revocations and $220.2 million for deactivations).

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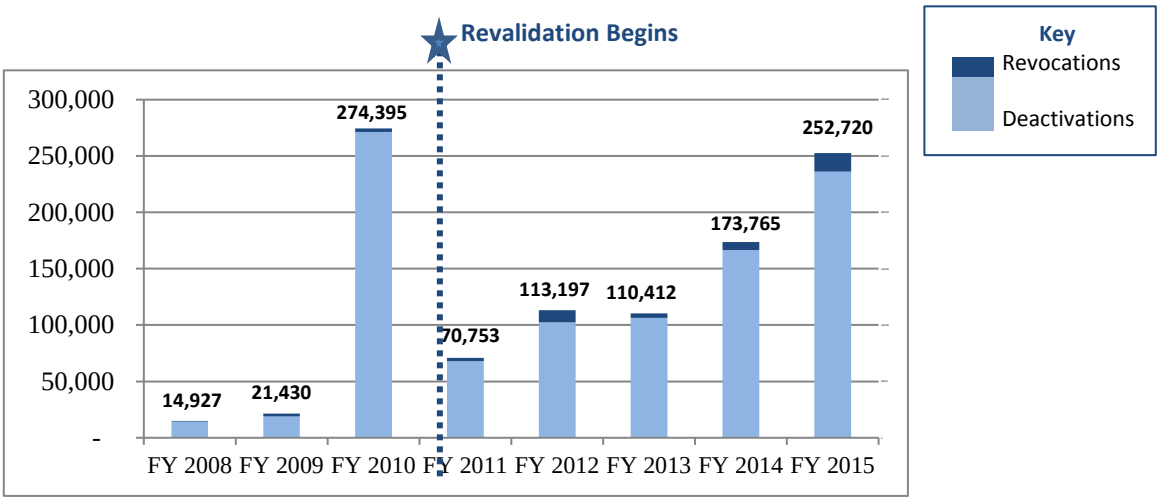
44 Previously referred to as the Automated Provider Screening system.

45 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.

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

47 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 1: Revocation and Deactivation Trend from FY 2008 though FY 2015



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

In April 2013, CMS issued a proposed rule[48] that would provide 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.[49]

3.2. Provider Revalidation

In FY 2015, CMS continued to revalidate the enrollments of all existing 1.5 million Medicare providers and suppliers under the new Affordable Care Act screening requirements. CMS met the Affordable Care Act requirement of having all revalidation notices mailed by March 23, 2015. These efforts ensure that only qualified and legitimate providers and suppliers can provide health care items and services to Medicare 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. States may

[48] 78 FR 25013 (April 29, 2013).

[49] 79 FR 72500 (December 5, 2014).

rely on Medicare revalidation results in order to meet revalidation requirements for dually-participating providers and suppliers.

In FY 2015, CMS revalidated the enrollment information for 448,290 providers and suppliers. The revalidation mailings were completed in 2015; however, revalidation processing continued through FY 2015. CMS has enrolled or revalidated enrollment information for approximately 1,680,382 Medicare providers and suppliers under the enhanced screening requirements of the Affordable Care Act.

3.3. Provider Enrollment, Chain and Ownership System (PECOS) and National Plan and Provider Enumeration System (NPPES) Improvements

The Provider Enrollment, Chain and Ownership System (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 2015, CMS made significant changes to PECOS to simplify access and improve the usability of the system, including the following changes:

- Implemented an enhancement that streamlined and enabled a way for providers and suppliers to navigate with ease within their PECOS web enrollment.
- Implemented an enhancement that pre-populates a dynamic required documents list for providers and suppliers based on their live web submission.
- Implemented an enhancement that allowed providers and suppliers to update their legal business name through PECOS Web without direct MAC involvement.
- Allowed providers and suppliers with large numbers of reassignments to submit PECOS web applications.

The National Plan and Provider Enumeration System (NPPES) is the system that supplies NPI numbers to healthcare providers, maintains their NPI record, and publishes the records online. CMS made significant improvements to the NPPES NPI Registry. The registry is the searchable portion of NPPES, also known as the "Public Search." The Registry publishes the information in NPPES, for free, anonymous public viewing. It also offers the data in downloadable files, and through an Application Programming Interface (API). In FY 2015, CMS released BETA version of the new NPPES Registry and also added connectivity with PECOS to enable providers to update their NPI record when they update PECOS record. This was a major milestone in the NPPES Modernization project.

Highlights of the new registry include the following:

- Redesigned to be consumer-oriented and has an open source tech platform
- "API" allowed outside systems to directly access the data, instead of downloading a five gigabyte file export
- Enhanced search features like capability to search by both an Individual or Organizational NPI at the same time,
- Redesigned with simpler layouts, faster performance, unlimited search results
- And established links to Google maps for provider addresses

3.4. Medicaid Provider Enrollment Oversight

As part of its oversight role in Medicaid, CMS works closely with SMAs to provide regulatory guidance, technical assistance, and other support with respect to provider enrollment. SMAs may rely on the screening completed by CMS for dually-enrolling providers to assist them in complying with their Medicaid screening requirements so that they do not have to re-screen such applicants. States may use Medicare screening data including site visits, payment of application fees, and fingerprint-based criminal background checks. For Medicaid-only FFS providers, SMAs 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."[50] 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 process for states to report and share information about Medicaid terminations. States may report to CMS all "for cause" Medicaid terminations of

[50] 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.

providers who have exhausted all applicable appeal rights or the timeline for appeal has expired for inclusion in the CMS provider termination system.

In FY 2015, CMS published "State Medicaid Director Letter re: Medicaid/CHIP Provider Fingerprint-Based Criminal Background Check." This letter initiated the timeline for SMAs to comply with the requirement to conduct FCBCs for "high" risk category providers.[51] CMS continued to strengthen program integrity in FY 2015 with an organizational change to align Medicaid provider enrollment within the same area that oversees Medicare provider enrollment. Because the provider screening and enrollment requirements generated by the Affordable Care Act are comparable between the Medicare and Medicaid programs, this change increases alignment of policy and guidance between programs, reduces burden to the SMAs to comply with the requirements for provider screening and enrollment, and improves the enrollment experience for providers in these programs.

3.5. Provider Enrollment Moratoria

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 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.[52] In January 2014, CMS extended these moratoria and expanded to include HHAs in the area surrounding Fort Lauderdale, Florida, areas surrounding Dallas and Houston, Texas, and Detroit, Michigan and on Part B ground ambulance suppliers in and around Philadelphia, Pennsylvania.[53] CMS has subsequently extended these moratoria in six month increments.

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 SMAs 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's

[51] State Medicaid Director (SMD) Letter #15-002 (June 1, 2015). In FY 2016, CMS published sub-regulatory guidance that provided states with flexibility regarding the deadline outlined in SMD Letter #15-002.

[52] 78 FR 46339 (July 31, 2013).

[53] 79 FR 6475 (February 4, 2014).

state partners were supportive of CMS's analysis and proposals, and together with CMS, determined that these moratoria would not create access to care issues for Medicaid or CHIP beneficiaries.

4. Continue to Build States' Capacity to Protect Medicaid

CMS assists states in building their internal capacity to conduct program integrity activities for Medicaid. 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, and federal resources for augmenting states' capacity for auditing Medicaid service providers. 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. Through reviews of state processes and procedures, CMS also identifies areas of improvement and works with the states to make sure their integrity programs are robust.

In addition, CMS continues to use HCFAC program discretionary funds to develop and implement enterprise systems that support Medicaid, in particular the Medicaid and CHIP Business Information Solution (MACBIS) initiative, which will improve the ability of CMS and the states to gather and analyze data that will support program integrity activities.

4.1. 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, provider screening and enrollment, and predictive analytics in Medicaid.

From the first course in 2008 through FY 2015, the MII has provided training to state employees and officials from 50 states, the District of Columbia, and Puerto Rico through 6,262 enrollments in 136 courses and 9 workgroups at no cost to the states. In addition, in FY 2013, the MII initiated its own professional accreditation program. 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, 2015, 226 state employees from 44 states have received the CPIP credential.

In FY 2015, the MII provided onsite training with 1,073 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)
- Program Integrity Fundamentals Seminar – CPIP course
- Managed Care Oversight Seminar (2 courses)
- ICD-10 CM Boot Camp (3 courses)
- Coding for Non-Coders
- CPT Outpatient Coding Boot Camp
- Medicaid Provider Enrollment Seminar
- CPT ICD-10CM & ICD-PCS Coding Boot Camp (formerly the Inpatient Coding Boot Camp)
- Emerging Trends in Medicaid and Medicare
- Interviewing & Interrogation Techniques Program
- Fundamentals of Medicaid Program Integrity Seminar (CMS Baltimore on-site)
- Medical Record Auditing
- Program Integrity Directors' Symposium
- Provider Auditing Fundamentals Seminar
- Evaluation & Management Boot Camp
- Data Analytics Symposium
- MII Advisory Group Meeting – workgroup

The distance learning sessions provided in FY 2015 included:

- Dental Schemes – Two Part Series
- Forensic Audits – Three Part Series
- CERT 101 and 2014 Medicare FFS Improper Payment Findings
- PERM 101 and 2014 Medicaid and CHIP Improper Payment Findings
- PERM State Standard Operating Procedures
- Coding for Non-Coders – Three Part Series
- Auditing for Managed Care
- National Drug Overview

4.2. 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.

After completing two separate comprehensive, regulation-based review cycles for every state, the District of Columbia, and Puerto Rico, CMS made a strategic shift to conduct more focused reviews of high-risk program integrity areas tailored to specific challenges facing states. Focused reviews began in FY 2014, concentrated primarily in selected expansion states, and 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. During FY 2015, CMS conducted focused reviews in 10 additional states (Connecticut, Delaware, Missouri, North Carolina, Nevada, Pennsylvania, Tennessee, Texas, Vermont, and Wisconsin) 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 (CAPs) addressing each finding and vulnerability identified during their review within 30 days of release of the report. CMS staff review each state's CAP, discuss any issues with the state during a conference call, and send a follow-up letter outlining the concerns. During subsequent reviews, CMS notes the progress each state has made in correcting inadequacies and vulnerabilities identified in previous reviews.

During FY 2016, CMS plans to add desk reviews targeted to specific issues such as assessing states' progress on CAPs from previous program integrity reviews, status of Payment Error Rate Measurement (PERM) CAPs, compliance with regulations regarding Medicaid RAC requirements, and compliance with regulations regarding provider terminations required by section 6501 of the Affordable Care Act (42 CFR 455.101).

4.3. 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 data from T-MSIS, 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 T-MSIS by states began on a rolling basis starting April 2015 with a goal of all states submitting data in 2017. 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 states' 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 the last year, CMS has invested significant resources in the development, implementation, and integration of two primary systems: the T-MSIS and 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 2015:

MACBIS

- Continue to enhance the change management process to manage change against the baseline.
- Continue identifying, developing, and documenting new requirements.
- Maintain and operate the MACBIS operational infrastructure.
- Continue migrating Medicaid and CHIP legacy systems to the new MACBIS operational infrastructure.
- Continue to phase in the enhancements to the foundational infrastructure that supports the business intelligence and analytical environment that provides data access.

- Plan and begin to execute a systematic transition of specific legacy Medicaid and CHIP IT systems into T-MSIS and/or MACPro.
- Begin to align data from legacy systems and store metadata to assist in the transition of legacy system's data to T-MSIS and MACPro.
- Provide program/project management support to all MACBIS projects.

T-MSIS

- Maintain and enhance the federal T-MSIS application.
- Maintain and enhance the database supporting data analysis and reporting with submitted data.
- Enhance the data analytic capabilities to support program integrity, the innovation center and duals office.
- Provide technical assistance and support for states on-boarding to T-MSIS and continue improving the timeliness and quality of state data submissions.
- Implement collecting performance indicators through the receipt and control process.

MACPro

- Migrate to the virtual data center the MACPro production application.
- Launched Adult Quality and Health Home Measures reporting.
- Maintain and begin implementation of Waiver Management System and Medicaid Model Data Lab functionality.
- Continue collecting requirements for subsequent releases based on business priorities.
- Provide outreach and education for MACPro to users.

4.4. Guidance and Technical Assistance

CMS provides technical assistance on program integrity to states and stakeholders, including CMS contractors, state MFCUs, the HHS OIG, other HHS agencies, and the DOJ including U.S. Attorneys' Offices and the FBI. Common topics include requests for assistance related to 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 a monthly call in which the program integrity directors of the 19 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 2015, CMS's New York field office hosted two semi-annual regional meetings of program integrity stakeholders from Medicaid, Medicare, and law enforcement agencies to discuss current fraud issues and recent cases.

- 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 during FY 2013 and FY 2014.

4.5. Toolkits to Educate Providers and Beneficiaries

The Education Medicaid Integrity Contractor (Education 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 was 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 SMAs, law enforcement agencies, provider and advocacy organizations, and other relevant groups.

CMS uses an online resource[54] 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, fraud awareness and reporting, as well as many others. These toolkits include print and electronic media, train-the-trainer guides, webinars, videos, and other innovative strategies for promoting successful practices and enhancing awareness of Medicaid fraud, waste, and abuse. The Education MIC also conducted eighteen train-the-trainer sessions for states using these educational toolkits during FY 2015.

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 to 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. CMS increased state participation in collaborative audits to a total of 41 states, the District of Columbia, and Guam, which represent an overwhelming majority of Medicaid program expenditures.

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

The most common collaborative audits have been conducted in the areas of hospice services, Medicaid credit balances, and emergency services to non-citizens.

During FY 2015, the Audit MICs identified $36.4 million in total Medicaid 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). For FY 2015, states reported a total federal and state share combined amount of MIC audit recoveries of $14.8 million and returned the federal share of $10.1 million to the Treasury.[55] CMS obligated $27.2 million for Audit MIC activities in FY 2015.

During FY 2015, 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 Medicaid Management Information System (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.

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 of care. To implement this requirement in part, for certain services, federal regulations set out aggregate upper payment limits (UPL). The UPL applies to facility benefits, including: inpatient and outpatient services provided in hospitals, clinics, nursing facilities, and intermediate care facilities for individuals with developmental disabilities, and institutes for mental disease. Certain facilities are exempted from the UPL requirements, such as 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

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

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 annual process provides CMS with information to verify that states are complying with UPL requirements each year and prior to the start of a state's fiscal year.

CMS uses the annual process 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.

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[56] (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.[57]

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.

[56] Public Law 108-173.

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

5. Extend Work in Medicare Parts C and D, Medicaid Managed Care, and Marketplace[58]

CMS is committed to expand its program integrity activities in capitated, managed care programs in Medicare and Medicaid, as well as in the Marketplace. As Medicaid expansion authorized by the Affordable Care Act continues to be implemented throughout the states, CMS expects Medicaid managed care enrollment to continue to grow. Enrollment in Medicare Parts C and D has experienced significant growth in recent years. CMS has strengthened oversight of Medicaid expenditures by working with state partners to improve financial accountability for managed care and FFS, provider rate setting, accuracy of state claiming, and beneficiary and provider eligibility processes, and has conducted oversight of Medicare Part D plan sponsors by conducting audits that detect whether plans are delivering the appropriate healthcare services and medications for which they are being paid.

CMS issued a notice of proposed rulemaking in FY 2015 to modernize the federal regulations around Medicaid managed care.[59] This was the first major update to these regulations in more than a decade, and one of the goals of the proposed rule was to strengthen the fiscal and programmatic integrity of Medicaid managed care. Accordingly, much of CMS's work to improve program integrity in Medicaid managed care for FY 2015 involved the development and refinement of these new regulations. A final rule was issued in FY 2016.

In FY 2015, CMS began a strategic effort to address program integrity issues relating to the federal Marketplace. CMS staff identified programmatic risks and vulnerabilities and, where possible, recommended potential mitigations. CMS staff also created Marketplace fraud, waste, and abuse training materials for both CPI and our law enforcement partners. In addition, CMS staff developed a framework for case intake and undertook investigations received from complaints. Many of these activities were in the preliminary stages during FY 2015 and continued into FY 2016.

For Medicare Part C and Part D, note that additional information can be found in other sections. For instance, information on Recovery Auditors can be found in section 2.13 and information on Risk Adjustment Data Validation (RADV) and improper payments can be found in section 6.4.

[58] Please see section 2.13 for activities regarding the Parts C and D Recovery Audit Program.

[59] 80 FR 31097 (June 1, 2015).

5.1. Medicare Drug Integrity Contractors (MEDICs)

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 Advantage (MA, or Part C) and Prescription Drug (Part D) programs. The NBI MEDIC's main functions include the following activities:

- Managing all incoming complaints about Medicare 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 Medicare 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 Part D plan sponsors, 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 2015, the NBI MEDIC received an average of 749 actionable complaints per month, processed an average of 51 requests for information from law enforcement per month, and referred an average of 46 cases to law enforcement per month. The NBI MEDIC referrals related to Medicare Part D resulted in sentences ordering restitution of $23.9 million, fines of $61,100, forfeitures of $650,000, and civil settlements of $12.2 million according to FY 2015 notifications from law enforcement. As a result of the NBI MEDIC's Law Enforcement Referrals, HHS recovered $36.8 million in FY 2015 from Part D sponsors. As a result of the NBI MEDIC's data analysis projects, HHS recovered $23.5 million in FY 2015 from Part D sponsors. The NBI MEDIC was responsible for assisting the HHS-OIG and DOJ through data analysis and investigative case development in achieving 75 convictions, 37 arrests, and 54 indictments from FY 2015 notifications.

The NBI MEDIC referrals related to Medicare Part C resulted in sentences ordering restitution of $16.7 million, fines of $511,250, and forfeitures of $4.7 million according to FY 2015 notifications from law enforcement. As a result of the NBI MEDIC's Law Enforcement Referrals, HHS recovered $21.9 million in FY 2015 from Part C sponsors.

In April 2015, CMS and the NBI MEDIC launched PLATO, a web-based data analytics tool designed to help plan sponsors combat potential fraud, waste, and abuse in the MA and Part D programs. PLATO was developed to assist plan sponsors in identifying and addressing potential fraud, waste, and abuse, as well as to encourage sharing information between plan sponsors, CMS, and law enforcement regarding the outcomes of their investigations.

PLATO can help plan sponsors identify suspicious pharmacies and providers, and assist in tracking investigations from start to finish. At this time, the tool provides users with national Part D summary information that is updated monthly so that an overall picture of provider activity can be obtained. This benefit will allow plan sponsors to overcome the constraint of being limited to only their drug claims processing information. PLATO also provides information from various public data sources and records, such as medical license information.

In addition, PLATO provides plan sponsors a tool to communicate their administrative and investigative actions taken against subjects and alerts other plan sponsors to questionable activity. Examples of actions that are entered and updated in real-time into PLATO include: terminations, payment suspensions, post-payment reviews, and referrals to law enforcement.

Outreach and Education (O&E) MEDIC

The Outreach and Education (O&E) MEDIC provides Part C and Part D plans with training tools through online content, webinars, and facilitation of quarterly fraud work groups.

In FY 2015, CMS hosted four Medicare Parts C & D Fraud, Waste, and Abuse Trainings, two as in-person events, and two as virtual training webinars. In addition, CMS hosted a webinar focused on drug diversion in March 2015. 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 180 individuals attended each in-person training, and more than 2,000 individuals attended each webinar. Through these events, CMS provided program integrity training to more than 4,300 fraud, waste, and abuse professionals. These trainings provided valuable information about MA and Prescription Drug fraud schemes and anti-fraud, waste, and abuse activities and initiatives. Additionally, during in-person trainings, attendees shared data and leads on suspected potential fraud that they take back to their organizations for further investigation. CMS also provided outreach and educational materials to program integrity stakeholders through the CMS O&E MEDIC website, which had more than 3,000 vetted members at the close of FY 2015.

5.2. Part C and Part D Program Integrity Oversight

In FY 2015, CMS continued to invest 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 MA 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 MA Plans and Prescription Drug Plans (PDPs). As part of the program integrity oversight of Parts C and D, CMS evaluates plan sponsors' operations for compliance with federal regulations and guidance.

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 recover funds paid to unauthorized prescribers. 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.[60] 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 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.[61]

5.3. Medicare Parts C and D Marketing Oversight

CMS takes compliance action against MA organizations, PDPs, Section 1976 Cost Plans, and Medicare-Medicaid Plans that fail to send timely and accurate Annual Notice of

[60] 77 FR 22072 (April 12, 2012).

[61] 79 FR 29843 (May 23, 2014), later revised in interim final rule 80 FR 25958 (May 6, 2015).

Change (ANOC)/Evidence of Coverage (EOC) documents to Medicare enrollees. The ANOC document provides the Medicare enrollee with a description of changes in the enrollee's existing coverage, costs, or service area that will become effective in January. The EOC document details health care benefits covered by the plan, available services, and cost-sharing. Both documents provide Medicare enrollees with vital information that can impact their ability to make informed choices concerning their Medicare health care and prescription drug options.

CMS performs annual timeliness and accuracy reviews of ANOC/EOC documents to ensure that Medicare enrollees receive correct ANOC/EOC documents within specified deadlines. CMS issues compliance notices to Plans/Part D Sponsors for late and/or inaccurate ANOC/EOC documents. Notices that may be issued to the plan include Notices of Non-Compliance (NONC), Warning letters (WL), and Ad Hoc Corrective Action Plans (CAP). CMS also has the option to refer a compliance action for a Civil Money Penalty (CMP) enforcement action when a Plan/Part D Sponsor substantially fails to comply with program and/or contract requirements.

The CY 2015 ANOC/EOC timeliness and accuracy review results are provided in the charts below.

Table 5: Compliance/Enforcement Actions Based on Timeliness Review

Compliance Action	Number of Contracts Affected	Number of Parent Organizations
Notice of Non-Compliance	22	19
Warning Letter	0	0
Ad-hoc Corrective Action Plan	0	0
Civil Money Penalty	1	1

Table 6: Compliance/Enforcement Actions Based on Accuracy Review

Compliance Action	Number of Contracts Affected	Number of Parent Organizations
Notice of Non-Compliance	137	43
Warning Letter	18	13
Ad-hoc Corrective Action Plan	4	4
Civil Money Penalty	6	5

5.4. Audits of Medicare Advantage and Part D Plan Sponsors

CMS conducts program audits of MA and Part D plan sponsors to evaluate their delivery of healthcare services and medications to beneficiaries. In order to conduct a comprehensive audit of a sponsor's operation and maximize Agency resources, program

audits in 2015, as well as in prior years, occur at the parent organization level. Therefore, all MA, MA-PD and PDP contracts owned and operated by the sponsor were included in the scope of the 2015 audits. The audits evaluated sponsor compliance in the following program areas:

- Compliance Program Effectiveness (CPE)
- Part D Formulary and Benefit Administration (FA)
- Part D Coverage Determinations, Appeals, and Grievances (CDAG)
- Part C Organization Determinations, Appeals, and Grievances (ODAG)
- Special Needs Plans Model of Care (SNP-MOC)

Sponsors have all program areas audited when possible, unless a protocol was not applicable to their operation. For example, if a sponsor does not operate a SNP plan, then they would not have a SNP MOC audit performed. Likewise, a standalone PDP does not have the ODAG protocol applied, since they do not offer the MA benefit.

In 2015, an average of 27 conditions of noncompliance were cited per sponsor audited which is decreased from an average of 35 conditions per audited sponsors in 2013. Sponsors who are cited conditions in their audit report are required to correct all deficiencies and undergo validation to ensure issues have been corrected before the program audit can be closed.

In general, program audits give CMS reasonable assurance that sponsors deliver benefits in accordance with the terms of their contract and plan benefit package. However, we also have authority to take enforcement actions, up to and including termination, if warranted, for findings that involve direct beneficiary harm or the potential to result in such harm. We will discuss our enforcement efforts in more detail in section 5.6 below.

We have greatly increased the level of transparency with respect to our audit materials, the performance of our audits and the results of those audits, including any enforcement actions that may result. We believe that program audits and consequences of possible enforcement actions are continuing to drive improvements in the industry and are increasing sponsor's compliance with core program functions in the MA and Part D program.

5.5. Compliance and Enforcement in Medicare Part C and Part D

CMS has the authority to take enforcement or contract actions when CMS determines that an MA or Part D plan sponsor either:

- Substantially fails to comply with program and/or contract requirements,
- Is carrying out its contract with CMS in a manner that is inconsistent with the efficient and effective administration of the Medicare Part C and Part D program requirements, or

- No longer substantially meets the applicable conditions of the Medicare Part C and D program.

Enforcement and contract actions include:

- CMPs,
- Intermediate sanctions (i.e., suspension of marketing, enrollment, payment), and
- Terminations.

In FY 2015, CMS issued 21 CMPs for a total of $5 million and placed three sponsors under marketing and enrollment sanction.

6. Provide Greater Transparency into Program Integrity Issues

CMS is dedicated to providing greater transparency into program integrity issues through education, outreach, partnership, strategic communications, and data releases. CMS is well positioned to work with its partners and stakeholders to share best practices and lessons learned in program integrity. Increased transparency and accountability ensure program efficiency and effectiveness.

6.1. Outreach and Education

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 suppliers 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 CERT 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.

Beneficiary Education

CMS and HHS launched the Fraud Prevention Campaign in January 2010 to increase public awareness about Medicare's fight against fraud. Each year, CMS informs Medicare beneficiaries on an ongoing basis about the importance of guarding their personal information against identity theft and how they can protect against and report suspected fraud. In FY 2015, this effort included the *Medicare & You* handbook and other beneficiary education materials, 1-800-MEDICARE, and www.medicare.gov. Similar messages are disseminated through a wide range of beneficiary touch points, including the Medicare Summary Notice, the MyMedicare.gov Message Center, and response letters to beneficiary inquiries.

In FY 2015, CMS developed beneficiary education materials addressing Part C and Part D fraud, including a pamphlet, an insert for plan Explanation of Benefits (EOB), and a video that alerts beneficiaries about the many ways that they can become victims of dishonest individuals who try to obtain their personal information under false pretenses, particularly during the enrollment period.

Beginning in September 2015, CMS conducted a national advertising campaign "Cracking Down on Fraud" to raise awareness about our efforts to fight fraud and how beneficiaries can participate. Fraud-related call volume at 1-800-MEDICARE increased by 15 percent during the 3-week airing of the television advertising. Social media outreach and other promotional efforts educated beneficiaries about how to identify suspicious activities, prevent fraud by protecting their Medicare number, and report fraud by calling 1-800-MEDICARE.

6.2. Healthcare Fraud Prevention Partnership (HFPP)

In July 2012, the Secretary of HHS and the U.S. Attorney General announced a 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 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 HCFAC program [section 1128C of the 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 and information to identify trends and patterns that will uncover fraud, waste, and abuse that may not otherwise be identified. By the end of FY 2015, the HFPP added 8 new partner organizations, bringing the total number of partners to 43. In FY 2015, the HFPP completed a number of studies using multiple partner data to address fraud in urine drug screening, pharmacy billing, misused codes, and false storefronts. In addition, 2012 public data files were used to identify outliers billing impossible days and inappropriate Evaluation and Management (E&M) coding levels in the areas of physical therapy and psychology.

Partners participated in the HFPP's first case information sharing session in 2015, resulting in an average of seven new leads per partner. Due to expanded partner-to-partner information sharing capabilities, CMS, states, and private insurers received 11 alerts about suspicious providers, 3 alerts of common fraud schemes and misused medical payment codes, and 6 blueprints for investigating specific medical procedures or products with high fraud risk. In FY 2015, the HFPP piloted a generalized data call method in order to reduce the data sharing effort and time to share. Through the generalized data call, CMS, states, and private insurers can: (1) reduce effort to provide data for joint studies, (2) automatically participate in new studies, (3) increase the breadth and number of concurrent fraud prevention studies, and (4) accelerate time to share study results.

6.3. Open Payments

Open Payments is a national 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 2015, CMS published 11.4 million payment records, transfers of value, or instances of ownership/investment interest that were reported during calendar year 2014. These financial transactions totaled $6.49 billion. CMS also re-published 2013 data due to updates made by industry, such as additions/deletions of records, resolution of disputes, and release of delay in publication records, so that the public has access to nearly one and a half years of fully identified data.

The Affordable Care Act requires the Secretary of HHS to collect and display information on payments and other transfers of value and ownership/investment interest annually. CMS publishes information for each reporting year on its public website, and updates the website annually with an additional full year of data. This public website is designed to increase access to, and knowledge about, healthcare industry financial relationships and provide the public with information to enable them to make informed decisions about their healthcare. Disclosure of the financial relationships between the 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 found on the Open Payments website.[62] The data displayed on the Open Payments website are self-reported by applicable manufacturers and GPOs.

To ensure that the healthcare industry is compliant with Open Payments reporting requirements, CMS has the authority to impose civil monetary penalties for late, inaccurate, and incomplete reporting. In 2015 CMS focused Open Payments compliance and enforcement activities on physician-owned distributors (PODs), which are generally a subset of GPOs, and failures to report in the Open Payments program. Through a focused outreach campaign, entities identified as potentially non-compliant were educated about Open Payments reporting requirements and brought into compliance as appropriate, without issuing any civil monetary penalties.

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 FY 2015. CMS hosted regular open forum discussions to share program updates and obtain feedback directly from stakeholders. In addition, CMS continued to improve the usability of the public website and Open Payments system.

Beginning with the report released in FY 2015,[63] which includes 2014 calendar year data, annual data publications will include a full calendar year of new payment data, as

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62 The Open Payments website is available at https://openpaymentsdata.cms.gov/.

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

opposed to the partial year of data reported for 2013. CMS will publish financial data for each program year by June 30th of the following year, as well as updates from previous program periods. In addition, CMS updates, or "refreshes," the Open Payments data at least once, annually, after its initial publication. The refreshed data includes data corrections made since the initial publication of data that were submitted by applicable manufacturers and GPOs.

The summary table below shows the number of records and value of payments published through FY 2015.

Summary of Program Year Data

	2013[1]	2014	Total Published (2013 and 2014)	2013 Delay in Publication[3]	2014 Delay in Publication[3]
Number of Records[2]	4.3 million	11.41 million	15.71 million	183,000	187,000
Value of payments	$3.43 billion	$6.49 billion	$9.92 billion	$454 million	$1.26 billion

[1] This number varies from the previously published Report to Congress due to updates made by industry such as additions/deletions of records, resolution of disputes, and release of delay in publication.
[2] A record is defined as a single row in a dataset that was reported by an applicable manufacturer or GPO.
[3] The Open Payments final rule 42 CFR 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.

6.4. Improper Payment Rate Measurement

The Improper Payments Information Act of 2002 (IPIA), 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)[64] 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 (CERT) program to calculate the improper payment rate in the Medicare FFS program. The CERT program considers any payment that should not have been made or that was paid at an incorrect amount (including both overpayments and underpayments) to be an improper payment. The program evaluates a stratified random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. Medical review professionals review the claim and submitted documentation to

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

make a determination of whether the claim was appropriately paid or denied in accordance with 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 insufficient documentation to determine whether the service or item was medically necessary. 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 outreach to the provider and supplier communities, and expanded reviews by the Medicare FFS Recovery Auditors.

The Medicare FFS improper payment rate for FY 2015 was 12.1 percent, representing $43.3 billion in improper payments. Additional information on the Medicare FFS improper payment methodology can be found in the FY 2015 HHS Agency Financial Report on pages 184-189.

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 once every three years.

The national Medicaid improper payment rate based on measurements that were conducted in fiscal years 2013, 2014, and 2015 was calculated and reported in the HHS FY 2015 AFR. The national Medicaid improper payment rate for FY 2015 was 9.8 percent; representing a projected $50.6 billion in improper payments including both the federal and state share. This was an increase in the improper payment rate from FY 2014 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, 10.6 percent; Medicaid managed care, 0.1 percent; and Medicaid eligibility, 3.1 percent.

The FY 2015 national CHIP improper payment rate, based on measurements that were conducted in 2013, 2014, and 2015, was 6.8 percent or $0.9 billion in estimated improper payments, including both the federal and state share. The national CHIP component improper payment rates were as follows: CHIP FFS, 7.3 percent; CHIP managed care, 0.4 percent; and CHIP eligibility, 4.2 percent. As with Medicaid, CHIP saw an increase in the improper payment rate from FY 2014 due to states having difficulties getting systems into compliance with new requirements.

Please note that, as mentioned in the HHS FY 2015 AFR, in light of changes to the way states adjudicate eligibility for Medicaid and CHIP under the Affordable Care Act, CMS is updating the eligibility component measurement methodology and related PERM program regulation to reflect these changes. In August 2013 and October 2015, CMS released guidance announcing temporary changes to PERM eligibility reviews. For FYs 2015 through 2018, CMS will not conduct the eligibility measurement component of PERM. During this time period, the national Medicaid eligibility improper payment rate will be held constant at the FY 2014 reported rate of 3.1 percent and the national CHIP eligibility improper payment rate held constant at the FY 2014 reported rate of 4.2 percent.

In place of the FYs 2015 through 2018 PERM eligibility reviews, all states are required to conduct eligibility review pilots. The eligibility review pilots provide more targeted, detailed information on the accuracy of eligibility determinations. The pilots use targeted measurements to: provide state-by-state programmatic assessments of the performance of new processes and systems in adjudicating eligibility, identify strengths and weaknesses in operations and systems leading to errors, and test the effectiveness of corrections and improvements in reducing or eliminating those errors. CMS is currently measuring cycles that will be reported in 2016 and 2017.

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

The Medicare MA and Part D programs have been identified as at risk for significant improper payments. In compliance with IPIA, CMS makes efforts to address improper payments in MA 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 revenue required to provide coverage of Original Medicare (Parts A and B) benefits to an enrollee with an average risk profile. CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on the individual enrollee's health status and demographic factors.[65] 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 2015 (based on payment year 2013) was 9.5 percent, or $14.1 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

[65] Under Part C, CMS may also make payments of rebates to plans that bid below the benchmark for their services area(s).

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 proceeded with the 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. For FY 2015, the RADV methodology included: a selection of a stratified random sample of beneficiaries for whom a risk adjusted payment was made in the payment year of the RADV audit, 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 is having a sentinel effect on the quality of risk adjustment data submitted in the future by plans for payment. CMS has conducted payment recovery at the beneficiary (not extrapolated) level for the 2007 RADV audits in the amount of $13.7 million. RADV audits of payment year 2011 will be the first CMS reviews for which CMS intends to recoup funds based on extrapolated estimates, and these audits are currently in progress. In addition, during FY 2015, CMS launched contract level audits for CY 2012.

- **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 2015 (based on payment year 2013) was 3.6 percent, or $2.2 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.

CMS has implemented the following corrective actions to address the Part D improper payment rate:

- **Training:** CMS will continue its national training sessions for Part D sponsors on Part D payment and data submission.

- **Outreach:** Formal outreach to plan sponsors will continue for invalid/incomplete documentation.

  - CMS distributed Plan Sponsor Summary Reports to all plans participating in the presriprtion drug event data validation (PEPV) component of the national payment error estimate. This report provided feedback on their submission and validation results against an aggregate of all other participating plan sponsors.
  - CMS distributed notices of non-compliance to plan sponsors who failed to provide documentation for the PEPV component of the national payment error estimate.
  - In December 2014, CMS conducted a listening session with several stakeholders from the Long Term Care and Long Term Care Pharmacy industry to get feedback on how to resolve a trend of missing or invalid signatures on Long Term Care medication orders selected for the PEPV audit.

- **New Regulatory Provisions:** CMS codified the Affordable Care Act requirement that Part D sponsors must report and return overpayments that they identify. CMS also established a payment recovery and appeal mechanism to be applied when CMS identifies erroneous payment data submitted by a Part D sponsor.

6.5. 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). In September 2015, CMS awarded a contract to conduct the pilot. CMS began collecting data on probable fraud to establish an estimate of probable fraud within HHAs in 2015.

This project will estimate probable fraud among HHAs to pilot test the measurement approach and calculate a service-specific estimate. The HHA service 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.

FY 2015 CMS Program Integrity Obligations[66]		Actual Amounts (in thousandss)
I.	**Address the Full Spectrum of Waste, Abuse, and Fraud**	
i.	Program Integrity Staffing and Support	$ 129,276
ii.	Fraud Prevention System	$ 16,491
iii.	Program Integrity Modeling and Analytics	$ 18,524
iv.	One PI Data Analysis	$ 34,302
v.	Benefits Integrity	$ 150,932
vi.	Medical Review	$ 191,178
vii.	Provider Audit	$ 153,876
viii.	Medicare Secondary Payer	$ 153,286
ix.	Medi-Medi	$ 55,461
x.	Appeals Initiatives	$ 7,885
xi.	Medicare Recovery Audit Program[67]	$ 147,656
	Subtotal[68]	$ 1,058,867
II.	**Proactively Manage Provider Screening and Enrollment**	
i.	Advanced Provider Screening	$ 21,037
ii.	Provider Enrollment, Chain and Ownership System (PECOS)	$ 28,836
iii.	Section 6401 Provider Screening/Other Enrollment[69]	$ 29,684
iv.	National Supplier Clearinghouse	$ 18,991
	Subtotal	$ 98,548
III.	**Continue to Build States' Capacity to Protect Medicaid**	
i.	State Medicaid Access to Data and Support	$ 68,969

[66] The chart represents total obligations for the CMS Center for Program Integrity, Medicare Integrity Program and Medicaid Integrity Program for Fiscal Year 2015 (10/1/2014 through 9/30/2015, inclusive).

[67] The Medicare Recovery Audit Program is not funded through a budget appropriation. RACs are funded and paid through contingency fees calculated on the basis of the amounts recovered as a result of their audit activity. In addition, RACs are paid for identifying underpayments.

[68] This total includes amounts for the Medicare Recovery Audit Program on line I.xi., which are not obligations under the budget authority.

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

FY 2015 CMS Program Integrity Obligations[66]		Actual Amounts (in thousandss)
	Subtotal	$ 68,696
IV. Extend Work in Medicare Parts C and D, Medicaid Managed Care, and Marketplace		
i.	MEDICs	$ 27,327
ii.	Part C and D Contract/Plan Oversight	$ 15,655
iii.	Monitoring, Performance Assessment, and Surveillance	$ 49,774
iv.	Program Audit	$ 34,843
v.	Compliance and Enforcement	$ 17,569
	Subtotal	$ 145,168
V. Provide Greater Transparency into Program Integrity Issues		
i.	Outreach and Education	$ 37,121
ii.	Healthcare Fraud Prevention Partnership	$ 19,407
iii.	Open Payments	$ 22,512
iv.	Error Rate Measurement Activities	$ 42,658
v.	Probable Fraud Measurement Study	$ 1,715
	Subtotal	$ 123,413
Total CMS Program Integrity Obligations[70, 71]		**$1,494,692**

[70] This total includes the amounts for the Medicare Recovery Audit Program on line I.xi., which are not obligations under the budget authority.

[71] For the purpose of calculating the three-year average return on investment in section 1.3.2, the Medicare obligation amount is $1,377.7 million.

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 for Fiscal Year 2015	February 2016	http://oig.hhs.gov/publications/docs/hcfac/FY2015-hcfac.pdf
Comprehensive State Program Integrity Review Reports	FY 2015	http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html
CMS Financial Report for Fiscal Year 2015	November 2015	https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CFOReport/Downloads/2015_CMS_Financial_Report.pdf
FY 2015 CMS Budget Justification	FY 2015	https://www.cms.gov/about-cms/agency-information/performancebudget/downloads/fy2015-cj-final.pdf
The Comprehensive Error Rate Testing Annual Report (Medicare Fee-For-Service)	FY 2015	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/2015_Improper_Payments_Report.pdf
Medicaid and CHIP 2015 Improper Payments Report	FY 2015	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicaid-and-CHIP-Compliance/Downloads/2015MedicaidandCHIPImproperPaymentsReport.pdf
Medicare FFS Recovery Audit Program	FY 2015	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/FY2015-Medicare-FFS-RAC-Report-to-Congress.pdf

Report	Issued	Availability
Program Year 2014 Open Payments Report to Congress	April 2016	https://www.cms.gov/OpenPayments/Downloads/Open-Payments-Report-to-Congress.pdf

ACO	Accountable Care Organization
AMA	American Medical Association
ANOC	Annual Notice of Change
API	Application Programming Interface
APS	Advanced Provider Screening
ASPE	Assistant Secretary for Planning and Evaluation
BCRS	Benefits Coordination and Recovery System
CAP	Corrective Action Plan
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CHIP	Children's Health Insurance Program
CHIPRA	Children's Health Insurance Program Reauthorization Act of 2009
CMS	Centers for Medicare & Medicaid Services
CMP	Civil Money Penalty
COB&R	Coordination of Benefits & Recovery
CPI	[CMS] Center for Program Integrity
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
EOC	Evidence of Coverage
FBI	Federal Bureau of Investigation
FCBC	Fingerprint-based Criminal Background Check
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
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
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
IPTIT	Integrated Project Team Information Technology
IVIG	Intravenous Immune Globulin
MA	Medicare Advantage
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
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
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NBI	National Benefit Integrity
NCCI	National Correct Coding Initiative
NSC	National Supplier Clearinghouse
NSVC	National Site Visit Contractor
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
OMHA	Office of Medicare Hearings and Appeals
One PI	One Program Integrity
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PEPV	Prescription Drug Event Data Validation
PERM	Payment Error Rate Measurement
PI	Program Integrity
PI Board	Program Integrity Board
PIM	Program Integrity Manual
PPS	Prospective Payment System
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
SBJA	Small Business Jobs Act of 2010
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
SMDL	State Medicaid Director Letter
SMRC	Supplemental Medical review Contractor
SPA	State Plan Amendment
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
ZPIC	Zone Program Integrity Contractor

Public Law	Title	Short Title
90-248	Social Security Amendments of 1967	
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	Affordable Care Act
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

Public Law	Title	Short Title
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA