



FY  
19

# Medicare & Medicaid Program Integrity

Annual Report to Congress



**Annual Report to Congress – Medicare and Medicaid Integrity Programs – FY 2019**  
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# Executive Summary

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The Annual Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2019 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report annually about the use of appropriated funds and the effectiveness of the use of such funds for Medicare and Medicaid program integrity activities.<sup>1</sup>

CMS's mission for program integrity is to detect and combat fraud, waste, and abuse of the Medicare and Medicaid programs. CMS achieves this mission by making the correct payment to the right entity for services covered under CMS programs. CMS also works with providers, states, and other stakeholders to support proper enrollment and accurate billing practices. This work focuses on protecting patients while also minimizing unnecessary burden on providers and states.

As federal health programs are quickly evolving, CMS's program integrity strategy must keep pace addressing emerging challenges. CMS developed a five-pillar program integrity strategy intended to modernize the Agency's approach and protect its programs for future generation.<sup>2</sup> This strategy focused on stopping bad actors, preventing fraud, mitigating emerging program risks, and reducing provider burden, and leveraging new technology.

## Medicare Program Integrity

Medicare processes over one billion Fee-for-Service FFS claims a year.<sup>3</sup> To do this properly – to “pay it right” – Medicare contractors must determine whether the claim is submitted by a legitimate provider or supplier for an item or services that is covered, reasonable and necessary, and properly documented in the medical record.<sup>4</sup>

**In FY 2019, CMS's program integrity activities, including both the prevention and recovery of improper payments, saved Medicare an estimated \$13.8 billion and produced a**

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<sup>1</sup> Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Act and not all Medicaid program integrity activities are funded under section 1936 of the Act. As such, this report includes other Medicare 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 program integrity units of the states that enhance the overall integrity of the Medicaid program, even if they are not funded under section 1936 of the Act. In addition, for the purposes of this document, the term “provider” may refer to a provider, supplier, physician, or non-physician practitioner, and the term may represent an individual or an organization.

<sup>2</sup> <https://www.cms.gov/newsroom/press-releases/fiscal-year-fy-2019-medicare-fee-service-improper-payment-rate-lowest-2010-while-data-points> and <https://www.cms.gov/outreach-and-education/outreachffsprovpartprogprovider-partnership-email-archive/2019-11-27>

<sup>3</sup> <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2019.pdf> at page 2.

<sup>4</sup> <https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Future-of-PI-RFI.pdf>

**return on investment of \$9.7 to 1 (see Table 3 for activity-specific savings).**<sup>5</sup> These activities help strengthen the integrity and sustainability of the Medicare program, while promoting quality and the efficient delivery and financing of health care.

In addition to the estimated savings and ROI cited above, CMS's program integrity efforts have contributed to a reduction in the improper payment rate in recent years. The Medicare FFS estimated improper payment rate decreased to 7.25 percent in FY 2019, from 8.12 percent in FY 2018, the third consecutive year the Medicare FFS improper payment rate has been below the 10 percent threshold for compliance established by the Improper Payments Elimination and Recovery Act of 2010. Progress in a number of important areas drove the FY 2019 decrease:<sup>6</sup>

- Home health claims corrective actions, including policy clarification and Targeted Probe and Educate for home health agencies, resulted in a significant **\$5.32 billion decrease** in estimated improper payments from FY 2016 to FY 2019.
- Other Medicare Part B services (e.g., physician office visits, ambulance services, lab tests, etc.) saw a \$1.82 billion reduction in estimated improper payments in FY 2019 due to clarification and simplification of documentation requirements for billing Medicare.
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) improper payments decreased an estimated \$1.29 billion from FY 2016 to FY 2019 due to various corrective actions implemented over the years.

### **Medicaid and Children's Health Insurance Program (CHIP) Program Integrity**

States and the Federal Government share mutual obligations and accountability for the integrity of Medicaid and the Children's Health Insurance Program (CHIP). This includes the application of effective safeguards to ensure the proper and appropriate use of both federal and state dollars and the provision of quality care to some of the nation's most vulnerable populations. While the responsibility for making proper payments in Medicaid primarily lies with the states, CMS plays a significant role in supporting state efforts to meet high program standards. **In FY 2019, federal and state collaborative program integrity efforts for Medicaid and CHIP resulted in estimated federal share<sup>7</sup> savings of \$1.1 billion (see Table 4 for activity-specific savings).**

CMS recently took a significant step by releasing the FYs 2019-2023 Comprehensive Medicaid Integrity Plan (CMIP) that seeks to protect taxpayer dollars and is based on the three pillars of

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<sup>5</sup> CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes; thus, some Medicare savings amounts may not be directly comparable to amounts in previous reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

<sup>6</sup> <https://www.cms.gov/newsroom/press-releases/fiscal-year-fy-2019-medicare-fee-service-improper-payment-rate-lowest-2010-while-data-points>

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

flexibility, accountability, and integrity. The CMIP includes stronger audit and oversight functions, increased beneficiary eligibility oversight, and enhanced enforcement of state compliance with federal rules.<sup>8</sup>

### **Collaboration with Law Enforcement in Program Integrity**

CMS coordinates closely with a variety of other partners to meet its program integrity objectives, including, but not limited to the Department of Health and Human Services Office of Inspector General (HHS-OIG); the Department of Justice (DOJ); State law enforcement officials, including those from the state Medicaid Fraud Control Units (MFCUs); and other federal, state and local agencies. Specifically, since FY 2018, CMS coordinates a Major Case Coordination initiative, providing an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after the development of fraud leads. Highlights of the Major Case Coordination in FY 2019 include:

- In April 2019, CMS implemented administrative actions as part of “Operation Brace Yourself,” a joint effort with HHS-OIG and DOJ to target fraudulent DMEPOS suppliers. As part of this effort, CMS implemented payment suspensions on 130 DMEPOS suppliers totaling \$74 million as of August 2019. CMS implemented payment suspensions on an additional seven DMEPOS suppliers subsequent to those initial actions. Forty suppliers under payment suspension voluntarily withdrew from the Medicare program and 45 suppliers were revoked from Medicare since that activity.
- CPI suspended Medicare payments to eight enrolled providers and revoked four providers in order to support the April 2019 coordinated law enforcement actions of the Appalachian Regional Prescription Opioid Strike Force (ARPO).
- In September 2019, CMS took administrative action in support of a federal law enforcement action involving five federal districts against 35 defendants associated with dozens of telemedicine companies and cancer genetic testing laboratories.<sup>9</sup> Also in September 2019, CMS participated in a coordinated health care fraud enforcement action in the northeastern United States, involving more than \$800 million and the distribution of over 3.25 million pills of opioids in “pill mill” clinics. This takedown also included the second phase of “Operation Brace Yourself”, where DOJ announced charges in that DMEPOS fraud case against defendants around the country, for their alleged participation in a massive DMEPOS telemarketing fraud scheme back on April 9, 2019.

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<sup>8</sup> <https://www.cms.gov/files/document/comprehensive-medicare-integrity-plan-fys-2019-2023.pdf>

<sup>9</sup> <https://www.justice.gov/opa/pr/federal-law-enforcement-action-involving-fraudulent-genetic-testing-results-charges-against>

### **Program Integrity Public/Private Partnerships**

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary public/private partnership between the Federal Government, state and local agencies, law enforcement entities, private health insurance plans, employer organizations, and health care anti-fraud associations. The purpose of the partnership is to exchange data and information between the partners to help improve capabilities to fight fraud, waste, and abuse in the health care industry. In FY 2019, the HFPP reached a membership level of 144 Partner organizations.<sup>10</sup> Collectively, these organizations represent more than 215 million covered lives, equivalent to more than three out of four insured Americans. Thirty-four of the current partners are actively submitting claim level data, representing 100 million individuals, or more than one in three insured Americans.

During FY 2019, the HFPP completed a number of studies using multiple partner data to address fraud, waste, and abuse. The HFPP also held quarterly Regional Information Sharing Sessions throughout FY 2019, allowing partners to participate in case sharing sessions, listen to panel discussions, receive updates from law enforcement, and collaborate with members from across the Partnership. In the summer of 2019, the HFPP published an issue paper to the Partnership titled “Fraud & Abuse in Recovery Treatment Services for Substance Use Disorders: An Issue Paper by the Healthcare Fraud Prevention Partnership.” In September 2019, the HFPP also hosted its annual Executive Board meeting, which expanded participation to include Partner executive leadership, and provided an opportunity for attendees to review HFPP successes and strategies.

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<sup>10</sup> The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control (HCFAC) Program Annual Report for Fiscal Year 2019 (The FY 2019 HCFAC Report) at page 10.

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# 1. Introduction

The Report to Congress on the Medicare and Medicaid Integrity Programs for Fiscal Year (FY) 2019 fulfills requirements in sections 1893(i)(2) and 1936(e)(5) of the Social Security Act (the Act). These provisions require the Centers for Medicare & Medicaid Services (CMS) to report annually about the use of appropriated funds and the effectiveness of the use of such funds for activities conducted under the Medicare and Medicaid Integrity Programs.

CMS is the agency within the Department of Health and Human Services (HHS) responsible for administering the Medicare program consistent with title XVIII of the Act. CMS is also responsible for providing direction and guidance to, and oversight of, state-operated Medicaid programs and Children's Health Insurance Programs (CHIP), consistent with titles XIX and XXI of the Act, respectively, in addition to other federal health care programs and activities. The Medicare and Medicaid Integrity Programs help protect Medicare and Medicaid against fraud, waste and abuse.

The Medicare and Medicaid programs provide coverage for a large proportion of Americans each year. Medicare enrollment has increased from 19 million beneficiaries in 1966 to approximately 60 million beneficiaries in FY 2019, while Medicaid enrollment has increased from 11 million beneficiaries in 1966 to about 75 million beneficiaries.<sup>11</sup>

The CMS Center for Program Integrity (CPI) is primarily responsible for implementation of the Medicare Integrity Program and the Medicaid Integrity Program. While other areas of CMS also engage in program integrity-related activities,<sup>12</sup> this report focuses on the program integrity activities led, or that had significant involvement, by CPI.

**During FY 2019, CMS's comprehensive program integrity efforts resulted in estimated Medicare savings of \$13.8 billion and estimated Medicaid and CHIP federal share<sup>13</sup> savings of \$1.1 billion.** This commitment to fiscal integrity allows CMS to focus on efforts to better serve patients and ensure that providers render high-quality care. Section 1.3 of this report provides activity-specific Medicare, Medicaid, and CHIP savings, and Appendix B provides detailed methodologies for all savings metrics.

## CMS Program Integrity Strategy

CMS's mission for program integrity is to detect and combat fraud, waste, and abuse of the Medicare and Medicaid programs. CMS makes sure it is paying the right entity the right amount for services covered under our programs. This work includes providers, states, and other

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<sup>11</sup> The 2019 CMS Agency Financial Report can be found at <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2019>.

<sup>12</sup> For example, the Office of Financial Management, the Center for Medicaid and CHIP Services, and the Center for Medicare also perform program integrity activities, such as the Medicare Secondary Payer (MSP) program and certain improper payment measurement programs.

<sup>13</sup> The Medicaid program is jointly funded by the Federal Government and states. The Federal Government pays states for a specified percentage of program expenditures, called the Federal Medical Assistance Percentage (FMAP). Therefore, program-integrity-related activities in Medicaid result in savings for both states and the Federal Government. CMS highlights the federal share (instead of the combined federal and state shares) of Medicaid savings for reporting consistency across savings metrics.

stakeholders to support proper enrollment and accurate billing practices, and focuses on protecting patients while also minimizing unnecessary burden on providers and states.

CMS developed a five-pillar program integrity strategy<sup>14</sup> intended to modernize the Agency's approach and protect its programs for future generations:

- 1. Stop Bad Actors.** CMS works with law enforcement agencies to identify and take action on those who defraud federal health programs. This collaboration allows CMS to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs.
- 2. Prevent Fraud.** CMS continues to focus on moving away from an expensive and inefficient “pay and chase” model to preventing fraud, waste and abuse on the front end. This focus includes making system changes to avoid similar fraudulent activities in the future, as well as developing policies, regulations, and processes to prevent the exploitation of vulnerabilities before claims payment.
- 3. Mitigate Emerging Programmatic Risks.** CMS recognizes the need to be vigilant in monitoring new and emerging areas of risk, and developing methods to address these risks. This includes maintaining flexibility to respond to future data and trends, tailor strategies accordingly, and use new approaches for high vulnerability services. CMS is also exploring ways to identify and reduce program integrity risks related to value-based payment programs by looking to experts in the health care community for lessons learned and best practices.
- 4. Reduce Provider Burden.** While CMS strengthens program integrity, the Agency also takes steps to ensure that these efforts do not create unnecessary time and cost burden on providers. Efforts in this area include targeted medical review with individualized education to assist rather than punish providers who make good faith claim errors. CMS is also working to make access to our coverage and payment rules more easily accessible to providers, as well as streamlining and reducing documentation requirements that are duplicative or unnecessary. Additionally, CMS is exploring ways to centralize provider screening and provider monitoring across payers.
- 5. Leverage New Technology.** CMS is looking to leverage new, innovative strategies and technologies, perhaps involving artificial intelligence and/or machine learning, to modernize and automate our program integrity efforts. This new technology could allow the Medicare program to review compliance on more claims with less burden on providers and less cost to taxpayers. CMS could use these innovations in both our current payment models, as well as in new payment models.

CMS organized this report around these strategic goals, with each section detailing specific aspects of CMS's program integrity efforts. Appendices at the end of this report provide additional information and references.

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<sup>14</sup> <https://www.cms.gov/blog/future-medicare-program-integrity>

## 1.1 Reporting Requirements

As required by sections 1893(i)(2) and 1936(e)(5) of the Act, CMS must report to Congress the use of appropriated funds and the effectiveness of the use of such funds for activities conducted under the Medicare and Medicaid Integrity Programs.<sup>15</sup> Section 1893(h)(8) of the Act also requires an annual report to Congress concerning the effectiveness of the Recovery Audit Programs under Medicare and Medicaid in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors including the savings to the program.

This report fulfills the reporting requirements with respect to the Medicare and Medicaid Integrity Programs, the Medicare Fee-for-Service (FFS) Recovery Audit Contractors (RACs), the Medicare Advantage (MA or Part C) and Medicare Prescription Drug Part D Program (Part D) RACs, and the Medicaid RACs.<sup>16</sup>

### 1.1.1 Medicare Program Integrity Funding

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>17</sup> established mandatory funding for the Medicare Integrity Program, which provided a stable funding source for Medicare program integrity activities not subject to annual appropriations. The Patient Protection and Affordable Care Act<sup>18</sup> increased the base funding level and applied an annual inflationary adjustment to that base funding level. This funding supports program integrity functions performed across CMS, including: Audits, Medicare Secondary Payer (MSP), Medical Review, Provider Outreach and Education, Benefit Integrity, and Provider Enrollment.

CMS receives additional mandatory funding under the Deficit Reduction Act of 2005 (DRA)<sup>19</sup> and the Patient Protection and Affordable Care Act, as well as discretionary Health Care Fraud and Abuse Control (HCFAC) program funding, subject to annual appropriation. CMS obligated a total of \$1.3 billion in FY 2019 for the Medicare Integrity Program.

Appendix A provides further information on the obligations for program integrity activities for both Medicare and Medicaid. Please note that this report includes activities funded outside of the Medicare or Medicaid Integrity Programs. Activities such as CMS Innovation Center models, the Medicare Shared Savings Program (MSSP), and the DMEPOS Competitive Bidding are included to provide a more complete discussion of CMS's efforts to address program integrity

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<sup>15</sup> Please note that not all Medicare program integrity-related activities are funded under section 1893 of the Act and not all Medicaid program integrity activities are funded under section 1936 of the Act. As such, this report includes other Medicare 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 program integrity units of the states that enhance the overall integrity of the Medicaid program.

<sup>16</sup> CMS is subject to other requirements to report to Congress, such as on the use of Health Care Fraud and Abuse Control program funds. This report details activities that may also be subject to other reporting requirements.

<sup>17</sup> Public Law 104-191.

<sup>18</sup> Public Law 111-148 and Public Law 111-152 collectively constitute the Patient Protection and Affordable Care Act.

<sup>19</sup> Public Law 109-171.

## 1.1.2 Medicaid Program Integrity Funding

The DRA added section 1936 to the Act to establish the Medicaid Integrity Program and provided CMS with dedicated funding to operate the program. 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 Patient Protection and Affordable Care Act amended the Act to increase this funding authorization each year by the Consumer Price Index for all urban consumers.<sup>20</sup> CMS obligated a total of \$84.4 million in FY 2019 for the Medicaid Integrity Program. In addition, CMS obligated a total of \$90.2 million in FY 2019 for Medicaid program integrity activities using discretionary HCFA funds.

Appendix A provides further information on the obligations for program integrity activities for both Medicare and Medicaid. Please note that this report includes activities funded outside of the Medicare or Medicaid Integrity Programs. Activities such as CMS Innovation Center models, the Medicare Shared Savings Program (MSSP), and the DMEPOS 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

As the largest purchaser of health care in the world, CMS maintains the nation's largest collection of health care data. Based on the latest 2019 projections, Medicare and Medicaid (including state funding) represent 37 cents of every dollar spent on health care in the United States (U.S.)—or looked at from three different perspectives: 54 cents of every dollar spent on nursing homes, 44 cents of every dollar received by U.S. hospitals, and 34 cents of every dollar spent on physician services.<sup>21</sup>

Medicare processes over one billion FFS claims a year, and accounts for approximately 15 percent of the federal budget. Since 1966, Medicare enrollment has increased from 19 million to over 60 million beneficiaries.<sup>22</sup>

States and the Federal Government jointly fund the Medicaid program, as CMS provides specified matching payments to the states and territories for Medicaid program expenditures and related administrative costs. Medicaid is the primary source of health care for more than 75 million beneficiaries. Approximately 12.3 million people are dually eligible and covered by both Medicare and Medicaid.<sup>23</sup>

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

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<sup>20</sup> 42 U.S.C. 1396u-6(e)(1)(D).

<sup>21</sup> CMS Financial Report Fiscal Year 2019, at page 2. <https://www.cms.gov/files/document/cms-financial-report-fiscal-year-2019>.

<sup>22</sup> *Id.* at page 2.

<sup>23</sup> <https://www.cms.gov/files/document/medicaremedicaidualenrollmenteverenrolledtrendsdatabrief.pdf>

Table 1: Program Integrity Contractors

Contractor	Program	Program Integrity Responsibilities
<b>Unified Program Integrity Contractors (UPICs)</b> <sup>24</sup>	Medicare FFS and Medicaid	<ul style="list-style-type: none"> <li>• Investigate leads generated by the Fraud Prevention System (FPS) and complaints from beneficiaries and a variety of other sources</li> <li>• Perform proactive data analysis to identify cases of suspected fraud, waste, and abuse in Medicare and Medicaid</li> <li>• Make recommendations to CMS or states for appropriate administrative actions (i.e., revocations and suspensions) to protect the Medicare Trust Funds and Medicaid dollars</li> <li>• Implement administrative actions (i.e., payment suspensions, prepayment edits, auto-denial edits) in coordination with the Medicare Administrative Contractors</li> <li>• Conduct medical review for Medicare and Medicaid program integrity purposes</li> <li>• Identify and investigate incidents of potential fraud, waste, or abuse that exist in Medicare and Medicaid</li> <li>• Make referrals to law enforcement for potential prosecution</li> <li>• Provide support for ongoing law enforcement investigations</li> <li>• Provide feedback and support to CMS to improve the Unified Case Management System</li> <li>• Identify improper payments to be recovered within Medicare and Medicaid</li> </ul>
<b>Medicare Administrative Contractors (MACs)</b>	Medicare FFS	<ul style="list-style-type: none"> <li>• Determine proper payment amounts, process and pay providers, suppliers, and individuals</li> <li>• Perform provider and supplier screening and enrollment</li> <li>• Audit the Medicare cost reports upon which CMS bases part of Medicare payments to institutional providers, such as hospitals and skilled nursing facilities</li> <li>• Conduct prepayment, post-payment medical review, and prior authorization</li> <li>• Analyze claims data to identify providers and suppliers with patterns of errors or unusually high volumes of particular claims types</li> <li>• Develop and implement prepayment edits</li> <li>• Provide beneficiary, provider, and supplier education, outreach, and technical assistance</li> <li>• Collect overpayment amounts identified through prepayment and post-payment review conducted by the MACs and other review contractors</li> </ul>
<b>Supplemental Medical Review Contractor (SMRC)</b>	Medicare FFS	<ul style="list-style-type: none"> <li>• Conducts nationwide medical review as directed by CMS</li> <li>• Notifies CMS and the MACs of identified improper payments and noncompliance with documentation requests</li> </ul>

Contractor	Program	Program Integrity Responsibilities
<b>Medicare FFS Recovery Audit Contractors (RACs)</b>	Medicare FFS	<ul style="list-style-type: none"> <li>• Conduct post-payment audits to identify a wide range of improper payments</li> <li>• Correct improper payments by collecting identified overpayments and restoring identified underpayments</li> <li>• Make recommendations to CMS about how to reduce improper payments in the Medicare FFS program</li> </ul>
<b>Coordination of Benefits &amp; Recovery (COB&amp;R) Contractors</b>	Medicare FFS Secondary Payer	<ul style="list-style-type: none"> <li>• Identify, develop, and recover Group Health Plan and Non-Group Health Plan debts</li> <li>• Provide customer service to beneficiaries, providers, attorneys, insurers, and employers</li> <li>• Perform data collection and electronic data interchange</li> <li>• Conduct business analysis, quality assurance activities, and outreach and education to stakeholders</li> <li>• Provide system development and data center support for all coordination of benefits and recovery information systems</li> </ul>
<b>National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)</b>	Medicare Part C and Part D	<ul style="list-style-type: none"> <li>• Conduct data analyses of Part C and Part D issues leading to potential identification of improper payments and regulatory compliance</li> <li>• Coordinate Part C and Part D program integrity outreach activities for stakeholders, including plan sponsors and law enforcement entities</li> <li>• Support CMS enforcement of Part C and Part D through Program Integrity focused audits of plan sponsors.</li> </ul>
<b>Investigations Medicare Drug Integrity Contractor (I-MEDIC)</b>	Medicare Part C and Part D	<ul style="list-style-type: none"> <li>• Detect, prevent, and proactively deter fraud, waste, and abuse (FWA) for high risk prescribers/pharmacies in Medicare Parts C and D</li> <li>• Conduct complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support which includes RFIs</li> </ul>
<b>Part D RAC</b>	Medicare Part D	<ul style="list-style-type: none"> <li>• Conduct post-payment reviews of reconciled Part D Prescription Drug Events (PDEs) data to identify a wide range of improper payments</li> </ul>
<b>State Medicaid RACs</b>	Medicaid FFS and Managed Care	<ul style="list-style-type: none"> <li>• Contract with state Medicaid agencies (SMAs) to identify and recover overpayments, and identify underpayments made to Medicaid providers</li> </ul>

## 1.3 Measuring Program Integrity Success

### 1.3.1 Improper Payment Rates

As required by the Improper Payments Information Act of 2002 (IPIA), as amended,<sup>25</sup> CMS calculates an improper payment rate for Medicare FFS, Part C, and Part D; Medicaid; and CHIP. Table 2 provides the gross improper payment rates (including both overpayments and

<sup>25</sup> Public Law 107-300, Public Law 111-204, and Public Law 112-248, respectively.

underpayments) and summarizes trends in the improper payment rates since 2013. Section 4.1 of this report provides specific information on how each program measures improper payment.

**Table 2: Reported Improper Payment Rates Trend for Reporting Years 2015-2019**

Program	2015	2016	2017	2018	2019
Medicare FFS	12.1%	11.0%	9.5%	8.1%	7.25%
Part C	9.5%	10.0%	8.3%	8.1%	7.87%
Part D	3.6%	3.4%	1.7%	1.7%	0.75%
Medicaid	9.8%	10.5%	10.1%	9.8%	14.9%
CHIP	6.8%	8.0%	8.6%	8.6%	15.83%

While this report discusses many of the ways that CMS works to reduce the improper payment rates for Medicare, Medicaid, and CHIP, the FY 2019 HHS Agency Financial Report (AFR) also includes a comprehensive overview of the improper payment rates for CMS programs, as well as the corrective actions implemented in FY 2019 to reduce improper payments.<sup>26</sup>

### 1.3.2 Medicare Program Integrity Savings

**In FY 2019, CMS’s Medicare program integrity activities saved an estimated \$13.8 billion.<sup>27</sup> This represents a return on investment of \$9.7 to 1.<sup>28</sup>** CMS provides activity-specific Medicare program integrity savings in Table 3,<sup>29</sup> programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

As a particular highlight in FY 2019, CMS and its law enforcement partners orchestrated multiple takedowns of fraudulent providers, and CMS’s administrative actions on these providers resulted in significant savings. Of the savings reported in Table 3, a total of \$750.5 million came from takedown-related actions, as well as concurrent and ensuing administrative actions (e.g., from CMS’s provider enrollment operations), on providers involved in DMEPOS, genetic testing, and home health fraud schemes.

**Table 3: Medicare Savings**

Type of Medicare Savings <sup>a</sup>	FY 2019 Savings (in millions)
Prevention Savings	
Automated Actions	

<sup>26</sup> HHS FY 2019 Agency Financial Report, at page 189. <https://www.hhs.gov/sites/default/files/fy2019-hhs-agency-financial-report-final.pdf>.

<sup>27</sup> CMS periodically updates the methodologies for Medicare savings metrics due to program and/or data source changes; thus, some Medicare savings amounts may not be directly comparable to amounts in previous reports. Appendix B provides information regarding which savings metrics underwent methodological changes.

<sup>28</sup> CMS calculates the fiscal year return on investment for the Medicare Integrity Program by dividing the total Medicare savings by the total Medicare obligations.

<sup>29</sup> In addition to the savings provided in Table 3, CMS’s program integrity activities may result in other benefits that are difficult to quantify, e.g., potential sentinel effects from CMS’s pre-claim review and prior authorization initiatives.

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<b>Type of Medicare Savings <sup>a</sup></b>	<b>FY 2019 Savings (in millions)</b>
National Correct Coding Initiative (NCCI) Procedure-to-Procedure Edits	\$251.2
NCCI Medically Unlikely Edits	\$366.0
Ordering and Referring Edits	\$122.3
Fraud Prevention System Edits	\$69.4
MAC Automated Medical Review Edits	\$1,011.4
UPIC Automated Edits	\$36.2
<b>Prepayment Review Actions</b>	
Medicare Secondary Payer (MSP) Operations	\$6,397.7
MAC Non-Automated Medical Reviews	\$69.6
UPIC Non-Automated Reviews	\$20.7
<b>Provider Enrollment Actions</b>	
Revocations	\$407.9
Deactivations	\$101.3
<b>Other Actions</b>	
Payment Suspensions	\$654.4
Medicare Part D Reconciliation Data Reviews	-\$5.6
<b>Total Prevention Savings <sup>b</sup></b>	<b>\$9,502.4</b>
<b>Recovered Savings</b>	
<b>Overpayment Recoveries</b>	
MSP Operations	\$2,919.7
MSP Commercial Repayment Center	\$167.3
MAC Post-Payment Medical Reviews	\$5.3
Medicare FFS RAC Reviews	\$119.9
SMRC Reviews	\$57.4
UPIC Post-Payment Reviews	\$113.6
Overpayments from Retroactive Revocations	\$1.4
Overpayments Related to Risk Adjustment Data	\$46.1
Medicare Part D Plan Sponsor Audits	\$3.8
Medicare Part D RAC Reviews	\$0.0
<b>Cost Report Payment Accuracy</b>	
Provider Cost Report Reviews and Audits	\$453.2
Cost-Based Plan Audits	\$42.4
<b>Plan Penalties</b>	
Medicare Part C and Part D Program Audits	\$0.6
Medical Loss Ratio Requirement	\$222.1
<b>Other Actions</b>	
Party Status Appeals	\$10.7
<b>Law Enforcement Referrals</b>	
UPIC Law Enforcement Referrals	\$72.3
I-MEDIC Part C and Part D Law Enforcement Referrals	\$18.5
<b>Total Recovered Savings <sup>b</sup></b>	<b>\$4,254.2</b>
<b>Total Savings (Prevention and Recovered) <sup>b</sup></b>	<b>\$13,756.6</b>

<sup>a</sup> Appendix B provides detailed methodologies for all metrics listed in this table.

<sup>b</sup> Savings values may not add to totals due to rounding.

### 1.3.3 Medicaid and CHIP Savings

States and the Federal Government share mutual obligations and accountability for the integrity of Medicaid and CHIP. This includes the application of effective safeguards to ensure the proper and appropriate use of both federal and state dollars and the provision of quality care to some of the nation’s most vulnerable populations. CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from Medicaid and CHIP financial management and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. **In FY 2019, these efforts resulted in estimated federal share savings of \$1.1 billion.** CMS provides activity-specific Medicaid and CHIP federal share savings in Table 4,<sup>30</sup> programmatic highlights in subsequent sections of this report, and detailed savings metric methodologies in Appendix B.

**Table 4: Medicaid and CHIP Savings**

Type of Medicaid and CHIP Savings <sup>a</sup>	FY 2019 Federal Share Savings (in millions)
<b>Medicaid and CHIP Financial Management</b>	
Averted Medicaid and CHIP Federal Financial Participation	\$257.7
Recovered Medicaid and CHIP Federal Financial Participation	\$370.4
<b>State-Reported Medicaid Overpayment Recoveries</b>	
UPIC Recoveries	\$17.8
State Medicaid RAC Recoveries	\$78.4
Office of Inspector General Compliant False Claims Act Recoveries	\$9.3
Other State Program Integrity Recoveries	\$352.2
<b>Total Savings <sup>b</sup></b>	<b>\$1,085.8</b>
<sup>a</sup> Appendix B provides detailed methodologies for all metrics listed in this table.	
<sup>b</sup> Savings values may not add to totals due to rounding.	

<sup>30</sup> Medicaid savings may differ in the HHS Agency Financial Report compared to the Report to Congress on the Medicare and Medicaid Integrity Programs because CMS pulls the data from Form CMS-64 at different times.

## 2. Stop Bad Actors

### 2.1 Partnership and Collaboration with Law Enforcement

#### 2.1.1 Major Case Coordination

CMS coordinates closely with a variety of other partners to meet its program integrity objectives, including but not limited to the Department of Health and Human Services Office of Inspector General (HHS-OIG), DOJ; and other federal agencies.

CMS's Major Case Coordination initiative provides an opportunity for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and fraud investigators to collaborate before, during, and after the development of fraud leads. This level of collaboration has contributed to several successful coordinated law enforcement actions and helped CMS better identify national fraud trends and program vulnerabilities. As a result of the work performed in the Major Case Coordination initiative, there has also been a marked increase in the number and quality of law enforcement referrals. In FY 2019, CPI conducted 42 Major Case Coordination meetings that included participants from CMS and law enforcement partners, including the Medicare Fraud Strike Force,<sup>31</sup> resulting in 540 referrals to law enforcement and 125 referrals to the Strike Force. Since implementation, there have been over 1,400 case reviews and 800 law enforcement referrals made as a result of Major Case Coordination.

Highlights of Major Case Coordination outcomes in FY 2019 include:

- In April 2019, CMS, along with our Federal and State law enforcement partners, participated in the largest ever prescription opioid law enforcement operation. The Appalachian Regional Prescription Opioid Surge Takedown resulted in charges against 60 individuals, including 53 medical professionals, for their alleged participation in the illegal prescribing and distributing of opioids and other dangerous narcotics and for health care fraud schemes. The charges involved over 350,000 prescriptions for controlled substances and over 32 million pills in West Virginia, Ohio, Kentucky, Alabama, and Tennessee. Law enforcement activity affected more than 24,000 patients in the region, who received prescriptions from these medical professionals over the past two years. CPI suspended Medicare payments to eight providers and revoked four providers in order to support coordinated law enforcement actions of the Appalachian Regional Opioid Strike Force.
- Also in April 2019, CMS implemented administrative actions as part of "Operation Brace Yourself," a joint effort with HHS-OIG and DOJ to target fraudulent DMEPOS suppliers. As part of this effort, CMS implemented payment suspensions on 130 DMEPOS suppliers in an amount that totaled \$74 million as of August 2019. CMS implemented payment suspensions on an additional seven DMEPOS suppliers subsequent to those initial actions. Forty suppliers under payment suspension voluntarily withdrew from the Medicare program, and 45 suppliers were revoked from Medicare since that activity.

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<sup>31</sup> The Medicare Fraud Strike Force is a key component of the joint HHS and DOJ Health Care Fraud Prevention and Enforcement Action Team, known as "HEAT."

- In September 2019, CMS took administrative action in support of a federal law enforcement action involving five federal districts against 35 defendants associated with dozens of telemedicine companies and cancer genetic testing laboratories.
- Also in September 2019, CMS participated in a coordinated health care fraud enforcement action in the northeastern United States, involving more than \$800 million and the distribution of over 3.25 million pills of opioids in “pill mill” clinics. This takedown also included the second phase of “Operation Brace Yourself”, where DOJ announced charges in that DMEPOS fraud case against defendants around the country, for their alleged participation in a massive DMEPOS telemarketing fraud scheme back on April 9, 2019.

### 2.1.2 Command Center

The CMS Command Center opened in July 2012 and provides a venue for Medicare and Medicaid policy experts, law enforcement officials, clinicians, and CMS fraud investigators to collaborate in real time before, during, and after the development of fraud leads. These collaborative activities enable CMS to more quickly and efficiently take administrative actions such as revocations of Medicare billing privileges and payment suspensions. In FY 2019, CPI conducted 42 Major Case Coordination meetings in the Command Center that included participants from CMS and law enforcement partners.

## 2.2 Provider Enrollment

Provider enrollment is the gateway to the Medicare and Medicaid programs, and careful and appropriate provider enrollment screening techniques are the key to preventing ineligible providers and/or suppliers from entering either program. Payments to potentially fraudulent providers, either directly via FFS arrangements, or through managed care plans, divert Medicare and Medicaid funds from their intended purpose, may deprive beneficiaries of needed services, and/or might harm beneficiaries who receive 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. By contrast, keeping ineligible entities and individuals from enrolling as providers in Medicare and state Medicaid programs allows the programs to avoid paying inappropriate claims to such parties and then later having to attempt to identify and recover those overpayments, which often is a burdensome and costly process. Provider screening identifies such individuals and entities before they are able to enroll and start billing.

CMS’s role in the provider and supplier enrollment process differs between 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 and supplier enrollment information in a variety of ways, such as claims payment and fraud prevention programs. States directly oversee the provider screening and enrollment process for their Medicaid programs, and CMS provides regulatory guidance and technical assistance to states.

## 2.2.1 Medicare Provider Screening and Site Visits

As required by law,<sup>32</sup> CMS established three levels of provider and supplier enrollment risk-based screening: “limited”; “moderate”; “high”; and a classification by provider- and supplier-types, subject to upward adjustment in certain circumstances.<sup>33</sup>

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 unannounced site visits in addition to all the requirements in the “limited” screening level. Providers and suppliers in the “high” risk category are subject to fingerprint-based criminal background checks (FCBCs) in addition to all of the requirements in the “limited” and “moderate” screening levels. In FY 2019, CMS denied approximately 771 enrollments and revoked 11 enrollments because of the FCBCs or a failure to respond to a request for fingerprints.

The Advanced Provider Screening (APS) system automatically screens all current and prospective providers and suppliers against a number of data sources, including provider and supplier licensing and criminal records, to identify and highlight potential program integrity issues for proactive investigation by CMS. APS continuously monitors all providers and suppliers against external licensure and criminal data sources to alert CMS of any actionable changes to licensure information or of any criminal flags. In FY 2019, APS conducted more than 6.3 million screenings. The number of screenings increased due to more frequent federal rescreening of providers, bulk screening of providers for preclusion list and additional screenings for Medicaid state pilot. These screenings generated more than 46,000 License Continuous Monitoring alerts and more than 3,000 Criminal Continuous Monitoring alerts, which resulted in approximately 85 revocations due to felony convictions and over 77 revocations due to licensure issues.

Site visits are a screening mechanism used to prevent questionable providers and suppliers from enrolling or maintaining enrollment in the Medicare program. The CMS-authorized site visit contractors validate that the provider or supplier complies with Medicare enrollment requirements during these visits. In FY 2019, there were 30,668 site visits conducted by the National Site Visit Contractor, which conducts site visits for most Medicare FFS providers and suppliers, and 26,438 conducted by the National Supplier Clearinghouse, which conducts site visits for Medicare DMEPOS suppliers. This work resulted in about 232 revocations due to non-operational site visit determinations for all providers and suppliers.

CMS’s provider screening and enrollment efforts in Medicare have had a significant impact on removing ineligible providers and suppliers from the program. In FY 2019, **CMS deactivated over 150,679 enrollments and revoked about 2,556 enrollments.**<sup>34</sup> The site visit and

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<sup>32</sup> Sec. 6401 Public Law 111–148

<sup>33</sup> 76 FR 5862 (Feb. 2, 2011).

<sup>34</sup> We note that revalidation results are point-in-time results, as deactivated providers could reactivate over time with updated practice information or after showing evidence of proper licensing.

revalidation requirements<sup>35</sup> have contributed to the deactivation<sup>36</sup> and revocation<sup>37</sup> of more than one million enrollment records since CMS started implementing these screening and enrollment requirements.

## 2.3 Provider Revalidation

DMEPOS suppliers are required to revalidate every three years and all other providers and suppliers are required to revalidate every five years. 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. States may rely on Medicare revalidation results in order to meet revalidation requirements for dually participating providers and suppliers.

In FY 2019, CMS continued its revalidation efforts, which includes regular revalidation cycles for all existing two million Medicare providers and suppliers. In FY 2019, CMS initiated revalidation for more than 245,000 providers and suppliers. In this same time period, close to 200,000 providers and suppliers have successfully completed revalidation and approximately 45,000 providers and suppliers have been deactivated.

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<sup>35</sup> Revalidation requires providers and suppliers to resubmit and recertify the accuracy of their enrollment information to maintain their Medicare billing privileges and for reevaluation under new screening guidelines.

<sup>36</sup> Deactivation means the provider's or supplier's billing privileges are stopped but can be restored upon the submission of updated information. See 42 CFR § 424.540.

<sup>37</sup> Revocation means the provider's or supplier's billing privileges are terminated. See 42 CFR § 424.535.

## 3. Prevent Fraud

### 3.1 Unified Program Integrity Contractors

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

Various UPIC administrative actions result in Medicare savings, including automated edit claim denials, non-automated review claim denials, provider revocations and deactivations, payment suspensions, overpayment recoveries, and law enforcement referrals.

The Fraud Prevention System (FPS) is one source of leads for UPICs. The FPS is a predictive analytics technology required by the Small Business Jobs Act of 2010, and it runs sophisticated algorithms against Medicare FFS claims nationwide. When FPS models identify aberrant activity or patterns, the system automatically generates and prioritizes leads for further review and investigation by UPICs. Based on the results of all information collected, the UPICs coordinate with CMS and the MACs in taking appropriate administrative action to recover improper payments and prevent future loss of funds, or the UPICs refer the case to law enforcement.

### 3.2 Integrated Data Repository and the One Program Integrity Portal

The Integrated Data Repository (IDR) contains Medicare Part A; Part B (including DMEPOS); MA (encounter); and Part D PDE, beneficiary, and provider data. This robust data warehouse supports program integrity analytics, such as the development of FPS models. CMS uses the IDR to provide broad, easy access to data and enhanced data integration while strengthening and supporting CMS's analytical capabilities.

CMS augments the data available in the IDR to provide a comprehensive view of Medicare and Medicaid data including claims, beneficiary data, and prescription drug information. For example, CMS has 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 Transformed Medicaid Statistical Information System (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 in conjunction with the IDR to provide access to robust business intelligence analytical tools and to facilitate data sharing with program integrity contractors and law enforcement. One PI provides a single access point to the data within the IDR, as well as analytic tools to review the data.

### 3.3 Part C and D Program Integrity

#### 3.3.1 Medicare Part C and Part D Program Oversight

In FY 2019, CMS continued to strengthen Part C and Part D oversight. As part of the program integrity oversight of Part C and Part D programs, CMS evaluates plan sponsors' operations for compliance with federal regulations and guidance. All Part C and Part D plan sponsors are required to have an effective program to prevent, detect, and correct non-compliance and fraud, waste, and abuse. These programs consist of written policies, procedures, and standards that articulate the organizations' commitment to complying with all applicable federal and state standards, including the prevention and detection of fraud and abuse in the Part C and Part D programs. Specifically, Part C and Part D plan sponsors must have a properly trained compliance officer vested with the daily operations of the compliance program, provisions for internal monitoring and auditing, and oversight of their first-tier downstream and related entities, as well as other requirements. Plan sponsors' compliance programs must include measures to prevent, detect, and correct noncompliance with CMS's program requirements, as well as fraud, waste, and abuse. In FY 2019, CMS continued to enhance its data analytic capabilities and improved coordination with law enforcement to provide a more comprehensive assessment of program integrity activities in the Part C and Part D programs.

#### 3.3.2 Medicare Drug Integrity Contractors

In FY 2019, HHS split the Medicare Part C and Part D program integrity initiatives between two contractors, the National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC)<sup>38</sup> and the Investigations MEDIC (I-MEDIC). The NBI MEDIC has a national focus related to plan oversight pertaining to the following Medicare Part C and Part D program integrity initiatives, including identification of program vulnerabilities, data analysis, health plan audits, outreach and education, and law enforcement support. The primary purpose of the I-MEDIC is to detect, prevent, and proactively deter fraud, waste, and abuse for high-risk prescribers or pharmacies in Medicare Part C and Part D by focusing primarily on complaint intake and response, data analysis, investigative activities, referrals to law enforcement partners, and law enforcement support.

As part of its work, the NBI MEDIC conducts analyses to identify trends, anomalies, and questionable provider and pharmacy practices, including aberrant opioid prescriptions. Examples include:

- Quarterly Pharmacy Risk Assessment, which categorizes pharmacies as high, medium, or low risk
- Quarterly Outlier Prescriber Assessment, which provides a peer comparison of the prescribing of Schedule II controlled substances
- Pill Mill Doctor Project/Pill Mill Prescriber 2.0, which identifies prescribers with a high risk of fraud, waste and abuse in prescribing Schedules II-IV controlled substances

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<sup>38</sup> At the end of FY 2019, the NBI MEDIC was re-named the Plan Program Integrity (PPI) MEDIC.

- Improper payments for drugs inappropriately paid under the Part D program without a medically accepted indication (e.g., Transmucosal Immediate Release Fentanyl<sup>39</sup>)

In January 2019, CMS launched a voluntary tool, Analytics and Investigations Collaborative Environment-Fraud, Waste and Abuse (AICE-FWA), in the Health Plan Management System (HPMS). AICE-FWA is designed to assist MA and Part D plan sponsors in identifying and addressing potential fraud, waste, and abuse, as well as to encourage information sharing between plan sponsors, law enforcement, states, and CMS. By providing users with monthly-updated national Part D summary information, AICE-FWA yields an overall picture of provider activity and allows users to identify suspicious pharmacies and providers, and overcomes the constraint of plan sponsors being limited to only their drug claims processing information. In addition, AICE-FWA provides plan sponsors with the opportunity to report their administrative and investigative actions taken against subjects, which serves to alert other plan sponsors to questionable activity. Examples of actions entered into AICE-FWA include terminations, payment suspensions, post-payment reviews, and referrals to law enforcement. CMS's federal law enforcement partners also use AICE-FWA.

### 3.3.3 Medicare Part C and Part D Marketing Oversight

CMS takes compliance action against Part C and Part D plan sponsors, Section 1876 Cost Plans,<sup>40</sup> and Medicare-Medicaid Plans that fail to send timely and accurate Annual Notice of Change (ANOC) and Evidence of Coverage (EOC) documents to Medicare enrollees. The ANOC provides a description of changes in the enrollee's existing coverage, costs, or service area that will become effective the following January. The EOC details health care benefits covered by the plan, available services, and cost sharing. Both documents provide Medicare enrollees with vital information that can influence their ability to make informed choices concerning their Medicare health care and prescription drug options.

CMS performs annual timeliness reviews of ANOC documents and accuracy reviews of ANOC and EOC documents to ensure that Medicare enrollees receive accurate information within specified deadlines. CMS issues notices, such as Notices of Non-Compliance, Warning Letters, and Ad-Hoc Corrective Action Plans, to Part C and Part D plan sponsors for sending late and/or inaccurate ANOC and EOC documents. CMS may determine a civil money penalty (CMP) should be imposed when a Part C or Part D plan sponsor substantially fails to comply with program and/or contract requirements involving ANOC and EOC documents.<sup>41</sup>

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<sup>39</sup> *CMS Opioid Misuse Strategy 2016*, available at <https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/Downloads/CMS-Opioid-Misuse-Strategy-2016.pdf>.

<sup>40</sup> Section 1876 cost plans are operated by a legal entity licensed as an HMO in accordance with a Medicare managed care risk or cost reimbursement contract under Section 1876 of the Social Security Act and Title 42, Part 417 of the Code of Federal Regulations

<sup>41</sup> The FY 2019 HCFAC Report at page 76.

### 3.3.4 Medicare Part C and Part D Audits

CMS conducts program audits of Part C and Part D plan sponsors, as well as organizations offering Medicare-Medicaid plans, to evaluate their delivery of health care items, services, and drugs to beneficiaries. Routine program audits occur at the parent organization level, whereby all plan contracts owned and operated by the parent organization are included in the audit scope, to maximize Agency resources. Plans subject to routine audits have all program areas reviewed, except where a protocol was not applicable to their operation.<sup>42</sup>

The audits in FY 2019 evaluated sponsor compliance in the following program areas:

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans Model of Care
- Medicare-Medicaid Plan – Service Authorization Requests, Appeals and Grievances
- Medicare-Medicaid Plan - Care Coordination and Quality Improvement Program Effectiveness

In 2019, CMS cited an average of 11 conditions of noncompliance per sponsor audited, which was similar to 2018 where CMS cited an average of 13 conditions per audited sponsor. Plan sponsors are required to correct cited deficiencies and undergo validation to ensure compliance before the program audit is closed.

In addition to the program audits performed above, Sections 1857(d)(1) and 1860D-12(b)(c) of the Act require the HHS Secretary to provide for the annual audit of financial records of at least one-third of the Medicare Advantage Organizations (MAOs), Prescription Drug Plans (PDPs) and Program of All-inclusive Care for the Elderly (PACE) organizations. The one-third financial audit program examines the health plans' financial records, data relating to costs, Medicare utilization, and the computation of plan bids.

In general, program and financial audits give CMS reasonable assurance that Part C and Part D plan sponsors deliver benefits in accordance with the terms of their contract and plan benefit package. CMS also has authority to take compliance and enforcement actions, up to and including termination, if warranted, for findings that involve direct beneficiary harm or the potential to result in such harm. During FY 2019, CMS completed 218 audits of MAOs and PDPs for the contract year 2017.

### 3.3.5 Medicare Part D Reconciliation Data Reviews

Part D plan sponsors receive monthly prospective payments from CMS. During benefit-year-end reconciliation, CMS compares its prospective payments to a plan with the plan's actual cost data,

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<sup>42</sup> For example, if a plan sponsor does not operate a Special Needs Plan then it would not have a Model of Care audit performed. Likewise, a stand-alone prescription drug plan does not have the Part C Organization Determinations, Appeals, and Grievances protocol applied because it does not offer the Part C benefit.

submitted through prescription drug event (PDE) records and direct and indirect remuneration (DIR) reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payments, which limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Risk corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending. To promote accuracy in the plan-reported data, CMS validates both PDE and DIR data in advance of reconciliation and works with the plans to resolve any issues.

### 3.3.6 Medical Loss Ratio Requirement

A medical loss ratio (MLR) represents the percentage of revenue a health insurance issuer uses for patient care or activities that improve health care quality, as opposed to other expenses that do not directly impact patient care or quality (e.g., marketing, profits, salaries, administrative expenses, and agent commissions). The minimum MLR requirement may create incentives for Part C and Part D plan sponsors to reduce overhead expenses, and ensure that taxpayers and enrolled beneficiaries receive value from Medicare plans. Part C and Part D plan sponsors must report the MLR for each contract they have with CMS.

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

### 3.3.7 Compliance Enforcement in Medicare Part C and Part D

CMS has the authority to take enforcement or contract actions when it determines that a Part C or Part D plan sponsor either:

- Substantially fails to comply with program and/or contract requirements
- Carries out its contract with CMS in a manner inconsistent with the efficient and effective administration of the Part C and Part D program requirements, or
- No longer substantially meets the applicable conditions of the Part C and Part D programs

Enforcement and contract actions may include CMPs, intermediate sanctions (e.g., suspension of marketing, enrollment, and payment), or contract terminations.

In FY2019, CMS issued six CMPs to Part C and Part D plan sponsors, placed three Part C plan sponsors and one Part D plan sponsor under enrollment sanctions, and terminated the contract of one Part C plan sponsor.<sup>43</sup>

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<sup>43</sup> Medicare Part C and Part D enforcement notices are available at <https://www.cms.gov/Medicare/Compliance-and-Audits/Part-C-and-Part-D-Compliance-and-Audits/PartCandPartDEnforcementActions-.html>.

### 3.4 Healthcare Fraud Prevention Partnership

The Healthcare Fraud Prevention Partnership (HFPP) is a voluntary, public-private partnership between the federal government, state agencies, law enforcement, private health insurance plans, employer organizations, and health care anti-fraud associations. The purpose of the partnership is to exchange data and information between the partners to help improve capabilities to fight fraud, waste, and abuse in the health care industry.<sup>44</sup> The HFPP aims to foster a proactive approach to detect and prevent health care fraud through data and information sharing. The HFPP works to provide:

- An unparalleled data source – The HFPP represents a full spectrum of health care payers that provide claims data that supports sophisticated data analytics
- Collaboration & strategic partnerships – HFPP Partners participate and guide the Partnership, have the opportunity to establish strategic collaborations across diverse stakeholders, and share critical time-sensitive information
- Material outcomes – The HFPP’s most important goal is generating comprehensive approaches, strategies, and leads that materially impact each Partner’s effort to combat health care fraud, waste, and abuse

To achieve its objectives, the HFPP uses a “Trusted Third Party” (TTP), a CMS contractor, to act as a “common data aggregator” under the HIPAA Privacy Rules. Under this model, the TTP is able to conduct cross-payer data aggregation and analysis services to identify potential fraud across payers, while ensuring that each Partner only has access to its own claims data.

Cross-payer studies enable the HFPP to proactively identify vulnerabilities in real time, significantly increasing the value of membership to all Partner organizations. The HFPP is currently using professional and institutional claims but is planning to expand to collect, pharmacy, and dental claims in the future. The HFPP uses a diverse variety of approaches to identify vulnerabilities in Partner data. These methods include:

- Standard searches to detect anomalies that may indicate the existence of fraud, waste, and abuse
- Scanning of incoming claims information against existing data sets, such as lists of deactivated providers
- Creation of reference files that list providers that may be suspect based on known risks
- Creation of informational content to support stakeholders in addressing vulnerabilities (e.g., white papers)

In FY 2019, the HFPP reached a membership level of 144 Partner organizations that included 48 state and local government agencies, 71 private payers, 12 federal agencies and 13 associations representing more than 215 million covered lives, which is equivalent to more than 3 in 4 insured Americans. Thirty-four of the current partners are actively submitting claim level data, representing 100 million individuals, or more than 1 in 3 insured Americans.<sup>45</sup>

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<sup>44</sup> The FY 2019 HCFAC Report, page 10.

<sup>45</sup> The FY 2019 HCFAC Report, page 10.

In addition, in FY 2019, partners submitted over 9.9 billion professional claim lines for conducting cross-payer analyses and, by the end of FY 2019, the HFPP commenced or completed more than 25 studies since program inception.

Example of studies developed or executed in FY 2019 include the identification of:

- Services billed under an “impossible day” scenario (including evaluation and management services, psychotherapy services, and physical and occupational therapy services)
- Deactivated providers that continue to submit claims for payment
- Providers that submitted claims after the ordering/referring provider was deactivated
- Abnormalities (such as billing for services more frequently than would normally be expected) pertaining to specific service areas including chronic care management, electroencephalograms, urine drug testing, and sleep studies

The HFPP also held quarterly Regional Information Sharing Sessions throughout FY 2019. These sessions allow Partners to participate in case sharing sessions, listen to panel discussions, receive updates from law enforcement, and have the opportunity to collaborate with members from across the Partnership.

In FY 2019, the HFPP published an issue paper entitled “Fraud and Abuse in Recovery Treatment Services for Substance Use Disorders: An Issue Paper by the Healthcare Fraud Prevention Partnership.” Issues related to substance use treatment fraud and abuse are significant and of high interest to Partners. The paper provides Partners with information that characterizes the key elements of substance use treatment fraud and abuse and supports Partner’s efforts to detect and deter those issues.

### **3.5 Medicare Beneficiary Education**

CMS undertakes various activities to inform Medicare beneficiaries about the importance of guarding their personal information against identity theft and how they can protect against and report suspected fraud. In FY 2019, CMS communicated key fraud prevention messages in beneficiary channels, including the *Medicare & You* handbook and other beneficiary education materials, through 1-800-MEDICARE, and via [Medicare.gov](https://www.medicare.gov). CMS disseminated similar messages through a wide range of beneficiary touch points, including the Medicare Summary Notice, the MyMedicare.gov Message Center, social media, direct-to-beneficiary emails, and response letters to beneficiary inquiries.

#### **Medicare Beneficiary Identifiers and the New Medicare Card**

Beginning in August 2017, CMS conducted a national “Guard Your Card” advertising campaign to alert beneficiaries about scams to obtain their Medicare number and the importance of protecting their number to prevent identify theft and Medicare fraud. The campaign also noted that Medicare would mail new Medicare cards to people with Medicare starting in early 2018 to help prevent personal identity theft. Earned and social media outreach and other promotional efforts continued into the fall to remind beneficiaries to protect their Medicare number and warning them about the types of scams that occur during the Medicare open enrollment period.

While new Medicare cards were being mailed out (April 2018 - January 2019), CMS ramped up outreach to beneficiaries making fraud prevention messaging more prominent in all channels we traditionally use to communicate with this audience. Key messages served to remind beneficiaries:

- they were getting a new card with a new, unique and more secure Medicare number
- they did not have to take action to get their new card
- the new card is free of charge
- once they received their new card, they must securely destroy their old card

CMS launched an aggressive localized earned media campaign to reach beneficiaries in each of the mailing waves when card mailing began in their states and territories. CMS continued this targeted strategy of ramping up outreach in the states and territories where a wave was about to begin, to help ensure beneficiaries were primed and engaged just before the new card hit their mailbox.

CMS proactively communicated through CMS's multiple existing beneficiary channels (Medicare.gov, local and national partnerships, social media, etc.) as well as constantly monitored feedback from our call center, regional offices, information intermediaries, etc. making adjustments as necessary to our fraud prevention messaging and outreach tactics as card mailing progressed and waves ended.

In January 2019, CMS announced that it finished mailing new cards to approximately 61 million people with Medicare, across all mailing waves before our April 2019 statutory deadline. Through national press, CMS reminded beneficiaries about the importance of protecting their new card against health care fraud and continued to share this message throughout 2019.

Unlike with the previous use of Social Security Numbers, CMS now has the ability to re-issue an individual's Medicare Beneficiary Identifier (MBI). Following the major takedowns related to DMEPOS, genetic testing, and home health fraud, CMS identified and reissued approximately 220,000 MBIs that were compromised in these fraud schemes, providing a safeguard for an estimated \$1.1 billion at risk.

## **3.6 National Correct Coding Initiative**

### **3.6.1 Medicare National Correct Coding Initiative**

Given the volume of claims processed by Medicare each day, and the cost associated with conducting medical review of an individual claim, CMS uses automated edits to help prevent improper payment without the need for manual intervention. CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment of Part B claims. NCCI Procedure-to-Procedure (PTP) edits prevent inappropriate payment for billing code pairs that in general should not be reported together by the same provider for the same beneficiary for the same date of service. NCCI Medically Unlikely Edits (MUEs) prevent payment for a potentially

inappropriate quantity of the same service rendered by the same provider for the same beneficiary on the same date of service. NCCI edits are refined and updated quarterly.<sup>46</sup>

### 3.6.2 Medicaid National Correct Coding Initiative

Section 1903(r) of the Act requires states to implement NCCI methodologies into their Medicaid Management Information Systems (MMIS) in order to process applicable Medicaid claims using the national NCCI methodologies, including the PTP edits and MUEs. CMS maintains a technical guidance manual and provides assistance to State Medicaid Agencies (SMAs) in the use of NCCI methodologies in their Medicaid programs. Similar to that for Medicare, the Medicaid NCCI edits are refined and updated quarterly.<sup>47</sup>

## 3.7 Medicare-Medicaid Data Match

The Medicare-Medicaid Data Match (Medi-Medi) activities support the integration of Medicaid and Medicare investigations and audits where possible. Medi-Medi functionality matches Medicaid and Medicare claims and other data to identify improper billing and utilization patterns. Analyses performed in the Medi-Medi program can reveal trends that are not evident in each program's claims data alone, making it an important tool in identifying and preventing aberrant billing practices and other schemes across both programs. CMS analyzes matched data to identify potential fraud, waste, and abuse patterns, and shares the results with the state. Participation in these activities is optional for the states. Each state's participation in Medi-Medi activities is designed to accommodate the individual complexity of that state's Medicaid program and associated program integrity efforts. During FY 2019, CMS collaborated with nineteen states that account for most of the expenditures in Medicaid.

CMS's Medi-Medi data matching activity has produced various law enforcement referrals on a variety of subjects, including individual health care providers, opioid prescribers, clinical labs, and hospitals. In certain instances, law enforcement cases have produced significant results from the support CMS has provided.

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<sup>46</sup> See sections 1.1 and 1.2 of Appendix B for further information regarding NCCI PTP edits and MUEs.

<sup>47</sup> These Medicaid NCCI edits and other resources are located on the Medicaid website (<https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>).

## 4. Mitigate Emerging Programmatic Risks

### 4.1 Improper Payment Rate Measurement

An improper payment occurs when a payment should not have been made, federal funds go to the wrong recipient, the recipient receives an incorrect amount of funds, or the recipient uses the funds in an improper manner. In addition, improper payments cited do not necessarily represent expenses that should not have occurred. For example, instances where there is no or insufficient documentation to support the payment as proper or improper are cited as improper payments. The Improper Payments Information Act of 2002, as amended by the Improper Payments Elimination and Recovery Act of 2010, and the Improper Payments Elimination and Recovery Improvement Act of 2012 requires federal agencies to review their programs and activities to identify programs that may be susceptible to significant improper payments, and for high risk programs, to estimate the amount of improper payments and develop and implement corrective actions. CMS works to better prevent, detect, and reduce improper payments through close review of our programs and activities using sound risk models, statistical estimates, and internal controls.<sup>48</sup>

In FY 2019, CMS continued its requirements to measure improper payments, as required under law, as well as its efforts to reduce and recover improper payments in its programs. Results of CMS's efforts are outlined herein.

#### 4.1.1 Medicare Fee-for-Service

CMS uses the Comprehensive Error Rate Testing (CERT) program to estimate the Medicare FFS improper payments. The CERT program reviews a stratified random sample of Medicare FFS claims to determine if CMS properly paid claims under Medicare coverage, coding, and billing rules. The Medicare FFS improper payment estimate also includes improper payments due to insufficient or no documentation.<sup>49</sup>

The CERT program considers improper payments to be:

- Any claim payment that should have been denied or was made in the wrong amount, including overpayments and underpayments. The claim counts as either a total or partial improper payment, depending on the error;
- Improper payments of all dollar amounts (i.e., there is no dollar threshold under which errors will not be cited); and
- Improper payments caused by policy changes as of the new policy's effective date (i.e., there is no grace period permitted).

CMS sampled approximately 50,000 claims during the FY 2019 report period. The improper payment rate estimated from this sample reflects all claims processed by the Medicare FFS program during the report period across four claim types:

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<sup>48</sup> <https://www.hhs.gov/sites/default/files/fy2019-hhs-agency-financial-report-final.pdf>

<sup>49</sup> *Id.* at 200.

- Part A claims, excluding hospital Inpatient Prospective Payment System (IPPS) (e.g., home health, inpatient rehabilitation facility (IRF), skilled nursing facility (SNF), and hospice)
- Part A hospital IPPS claims
- Part B claims (e.g., physician, laboratory, and ambulance services)
- DMEPOS

The national Medicare FFS estimated improper payment rate for FY 2019 was 7.25 percent, representing \$28.91 billion in gross improper payments. The FY 2019 improper payment rate decreased from the prior year's reported 8.12 percent due to reduced improper payments for home health, Part B, and DMEPOS claims. Although the improper payment rate for these services and the gross Medicare FFS improper payment rate decreased, improper payments for SNF, hospital outpatient, IRF, and home health claims continued to be major contributing factors to the FY 2019 Medicare FFS improper payment rate, comprising 36.01 percent of the overall estimated improper payment rate. While the factors contributing to improper payments are complex and vary by year, the primary causes of improper payments continue to be insufficient documentation and medical necessity errors.<sup>50</sup>

#### 4.1.2 Medicaid and CHIP

CMS uses the Payment Error Rate Measurement (PERM) program to estimate national 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 measures Medicaid and CHIP improper payment rates using three 17-state cycles so that each state is reviewed once every three years. The FY 2019 national Medicaid improper payment rate estimate was 14.90 percent, representing \$57.36 billion in improper payments. The FY 2019 national CHIP improper payment rate estimate was 15.83 percent, totaling \$2.74 billion in improper payments.

While the Medicaid and CHIP improper payment rates increased between FY 2018 and FY 2019, these results are not comparable because the measurement has changed significantly. Most notably, FY 2019 was the first year in which CMS reintegrated the PERM eligibility component into the measurement, which is a driver of Medicaid and CHIP improper payments, as described below. CMS will complete the review of the remaining 33 states and the District of Columbia under the new eligibility requirements over the next two years and establish a baseline in FY 2021 once all states are measured under the new requirements.

Medicaid and CHIP eligibility improper payments in FY 2019 were mostly due to insufficient documentation to verify eligibility, related primarily to income or resource verification. There were both situations where the required verification was not done at all and where there is indication the verification was initiated but there was no documentation to validate the verification process was completed, and non-compliance with eligibility redetermination requirements. The CHIP improper payment rate was also driven by claims where the beneficiary was incorrectly determined eligible for CHIP, but upon review was found eligible for Medicaid, mostly related to beneficiary income calculation. Continued non-compliance with provider

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<sup>50</sup> *Id.* at 201

enrollment, screening, and National Provider Identifier requirements, including compliance with newer requirements for provider revalidation of enrollment and rescreening, was also a driver of improper payments.

CMS works closely with states to develop state-specific corrective action plans to reduce improper payments. All states are responsible for implementing, monitoring, and evaluating the effectiveness of their plans, with assistance and oversight from CMS.<sup>51</sup>

### 4.1.3 Medicare Part C and Part D Programs

In the Medicare Part C and Part D programs, 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 (Part A and Part 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.<sup>52</sup> 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.

For FY 2019, the Part C improper payment estimate was 7.87 percent, representing \$16.73 billion in improper payments. This represents a decrease from the FY 2018 rate of 8.10 percent, representing \$15.55 billion in improper payments, and was driven primarily by MA organizations submitting a greater number of accurate medical records validating the diagnoses for which they were paid.<sup>53</sup>

For Part D, CMS measures the inconsistencies between the information reported on prescription drug events (PDEs) and the supporting documentation submitted by Part D sponsors, including prescription record hardcopies (or medication orders, as appropriate) and detailed claims information. Based on these reviews, each PDE in the audit sample is assigned a gross drug cost error, which is applied to a representative sample of beneficiaries to determine the Part D improper payment estimate.

For FY 2019, the Part D improper payment estimate is 0.75 percent, or \$610 million in improper payments. This represents a decrease from the FY 2018 estimate of 1.66 percent, or \$1.32 billion in improper payments, and was driven primarily by errors being smaller in magnitude than in the previous years.<sup>54</sup>

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<sup>51</sup> <https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf>

<sup>52</sup> Under MA, CMS may also make payments of rebates to plans that bid below the benchmark for their services area(s).

<sup>53</sup> <https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs>

<sup>54</sup> <https://www.cms.gov/newsroom/fact-sheets/2019-estimated-improper-payment-rates-centers-medicare-medicaid-services-cms-programs>

## 4.2 Recovery Audit Programs

### 4.2.1 Medicare Fee for Service (FFS)

Section 1893(h) of the Act requires the establishment of a nationwide Medicare FFS Recovery Audit Program, and Recovery Audit Program contractors are known as RACs. The mission of the Medicare FFS Recovery Audit Program is to identify and correct overpayments made on claims for health care items and services provided to beneficiaries, to identify underpayments to providers, and to provide information that allows CMS to implement corrective actions that will prevent future improper payments.

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

#### Results

Table 5 breaks out overpayments collected, underpayments restored, and amounts overturned on appeal in the FFS RAC regions in FY 2019, including both old and new.

**Table 5 RAC Performance**

FFS RAC Region/Name	Collected Overpayments (in millions)	Restored Underpayments (in millions)	Overtured on Appeal <sup>a</sup> (in millions)
<b>1/ Performant</b>	14.07	0.71	0.81
<b>2/ Cotiviti</b>	39.85	3.65	5.73
<b>3/ Cotiviti</b>	25.45	2.54	3.95
<b>4/ HDI/HMS</b>	61.46	2.19	10.91
<b>5/ Performant</b>	14.73	0.26	0.23
<b>Unknown/Old Contracts<sup>55</sup></b>	6.46	8.96	2.20
<b>Totals<sup>b</sup></b>	<b>162.03</b>	<b>18.30</b>	<b>23.83</b>

**Note: Payments made to providers under the Hospital Appeal Settlement process resulted in reduced collected overpayments. Because these reductions could not always be offset by other collected amounts, some resulted in an overall negative amount being reported.**

<sup>55</sup> The original FFS RACs (Regions A, B, C, and D) stopped reviewing new claims as of July 31, 2016. Per the FFS RAC Statement of Work (SOW), from August 2016 until January 31, 2018, the original FFS RACs were in their “contract closeout and reconciliation” period, which involved administrative activities only (no reviews). These activities included CMS recoupment of funds from providers on improper payments, RAC invoicing for contingency payments on eligible claims, allowing the RACs to support the appeal process, and allowing CMS to recoup contingency fees from overturned appeals. New FFS RAC contracts (Regions 1, 2, 3, 4, and 5) were awarded on October 31, 2016.

FFS RAC Region/Name	Collected Overpayments (in millions)	Restored Underpayments (in millions)	Overtured on Appeal <sup>a</sup> (in millions)
<sup>a</sup> Overtured amounts include collected overpayments from previous FYs.			
<sup>b</sup> Savings values may not add to totals due to rounding.			

In FY 2019, the program identified approximately \$219.98 million in overpayments and recovered \$162.03 million, before taking into account appeal dispositions. Additional results and analysis of Recovery Audit Program data are available for download at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Resources>.

### FFS RAC Appeals

Providers who disagree with a RAC’s improper payment determination may utilize the multilevel administrative appeals process under section 1869 of the Act. RAC appeals follow the same appeal process as other Medicare claim determinations. Throughout the first four levels of the appeals process, in FY 2019, there were 34,001 appeal decisions rendered for claims with overpayments identified by the RACs. Claims may have had initial overpayment determinations made prior to FY 2019 and appealed claims may be counted multiple times if the claim had appeal decisions rendered at multiple levels during FY 2019. For example, if a claim was appealed to the first level and received a decision in FY 2018, then appealed to the second level and received a decision in FY 2019, both decisions are counted.

Of the 34,001 total appeals decided in FY 2019, 18,449 decisions, or 54 percent were overturned with decisions in the provider’s favor (see Table 6). While the percentage of appeals decisions overturned seems high, the figure is misleading. When compared to the total number of claims (143,734) that were corrected by the RACs in FY 2019, the total number of appeal decisions (34,001) is equal to 23 percent. The resulting overturns then represent only 12.7 percent of the total number of claims corrected by the RAC, which is significantly less than the 54 percent referenced as overturned in the provider’s favor.

It is also worth noting that Table 6 reflects claim decisions, not claims. Therefore, the same claim may be counted more than once. For example, a claim appealed to the MAC which was upheld (favorable to the RAC) and then also appealed to the QIC, with decisions both in FY 2019, would count twice against the total. The majority of overturns that occur at the MAC level are due to the submission of documents on appeal that were not initially submitted to the RAC. Therefore, the initial RAC decision was based on incomplete documentation.

Table 6. RAC Appeals

Appeal Level	Total Decisions in FY 2019	Favorable/ Partially Favorable Decision	Percent Overturned
1 (MAC)	18,795 <sup>56</sup>	11,041	59%
2 (QIC)	1,971 <sup>57</sup>	735	37%
3 (ALJ)	13,205 <sup>58</sup>	6,671	51%
4 (Departmental Appeals Board (DAB))	30 <sup>59</sup>	2	7%
<b>Totals</b>	<b>34,001</b>	<b>18,449</b>	<b>54%</b>

### Oversight

CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program and CMS regularly evaluates the RACs' performance and adherence to program requirements. Staff members go on location to observe medical reviews, information technology systems, and customer service areas. In addition to onsite visits, CMS conducts desk audits on claims to confirm that all aspects of the review process were correctly completed and documented. CMS also uses an independent validation contractor to perform accuracy and validation reviews for all RAC regions. These monthly accuracy reviews include randomly selected samples of claims for which the RAC has determined there was an improper payment. These samples include all claim and provider types that were reviewed by the RACs. The validation contractor calculates an accuracy rate for each RAC region. The RACs also engage in regular meetings with the MACs, provider groups, and other stakeholders to discuss review topics and issues. If there are performance concerns, CMS notifies the RAC and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Reporting System (CPARS) for an overall performance rating for the year. These results are available to all federal agencies that wish to procure contracts with these entities.

### 4.2.2 Part C and Part D

Section 1893(h) of the Act expands the RAC program to Medicare Part C and Part D. Despite the success of RACs in Medicare FFS, however, CMS has found that the use of RACs in Medicare Part C and Part D has not been an effective oversight mechanism. RAC vendors have reported that Medicare Part C and Part D are an unattractive business model for overpayment identification and collection because of differing payment structures, a narrow scope of payment error, and unlimited appeal timeframes. As a result, there is little incentive for RACs to perform

<sup>56</sup> Total MAC Decisions does not include 938 dismissed claims.

<sup>57</sup> Total QIC Decisions does not include 145 dismissed claims.

<sup>58</sup> Total ALJ Decisions does not include 47 remanded claims and 4,932 dismissed claims.

<sup>59</sup> Total DAB Decisions does not include 4 remanded claims and 491 dismissed/withdrawn claims.

the audits in Part C and Part D, and CMS has realized little return on investment for these activities.

The Part C RAC objectives (i.e., identifying and recouping overpayments) are being met through contract-level Risk Adjustment Data Validation (RADV) audits conducted by CMS with the use of non-RAC contractors that perform medical review, payment error calculations, and other supportive tasks. The contract-level RADV audit program is the primary corrective action to reduce the Part C improper payment rate through the identification and collection of overpayments. Through contract-level RADV audits, medical records are reviewed and MAOs are held financially accountable when the MAO-submitted diagnostic data for risk adjustment purposes does not conform to program rules.

In April 2019, CMS launched the payment year 2014 RADV audit and held a training webinar for MA organizations selected for audits. The payment year 2015 RADV audit launched in September 2019 and a training webinar was conducted in December 2019. The purpose of the trainings was to prepare the MA industry for the selection of audited MA organizations for RADV audits. The payment year 2014 RADV audit medical record submission phase is complete.

In a similar circumstance to the Part C RAC, the Part D RAC objectives (i.e., identifying and recouping overpayments) are currently being met by the NBI-MEDIC, a non-RAC contractor. The NBI-MEDIC's workload is substantially like that of the Part D RAC, and the NBI-MEDIC has a robust program to identify improper payments. After the NBI-MEDIC identifies improper payments, CMS requests that plan sponsors delete PDE records that are associated with potential overpayments. Subsequently, CMS validates whether plan sponsors delete the PDEs and do not resubmit such PDEs for payment. As noted previously, the NBI-MEDIC's responsibilities relate to plan oversight and pertain to specific initiatives like data analysis, health plan audits, outreach and education, and law enforcement support. In FY 2019, the NBI-MEDIC continued audits that identified potentially improper payments and conducted education and outreach for Part D plan sponsors.

### **4.2.3 Medicaid**

Section 1902(a)(42) of the Act requires states to establish Medicaid RAC programs. Each state has the flexibility to tailor its RAC program, where appropriate, with guidance from HHS. In FY 2019, 31 states had CMS-approved exceptions to Medicaid RAC implementation due to high managed care penetration and issues related to procurement. Seventeen states and the District of Columbia had operational RAC programs in FY 2019.

## **4.3 Medicare Fee-for-Service Medical Review**

Consistent with sections 1815(a), 1833(e), 1862(a)(1), and 1893 of the Act, CMS is required to protect the Medicare Trust Funds by taking corrective actions to prevent and reduce improper payments. CMS contracts with a variety of medical review contractors, including the MACs and

SMRC, to perform medical review for claims paid by the Medicare FFS program.<sup>60</sup> Medical review involves both automated and manual processes to ensure that only claims for items and services that meet all Medicare coverage, payment, and coding requirements are paid. Medical review activities concentrate on areas identified through a variety of means, including targeted data analysis, Comprehensive Error Rate Testing (CERT) results, and oversight agency findings that indicate questionable billing patterns. CMS incorporates provider feedback processes, such as one-on-one education and detailed medical review results notifications to encourage proper billing.

### 4.3.1 Targeted Probe and Educate

CMS's Targeted Probe and Educate (TPE) program helps providers and suppliers reduce claim denials and appeals through one-on-one education by the MACs. As part of TPE, the MACs focus on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Under the TPE strategy, MACs conduct up to three rounds of review of 20-40 claims per round, with one-on-one education provided at the conclusion of each round. Providers/suppliers are also offered individualized education during each round of review to more efficiently fix simple problems. The goal of TPE is to help providers and suppliers meet Medicare's payment policy requirements. TPE also reduces burden on those providers and suppliers who, based on data analysis, are already submitting claims that are compliant with Medicare policy.<sup>61</sup>

Since inception, the MACs have reviewed approximately 13,000 providers and suppliers resulting in the review of over 435,000 claims. During the same time period, MACs have also made 90,000 educational contacts to assist providers and suppliers with the TPE audits and future billing.<sup>62</sup>

### 4.3.2 Supplemental Medical Review (Post-payment)

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

In FY 2019, the traditional SMRC medical review activities continued on a small scale to facilitate contract closure and the procurement and award of a new contract. The SMRC

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<sup>60</sup> The UPICs also perform medical review, as discussed in section 3.1, as well as the Recovery Audit Contractors, as discussed in section 3.3.

<sup>61</sup> *Targeted Probe and Educate Qs & As* can be found at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/Downloads/TPE-QAs.pdf>

<sup>62</sup> The general numbers reported here are publicly available in the TPE Q&A document: <https://www.cms.gov/files/document/updated-tpe-qas.pdf>. See questions 14, 15 and 16.

performed post-payment reviews on multiple areas, such as positive airway pressure device replacements, DME provided to patients during a SNF stay, emergency ambulance services, hospice services, non-emergency ambulance services, spinal cord stimulators, providers who ordered DME, and IRF services. CMS uses the reviewers' results to improve billing accuracy. Results are shared with providers through detailed review results letters and possible overpayment determinations. These letters include educational information regarding what was incorrect in the original claim billing.

The scope of the new SMRC contract was expanded in FY 2019 to provide support to a variety of CPI initiatives, including medical review activities to support our fraud-fighting functions and to review issues identified through the Healthcare Fraud Prevention Partnership (HFPP).

#### **4.4 Medicare Provider Cost Report Audits**

Auditing of cost reports is one of CMS's primary instruments to safeguard payments made to institutional providers, such as hospitals, SNFs, and end-stage renal dialysis facilities. Although many of these providers have most of their claims paid through a prospective (bundled) payment system, reimbursement of several items continues on an interim basis, subject to final payment after a cost reconciliation process. These providers submit an annual Medicare cost report that, after the settlement process, forms the basis for reconciliation and final payment to the provider. The cost report includes calculations of the final payment amount for items such as graduate medical education, disproportionate share hospital (DSH) payments, and Medicare bad debts.

The cost report audit process provides a method to detect improper payments, as well as reasons these improper payments have occurred. These reasons for improper payments provide insight into potential payment vulnerabilities, the recognition of which can strengthen and focus the program integrity response. The audit process includes the timely receipt and acceptance of provider cost reports, the performance of desk reviews, audits of those cost reports, and the final settlement of the provider cost reports. The audit/settlement process determines whether providers have been paid properly, in accordance with CMS regulations and instructions. During FY 2019, the MACs received and accepted approximately 54,113 Medicare cost reports. This included initial cost report filings as well as amended filings. Approximately 31,310 cost reports were tentatively settled and approximately 39,675 cost reports were desk reviewed. In addition, the MACs completed approximately 478 audits.

#### **4.5 Medicare Shared Savings Program**

The Medicare Shared Savings Program (Shared Savings Program) is a voluntary program that facilitates coordination and cooperation among providers and suppliers to improve the quality of care for Medicare fee-for-service beneficiaries and reduce the rate of growth in expenditures under Medicare Parts A and B. Eligible groups of providers and suppliers may participate in the Shared Savings Program by forming or participating in an Accountable Care Organization (ACO). When an ACO succeeds both in delivering high-quality care and reducing Medicare expenditures, the ACO may share in the savings it achieves for the Medicare program. If the

ACO participates in a two-sided risk track under the Shared Savings Program, it may be liable for a portion of any losses incurred by Medicare.<sup>63</sup>

CMS has developed a streamlined provider and supplier screening process to enhance program integrity efforts for the Shared Savings Program that relies in part on safeguards associated with Medicare FFS enrollment. 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 sanctions, payment suspensions, and FPS alerts. CMS also coordinates a screening process with law enforcement for additional checks of program integrity issues. CMS may deny an ACO's application, reject the addition of a provider, supplier, or ACO participant, or impose additional safeguards on ACO participants whose screening reveals a history of program integrity issues or affiliation with individuals or entities that have a history of program integrity issues. CMS monitors ACO participant and SNF affiliate<sup>64</sup> Medicare enrollment on a biannual basis and will remove from the Medicare Shared Savings Program any ACO Participants and SNF affiliates that are no longer enrolled in Medicare.

Additionally, CMS conducts monitoring to ensure that ACOs are in compliance with the program integrity requirements of the Shared Savings Program. For example, CMS conducts monitoring to verify that any changes to the governing body of an ACO or changes in ACO participants meet regulatory requirements. CMS also audits the accuracy of reported quality data and recalculates risk adjusted historical benchmarks as necessary to maintain the integrity of financial benchmarks used to determine whether the ACO has generated shared savings or shared losses.

## 4.6 Medicare Appeals and Party Status

When Medicare beneficiaries, providers of services, or suppliers disagree with a coverage or payment decision made by CMS or a CMS contractor, they have the right to appeal; there are similar appeal rights when an enrollee, a health care provider, or prescriber disagrees with a coverage or payment decision by an MA plan or Part D plan.<sup>65</sup> Although CMS continues to strengthen Medicare program integrity to combat all improper payments, including fraud, waste, and abuse, the Agency remains equally committed to protecting the rights of Medicare beneficiaries, providers, and suppliers through the Medicare appeals process.

The Act and implementing regulations adopted by CMS establish five levels to the Medicare appeals process:

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<sup>63</sup> For more information, please visit the Medicare Shared Savings Program [webpage](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram) at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram>

<sup>64</sup> ACO SNF affiliates are associated with those ACOs that are approved to use the Shared Savings Program SNF 3-Day Rule Waiver.

<sup>65</sup> <https://www.hhs.gov/about/agencies/omha/the-appeals-process/index.html>; <https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/index>; <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/index>; and <https://www.cms.gov/Medicare/Appeals-and-Grievances/MedPrescriptDrugApplGriev/index>

- Level 1: In Medicare FFS, a redetermination by a MAC; in MA, a reconsideration by a MA plan; or for Part D, a redetermination by a Part D plan sponsor
- Level 2: In Medicare FFS, a reconsideration by a Qualified Independent Contractor (QIC); in MA, an automatic reconsideration by an Independent Review Entity (IRE); or for Part D, a reconsideration by an IRE requested by an enrollee.<sup>66</sup>
- Level 3: A hearing by an Administrative Law Judge (ALJ) in the HHS Office of Medicare Hearings and Appeals (OMHA) or review by an attorney adjudicator in certain circumstances
- Level 4: Review by the Medicare Appeals Council in the HHS Departmental Appeals Board (DAB)
- Level 5: Judicial review in U.S. District Court

The reviews at Levels 1 and 2 in the Medicare FFS, MA and Part D programs are governed by separate and different regulations. Level 3 and 4 reviews are generally governed by many of the same regulations for the Medicare FFS and MA programs (with some differences to account for different statutory requirements and the different roles of the QIC and the MA plan). Level 3 and 4 reviews for the Part D program are governed by separate and different regulations.

For the FFS program, CMS regulations at 42 CFR §§ 405.1010-1012 allow QICs, which are responsible for conducting Level 2 appeals, to participate in ALJ hearings either as a party participant, a “non-party” participant, or as a witness, and CMS provides funding for such activities.

In FFS appeals, while “non-party” participation limits the QIC to submitting written position papers and providing testimony to clarify factual or policy issues, participation as a party allows the QIC additional opportunities to represent its position related to its decision-making by providing the QIC the right to call witnesses, cross-examine witnesses, and present evidence. In Part D appeals, the IRE or the Part D plan sponsor may request “non-party” participation in an ALJ hearing but not participation as a party. Non-party participation by the IRE or Part D plan sponsor may include filing position papers and/or providing testimony to clarify factual or policy issues in a case, but it does not include calling witnesses or cross-examining the witnesses of an enrollee.

Generally, the QICs will invoke party status when there is a significant amount in controversy at issue, there are national policy implications, or there are areas of particular interest for CMS. When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully upholds the prior decision or dismisses the case, CMS considers the estimated amount in controversy as savings. FFS data shows ALJ overturn rate is lower in cases in which the QIC participates as a party.<sup>67</sup>

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<sup>66</sup> Beginning in plan year 2021, adverse at-risk redeterminations made by a Part D plan under its drug management program must be automatically forwarded to the Part D IRE.

<sup>67</sup> In FY 19, the overall adjudicated reversal rate by the ALJ was 43.7 percent. However, in that same period, in cases in which the QIC participated as a Party, the adjudicated reversal rate was 25.9 percent. In sum, when the QIC participated as a Party in an ALJ hearing, the overturn rate was 17.8 percentage points lower.

CMS also actively participates in an HHS intra-agency appeals workgroup. CMS and our HHS partners are implementing initiatives with the goal of improving the efficiency of the appeals process.

## 4.7 Medicare Secondary Payer

The Medicare Secondary Payer (MSP) program ensures that when Medicare is a secondary payer (the provider of coverage that pays after another “primary” insurance), Medicare does not pay, or recovers Medicare funds that were paid conditionally, once another individual or entity is determined to be primarily responsible for payment. Sections 1862(b)(7) and (8) of the Act, as added by section 111 of the Medicare, Medicaid, and SCHIP (State Children’s Health Insurance Program) Extension Act of 2007 (MMSEA),<sup>68</sup> added mandatory reporting requirements with respect to Medicare beneficiaries who have coverage under Group Health Plan (GHP) arrangements as well as for Medicare beneficiaries who receive settlements, judgments, awards or other payment from liability insurance (including self-insurance), no-fault insurance, or workers’ compensation, collectively referred to as Non-Group Health Plan (NGHP) or NGHP insurance. The mandatory insurer reporting requirements continue to be the primary source of new MSP information reported to CMS from group health plans and other insurers, and the annual number of new MSP records posted to CMS’s systems remains more than twice the number posted before this provision’s implementation.

### Commercial Repayment Center (CRC) Recovery Auditors

The Commercial Repayment Center (CRC) Recovery Auditor recovers Part A and Part B payments made by the Medicare program when another entity had primary payment responsibility. There are two broad situations where the CRC makes recoveries. The first is when a beneficiary has or had coverage through an employer-sponsored GHP. The CRC generally recovers Medicare’s mistaken payments in this situation from employers. The second situation is the recovery of certain conditional payments where an applicable plan (a non-GHP entity such as a liability insurer, no-fault insurer, or workers’ compensation entity) had primary payment responsibility. In this situation, the CRC recovers Medicare payments from the applicable plan.

## 4.8 Medicaid Program Integrity

The Medicaid program is a federal-state partnership, and that partnership is central to the program’s success. While states have primary responsibility for direct oversight of their programs, CMS plays a critical role in ensuring that states are compliant with federal statute and regulations. As a result, CMS undertakes a wide array of activities to oversee and support states’ Medicaid program integrity efforts.

Section 1936(d) of the Act directs the Secretary of HHS to establish, on a recurring 5-fiscal year basis, a comprehensive plan for ensuring the integrity of the Medicaid program by combatting fraud, waste, and abuse. CMS released the most recent Comprehensive Medicaid Integrity Plan

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<sup>68</sup> Public Law 110-173.

(CMIP), which sets forth CMS’s strategy to safeguard the integrity of the Medicaid program for FYs 2019-2023.<sup>69</sup>

The CMIP is shaped by the following themes:

- **Patients First:** CMS’s overarching strategy is built upon the goal of putting patients first because fraud, waste, and abuse not only result in loss of program funds but can directly harm beneficiaries when Medicaid is billed for unnecessary or undelivered services.
- **Federal-State Partnership:** Medicaid program integrity efforts can only succeed when CMS and states work in partnership. To facilitate and improve the federal-state partnership, CMS is adjusting its Medicaid oversight in ways that are more mindful of the uniqueness of each state’s size, resources, delivery systems, and level of risk.
- **Flexibility, Accountability, and Integrity** are the three key principles that ground CMS’s vision for transforming the Medicaid program. CMS applies these principles in its program integrity work to achieve: (1) greater flexibility in program integrity approaches to empower individual states to create innovative programs; (2) stronger accountability for cost-effective program integrity outcomes and reducing improper payments; and (3) enhanced program integrity, employing new and evolving initiatives to work in partnership with state.

Building upon CMS’s existing program integrity efforts, this CMIP includes new and enhanced Medicaid program integrity initiatives that CMS announced in the Medicaid Program Integrity Strategy that was released in June 2018.<sup>70</sup> Highlights of the program integrity elements from the CMIP that CMS engaged in during FY 2019 are described in greater detail in the following sections.

#### 4.8.1 Eligibility and Payment Integrity

A large driver of the Medicaid and CHIP improper payment rates in FY 2019 was state noncompliance with various beneficiary eligibility requirements and processes. Making accurate beneficiary eligibility determinations helps make sure that only truly eligible individuals are enrolled in Medicaid and CHIP, which protects the integrity of the Medicaid program and CHIP, as well as taxpayer dollars. In FY 2019, CMS conducted several oversight activities of states’ beneficiary eligibility determinations.

##### The Medicaid Eligibility Quality Control (MEQC) Program

Under the Medicaid Eligibility Quality Control (MEQC) program, states design and conduct pilots to evaluate the processes that determine an individual’s eligibility for Medicaid and CHIP benefits. These MEQC pilots are conducted during the two-year intervals (“off-years”) that occur between their triennial PERM review years, allowing states to implement prospective improvements in eligibility determination processes prior to their next PERM review. Consistent with federal requirements, states have great flexibility in designing pilots to focus on vulnerable or error-prone areas as identified by the PERM program and by the state. However, CMS may

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<sup>69</sup> <https://www.cms.gov/files/document/comprehensive-medicare-integrity-plan-fys-2019-2023.pdf>

<sup>70</sup> [CMS announces initiatives to strengthen Medicaid program integrity](#), press release, June 26, 2018

require states to target specific areas of vulnerability in states that have consecutive PERM eligibility improper payment rates over 3 percent. In addition, states are required to devote part of their MEQC pilots to reviews of improper denials or terminations, which are not addressed through PERM reviews. For cases where individuals were erroneously determined eligible, states are also required to assess the financial implications of the errors during the 3-month period after the effective date of the erroneous eligibility determination. States will be required to return the federal share of any such overpayments made as a result of these erroneous eligibility determinations through their quarterly expenditure reports.

### **Audits of Beneficiary Eligibility Determinations**

To ensure compliance with the eligibility determination requirements for the adult group, CMS began new eligibility audits in FY 2019 in several states (New York, Kentucky, Louisiana, and California) in which the HHS-OIG and State Auditors previously identified vulnerabilities in the states' eligibility systems. CMS audits in these high-risk states focused on: (1) identifying whether the state determined Medicaid eligibility for individuals in the adult group in accordance with federal and state eligibility requirements and claimed the appropriate FMAP; (2) comparing current review findings to similar findings of the HHS-OIG to ensure those identified findings had been appropriately addressed; (3) identifying and assessing the impact of any changes to Medicaid eligibility policy due to the ACA; and (4) determining whether the adult group eligibility and enrollment process impacted other eligibility categories in the state. CMS is also calculating the amounts inappropriately paid, if any, to the states due to improper eligibility determinations.

## **4.8.2 Review of State Program Integrity Activities**

Conducting oversight of states' program integrity activities is an important component of CMS's plan to protect the integrity of the Medicaid program. Specifically, CMS conducts state program integrity reviews and oversight of states' PERM Corrective Active Plans (CAPs) to ensure states are complying with federal rules and requirements.

### **State Program Integrity Reviews**

CMS conducts focused reviews on high-risk areas, such as managed care, new statutory and regulatory provisions, nonemergency medical transportation, and personal care services. Focused program integrity reviews include onsite state visits to assess the effectiveness of each state's program integrity oversight functions and to identify areas of regulatory non-compliance and program vulnerabilities. In FY 2019, CMS continued to conduct focused reviews of high-risk program integrity areas, such as managed care and personal care services in selected states. In addition to the focused reviews, CMS also conducted desk reviews of states' program integrity activities to increase the number of states and topics that are assessed each year. Beginning in FY 2019, CMS also conducted desk reviews related to states' responses to the opioid crisis and completion of corrective actions from previous program integrity reviews. Additional areas for future desk reviews may include terminated providers that should no longer be billing Medicaid and compliance with Medicaid payment suspension requirements.

### **Corrective Actions to Reduce Payment Errors**

In an intensive effort to solve the root causes of payment errors identified by the PERM program, CMS provides support and technical assistance to states as they develop and implement PERM

CAPs, and CMS will monitor and evaluate their effectiveness. CMS works directly with states to help identify vulnerabilities and overcome barriers that prevent resolution of identified deficiencies with the goal of eliminating repeat findings. Along with increased support, CMS will hold states accountable for reducing their improper payment rates. CMS requires states to meet more stringent PERM CAP requirements if they have consecutive PERM eligibility improper payment rates exceeding the 3 percent national standard, pursuant to section 1903(u) of the Act. Under current regulations, CMS will pursue disallowances for states that fail to demonstrate a good faith effort by satisfying PERM CAP and MEQC pilot requirements.<sup>71</sup>

### 4.8.3 Medicaid Managed Care Medical Loss Ratio (MLR) Reviews

The 2016 Medicaid managed care final rule<sup>72</sup> strengthens the fiscal integrity in Medicaid and CHIP managed care by requiring more transparency in the managed care rate setting process and adding standards for the calculation and reporting of MLRs and encounter data submissions. The final rule stipulates that states must require managed care plans to submit financial and other data supporting service encounters, the actuarial soundness of capitation rates, and reported MLRs. In FY 2019, CMS conducted a review of California’s Medicaid managed care plans’ financial reporting, focusing on MLRs and rate setting. Released in June 2020, CMS’s review verified whether California’s managed care plans’ expenditures for providing health care services were reported accurately and supported capitation rates specified in managed care plans’ contracts.<sup>73</sup> California previously conducted its own review of its managed care plans’ MLR reporting, resulting in recoupments from managed care plans amounting to \$2.56 billion. CMS’s review determined that California correctly identified findings and overpayments. CMS did not identify any new findings; however, CMS identified several areas for improvement when California calculates and reviews each managed care plan’s MLR in the future.

### 4.8.4 State Access to Medicare Data

Approximately 12.3 million Americans are dually enrolled in Medicare and Medicaid, and providers and managed care plans that serve Medicaid patients often participate in Medicare as well. This overlap means that Medicare program integrity data offers the potential to greatly enhance state Medicaid program integrity efforts. Analyzing both Medicare and Medicaid claims data enables CMS and states to detect duplicate and other improper payments for services billed to both programs. Sharing information among federal and state investigators about aberrant providers or plans can improve the identification of improper billing and optimize investigative resources. Through the State Data Resource Center (SDRC), state Medicaid agencies may request Medicare data, free of charge, for individuals who are dually enrolled in Medicare and Medicaid to support care coordination and program integrity functions, such as preventing duplicate payments by Medicare and Medicaid. A state Medicaid agency may request Medicare eligibility and enrollment data, Medicare Parts A and B claims, and Part D pharmacy claims. The SDRC offers frequent

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<sup>71</sup> [See 42 CFR Part 431.1010](#)

<sup>72</sup> [81 FR 27497](#), May 6, 2016

<sup>73</sup> <https://www.cms.gov/files/document/california-medical-loss-ratio-examination-report.pdf>

webinars on a variety of topics such as linking Medicare and Medicaid databases and program integrity data requests.

CMS also administers the Medicare-Medicaid Data Match (Medi-Medi) program, through which Medicare and Medicaid claims for dually enrolled beneficiaries are matched at the provider and beneficiary level to check for duplications. State participation is voluntary; as of December 2019, 19 states participate in the Medi-Medi program. CMS's Unified Program Integrity Contractors perform analyses of Medicare-Medicaid matched data and collaborate with state Medicaid agencies to conduct investigations and audits. CMS also provides states access to Medicare data sources in a data warehouse environment, upon request. These Medicare data sources include Medicare Parts A and B claims, Part D pharmacy claims, and Medicare-Medicaid matched data. CMS reaches out to states to inform them of opportunities to access these data sources and provides states with guidance on using these data sets and applying advanced analytics. CMS and states are able to identify duplicate Medicare and Medicaid payments and other types of improper payments for services billed to both programs.

#### **4.8.5 Strengthen Medicaid Data Analytics and Audits**

Strong data collection and analysis will enable smarter efforts to tackle fraud, waste, and abuse. CMS is enhancing data sharing and collaboration to tackle program integrity efforts in both the Medicare and Medicaid programs.

##### **Transformed Medicaid Statistical Information System (T-MSIS) Data Use**

Continuous T-MSIS data quality review and improvement is an essential and ongoing task, which CMS expects states to maintain as a permanent and ongoing process of their operations. CMS outlined expectations for states to address T-MSIS data quality issues by identifying 12 top priority items that states were expected to either resolve by February 2019 or submit corrective action plans, followed by additional guidance to states regarding T-MSIS state compliance in March 2019. In FY 2019, CMS continued efforts to address T-MSIS data quality and use, which included validating the quality and completeness of T-MSIS data for program integrity purposes. CMS's ongoing goal is to use advanced analytics and other innovative solutions to both improve T-MSIS data and maximize the potential for program integrity purposes. This will allow CMS to identify instances like a beneficiary receiving more hours of treatment than hours in a day or other flags that necessitate further investigation. CMS's Unified Program Integrity Contractors and our other program integrity analytics contractors have begun testing T-MSIS data and will submit state-specific reports and recommendations to CMS regarding the use of T-MSIS data for program integrity going forward. As T-MSIS data quality meets required criteria, CMS will incorporate T-MSIS data into both Medicaid-specific and multi-program analytics to allow states, CMS, and other stakeholders the ability to observe and address trends or patterns indicating potential fraud, waste, and abuse in Medicaid.

##### **Data Analytics Pilots**

CMS remains committed to utilizing advanced analytics and other innovative solutions to both improve Medicaid eligibility and payment data and maximize the potential for the data to be used for program integrity purposes. CMS is a national leader in the use of predictive analytics to identify program integrity vulnerabilities. The CMS Fraud Prevention System (FPS) streams Medicare Part A and Part B claims on a national basis, running claims against multiple algorithms that identify

patterns of fraud, waste, and abuse. Claims may be automatically denied based upon edits, and alerts (or leads) are created for additional investigation when the FPS identifies claims and other data that suggest aberrant billing. CMS will share its extensive knowledge, gained from analyzing large, complex Medicare data sets, to support states in analyzing Medicaid claims data to identify potential program integrity issues based on state and CMS priorities. CMS anticipates that continuing to work with states to improve the quality of T-MSIS data will enable states and CMS to perform analyses useful for program integrity and program management. Through forums, such as the Medicaid Integrity Institute, CMS will share FPS algorithms and provide data analytic support as necessary to assist states with their program integrity efforts.

#### 4.8.6 Provider Screening and Enrollment

As part of its oversight role in Medicaid, CMS works closely with state Medicaid agencies to provide regulatory guidance, technical assistance, and other support with respect to provider screening and enrollment.

##### Provider Screening Data Sources

CMS has significantly expanded data sources available to states for provider screening and enrollment over the past few years and continues to enhance the usability of these data sources through ongoing work with state partners. By the end of FY 2018, CMS completed transitioning state access to these databases to a new online portal, the Data Exchange (DEX) system, to provide states with enhanced data formats and an improved user interface. DEX allows CMS to share Medicare revocation data with the Medicaid programs of every state, which in turn use DEX to share terminated Medicaid and CHIP provider information with CMS and other states. By March 2019, all 50 states and Puerto Rico had access to DEX.

CMS will continue to work with states to ensure adoption of the DEX system and to determine the need for future enhancements that may benefit states. DEX provides enhanced functionality for the exchange of the following types of data for provider screening and enrollment:

- Provider Terminations: States must deny or terminate the enrollment of any provider that is terminated for cause under Medicare or under the Medicaid program or CHIP of any other state.<sup>45</sup> DEX is CMS's centralized online mechanism for sharing reciprocal Medicare and Medicaid/CHIP provider revocation and termination data.
- Death Master File: DEX provides states with access to the Social Security Administration's Death Master File (DMF), which states are required to check as part of provider screening and revalidation to ensure that identities of deceased providers are not used fraudulently to bill Medicaid. Complete access to the DMF was previously available to states only through a paid subscription, which some states had identified as a challenge.
- Provider Enrollment, Chain and Ownership System (PECOS): To provide state access to key Medicare provider enrollment information, CMS has provided states with training and direct access to the Medicare provider enrollment system known as PECOS since 2012, regular data extracts from PECOS since 2013, and enhanced usability to assist states' Medicaid provider screening since 2014. These improved PECOS data extracts are now available to states to download through DEX. Additionally, CMS launched the PECOS States' page in January 2017, which included provider enrollment information

such as Medicare enrollment status, site visit information, fingerprint results, ownership information, reassignments, Medicare risk levels, and more.

- **Medicare Exclusion Database (MED) Extracts:** CMS also provides states with access through DEX to the MED, which contains the HHS-OIG’s data regarding individuals and entities excluded from federally funded health care programs, which states are required to check as part of Medicaid provider screening and revalidation.

In addition, some states have faced challenges implementing the required activities to comply fully with enhanced provider screening requirements. As a result, non-compliance with provider screening requirements has been a primary driver of improper Medicaid and CHIP payments since FY 2014. To reduce the burden of conducting screening for new enrollments and revalidation of Medicaid providers, CMS allows states to use provider screening results from Medicare, CHIP, or other State Medicaid agencies. To assist in this work, CMS currently offers a data compare service for provider screening that allows a state to rely on Medicare’s screening in lieu of conducting state screening. This service reduces state burden, particularly for provider revalidation, because it allows states to remove dually enrolled providers from their revalidation workload. Using the data compare service, a state provides a list of Medicaid providers to CMS and then CMS returns information indicating for which providers the state can rely on Medicare’s screening. As of June 2019, 26 states and territories had participated in the data compare service. CMS will continue to work with states on an ongoing basis to promote the advantages of the data compare service to work toward the goal of expanding use of the service to all states.

### **Provider Enrollment: Guidance and Technical Assistance**

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

- CMS published the first edition of the Medicaid Provider Enrollment Compendium (MPEC) in March 2016—a culmination of sub-regulatory guidance to assist states in the implementation of provider screening and enrollment requirements. CMS published updates to the MPEC in FY 2018, which focused on applying new screening and enrollment requirements to Medicaid managed care network providers.
- CMS provider enrollment experts and a State Assessment contractor conduct onsite visits and follow-up visits to provide direct, individualized technical assistance to states in strengthening their provider screening and enrollment processes to meet federal requirements. CMS along with the State Assessment contractor, assess state compliance with enrollment requirements, work to reduce state burden by helping states leverage Medicare screening and enrollment data, conduct a gap analysis, and develop strategic blueprints to help states improve their enrollment processes. In FY 2019, CMS and the State Assessment contractor visited and worked with 32 states. CMS will expand its work by providing assistance to additional states until all states have had the opportunity to meet.
- Going forward, CMS will also continue monthly calls with states to understand challenges or barriers states currently face, to facilitate the exchange of noteworthy practices among states, and to respond to questions regarding guidance or other provider

enrollment issues. CMS has also dedicated an additional monthly call focused entirely on provider enrollment and screening issues in Medicaid managed care.

### **Screening Medicaid Providers**

As part of the Medicaid Program Integrity Strategy, CMS began piloting a centralized process to screen Medicaid-only providers on behalf of states on an opt-in basis, similar to the current process in place for Medicare. The purpose of this effort is to explore whether centralization of Medicaid provider screening can reduce state and provider burden, better ensure providers are screened appropriately based on categories of risk, and address a major source of improper payments. CMS has recruited two states, Iowa and Missouri, and began screening their Medicaid-only providers through databases for valid licenses, criminal background checks, and the federal Treasury's Do Not Pay portal in late FY 2019. Iowa and Missouri are currently evaluation screening results. CMS will evaluate the results and impact of the pilot and assess the value of expanding the service to more states in the future.

### **4.8.7 Medicaid Integrity Institute**

Since 2008, CMS has offered training to state program integrity staff at no cost to states through the Medicaid Integrity Institute (MII), which provides both residential classroom training and distance learning webinars to enhance the professional qualifications of state Medicaid integrity staff across the nation. The MII offers a program of courses and examinations for the Certified Program Integrity Professional designation, which is recognized by the American Association of Professional Coders and the National Health Care Anti-Fraud Association. Courses at the MII also provide opportunities to discuss emerging trends, support new initiatives, and strengthen collaboration among state and federal partners. In FY 2019, CMS updated and expanded MII training for state program integrity staff to meet new state challenges and federal priorities. CMS hosted 18 courses in FY 2019, with emphasis on beneficiary eligibility and fraud, provider enrollment, HFPP, UPIC and State collaboration, and Medicaid managed care. CMS also took steps to integrate MII training more closely with follow-up technical assistance when state staff return to their respective agencies to facilitate applying lessons learned at MII to solving problems at the state level.

## **4.9 Durable Medical Equipment, Prosthetics, Orthotics and Supplies**

### **4.9.1. DMEPOS Investigations**

DMEPOS suppliers have historically posed a high risk of fraud to the Medicare program and CMS has undertaken an aggressive strategy to address this risk. In FY 2019, UPICs continued conducting site visits and interviews of DMEPOS suppliers, providers, and beneficiaries receiving DMEPOS items in high billing areas.

## 4.9.2 Competitive Bidding<sup>74</sup>

The DMEPOS Competitive Bidding Program was mandated by Congress through the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which requires that Medicare replace the previous fee schedule payment methodology for select DMEPOS items with a competitive bid process.

Under the DMEPOS Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items to people with Medicare living in, or visiting, competitive bidding areas. Medicare payment is not made for claims for items subject to the program that are submitted by entities other than contract suppliers and certain exempted suppliers, thereby reducing the ability of entities to commit fraud and allowing for better oversight of suppliers receiving payment.<sup>75</sup>

The savings experienced as a result of the DMEPOS Competitive Bidding Program predominantly come from lower payments and decreased unnecessary utilization.<sup>76</sup>

The Medicare DMEPOS Competitive Bidding Program works with other fraud, waste, and abuse initiatives and is currently saving over \$2 billion per year without negatively impacting health outcomes.<sup>77</sup>

The DMEPOS Competitive Bidding Program has been an essential tool to help Medicare set market-based payment rates for DMEPOS items, save money for beneficiaries and taxpayers, and limit fraud and abuse in the Medicare program. The program has saved billions of dollars since implementation, while ensuring access to quality items and services.<sup>78</sup>

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<sup>74</sup> The DMEPOS Competitive Bidding Program was initially required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) [Public Law 108-173], modified by Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) [Public Law 110-275], and expanded by the Patient Protection and Affordable Care Act. It is an 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.

<sup>75</sup> On March 7, 2019, CMS announced plans to consolidate the competitive bidding areas (CBAs) included in the Round 2 Recompete and Round 1 2017 DMEPOS Competitive Bidding Program into a single round of competition named Round 2021. Round 2021 contracts are scheduled to become effective on January 1, 2021, and extend through December 31, 2023., therefore they will be reported in those fiscal years in which they are effective.

<sup>76</sup> All DMEPOS Competitive Bidding Program contracts expired on December 31, 2018. As of January 1, 2019, there is a temporary gap in the entire DMEPOS Competitive Bidding Program that CMS expects will last until December 31, 2020. During the temporary gap, any Medicare enrolled DMEPOS supplier may furnish DMEPOS items and services to people with Medicare.

<sup>77</sup> [https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS\\_Toolkit.html](https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/DMEPOS_Toolkit.html)

<sup>78</sup> "DMEPOS Competitive Bidding Round 2021". Fact Sheet (March 8, 2019): <https://www.cms.gov/newsroom/fact-sheets/dmepos-competitive-bidding-round-2021>

### 4.9.3 DMEPOS Prior Authorization

CMS issued a DMEPOS prior authorization final rule in FY 2016 that establishes a prior authorization program for certain DMEPOS items that are frequently subject to unnecessary utilization.<sup>79</sup> The rule defines unnecessary utilization as “the furnishing of items that do not comply with one or more of Medicare’s coverage, coding, and payment rules.” The rule also establishes a list of DMEPOS items that could be subject to prior authorization before items or services are provided and payment is made.

In FY 2017, CMS began implementing prior authorization for two types of group 3 power wheelchairs (HCPCS codes K0856 and K0861) in a staggered approach. In March 2017, prior authorization began in Illinois, Missouri, New York, and West Virginia, which was followed by a nationwide expansion in July 2017. On September 1, 2018, CMS implemented prior authorization nationwide for 31 types of PMDs that were previously included in the PMD Demonstration.<sup>80</sup> On July 22, 2019, CMS implemented prior authorization for seven additional power wheelchairs (HCPCS codes K0857, K0858, K0859, K0860, K0862, K0863, and K0864) nationwide. In addition to the power wheelchairs, CMS implemented prior authorization on July 22, 2019 for five pressure reducing support surfaces (HCPCS codes E0193, E0277, E0371, E0372, and E0373) in California, Indiana, New Jersey, and North Carolina.

## 4.10 Demonstrations and Models

CMS conducts a number of innovative demonstrations and models designed to test improved methods for the prevention and identification of potential fraud, waste and abuse, with the goal of reducing program expenditures while preserving or enhancing the quality of care.<sup>81</sup>

### 4.10.1 Demonstrations

Section 402(a)(1)(J) of the Social Security Amendments of 1967<sup>82</sup> 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.

#### Review Choice Demonstration for Home Health Services

In FY 2019, CMS implemented the Review Choice Demonstration for Home Health Services, based on stakeholder feedback on CMS’s previous Pre-Claim Review Demonstration.<sup>83</sup> The demonstration offers providers increased flexibility and choice, as well as risk-based changes to reward providers who show compliance with Medicare home health policies. The demonstration gives providers in the demonstration states an initial choice of three options – pre-claim review,

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<sup>79</sup> CMS–6050–F, 80 FR 81674 (Dec. 30, 2015).

<sup>80</sup> 83 FR 25947 (June 5, 2018)

<sup>81</sup> While these demonstrations and models contribute towards CMS’s program integrity objectives, they are not part of the Medicare or Medicaid Integrity Programs. These demonstrations and models are supported by other sources and authorities.

<sup>82</sup> Public Law 90-248.

<sup>83</sup> 83 FR 25012 (May 31, 2018)

post payment review, or minimal post payment review with a 25 percent payment reduction for all home health services. A provider's compliance with Medicare billing, coding, and coverage requirements determines the provider's next steps under the demonstration.

The demonstration applies to Home Health and Hospice Medicare Administrative Contractor (HH/H MAC) Jurisdiction M (Palmetto GBA) providers operating in Illinois, Ohio, Texas, North Carolina, and Florida for five years, with the option to expand to other states in the Palmetto/JM Jurisdiction. CMS implemented the demonstration in Illinois on June 1, 2019 and in Ohio on September 30, 2019. This demonstration will assist in developing improved methods to identify, investigate, and prosecute potential fraud in order to protect the Medicare Trust Funds, potentially reduce the rate of improper payments, and improve provider compliance with Medicare rules and requirements.

#### 4.10.2 Models

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

##### **Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport**

In FY 2019, CMS continued implementing a Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport. This began as a three-year model on December 1, 2014 for transports occurring on or after December 15, 2014 in Pennsylvania, New Jersey, and South Carolina.<sup>84</sup> Then, as required by section 515 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA),<sup>85</sup> beginning January 1, 2016, five additional states (North Carolina, Virginia, West Virginia, Maryland, and Delaware) and the District of Columbia were included in the model.<sup>86</sup> CMS announced that it will expand the model nationwide, as the model has met all expansion criteria under section 1834(1)(16) of the Act (as added by section 515(b) of MACRA (Pub. L. 114-10)).<sup>87</sup>

Expenditure data reflects that, in the model's first four years, average spending in the initial three states decreased from \$18.9 million to \$6.2 million per month, while data from the first three years of the model for the additional states reflects that average spending decreased from \$5.7 million to \$2.9 million per month.<sup>88</sup>

#### 4.11 Federally-Facilitated Exchanges

To the extent permitted by states, licensed agents and brokers may assist consumers to determine their eligibility for insurance affordability programs, including those offered

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<sup>84</sup> 79 FR 68271 (Nov. 14, 2014)

<sup>85</sup> PL 114-10.

<sup>86</sup> 80 FR 64418-19 (Oct. 23, 2015)

<sup>87</sup> 85 FR 74725 (Nov. 23, 2020)

<sup>88</sup> FY 2019 HHS Agency Financial Report <https://www.hhs.gov/sites/default/files/fy-2019-hhs-agency-financial-report.pdf> (Nov. 13, 2019)

through the Federally-Facilitated Exchange (FFE). These agents and brokers offer information to consumers on advance payments of the premium tax credit and help enroll them in qualified health plans (QHPs). Due to the financial incentives involved and agent/broker access to consumers' personal information, this can create opportunities for fraud, waste and abuse.

CPI continued refining program integrity operations for the FFE during FY 2019. The Marketplace Complaints Review Contractor (MCRC) reviewed and categorized more than 10,000 consumer complaints, escalating the most urgent consumer harm cases for urgent handling when necessary. The Marketplace Program Integrity Contractor (MPIC) then triaged the complaints, using statistics and other data analytics, and conducted investigations of potential misconduct and fraud by insurance agents and brokers. The MPIC also continued refining high-risk data indicators to help support complaint-driven investigations and to initiate data-driven investigations of entities exhibiting unusual patterns of behavior. The MPIC also used state Departments of Insurance databases to verify the licensure status of thousands of insurance agents and brokers actively assisting consumers on the FFE.

In FY 2019, CMS greatly reduced the amount of time needed, from months to weeks, for resolving consumer complaints alleging unauthorized or fraudulent enrollments into FFE plans that they either did not know about or did not give consent. CMS works with health plan issuers to research and cancel fraudulent health insurance policies in order to alleviate unwarranted tax liabilities for consumers. In FY 2019, CMS cancelled more than 3,400 unauthorized enrollments due to suspected fraud.

Other fraud allegations come to CPI from health plan issuers whose own data analytics reveal potentially fraudulent enrollments, such as those associated with sober home schemes. In FY 2019, CMS approved the cancellation (i.e., rescission) of more than 150 health insurance policies. Rescinding policies associated with fraud schemes protects issuers from high dollar fraudulent claims, which in turn helps safeguard the integrity of health plans participating in the FFE.

CMS also continued to support law enforcement agencies around the country, investigating possible fraud impacting consumers and issuers participating in the FFE, by servicing requests for FFE data and program information. When necessary, CMS refers cases to law enforcement and/or regulatory agencies, such as states' Departments of Insurance, for investigation or to take actions within their jurisdictions.

## 4.12. Open Payments

The Open Payments program is a statutorily required, national disclosure program that promotes transparency and accountability by making information about the financial relationships between

the health care industry (reporting entities)<sup>89</sup> and providers (covered recipients)<sup>90</sup> available to the public.

The Open Payments data includes payments and other transfers of value made by reporting entities to covered recipients, along with ownership and investment interests held by physicians or their immediate family members in the reporting entities. Payments are reported across three main categories:

- **General Payments:** Payments or other transfers of value that are not in connection with a research agreement or research protocol. General payments may include, but are not limited to honoraria, gifts, meals, consulting fees, and travel compensation.
- **Research Payments:** Payments or other transfers of value made in connection with a formal research agreement or research protocol.
- **Physician Ownership Information:** Information about the ownership or investment interests those physicians or their immediate family members have in the reporting entities.

In FY 2019, CMS published Program Year 2018 data, completing the fifth full year of data reported to Open Payments. This included the publication of 11.4 million payment records, transfers of value, or instances of ownership/investment interest reported during calendar year 2018. These financial transactions totaled \$9.35 billion. In addition to the publication of Program Year 2018 data, all previous program years were refreshed and republished<sup>91</sup> to reflect any updates made by reporting entities during the 2018 program year cycle.

Disclosure of the financial relationships between the reporting entities and covered recipients does not signify an inappropriate relationship, and Open Payments does not prohibit such transactions. Reporting entities, after giving providers an opportunity to review and dispute the data, self-report the data displayed on the Open Payments website. The public can search, download, and evaluate the reported data found on the Open Payments website (<https://openpaymentsdata.cms.gov/>). The Open Payments search tool is a crucial component of the program as it is the vehicle that provides the public access to the Open Payments data. CMS continues to maintain the search tool and make updates for optimal user experience and accessibility. The following are the notable enhancements to the search tool throughout 2019:

- **Query Builder Tool** –The new Query Builder tool allows users to build their own queries to search the vast Open Payments data.

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<sup>89</sup> Reporting entities refers to applicable manufacturers and group purchasing organizations (GPOs) required to report payments or transfers of value to covered recipients under the Open Payments Program (42 USC §1320a-7h).

<sup>90</sup> Covered recipients are any physicians (excluding medical residents) who are not employees of the applicable manufacturer that is reporting the payment; or teaching hospitals that receive payment for Medicare direct graduate medical education (GME), inpatient prospective payment system (IPPS) indirect medical education (IME), or psychiatric hospital IME programs during the last calendar year for which such information is available.

<sup>91</sup> Refreshed and republished data includes data corrections made to reported payments since the initial publication of data that were submitted by applicable manufacturers and GPOs.

- **Homepage Autocomplete Search Update** – An auto-complete function was added to the homepage search to enable faster and more successful searches.
- **All Years Data View** – An “All Years” view of the data was added to entity profiles and across several applications for users to see a sum of data for all available years instead of only viewing data for a single year at a time.
- **Search Tool Survey** – A simple question survey was added to the search tool site during designated periods of time. The survey was available three different times throughout FY 2019 and results showed consistent positive user experience. CMS publishes financial data for each program year.<sup>92</sup>

In FY 2019, Open Payments continued compliance efforts focused on improving the timeliness, accuracy, and completeness of the reported data. These efforts resulted in the inclusion of previously unreported data and the correction of errors in approximately 2.97 million records with an associated value of about \$679 million.

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 2019.

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<sup>92</sup> The program year coincides with the calendar year. In this case, the program year is the calendar year ended December 31, 2017.

## 5. Reduce Provider Burden

### 5.1 Outreach and Education – Medicare Fee-for-Service

One of the goals of provider outreach and education in the Medicare FFS program is to reduce improper payments by ensuring that providers have timely and accurate information they need to bill correctly the first time. The MACs educate Medicare providers, suppliers, and their staff about Medicare policies and procedures, including local coverage determinations; significant changes to the Medicare program; and issues identified through review of provider inquiries, claim submission errors, medical review data, CERT program data, and other relevant sources. 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 MAC-developed materials.

CMS-developed materials include Medicare Learning Network® (MLN) educational products, information, and resources for the health care professional community. For example, MLN Matters articles provide content from clinicians, billing experts, and CMS subject matter experts that explains Medicare policies and the latest changes to CMS programs. Other MLN products, such as webinars, fact sheets, and listserv messages are also used to provide educational messages to CMS stakeholders. MAC-developed materials include education on local coverage determinations and listserv messages tailored to the relevant MAC jurisdiction. CMS receives significant positive feedback from providers and suppliers on the value of these educational materials.

### 5.2 Outreach and Education – Medicare Part C and Part D

In FY 2019, CMS continued the sharing of educational training tools for MA and Part D plans on the Health Plan Management System (HPMS). MA and Part D plans are able to access educational presentations, fact sheets, and booklets on the same HPMS platform where CMS makes available other pertinent information such as CMS communications, operational information, and policy materials.

CMS also led the development of multiple training events in FY 2019, pertaining to current Medicare Parts C and Part D fraud schemes; fraud prevention techniques; and anti-fraud, waste, and abuse activities. The training events consisted of the following:

- Two smaller in-person events, involving approximately 30 to 40 individuals, at the CPI Command Center where participants were educated about the latest trends in Medicare Part C and Part D fraud, waste and abuse. Attendees included participants from Medicare Parts C and Part D plans, law enforcement and the NBI MEDIC. Attendees reported an overwhelmingly positive experience, and also provided feedback about topics for future training events that were considered for the larger offsite training event.
- A larger offsite training event was held with 177 attendees, including Medicare Part C and Part D plan sponsors, law enforcement, NBI MEDIC and CMS staff. The event included group discussions, highly interactive information-sharing exercises, and presentations and panel discussions that featured active question-and-answer segments. The audience reacted positively to the overall event, reporting that the information shared will be useful for their work in combating FWA.

- Two opioid missions with eight plan sponsors. These are collaborative educational meetings to review the monitoring and educating of high-volume, Schedule II opioid analgesic prescribers to ensure that opioid analgesics used by Medicare beneficiaries are prescribed at safe dosages, not used concurrently in combinations with increased overdose risk to beneficiaries, and are for medically necessary use. Attendees included, plans sponsors, NBI MEDIC, I-MEDIC and law enforcement.

### 5.3 Program Integrity Annual Meeting

In FY 2019, CMS held an in-person, three-day conference onsite at CMS Headquarters, designed to promote collaboration between CMS and our stakeholders to address potential vulnerabilities, strengthen our program integrity efforts, and minimize unnecessary administrative burden for providers. The Program Integrity Annual Meeting had 373 attendees from CMS, DOJ, HHS-OIG, MACs, UPICs, NBI MEDIC, RACs, CERT contractor, Medical Review Accuracy Contractor (MRAC), and other PI support contractors. Speakers presented ways to detect fraud and reduce improper payments, while also contributing to CMS’s goal of reducing provider burden. Topics covered included data analysis, provider enrollment, fraud prevention, stakeholder engagement, medical review, and burden reduction.

### 5.4 Medicaid Educational Toolkits

CMS uses an online resource for Medicaid program integrity education, which provides public access to educational toolkits covering a variety of topics, such as dental compliance and beneficiary card sharing.<sup>93</sup> 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. In 2019, CMS began the process to review and update the educational material that is available for state Medicaid Agencies, and is redesigning the Medicaid educational webpages for enhancements.

State Medicaid Program Integrity units also have access to the Regional Information Sharing System (RISS). The MII supports this Medicaid program integrity workspace, which is a secure, web-based portal for collaboration, and dissemination where all states can exchange documents, tips, and best practices about Medicaid program integrity under the auspices of the DOJ Office of Legal Education. Educational material, including course material from the MII as well as the NCCI Medicaid code sets, is maintained on RISS.

### 5.5 Open Door Forums

Open Door Forums (ODFs) are calls that are held on a regular basis, where CMS connects with providers on various topics of interest. Among other purposes, CMS uses these ODFs to share information and answer questions on the programs and projects in which program integrity is involved. For example, CMS has provided updates to the public on the new Medicare cards, (see

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<sup>93</sup> Medicaid Program Integrity online toolkits are available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/edmic-landing.html>.

Section 3.5). CMS also hosts Special ODFs throughout the year to discuss our program integrity initiatives more in depth, such as new prior authorization programs, or the Documentation Requirements Lookup Service. CMS makes Open Door Forums and other presentations available as an audio podcasts, free of charge.<sup>94</sup>

## 5.6 Provider Compliance Focus Groups

Focus groups are a way for providers and CMS to meet in-person or via the web to share ideas and collect feedback and opinions on a number of program integrity programs and projects CMS runs. CMS held focus groups in October 2018 and July 2019. The October 2018 focus group had 288 individuals registered for attendance. The July 2019 focus group had 228 registered individuals. Topics discussed included: telehealth, comparative billing reports, the QIC Appeals Demonstration, TPE, documentation requirements, electronic submission of medical documentation (esMD) and updates to questions asked at previous focus group meetings. All focus group meetings include an Open Mic session during which participants are encouraged to ask questions and provide feedback about Medicare FFS compliance topics. Participants are encouraged to ask questions and be actively engaged throughout the half-day events.

## 5.7 In-Person Provider Enrollment Conferences

In March 2019, April 2018 and September 2017, CMS hosted National Provider Enrollment conferences, where provider enrollment experts from CMS and providers and their support staff met to discuss challenges, explore opportunities for collaboration, and exchange ideas to improve provider enrollment.

The March 2019 conference was held in Nashville, Tennessee and included the following subjects:<sup>95</sup>

- [Provider Enrollment 101](#)
- [Medicare Effective Dates](#)
- [Medicaid Provider Enrollment](#)
- [DMEPOS Enrollment](#)
- [Maintaining Compliance and the Appeals Process](#)
- [Provider Enrollment, Chain, and Ownership System \(PECOS\) 101](#)
- [Federally Qualified Health Centers Enrollment](#)

## 5.8 National Provider Compliance Conference

The in-person inaugural National Provider Compliance Conference was held in FY 2019. The event provided compliance professionals with informative presentations and discussions focused on the efficient and effective submission of Part A and Part B claims, including home health, hospice, and DMEPOS claims. The conference was designed to encourage interactive

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<sup>94</sup> <https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts>

<sup>95</sup> <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Provider-Enrollment-Events>

communication and offered learning opportunities in the form of individual presentations, panel discussions, and subject matter breakouts, in addition to forums for meaningful stakeholder engagement. A total of 241 attendees participated in the 1-1/2-day conference. Of the total attendees, 87 percent of respondents stated that they would attend this conference again, while 88 percent of respondents stated they will be implementing improvements to their work as a result of something they have learned at this conference.

## 5.9 Victimized Provider Project

CMS works with providers who claim to be victims of identity theft and who have suffered financial liabilities in the form of Medicare overpayments or debts through the Victimized Provider Project (VPP). The VPP attempts to validate and remediate a provider's claims as an identity theft victim. CMS wants to ensure that no provider is re-victimized through the wrongful assignment of debts.<sup>96</sup>

## 5.10 Central Repository for Requirements Documentation

CMS is striving toward the development of a central repository of documentation requirements for all programs and all payers that is easily accessible within the electronic health record (EHR) in order to minimize improper payments and reduce provider and supplier burden. A recent key focus of this effort is the development of a prototype Medicare FFS Documentation Requirements Lookup Service (DRLS). The DRLS will allow providers and suppliers to identify Medicare FFS prior authorization and documentation requirements within their EHR or integrated practice management system, reducing provider and supplier burden while simultaneously addressing a leading cause of improper payments – missing or incomplete documentation. We are also working with the DaVinci project, a private-sector initiative led by Health Level 7 (HL7®), a standards development organization focused on accelerating the adoption of HL7® Fast Health Interoperability Resources (FHIR®) as the standard to support and integrate the exchange of value-based care data.<sup>97</sup>

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<sup>96</sup> <https://www.cms.gov/About-CMS/Components/CPI/VictimizedProviderProject>

<sup>97</sup> <https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Future-of-PI-RFI.pdf>

## 6. Leverage New Technology

### 6.1 Provider Enrollment Systems

#### 6.1.1 Provider Enrollment, Chain and Ownership System (PECOS) Improvements

PECOS is the Internet-based system that providers and suppliers use to enroll, revalidate, or make changes to their enrollment information in the Medicare FFS program. CMS made significant improvements to the system to make it easier for providers and suppliers to access and use the system. In FY 2019, CMS engaged providers and suppliers regularly 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
- Organizing the National Provider Enrollment Conference
- Conducting education and outreach through listservs, CMS.gov, PECOS homepage, Medicare Learning Network® (MLN) Matters Articles, change requests, and national provider calls

In FY 2019, CMS made significant changes to PECOS to simplify access, improve the usability and enhance the security of the system, including the following changes:

- Added initial features necessary to facilitate the future implementation of Multi-Factor Authentication
- Implemented the enhancements necessary to ensure all enrollment data that flows to the claims system comes directly from PECOS
- Continued enhancing and streamlining the process that expedites the enrollment processing for users by allowing digital upload of the signature pages
- Implemented enhancements to the Provider Enrollment Process to support the Program Integrity Enhancements to the Provider Enrollment Process Final Rule (CMS-6058-FC)<sup>98</sup>
- Implemented a Medicare ID Search tool in the provider interface to ease the process of finding the Medicare billing numbers to assist the provider community with any inquiries

#### 6.1.2 National Plan and Provider Enumeration System (NPPES) Improvements

The National Plan and Provider Enumeration System (NPPES) supplies the NPI numbers to health care providers, maintains their NPI record, and publishes the records online. In FY 2019, CMS made changes to the NPPES security and enhanced features for managing and enumerating NPIs. The enhancements include:

- Streamlined and enhanced the bulk upload and bulk enumeration process for large organizations

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<sup>98</sup> 84 Fed. Reg. 47794 (Sept. 10, 2019)

- Strong focus on security enhancement, including groundwork necessary to implement multi-factor authentication
- Focus on user experience ease and simplifying the process of submitting NPI requests

## 6.2 Medicaid and CHIP Business Information Solutions

The Medicaid and CHIP Business Information Solutions (MACBIS) is a CMS enterprise-wide initiative to ensure the Medicaid and Children’s Health Insurance Program (CHIP) data infrastructure and automated tools are commensurate to the programs’ role in the United States healthcare system. This initiative creates a more robust and comprehensive information management strategy—a “transformed data state”—to integrate Medicaid and CHIP operational, quality, and performance data for the first time. MACBIS consists of several product development efforts aimed at delivering an integrated set of modern digital products focused on ensuring CMS delivers on the following objectives:

- CMS will advance innovation in state Medicaid Programs by implementing changes that decrease burden while increasing accountability for outcomes.
- CMS will use data to accelerate quality improvement and drive accountability for results.
- CMS will ensure that every federal dollar is spent with integrity.
- CMS is the model for customer service and efficiency with states.

The “business” operations of Medicaid and CHIP take place across a continuum beginning with policy formulation (often in the form of legislation and/or regulation) and then continues to implementation to monitoring and financial management to evaluation. In an ideal world, these processes inform each other and flow seamlessly. This continuum requires a modern and robust set of automated tools, all working together to accomplish the CMS mission

Current MACBIS products and services include:

**Table 7: MACBIS Products and Services**

Product	Description
T-MSIS (Transformed Medicaid Statistical Information System)	The purpose of the T-MSIS product is to ensure that accurate, complete, and timely Medicaid and CHIP is available to enable powerful data analytics for policy research, policy decisions, and improved healthcare outcomes for Medicaid and CHIP populations.
Data Quality Operations and Services	This product and services offering from the MACBIS team is aimed at ensuring that states have timely and actionable feedback about the quality of the data they submit to CMS, along with technical assistance and support to improve data quality.
MACPro/Workflow	MACPro is a suite of products designed to enhance the Federal-State partnership in Medicaid & CHIP through automated workflows, structured data and document management to replace legacy, paper based process for SPAs, Waivers, APDs and other state-reported data.

MACPro/eAPD	As a core function of the MACPro suite, the eAPD system will serve as a singular, streamlined portal for state, federal, and associated partners to develop, review, track, analyze, and share APD, contract submissions, and data to improve accountability and outcomes associated with the State’s Medicaid business needs.
MACFin (Medicaid and CHIP Financials)	MACFin will be a modern, integrated product suite that will replace the current Medicaid Budget and Expenditure System (MBES) and incorporate and improve other existing business processes related to Medicaid and CHIP financial management.
MDP (Medicaid Drug Program)	Medicaid Drug Programs (MDP) administers the mission-critical Medicaid pharmacy systems which resulted in Federal and State rebate revenues of approximately \$35 billion in FFY 2019 and \$34.7 billion in FFY 2018. Medicaid Drug Programs (MDP) is essential to ensure the accuracy of the Medicaid Drug Program data. MDP is currently under new design and development to improve workflows and ensure better accuracy for the entire Medicaid drug program.
AREMAC (Analytic and Reporting Environment for Medicaid & CHIP)	AREMAC’s mission is to unleash the power of data to improve the lives of Medicaid and CHIP beneficiaries. AREMAC aims to be the trusted one-stop shop for all Medicaid and CHIP data. Currently, AREMAC is building reports and dashboards to support CMCS make data-driven program and policy decisions. Longer-term, AREMAC intends to enable users to develop self-service proficiency and expertise in their data domain.

CMS will use MACBIS data to support detection of fraudulent patterns in state Medicaid programs, as well as to conduct 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 certain Medicare data pertaining to beneficiaries in their states, 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.

T-MSIS is currently the primary source for Medicaid and CHIP data around beneficiary eligibility and enrollment, providers, claims and managed care encounters, and financials. All states have been reporting T-MSIS data monthly as of early 2018. Data quality has also been a significant focus since 2017 to improve the overall data set given its importance to Medicaid and CHIP. In August 2018, CMS issued [State Health Official \(SHO\) letter 18-008](#)<sup>99</sup> informing states of T-MSIS data quality expectations. SHO 18-008 provided information regarding the steps CMS will be taking to assess, improve, and maintain T-MSIS data quality, and advised states to consider T-MSIS data quality efforts a permanent and ongoing part of their state T-MSIS operations. In March 2019, CMS issued an [Information Bulletin](#)<sup>100</sup> conveying CMS priorities for T-MSIS data quality as well as a timeline for assessing state T-MSIS reporting. States that did

<sup>99</sup> <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO18008.pdf>

<sup>100</sup> <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib031819.pdf>

not meet requirements were at risk for reduced enhanced Federal Financial Participation for operational costs of systems. State specific data quality assessment letters were sent in April and in the fall of 2019.

As a result of state data quality improvements, a significant milestone was achieved in the fall of 2019 whereby the first set of T-MSIS data called Research Identifiable Files (RIFs) were publicly released.

The following represent some of the major milestones achieved in FY 2019:

- Issued state-specific letter regarding T-MSIS data quality and addressing minimum data quality requirements to avoid potential compliance actions
- MACFin first functional delivery of software within 7 months of contract award – DSH allotments, incremental legacy improvements
- MDP delivered FDA data verifications and Drug Utilization Review Survey
- AREMAC (data warehouse) delivered first production use by users (and received authority to operate)
- Publicly released T-MSIS Research Identifiable Files (RIFs)
- Produced objective measures for T-MSIS data quality and “missingness” reports (data usability)<sup>101</sup>
- Implemented several enhancements to the TMSIS operations dashboard, incorporating an executive view and improved data quality summaries
- T-MSIS data generated more than 7 leads for program integrity.
- Published first Substance Use Disorder (SUD) Data Book as required by the SUPPORT Act

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<sup>101</sup> For data usability, CMS created the DQ Atlas, which presents state-level data quality assessments via comparisons to benchmarks across key topics for all data years. One common measure is missingness, in which CMS flags states that are missing high amounts of data, either in lieu of or in combination with an external benchmark – this varies by state. The purpose of DQ Atlas is to help data users decide what data is suitable for their analyses. States also use the Operations Dashboard and Data Quality Tool to review and improve T-MSIS Data Quality or related missingness measures and rules.

## Appendix A – Program Integrity Obligations

CMS Program Integrity Obligations (amounts in thousands) <sup>102</sup>	FY 2019 Actual Amounts (in thousands)
<b>Audits &amp; Appeals</b>	
Audits	\$251,352
Appeals Initiatives	\$4,219
<b>Audits &amp; Appeals Subtotal</b>	<b>\$255,571</b>
<b>Medical Review</b>	
Medical Review Subtotal	\$231,266
<b>Medicare Secondary Payer</b>	
Medicare Secondary Payer Subtotal	\$110,425
<b>PI Investigation, Systems &amp; Analytics</b>	
Benefits Integrity	\$186,721
PI Modeling & Analytics	\$33,626
Systems	\$74,267
Exchange Program Integrity <sup>103</sup>	\$14,873
<b>PI Investigation, System &amp; Analytics Subtotal</b>	<b>\$309,488</b>
<b>Technical Assistance, Outreach &amp; Education</b>	
Outreach and Education – Medicare	\$47,549
Outreach and Education – Medicaid	\$15,769
Healthcare Fraud Prevention Partnership	\$15,867
Senior Medicare Patrol	\$18,000
<b>Technical Assistance, Outreach &amp; Education Subtotal</b>	<b>\$97,185</b>
<b>Provider Enrollment &amp; Screening</b>	
Provider Enrollment, Chain and Ownership System (PECOS)	\$56,282
Advanced Provider Screening	\$35,251

<sup>102</sup> This table represents total obligations for the CMS Center for Program Integrity, Medicare Integrity Program, and Medicaid Integrity Program for FY 2019 (10/1/2018 through 9/30/2019, inclusive).

<sup>103</sup> These Exchange activities are funded with discretionary HCFAC resources.

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Appendix A – Program Integrity Obligations

CMS Program Integrity Obligations (amounts in thousands) <sup>102</sup>	FY 2019 Actual Amounts (in thousands)
National Supplier Clearinghouse	\$17,219
Section 6401 Provider Screening/Other Enrollment <sup>104</sup>	\$4,438
Provider Enrollment & Screening Subtotal	\$113,189
Error Rate Measurement <sup>105</sup>	
Error Rate Measurement Subtotal	\$72,013
Provider & Plan Oversight	
Open Payments	\$14,812
Parts C & D	\$25,429
Medicaid	\$11,862
Provider & Plan Oversight Subtotal	\$52,103
Program Support & Administration	
Program Support & Administration Subtotal	\$287,827
Recovery Audit Contractors <sup>106</sup>	
Recovery Audit Contractors Subtotal	\$77,768
Total CMS Program Integrity Obligations <sup>107</sup>	\$1,606,835

<sup>104</sup> This amount includes funding from sources other than HCFAC or DRA.

<sup>105</sup> In addition to Medicare and Medicaid, this includes Exchange activities funded with discretionary HCFAC resources.

<sup>106</sup> The Medicare Recovery Audit Program is not a budget appropriation. RACs receive payment through contingency fees based on the amounts recovered from their audit activity. In addition, RACs receive payment for identifying underpayments.

<sup>107</sup> This total includes amounts for the Medicare Recovery Audit Program, which are not obligations under the budget authority.

## Appendix B-1 – Medicare Savings Methodology

### Introduction

CMS measures its program integrity return on investment (ROI) based on Medicare savings achieved through program-integrity-funded activities that prevent or recover improper payments. Savings represent the numerator of the ROI, while the Medicare program integrity obligations represent the denominator. This appendix provides the methodologies used to determine the Medicare savings amounts presented in the FY 2019 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings*.

### Prevention Savings

CMS calculates prevention savings attributable to prepayment administrative actions in the Medicare fee-for-service (FFS) program (also known as Medicare Part A and Part B) and the Medicare prescription drug benefit program (Part D). Prevention savings are the estimated amounts Medicare would have paid providers<sup>108</sup> or plan sponsors in the absence of these actions. The following table lists CMS’s prevention activities.

Prevention Activities	Medicare Program
<b>Automated Actions</b>	
National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits	FFS
NCCI Medically Unlikely Edits (MUEs)	FFS
Ordering and Referring (O&R) Edits	FFS
Fraud Prevention System (FPS) Edits	FFS
Medicare Administrative Contractor (MAC) Automated Medical Review Edits	FFS
Unified Program Integrity Contractor (UPIC) Automated Edits	FFS
<b>Prepayment Review Actions</b>	
Medicare Secondary Payer (MSP) Operations	FFS
MAC Non-Automated Medical Reviews	FFS
UPIC Non-Automated Reviews	FFS
<b>Provider Enrollment Actions</b>	
Revocations	FFS
Deactivations	FFS
<b>Other Actions</b>	
Payment Suspensions	FFS
Medicare Part D Reconciliation Data Reviews	Part D

<sup>108</sup> For the purpose of this document, the term “provider” may refer to a provider, supplier, physician, or non-physician practitioner, and the term may represent an individual or an organization.

## 1 Automated Actions

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

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

### 1.1 National Correct Coding Initiative Procedure-to-Procedure Edits

<b>Savings:</b>	The estimated amount Medicare FFS did not have to pay for all unique claim lines denied or reduced in payment due to a PTP edit, accounting for any subsequently paid claim lines.
<b>Data Source:</b>	Multi-Carrier System (MCS) and Fiscal Intermediary Shared System (FISS) claims data in the CMS Integrated Data Repository (IDR)

CMS developed NCCI edits to promote national correct coding practices and reduce inappropriate payments from improper coding in Medicare Part B claims. The coding decisions for these edits are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual*, Medicare policies, coding guidelines developed by national societies, and standards of medical and surgical practice. NCCI edit tables are refined and updated quarterly to address changes in coding guidelines and additions, deletions, and modifications of Healthcare Common Procedural Coding System (HCPCS)/CPT codes.<sup>109</sup> NCCI edits apply to services rendered by the same provider for the same beneficiary on the same date of service (DOS).

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

<sup>109</sup> When billing Medicare, health care providers use HCPCS/CPT codes to define medical services performed on patients.

payment for the claim line containing the eligible code and denies payment for the claim line containing the other code.

NCCI PTP edits are used to adjudicate claims for practitioner, ambulatory surgical center, outpatient hospital, outpatient therapy, and some home health services. Practitioner and ambulatory surgical PTP edits occur in MCS, and outpatient hospital and outpatient therapy services edits occur in FISS. These edits occur before claims are sent to the Common Working File (CWF).

For every incoming claim line, PTP edits test for edit code pairs between the reported HCPCS/CPT code and all other codes submitted at the same time or in the claims history for the same provider, beneficiary, and DOS. Thus, it is possible to trigger an NCCI PTP edit by billing a code after payment of a different code from a PTP edit for the same provider, beneficiary, and DOS. If the code on the current claim line is the non-payable code in the edit pair, it is automatically denied. If the code on the current claim line is the payable code in the edit pair, in most cases, the claims processing system automatically reduces the allowed payment for the payable code by the amount previously allowed for its non-payable code pair (referred to as a cutback in this document).<sup>110</sup>

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

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

### *1. Identifying PTP Edit Denials and Cutbacks*

System logic in MCS or FISS automatically appends a specific reduction/audit or reason code to claim lines that fail one of the PTP edits. During processing, claim lines may be denied for multiple errors. CMS attributes savings to PTP edits only when a PTP edit code is the system's highest priority reason for denying or reducing payment for a claim line.<sup>111</sup>

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

### *2. Pricing PTP Edit Denials and Cutbacks*

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<sup>110</sup> The PTP edits savings metric includes the cutback amounts from such claim lines in MCS only, as reduced allowed payments almost never occur in conjunction with PTP edit denials in FISS.

<sup>111</sup> Because claims can be denied at the claim- and/or claim-line level in FISS, CMS considers PTP-denied claim lines in PTP edit savings *only if* there is no claim-level denial for a non-PTP-edit reason.

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

- *MCS*: In MCS, most denied/cutback claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been fully payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.<sup>112</sup> For each unique denial, CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.<sup>113, 114</sup> For each unique cutback, CMS first determines the cutback amount by subtracting the allowed payment amount from the system-generated or average price. CMS then multiplies the cutback amount by 80 percent to estimate what Medicare did not have to pay.
- *FISS*: Unlike MCS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each PTP denial based on the applicable pricing mechanism.<sup>115</sup> CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) the Hospital Outpatient Prospective Payment System (OPPS), 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from PTP denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. Accounting for Subsequent Payment

To determine savings, CMS accounts for providers who successfully appeal or resubmit previously denied/cutback services. Specifically, where there are any subsequently paid claim lines for a previously denied/cutback service, CMS subtracts the allowed payment amount of those subsequently paid claim lines from a) the priced amount of the earliest denial, up to that priced amount, or b) the cutback amount of the earliest cutback, up to that cutback amount. Subsequently paid claim lines include those that were processed on or after the date of the earliest denial/cutback

<sup>112</sup> For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>113</sup> In the methodology for this and other edits involving Part B services, CMS uses 80 percent as a conservative estimate of what Medicare did not have to pay a provider. There may be denied services for which Medicare would have paid 100 percent or the beneficiary would have paid 100 percent as part of his/her deductible.

<sup>114</sup> In the methodology for this and other edits across MCS, FISS, and the Viable Information Processing Systems (VIPS) Medicare System (VMS), CMS multiplies savings estimates by 98 percent to account for sequestration.

<sup>115</sup> CMS uses the provider-billed amount to estimate the price in the following situations: 1) when pricing indicators are unavailable and 2) for claim lines priced under the fee schedule where the calculated amount using CMS's pricing methodology is greater than the billed amount.

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and that share the same claim type code, HCPCS code, provider, beneficiary, and DOS. All amounts used in these steps have the estimated beneficiary coinsurance removed, where appropriate.

For a given PTP denied/cutback claim line, CMS reports savings in the fiscal year during which the DOS for that claim line occurred. The calculation of PTP edits savings uses claims data captured 90 days after the end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.<sup>116</sup>

## 1.2 National Correct Coding Initiative Medically Unlikely Edits

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

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

First implemented in 2007, NCCI MUEs prevent payment for billing an inappropriate quantity of the same service<sup>117</sup> rendered by the same provider for the same beneficiary on the same DOS. An MUE for a given service defines the maximum units of that service that a provider would report under most circumstances for the same beneficiary on the same DOS. MUEs are adjudicated either as claim line edits or DOS edits. If the MUE is adjudicated as a claim line edit, the units of service (UOS) on each claim line are compared to the MUE value for the HCPCS/CPT code on that claim line. If the UOS exceed the MUE value, all UOS on that claim line are denied. If the MUE is adjudicated as a DOS edit, the MUE value is compared to the sum of all UOS for the same HCPCS/CPT code, provider, beneficiary, and DOS on claim lines of the current claim and paid claim lines of previously submitted claims. If the sum of all UOS exceeds the MUE value, all UOS for that HCPCS/CPT code and DOS are denied on the current claim.

NCCI MUEs apply to claims for hospital outpatient services; practitioner services; ambulatory surgery center services; and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Before claims are sent to CWF, practitioner and ambulatory surgical MUEs are implemented in MCS, DMEPOS MUEs are implemented in VMS, and hospital outpatient service MUEs are implemented in FISS.

If a HCPCS/CPT code has an MUE adjudicated as a claim line edit, and when justified by clinical circumstances documented in the medical record, providers may use specific modifiers to report the same HCPCS/CPT code on separate claim lines in order to receive payment for medically necessary services in excess of the MUE value. After an MUE denial, a provider could resubmit the service

<sup>116</sup> A provider has up to one year to submit a claim and, thereafter, a specified period to file an appeal if the claim is denied. There may be a small percentage of claim line denials and appeals for a given fiscal year that are not included in the savings calculation. This is due to claims submission, adjudication, and appeal decisions after the data capture. This applies to all metrics that use claims data captured 90 days after the end of the fiscal year.

<sup>117</sup> For the purpose of this document, the term “service” generally refers to an item or service.

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with corrected information that makes the claim payable. Providers also have the right to use the Medicare FFS appeals process to appeal denials due to either claim line or DOS MUEs.

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

*1. Identifying MUE Denials*

System logic in MCS, VMS, and FISS automatically appends a specific reduction/audit, action, or reason code, respectively, to claim lines that fail an MUE. During processing, claim lines may be denied for multiple errors. CMS attributes savings to MUEs only when an MUE code is the system's highest priority reason for denying a claim line.<sup>118</sup>

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

*2. Pricing MUE Denials*

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

- *MCS*: In MCS, most denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.<sup>119</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS*: In VMS, most MUE denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new

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<sup>118</sup> Because claims can be denied at the claim- and/or claim-line level in FISS, CMS considers MUE-denied claim lines in MUE savings *only if* there is no claim-level denial for a non-MUE reason.

<sup>119</sup> For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

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or used equipment, etc.).<sup>120</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claim lines; thus, CMS approximates the price for each MUE denial based on the applicable pricing mechanism.<sup>121</sup> CMS uses a combination of claim attributes to determine if the denied claim line would have been subject to 1) the Hospital OPPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price. CMS does not count any savings from MUE denied claim lines that were packaged under OPPS, since such claim lines would not have received separate pricing or payment.

3. *Accounting for Subsequent Payment*

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

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

1.3 Ordering and Referring Edits

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

<sup>120</sup> For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

<sup>121</sup> CMS uses the provider-billed amount to estimate the price in the following situations: 1) when pricing indicators are unavailable and 2) for claim lines priced under the fee schedule where the calculated amount using CMS’s pricing methodology is greater than the billed amount.

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

Physicians or other eligible professionals must be enrolled in or validly opted out of the Medicare program to order or refer certain items or services for Medicare beneficiaries. In addition, only physicians and certain types of non-physician practitioners are eligible to order or refer such items or services for Medicare beneficiaries. CMS implemented O&R edits to validate Part B clinical laboratory and imaging, DMEPOS, and home health claims that require identification of the ordering/referring provider.<sup>122</sup> O&R edits prevent inappropriate payment for items or services when the ordering/referring provider: 1) does not have an approved Medicare enrollment record or a valid opt-out affidavit and a valid National Provider Identifier (NPI) or 2) is not eligible to order or refer items or services for Medicare beneficiaries.<sup>123</sup> Part B clinical laboratory and imaging, DMEPOS, and home health O&R edits are implemented in MCS, VMS, and FISS, respectively, before claims are sent to CWF.

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

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

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

### *1. Identifying O&R Edit Denials and Rejections*

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

In FISS, CMS identifies O&R denials/rejections at the claim level to ensure appropriate attribution of savings. When a home health claim fails an O&R edit, system logic automatically appends a

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<sup>122</sup> The term ordering/referring provider denotes the person who ordered, referred, or certified an item or service reported in a claim.

<sup>123</sup> CMS calculates savings from Phase 2 O&R edits, which were fully implemented in January 2014. See MLN Matters® article #SE1305 "Full Implementation of Edits on the Ordering/Referring Providers in Medicare Part B, DME and Part A Home Health Agency (HHA) Claims" for additional information. CMS also includes savings from a previously-implemented edit that identifies claims missing the required matching NPI for the ordering/referring provider.

specific reason code to the claim, indicating that the O&R edit was the reason for denying or rejecting the entire claim.

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

## 2. Pricing O&R Edit Denials and Rejections

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

- *MCS*: In MCS, most denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using claim lines paid in the same quarter for the same HCPCS code and other matching characteristics, including the claims processing contractor, locality, place of service, and pricing modifier.<sup>124</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS*: In VMS, few O&R edit denied/rejected claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).<sup>125</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

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<sup>124</sup> For a small number of HCPCS codes, there may not be a paid claim line in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

<sup>125</sup> For a small number of HCPCS codes, there may not be paid claim lines with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price, in the rare cases that the billed amount is less than the system-generated or average price.

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- *FISS*: FISS does not store the priced amount of denied/rejected claims; thus, CMS approximates the price for each O&R denial/rejection by replicating the home health prospective payment system (PPS) pricing formula.

### 3. Accounting for Subsequent Payment

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

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

## 1.4 Fraud Prevention System Edits

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

**Data Source:** 1) FPS and 2) CWF claims data

The FPS is capable of evaluating claims for episodes of care that span different service types or providers (e.g., inpatient care, outpatient and practitioner services, and DME) as well as those that span multiple visits over a period of time. Because of its integrated potential fraud identification capabilities, CMS implements both edits and analytical models in the FPS to address vulnerabilities for fraud, waste, and abuse on a national level. When a vulnerability is identified, CMS conducts a rigorous assessment to determine if an FPS edit is an appropriate and effective action against that vulnerability, or if other approaches, such as an FPS model<sup>126</sup> or provider education, are better suited for the issue. CMS continuously develops new FPS edits and updates existing edits.

FPS edits screen Medicare FFS claims prior to payment. FPS edits automatically reject or deny claim lines for non-covered, incorrectly coded, or inappropriately billed services not payable under Medicare policy. FPS edits occur after NCCI, prepayment, and local MAC edits but prior to some CWF edits. Providers have the right to appeal FPS edit denials through the Medicare FFS appeals

<sup>126</sup> FPS models look for aberrant billing patterns in post-payment claims data. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for further review and investigation by UPICs.

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process. Unlike for denials, providers may not appeal FPS rejections, but they are allowed to resubmit their claims with additional or corrected information.

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

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

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

### 1.5 Medicare Administrative Contractor Automated Medical Review Edits

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

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

The MACs serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program. CMS awards a geographic jurisdiction to each MAC to process and pay Medicare Part A and Part B medical claims<sup>127</sup> or DME claims. The MACs perform a variety of operational functions, but this document focuses on MAC activities in support of program integrity.

CMS works with each MAC to develop improper payment reduction strategies, based on vulnerabilities identified by the Comprehensive Error Rate Testing (CERT) program,<sup>128</sup> the Government Accountability Office (GAO), the Department of Health and Human Services Office of Inspector General (HHS-OIG), the Medicare FFS Recovery Audit Contractors (RACs), and other sources. The MACs' medical review efforts focus on reducing payment errors; thus, the MACs refer cases of potential fraud to UPICs. The MACs conduct most of their medical review activities

<sup>127</sup> CMS contracts with four of the A/B MACs to also process home health and hospice claims across the nation.

<sup>128</sup> Through the CERT program, CMS annually calculates the Medicare FFS improper payment rate by determining if claims in a statistically-valid random sample were properly paid under Medicare coverage, coding, and billing rules.

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prior to payment using both automated and non-automated, or manual, methods (see Appendix B-1 Section 2.2 for non-automated medical reviews that occur prior to payment and Appendix B-1 Section 5.3 for post-payment medical reviews).

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

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

*1. Identifying MAC Automated Medical Review Edit Denials*

System logic in MCS and VMS automatically appends a specific Program Integrity Management Reporting (PIMR) activity code<sup>129</sup> to claim lines that fail an automated medical review edit. In MCS, CMS identifies automated medical review denials as those denied claim lines tagged with the MAC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies automated medical review denials as those denied claim lines with a combination of the MAC-specific automated PIMR activity code and a medical review edit code in the automated range provided by each MAC.<sup>130</sup>

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of automated review.<sup>131</sup> For services subject to claim-level reimbursement, CMS

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<sup>129</sup> CMS previously maintained a PIMR system, which interfaced with the claims processing systems and provided system-generated reports of cost, savings, and workload data related to each MAC's medical review unit. Although CMS retired the PIMR system in 2012, it retained the PIMR data fields in the claims processing systems for the MACs' continued use.

<sup>130</sup> CMS does not currently have a comprehensive way to determine if a MAC medical review denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over MAC medical review denials.

<sup>131</sup> The MACs annually provide CMS with lists of edit and denial reason codes used for medical review. CMS also includes the cross-contractor reason code 56900 (failure to comply with an ADR) as a MAC-specific code, when other claim attributes indicate a MAC reviewed the applicable claim/claim line. In some cases, MAC-denied claims/claim lines do not have an edit reason code or PIMR code to indicate automated or non-automated medical review. CMS counts these cases as automated medical review savings because MAC denials without an edit reason code most frequently have an automated PIMR code.

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identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim<sup>132</sup> or claim line level.<sup>133</sup>

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

## 2. Pricing MAC Automated Medical Review Edit Denials

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

- **MCS:** In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.<sup>134</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- **VMS:** In VMS, the majority of MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).<sup>135</sup> CMS

<sup>132</sup> For services reimbursed at the claim line level, if CMS identifies a MAC denial at the claim level, CMS excludes from savings any claim lines with non-MAC-specific denial reason codes.

<sup>133</sup> CMS considers MAC-denied claim lines in MAC medical review savings *only if* the claim-level denial reason code is 1) a MAC or UPIC-specific medical review code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

<sup>134</sup> For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>135</sup> For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated medical review denial based on the applicable pricing mechanism.<sup>136</sup> CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

### 3. Accounting for Subsequent Payment

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

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

## 1.6 Unified Program Integrity Contractor Automated Edits

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

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

The primary goal of UPICs is to identify cases of suspected fraud, waste, and abuse; develop cases thoroughly and in a timely manner; and take immediate action to ensure that Medicare funds are not inappropriately paid. UPICs have teams of investigators, data analysts, and medical reviewers to

<sup>136</sup> CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

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perform program integrity functions for the Medicare FFS program and the Medicare-Medicaid Data Match Program. CMS has established geographic program integrity jurisdictions to cover the nation, and each UPIC operates in a specific jurisdiction. UPICs receive leads about potential fraud from several sources, including complaints, MACs, FPS, CMS, and HHS-OIG. UPICs also conduct their own proactive data analysis to look for aberrant billing patterns.

During investigations, UPICs may request and review medical records from providers; analyze data; conduct interviews with beneficiaries, providers, or other medical personnel; and conduct onsite visits to provider locations. Based on the findings and CMS's approval, UPICs initiate appropriate administrative actions, such as denying or suspending payment that should not be made to a provider due to reliable evidence of fraud or abuse.<sup>137</sup>

Automated edits are among the administrative actions a UPIC may initiate. A UPIC may request that the MAC within its jurisdiction implement automated edits<sup>138</sup> to address program integrity issues and prevent the loss of future Medicare funds. In most cases, the MACs must comply with UPICs' requests to install automated edits in the relevant local claims processing system. Depending on the issue, these UPIC-initiated edits may automatically deny payment for 1) non-covered, incorrectly coded, or inappropriately billed services, 2) services submitted by suspicious providers, or 3) certain types of services for beneficiaries identified as part of a fraud scheme. Another type of UPIC automated edit denies claim lines that had been suspended for non-automated review but the provider did not respond in a timely manner to an ADR. Providers have the right to appeal UPIC automated edit denials through the Medicare FFS appeals process.

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

### *1. Identifying UPIC Automated Edit Denials*

System logic in MCS and VMS automatically appends a specific PIMR activity code to claim lines that fail an automated edit. In MCS, CMS identifies UPIC automated edit denials as those denied claim lines tagged with the UPIC-specific automated PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies automated edit denials as those denied claim lines with the UPIC-specific automated PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.<sup>139</sup>

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<sup>137</sup> The administrative actions that may result from UPIC investigations include automated edits, non-automated reviews (Appendix B-1 Section 2.3) provider enrollment revocations and deactivations (Appendix B-1 Section 3), payment suspensions, post-payment reviews (Appendix B-1 Section 5.6), and referrals to law enforcement (Appendix B-1 Section 9.1).

<sup>138</sup> Depending on the jurisdiction, a UPIC may install DME automated edits in VMS, the system that processes DME claims.

<sup>139</sup> CMS does not currently have a comprehensive way to determine if a UPIC denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over UPIC automated edit denials.

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Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC automated denials as those denied claims or claim lines with a UPIC-specific code as the denial reason and a UPIC-specific edit reason code or PIMR code indicative of automated review.<sup>140</sup> For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim<sup>141</sup> or claim line level.<sup>142</sup>

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

## 2. Pricing UPIC Automated Edit Denials

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

- *MCS*: In MCS, most UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.<sup>143</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

<sup>140</sup> The MACs annually provide CMS with lists of edit and denial reason codes used for UPICs. CMS also includes the cross-contractor reason code 56900 (failure to comply with an ADR) as a UPIC-specific code, when other claim attributes indicate a UPIC reviewed the applicable claim/claim line. In some cases, UPIC-denied claims/claim lines do not have an edit reason code or PIMR code to indicate automated or non-automated review. CMS counts these cases as automated review savings.

<sup>141</sup> For services reimbursed at the claim line level, if CMS identifies a UPIC denial at the claim level, CMS excludes from savings any claim lines with non-UPIC-specific denial reason codes.

<sup>142</sup> CMS considers UPIC-denied claim lines in UPIC savings *only if* the claim-level denial reason code is 1) a UPIC-specific code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

<sup>143</sup> For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

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- *VMS*: In VMS, the majority of the UPIC automated edit denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).<sup>144</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each automated denial based on the applicable pricing mechanism.<sup>145</sup> CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

### 3. Accounting for Subsequent Payment

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

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

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<sup>144</sup> For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>145</sup> CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

## 2 Prepayment Review Actions

Some claims may require manual examination before they are paid to ensure that providers complied with Medicare policy. This document uses the broad category of prepayment review actions to describe program integrity activities involving manual processing prior to an initial claim determination. CMS calculates prepayment review action savings from the following activities for Medicare FFS claims:

- Medicare Secondary Payer (MSP) Operations<sup>146</sup>
- MAC Non-Automated Medical Reviews
- UPIC Non-Automated Reviews

### 2.1 Medicare Secondary Payer Operations

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

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

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

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

- Group health plan (GHP)<sup>147</sup>

<sup>146</sup> MSP operations involve the collection and identification of MSP occurrences and the application through automated edits and manual examination of claims.

<sup>147</sup> A GHP is a health insurance plan offered by an employer or other plan sponsor (e.g., union or employee health and welfare fund). A Medicare beneficiary may be eligible for GHP employee/family coverage if he/she or a spouse is currently working, or for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Specific situations, including employer size and the beneficiary's status (e.g., age 65 or older, disabled, and/or end-stage renal disease), determine whether Medicare or the GHP has primary payment responsibility. Some Medicare beneficiaries have retiree GHP coverage through a former employer. For these beneficiaries, Medicare is always the primary payer, and the retiree GHP is the secondary payer.

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- Liability insurance (including self-insurance)<sup>148</sup>
- No-fault insurance<sup>149</sup>
- Workers' compensation (WC)<sup>150</sup>

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

CMS's MSP operations involve prevention of erroneous primary payments as well as recovery of mistaken or conditional payments made by Medicare (see Appendix B-1 sections 5.1 and 5.2 for additional information about recovery efforts). CMS collects information about Medicare beneficiaries' other health insurance or coverage through a variety of methods. These methods include mandatory reporting by other insurers regarding covered Medicare beneficiaries, beneficiary self-reporting of other coverage, and claims investigations. In addition, Medicare providers are obligated to ask Medicare beneficiaries about other coverage and submit that information with Medicare claims.

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

Some MSP-related claims may require manual intervention by the MACs. A claims examiner reviews the claim and information about other coverage. Depending on the findings regarding payment responsibility, the claim may be adjusted such that Medicare only makes a secondary payment, or the claim may be rejected or denied. The MACs then attribute costs avoided to the associated MSP records.<sup>151</sup>

Providers may appeal or resubmit a denied/rejected claim and provide additional information to support receiving payment. If the primary payer is not expected to promptly pay the claim, a provider may receive a conditional payment from Medicare (see Appendix B-1 Section 5.1). If the primary payer denies the claim or makes an exhausted benefits determination, a provider may bill Medicare and include documentation of the primary payer's denial or determination. Medicare may make a payment, as Medicare coverage allows.

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<sup>148</sup> Liability insurance may pay for medical expenses resulting from negligence, such as inappropriate action or inaction that causes injury. Examples of liability insurance types include automobile, uninsured/underinsured motorist, homeowners', product, and malpractice.

<sup>149</sup> No-fault insurance may pay for medical expenses resulting from injury in an accident, regardless of who is at fault for causing the accident. Examples of no-fault insurance types include automobile, homeowners', and commercial.

<sup>150</sup> WC refers to a law or plan requiring employers to cover employees who get sick or injured on the job.

<sup>151</sup> The MACs' MSP-related claims processing efforts are not currently included in the MSP program obligations in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

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To determine savings, the amount Medicare would have paid as the primary payer is based on the Medicare fee schedule and Medicare coverage of items and services. What Medicare pays as the secondary payer is subtracted from this amount. In general, savings are reported in the fiscal year during which the dates of service or dates of discharge for the applicable claims occurred.<sup>152</sup> For WCMSAs,<sup>153</sup> the full amount set aside is reported in the fiscal year during which the agreement is set up. Because Medicare does not receive ongoing WC claims, yearly savings due to WCMSAs cannot be determined.

## 2.2 Medicare Administrative Contractor Non-Automated Medical Reviews

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

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

In addition to automated medical review edits (see Appendix B-1 Section 1.5), the MACs conduct non-automated, or manual, medical reviews where there is risk for improper payment. In MCS, VMS, and FISS, the MACs implement non-automated medical review edits, which suspend all or part of a claim possessing the targeted criteria for review. The MACs may request additional documentation from providers (i.e., through an ADR), and specific time frames apply to providers' submission of documentation and the MACs' completion of reviews. Each MAC has a medical review staff of trained clinicians and claims analysts, who review claims and associated documentation in order to make coverage and payment determinations. Claim lines that are inconsistent with Medicare policy are denied payment or, in certain situations, are up- or down-coded for adjusted payment. The MACs also offer providers education to resolve errors and improve future accuracy.<sup>154</sup> Providers have the right to appeal MAC non-automated medical review denials through the Medicare FFS appeals process.

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

<sup>152</sup> For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

<sup>153</sup> A workers' compensation settlement may provide for funds to be set aside to pay for future medical and/or prescription drug expenses related to an injury, illness, or disease. A WCMSA may be set up for using these funds. Medicare will not pay for any medical expenses related to the injury, illness, or disease until all of the set-aside funds are used appropriately.

<sup>154</sup> Effective FY 2018, CMS implemented Targeted Probe and Educate (TPE), a national medical review strategy that focuses on providers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. TPE involves up to three rounds of prepayment or post-payment claim review combined with individualized provider education. See Appendix B-1 Section 5.3 for information about MAC post-payment medical reviews.

### 1. Identifying MAC Non-Automated Medical Review Denials

In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.<sup>155</sup> In MCS, CMS identifies non-automated medical review denials as those denied claim lines tagged with a MAC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS generally identifies non-automated medical review denials as those denied claim lines with a combination of a MAC-specific non-automated review PIMR activity code and a medical review edit code in the non-automated ranges provided by each MAC.<sup>156</sup>

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies MAC non-automated medical review denials as those denied claims or claim lines with a MAC-specific medical review code as the denial reason and a MAC-specific edit reason code or PIMR code indicative of non-automated medical review.<sup>157</sup> For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim<sup>158</sup> or claim line level.<sup>159</sup>

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

### 2. Pricing MAC Non-Automated Medical Review Denials

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

<sup>155</sup> The MAC non-automated PIMR categories include manual routine review, prepayment complex manual review, and prepayment complex manual probe review.

<sup>156</sup> For VMS, CMS notes two methodological items related to attribution. First, for the rare cases where a claim line has a category mismatch between the PIMR activity code and the medical review edit code (e.g., an automated PIMR activity code and a medical review edit code in the non-automated range), CMS categorizes the denial based on the medical review edit code. Second, CMS does not currently have a comprehensive way to determine if a MAC medical review denial is the system's highest priority reason for denying the claim line. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over MAC medical review denials.

<sup>157</sup> The MACs annually provide CMS with lists of edit and denial reason codes used for medical review.

<sup>158</sup> For services reimbursed at the claim line level, if CMS identifies a MAC denial at the claim level, CMS excludes from savings any claim lines with non-MAC-specific denial reason codes.

<sup>159</sup> CMS considers MAC-denied claim lines in MAC medical review savings *only if* the claim-level denial reason code is 1) a MAC or UPIC-specific medical review code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

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- *MCS*: In MCS, most MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in MCS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit of service using paid claim lines from the same quarter that share the same HCPCS code and other matching characteristics, including claims processing contractor, locality, place of service, and pricing modifier.<sup>160</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *VMS*: In VMS, the majority of MAC medical review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).<sup>161</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated medical review denial based on the applicable pricing mechanism.<sup>162</sup> CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

### 3. Accounting for Subsequent Payment

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

Subsequently paid claims or claim lines include those that were processed on or after the date of the earliest denial and that share the same attributes. In MCS and VMS, these attributes are the same

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<sup>160</sup> For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>161</sup> For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>162</sup> CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

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

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

### 2.3 Unified Program Integrity Contractor Non-Automated Reviews

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

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

In addition to automated edits (see Appendix B-1 Section 1.6), a UPIC may request that the MAC in their jurisdiction implement non-automated prepayment review edits in the local claims processing system<sup>163</sup> to identify and suspend claims for medical review prior to payment.

To initiate non-automated review, the MAC sends an ADR to the provider under review. In that notice, the provider is instructed to provide the necessary medical record documentation to the UPIC for further review. In accordance with CMS guidance, the provider must submit the necessary documentation to the UPIC within 45 calendar days or the claims are denied.<sup>164</sup> Once the documentation is received, the UPIC examines the medical records for compliance with Medicare policy while determining if there is evidence of fraud, waste, or abuse. When the medical documentation does not support the services billed by the provider, the UPIC denies or adjusts payment for the claims. Providers have the right to appeal UPIC non-automated review denials through the Medicare FFS appeals process.

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

#### 1. Identifying UPIC Non-Automated Review Denials

<sup>163</sup> Depending on the jurisdiction, a UPIC may install DME prepayment review edits in VMS, the system that processes DME claims.

<sup>164</sup> CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

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In MCS and VMS, the MACs set up processes to append a characterizing PIMR activity code that captures the category of medical review edit that fired on a given claim line.<sup>165</sup> In MCS, CMS identifies UPIC non-automated review denials as those denied claim lines tagged with a UPIC-specific non-automated review PIMR activity code and a medical review suspense audit code indicated as the system's highest priority reason for denying the claim line. In VMS, CMS identifies non-automated review denials as those denied claim lines with a UPIC-specific non-automated review PIMR activity code and a medical review edit code in the ranges allocated by each MAC for UPIC use.<sup>166</sup>

Unlike MCS and VMS, FISS reimburses services at either the claim (e.g., for Part A inpatient services) or claim line level (e.g., for outpatient services). Accordingly, CMS identifies UPIC non-automated review denials as those denied claims or claim lines with a UPIC-specific code as the denial reason and a UPIC-specific edit reason code or PIMR code indicative of non-automated review.<sup>167</sup> For services subject to claim-level reimbursement, CMS identifies denials at the claim level. For services subject to claim-line-level reimbursement, CMS identifies denials at either the claim<sup>168</sup> or claim line level.<sup>169</sup>

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

## 2. Pricing UPIC Non-Automated Review Denials

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

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

<sup>165</sup> The program integrity contractor non-automated PIMR categories include manual routine review, prepayment complex probe review, prepayment complex provider-specific review, and prepayment complex manual review.

<sup>166</sup> CMS does not currently have a comprehensive way to determine if a UPIC non-automated review denial is the system's highest priority reason for denying the claim line in VMS. Partially to this end, CMS excludes from savings those claim lines denied as duplicates, since that is a higher priority reason over UPIC review denials.

<sup>167</sup> The MACs annually provide CMS with lists of edit and denial reason codes used for UPICs.

<sup>168</sup> For services reimbursed at the claim-line level, if CMS identifies a UPIC denial at the claim level, CMS excludes from savings any claim lines with non-UPIC-specific denial reason codes.

<sup>169</sup> CMS considers UPIC-denied claim lines in UPIC savings *only if* the claim-level denial reason code is 1) a UPIC-specific code (and the claim status is paid or rejected), 2) missing, or 3) an administrative code indicating that all lines on the claim were individually denied or rejected by line-level edits.

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place of service, and pricing modifier.<sup>170</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.

- *VMS*: In VMS, most of UPIC non-automated review denied claim lines contain a system-generated price, specifically the Medicare-approved charge if the claim line had been payable. When a system-generated price for a claim line is unavailable in VMS, CMS approximates the price. Specifically, CMS calculates an average allowed payment amount per unit using paid claim lines with the same HCPCS code and other matching characteristics, including the ZIP code, quarter, and equipment modifier categories (e.g., capped rentals, items requiring frequent servicing, new or used equipment, etc.).<sup>171</sup> CMS multiplies the system-generated or average price by 80 percent to remove the beneficiary coinsurance and estimate what Medicare did not have to pay the provider.
- *FISS*: Unlike MCS and VMS, FISS does not store the priced amount of denied claims or claim lines; thus, CMS approximates the price for each non-automated review denial based on the applicable pricing mechanism.<sup>172</sup> CMS uses a combination of claim attributes to determine if the denied claim or claim line would have been subject to 1) a PPS, 2) reasonable cost payment, or 3) a fee schedule. CMS then calculates the price by replicating the specific pricing formula. If the claim or claim line would have been subject to coinsurance, CMS removes the estimated beneficiary coinsurance from the replicated price.

### 3. Accounting for Subsequent Payment

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

<sup>170</sup> For a small number of HCPCS codes, there may not be a paid claim line in MCS in the calendar year corresponding to the current claim's DOS. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>171</sup> For a small number of HCPCS codes, there may not be a paid claim line in VMS with matching characteristics. In such cases, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS also uses the provider-billed amount to estimate the price in the rare cases that the billed amount is less than the system-generated or average price.

<sup>172</sup> CMS was unable to replicate the price for a small number of claims and claim lines in FISS. For claim lines where CMS cannot determine the applicable fee schedule, CMS uses the provider-billed amount multiplied by 70 percent to estimate the price. CMS excludes from savings claims or claim lines missing key information to replicate the applicable PPS or reasonable cost pricing formula.

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

### 3 Provider Enrollment Actions

Providers must enroll in the Medicare FFS program to be paid for covered services they furnish to Medicare beneficiaries. In order to enroll, providers must submit a paper CMS-855 enrollment application or a corresponding online application through the Provider Enrollment, Chain, and Ownership System (PECOS) and then undergo risk-based screening. If a prospective provider does not meet eligibility requirements, CMS denies enrollment. Once enrolled, providers are responsible for keeping their enrollment information (e.g., address, practice location, adverse legal actions, etc.) up-to-date. CMS may revoke or deactivate a currently enrolled provider’s Medicare billing privileges if the provider’s behavior triggers one or more of the 14 revocation reasons or three deactivation reasons.

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

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

#### 3.1 Revocations

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

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

CMS has 14 regulatory reasons upon which to revoke a provider’s Medicare FFS billing privileges. Examples include non-compliance with Medicare enrollment requirements, certain felony convictions, submission of false or misleading application information, determination that the provider is non-operational, abuse of billing privileges, failure to comply with enrollment reporting requirements, and termination of Medicaid billing privileges. Depending on the revocation reason, CMS bars a provider from re-enrolling in Medicare for one to three years.

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

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

CMS calculates costs avoided for fully revoked providers at the professional identifier and provider type level.<sup>173</sup> As the professional identifier, CMS uses the NPI for individual providers and the Employer Identification Number (EIN) for provider organizations. CMS defines a full revocation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a revocation within the fiscal year.<sup>174</sup> To calculate savings, CMS captures PECOS enrollment data and CWF claims data as of 90 days after the end of the fiscal year to allow time for revocation appeals as well as for claims submission, adjudication, and appeals/resubmission.

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

*1. Projecting Costs Avoided*

CMS projects what Medicare would have paid a fully revoked provider based on the earliest 12 months of claims history in the 18 months preceding the provider’s full revocation date.<sup>175</sup> Using the paid claims in this 12-month period and placing higher weights on previous months of billing, CMS calculates the weighted moving average for each month of the revoked provider’s re-enrollment bar to project the Medicare payments that provider would have received. The sum of the payment projections for each month represents the costs avoided for the revoked provider during the length of its re-enrollment bar.

*2. Accounting for Billing Picked Up by Active Providers*

CMS uses provider-type-specific adjustment factors to account for beneficiaries receiving care from other providers after their original provider is revoked. Each adjustment factor estimates the percentage of a revoked provider’s previous billing not expected to be shifted to other active providers. Thus, an adjustment factor represents the proportion of projected costs avoided that CMS

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<sup>173</sup> CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DME supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

<sup>174</sup> In FY 2019, CMS implemented this updated definition of a fully revoked provider to better characterize revocation actions within fiscal year reporting periods.

<sup>175</sup> CMS uses the earliest 12 months in the 18 months preceding the provider’s revocation date because a provider may change its billing practices closer to the revocation date, especially if the provider becomes aware of CMS conducting a review or investigation of its claims.

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expects Medicare to realize as savings due to a revocation. To estimate savings due to fully revoking a provider, CMS multiplies the projected costs avoided for that provider by the appropriate provider-type-specific adjustment factor.

CMS developed the provider-type-specific adjustment factors by analyzing the change in service utilization by the beneficiaries of a historical sample of fully-revoked providers.<sup>176</sup> For each fully-revoked provider in the sample, CMS identified the beneficiaries and which services they received from that provider in the 180 days before the revocation became effective. CMS then calculated the following amounts:

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

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

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

### 3.2 Deactivations

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

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

<sup>176</sup> CMS’s calculation of cost avoidance adjustment factors is based on methodology certified by HHS-OIG.

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CMS has three regulatory reasons upon which to deactivate, or stop, a provider's billing privileges. These reasons are no submission of Medicare claims for 12 consecutive calendar months, failure to report a change in information (e.g., practice location, billing services, or ownership), and failure to respond to a CMS notice to submit or certify enrollment information.<sup>177</sup> Unlike revocations, deactivations have no re-enrollment bars. In most cases, a provider can reactivate its enrollment in Medicare at any time by submitting a new enrollment application or recertifying the information on file.

CMS calculates costs avoided for fully deactivated providers at the professional identifier and provider type level.<sup>178</sup> As the professional identifier, CMS uses the NPI for individual providers and the EIN for provider organizations. CMS defines a full deactivation as an NPI or EIN by provider type that has no approved enrollments and for which the latest action was a program-integrity-related deactivation within the fiscal year.<sup>179</sup> To calculate savings, CMS captures PECOS enrollment data and CWF claims data as of 90 days after end of the fiscal year to allow time for claims submission, adjudication, and appeals/resubmission.

CMS estimates the amount that Medicare did not pay fully deactivated providers in three steps: 1) projecting costs avoided, 2) accounting for reactivations within 12 months, and 3) accounting for billing picked up by active providers.

*1. Projecting Costs Avoided*

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

*2. Accounting for Reactivations within 12 Months*

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

*3. Accounting for Billing Picked Up by Active Providers*

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<sup>177</sup> In addition to the three regulatory reasons, CMS may also deactivate providers for other reasons, e.g., due to death or voluntary withdrawal from Medicare. In determining savings, CMS excludes deactivation reasons that do not represent active intervention to promote program integrity.

<sup>178</sup> CMS uses the following provider types: Medicare Part B organization, Medicare Part B individual practitioner, DME supplier, home health agency, hospice, skilled nursing facility, and other Medicare Part A provider.

<sup>179</sup> In FY 2019, CMS implemented this updated definition of a fully deactivated provider to better characterize deactivation actions within fiscal year reporting periods.

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

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

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

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

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

## 4 Other Actions

### 4.1 Payment Suspensions

<b>Savings:</b>	The projected amount Medicare FFS did not pay providers during payment suspension, based on a weighted moving average of each
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<sup>180</sup> CMS’s calculation of cost avoidance adjustment factors is based on methodology certified by HHS-OIG.

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<b>Data Source:</b>	<p>provider's historically paid claims and adjusted to exclude the amount of billing adjudicated as payable during the projection period.</p> <p>1) Unified Case Management (UCM) system, 2) PECOS, and 3) IDR claims data during the period of and 12 months prior to payment suspension for each provider</p>
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CMS has authority to suspend payment to a provider when there is reliable information that an overpayment exists, when payments to be made may not be correct, or when there is a credible allegation of fraud existing against a provider. When CMS approves a payment suspension, program integrity contractors (e.g., UPICs) coordinate with the MACs to implement a payment suspension edit to withhold, i.e., suspend, payment for allowable claims submitted during the period of payment suspension. CMS implements payment suspensions for six months and can approve extensions to the payment suspension period in six-month increments. Upon termination of the payment suspension, withheld funds are applied to any Medicare overpayment assessed on the provider.

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

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

*1. Projecting costs avoided*

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

In the case that a provider's payment suspension is shorter than six months (e.g., the payment suspension has a termination date less than 180 days from effectuated date, or the provider is revoked or deactivated during the payment suspension), CMS adjusts the cost avoidance projection to reflect the length of payment suspension.

*2. Accounting for billing adjudicated as payable during the projection period*

To estimate savings, CMS subtracts the amount for claims processed during the payment suspension and adjudicated as payable from the cost avoidance projection, as this amount is either paid to the provider or used to settle any unpaid overpayment upon payment suspension termination. For providers whose payment suspension projection period is contained within the

fiscal year, CMS subtracts suspended payments from the cost avoidance projection. For providers placed on payment suspension late in the fiscal year and therefore for whom CMS does not have complete claims information, CMS projects the payable amount that would be suspended based on known claims adjudicated as payable during the payment suspension. CMS then subtracts this amount from the cost avoidance projection.

### *3. Accounting for revoked and deactivated providers*

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

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

## 4.2 Medicare Part D Reconciliation Data Reviews

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

A plan receives monthly prospective payments from CMS for the direct subsidy, the low-income cost-sharing subsidy, and the reinsurance subsidy. During benefit-year-end reconciliation, CMS compares its prospective payments to a plan with the plan's actual cost data, submitted through prescription drug event (PDE) records<sup>181</sup> and direct and indirect remuneration (DIR)<sup>182</sup> reporting, to settle any residual payments required between CMS and the plan sponsor. CMS also determines any risk corridor payment.

CMS validates both PDE and DIR data in advance of reconciliation and quantifies savings for each initiative, described in the following sections. In the FY 2019 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings* provides the sum of savings from both the PDE data quality review and DIR data review initiatives.

### *Prescription Drug Event Data Quality Review*

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<sup>181</sup> Every time a beneficiary fills a prescription under a Part D plan, the plan sponsor must submit a PDE summary record to CMS. A PDE record contains information about the beneficiary, prescriber, pharmacy, dispensed drug, drug cost, and payment.

<sup>182</sup> DIR is any price concession or arrangement that serves to decrease the costs incurred by a Part D sponsor for a drug. Examples of DIR include discounts, rebates, coupons, and free goods contingent on a purchase agreement offered to some or all purchasers, such as manufacturers, pharmacies, and enrollees. Some DIR, namely POS price concession, is already reflected in the drug price reported on the PDE. Plans must report other types of DIR annually to CMS.

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<b>Savings:</b>	The sum of the differences in gross covered drug costs between the initial and corrected versions of PDEs flagged during pre-reconciliation data quality review and subsequently adjusted or deleted by Part D plan sponsors.
<b>Data Source:</b>	PDE records from the IDR, which are flagged and tracked by the data analysis contractor

During the benefit year, CMS conducts data analysis and validation of PDE records to flag data quality issues for Part D sponsors’ review and action. This pre-reconciliation data quality review initiative promotes accuracy in the plan-reported financial data used in the Part D year-end payment reconciliation process. CMS’s Part D data analysis contractor receives a weekly data stream from the Drug Data Processing System (DDPS)<sup>183</sup> and analyzes PDE records for outliers or potential errors in the following categories:

- Total gross drug cost
- Per-unit drug price
- Quantity/daily dosage
- Duplicate PDEs<sup>184</sup>
- MSP issues
- Covered plan-paid and low income cost-sharing amounts in the catastrophic coverage phase of the benefit

The Part D data analysis contractor posts reports of flagged PDEs to a PDE analysis website shared with Part D plan sponsors. Sponsors have specified time frames to review, investigate, and act on the reports by a) providing a written response explaining the validity of a PDE or b) adjusting or deleting a PDE accordingly if the PDE is invalid.<sup>185</sup> The Part D data analysis contractor stops reviewing and flagging PDEs for a given benefit year when CMS finalizes payment reconciliation, typically in September following the benefit year.

Among the PDEs flagged during pre-reconciliation data quality review, CMS quantifies savings by summing the differences in gross covered drug costs between the initial and corrected versions of PDEs adjusted or deleted by plan sponsors. This metric represents the reduction in drug costs included in the payment reconciliation process.<sup>186</sup> The calculation of data quality review savings

<sup>183</sup> Before CMS conducts data quality reviews, PDE records are subject to edits in both the Prescription Drug Front-End System and the DDPS.

<sup>184</sup> CMS’s data analysis contractor looks for potential duplicate PDEs for the same beneficiary, DOS, and drug, where the PDEs have different values in one or more of other key claim identifiers and thus were not rejected by edits immediately upon submission.

<sup>185</sup> A PDE adjustment is made to the original PDE record, and the record is marked with an “adjustment” indicator. When a PDE record is deleted, the record is marked with a “deletion” indicator. Deleted PDEs are retained as records in the data system but are excluded from the reconciliation process.

<sup>186</sup> The impact of pre-reconciliation data quality review is not currently assessed through a comparative reconciliation simulation; thus, this metric represents aggregate savings potentially realized by Medicare, plans, and beneficiaries, depending on the circumstances.

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typically uses benefit-year data captured in September following the benefit year.<sup>187</sup> For a given benefit year, CMS reports savings in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

*Direct and Indirect Remuneration Data Review*

<b>Savings:</b>	The sum of the differences in Medicare's reinsurance and risk corridor shares, comparing a reconciliation simulation using the initially-submitted DIR with the actual reconciliation using the reviewed and finalized DIR for each plan.
<b>Data Source:</b>	1) DIR data reported by Part D plan sponsors in the Health Plan Management System (HPMS) and 2) Part D Payment Reconciliation System

Part D plan sponsors submit benefit-year DIR reports through CMS's HPMS. The summary DIR report contains data at the plan benefit package level. If a sponsor received DIR at the sponsor or contract level, it must apply one of CMS's reasonable allocation methodologies to allocate DIR to the plan benefit package level.<sup>188</sup> Sponsors must also include good faith estimates for DIR that is expected for the applicable contract year but has not yet been received.

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

CMS uses the reviewed and finalized DIR data in the year-end Part D payment reconciliation process for each plan, specifically to determine the reconciliation amounts for Medicare's reinsurance subsidy and risk corridor payment/recoupment. Holding all other data constant, CMS also runs a reconciliation simulation for each plan using the initially submitted DIR data to calculate what the reinsurance and risk corridor amounts would have been. For each type of payment, CMS subtracts the actual amount from the simulated amount.<sup>189</sup> CMS calculates savings from DIR review as the sum of these reinsurance and risk corridor differences across all plans.<sup>190</sup> For a given benefit year, CMS reports savings in the fiscal year during which it conducts that benefit year's reconciliation payment adjustments with plan sponsors.

<sup>187</sup> For PDE adjustments/deletions that occur between plan sponsors' data submission deadline for payment reconciliation (typically the end of June) and September, associated savings are realized in CMS's global reconciliation re-opening, which usually occurs four years after a given payment year.

<sup>188</sup> Part D plan sponsors must also report DIR at the 11-digit National Drug Code level, so that CMS can provide annual sales of branded prescription drugs to the Secretary of the Treasury to determine the fee amount to be paid by each manufacturer.

<sup>189</sup> For the reinsurance subsidy, CMS compares Medicare's simulated and actual amounts owed, i.e., 80 percent of the allowable reinsurance costs; thus, the comparison does not involve CMS's monthly prospective reinsurance payments.

<sup>190</sup> Program of All-Inclusive Care for the Elderly (PACE) plans are excluded from this analysis, because PACE plans typically do not receive rebates.



## Appendix B - Program Integrity Savings Methodology

## Recovered Savings

CMS calculates recovered savings attributable to program integrity activities in Medicare FFS, Medicare Advantage (i.e., Part C), and Medicare Part D. Recovered savings represent amounts that CMS took back or retained from providers, plan sponsors, or other insurers/entities due to Medicare payment policy and requirements. The following table lists CMS's recovery activities.

<b>Recovery Activities</b>	<b>Medicare Program</b>
<b>Overpayment Recoveries</b>	
MSP Operations	FFS
MSP Commercial Repayment Center (CRC)	FFS
MAC Post-Payment Medical Reviews	FFS
Medicare FFS Recovery Audit Contractor (RAC) Reviews	FFS
Supplemental Medical Review Contractor (SMRC) Reviews	FFS
UPIC Post-Payment Reviews	FFS
Overpayments from Retroactive Revocations	FFS
Overpayments Related to Risk Adjustment Data	Part C and Part D
Medicare Part D Plan Sponsor Audits	Part D
Medicare Part D RAC Reviews	Part D
<b>Cost Report Payment Accuracy</b>	
Provider Cost Report Reviews and Audits	FFS
Cost-Based Plan Audits	Cost-Based Plans
<b>Plan Penalties</b>	
Medicare Part C and Part D Program Audits	Part C and Part D
Medical Loss Ratio (MLR) Requirement	Part C and Part D
<b>Other Actions</b>	
Party Status Appeals	FFS
<b>Law Enforcement Referrals</b>	
UPIC Law Enforcement Referrals	FFS
I-MEDIC Part C and Part D Law Enforcement Referrals	Part C and Part D

## 5 Overpayment Recoveries

Given the volume of claims submitted to Medicare, CMS cannot review every claim prior to payment. Thus, CMS conducts a wide range of post-payment activities to identify improper payments and recover overpayments. An overpayment is any amount a provider or plan receives in excess of amounts properly payable under Medicare statutes and regulations. Overpayments are

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considered debts owed to the federal government, and CMS has the authority to recover these amounts. CMS reports savings from the following overpayment<sup>191</sup> recovery activities:

- *Medicare FFS*
  - MSP Operations
  - MSP Commercial Repayment Center (CRC)
  - MAC Post-Payment Medical Reviews
  - Medicare FFS Recovery Audit Contractor (RAC) Reviews
  - Supplemental Medical Review Contractor (SMRC) Reviews
  - UPIC Post-Payment Reviews
  - Overpayments from Retroactive Revocations
  
- *Medicare Part C and Part D*
  - Overpayments Related to Risk Adjustment Data
  - Medicare Part D Plan Sponsor Audits
  - Medicare Part D RAC Reviews

### 5.1 Medicare Secondary Payer Operations

<b>Savings:</b>	The amount of conditional and mistaken payments Medicare FFS recovered from 1) providers, 2) beneficiaries who received settlements from other insurers/WC carriers, and 3) global settlements with liability insurers.
<b>Data Source:</b>	1) CROWD system and 2) CMS records of global settlements with liability insurers

CMS’s MSP operations include the recovery of mistaken and conditional payments made by Medicare, when another payer has primary payment responsibility (see Appendix B-1 Section 2.1 for MSP background information). CMS reports recovered Medicare payments in the fiscal year during which they are collected.<sup>192</sup> Mistaken payments may occur if information about other coverage is unavailable or inaccurate at the time a claim is received. Medicare makes conditional payments for covered services on behalf of beneficiaries, when the primary payer is not expected to pay promptly for a claim. For example, Medicare may make a conditional payment in a contested compensation case, when there is a delay between the beneficiary’s injury and the primary payer’s determination or settlement. The purpose of conditional payments is to ensure continuity of care for Medicare beneficiaries and to avoid financial hardship on providers while awaiting decisions in disputed cases. CMS initiates recovery actions once information about primary coverage becomes available, either through new reporting or settlement of a case.

<sup>191</sup> For the purpose of this document, the overpayment recoveries category includes CMS’s recovery of mistaken and conditional Medicare payments, when Medicare should not be the primary payer. This occurs through MSP operations and the MSP Commercial Repayment Center.

<sup>192</sup> For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

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

The MACs conduct MSP-related recovery from providers.<sup>193</sup> Activities include identifying claims to be recovered, requesting and receiving repayment, and referring unresolved debts to the Department of the Treasury. Most of the MACs' recovery efforts occur through claims processing. The MACs conduct post-payment adjustments for claims that another insurer/entity should have paid in part or full. In cases of duplicate primary payment by Medicare and another insurer/entity—i.e., the provider received a primary payment from both Medicare and another insurer/entity for a given episode of care—the MACs recover Medicare's portion from the provider.

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

## 5.2 Medicare Secondary Payer Commercial Repayment Center

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

**Data Source:** CROWD system

The CRC is CMS's RAC responsible for MSP cases when an entity such as an insurer, employer, or WC carrier is the identified debtor (see Appendix B-1 sections 2.1 and 5.1 for additional information about MSP operations). The CRC recovers Medicare's mistaken primary payments from GHPs (typically from the employer, insurer, claims processing third-party administrator, or other plan sponsor) as well as conditional payments from applicable plans (liability insurers, no-fault insurers, or WC carriers) when the insurer/WC carrier has accepted ORM. CMS pays the CRC on a contingency fee basis, i.e., a percentage of the amount the identified debtor returned to Medicare.

For recovery of conditional payments from applicable plans, the CRC first issues the insurer/entity a notice of the claims conditionally paid by Medicare. The insurer/entity has the opportunity to

<sup>193</sup> The MACs' MSP-related recovery efforts are not currently included in the MSP program obligations in the Annual Report to Congress on the Medicare and Medicaid Integrity Programs.

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

CMS reports recovered Medicare payments in the fiscal year during which they are collected.<sup>194</sup> CMS calculates the CRC savings as the sum of direct payments from debtors and delinquent debt collections from the Department of the Treasury, minus excess collections that were refunded.<sup>195, 196</sup>

### 5.3 Medicare Administrative Contractor Post-Payment Medical Reviews

<b>Savings:</b>	The amount of MAC-identified overpayments that Medicare FFS recovered, minus the amount that had been collected on MAC-identified overpayments overturned on appeal in the fiscal year.
<b>Data Source:</b>	1) Healthcare Integrated General Ledger Accounting System (HIGLAS) and 2) VMS

While the MACs primarily focus on preventing improper payments (see Appendix B-1 sections 1.5 and 2.2), they may also conduct some post-payment review of claims when there is the likelihood of a sustained or high level of payment error. When conducting a post-payment review, a MAC may request additional documentation from a provider. The provider must submit documentation within a specified time frame, though the MAC has the discretion to grant extensions. If a provider does not submit the requested documentation in a timely manner, the MAC denies the claims.

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

<sup>194</sup> For full details of the savings methodology, please see CMS Publication 100-05: Medicare Secondary Payer Manual, Chapter 5 - Contractor Prepayment Processing Requirements.

<sup>195</sup> Excess collections may occur if the Department of the Treasury offsets against a payment due to the debtor by another federal program at the same time that a debtor makes a direct payment to the CRC.

<sup>196</sup> CMS does not include interest collected as savings; however, interest may be included in net MSP CRC collections amounts provided in other reports (e.g., the Medicare Secondary Payer Commercial Repayment Center Report to Congress).

Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

Overpayment recoveries are tracked in HIGLAS for Part A and Part B receivables and in VMS for DME receivables. CMS calculates savings as the sum of collections received for Part A, Part B, and DME receivables in the fiscal year during which the collection occurred.<sup>197</sup> Offsets or recoupments made on overpayments that are fully or partially overturned on appeal are removed from savings in the fiscal year during which the appeal is processed.

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

#### 5.4 Medicare Fee-for-Service Recovery Audit Contractor Reviews

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

**Data Source:** RAC Data Warehouse (RACDW)

CMS has multiple RACs that review post-payment Medicare FFS claims in defined geographic regions.<sup>198</sup> The Medicare FFS RACs' reviews focus on service-specific issues related to national and local Medicare policy. CMS approves all new issues for potential audits before the Medicare FFS RACs begin reviews. The Medicare FFS RACs may submit proposed review issues to CMS on a rolling basis. At times, CMS will also send the Medicare FFS RACs issues of potential improper payments identified by the MACs, UPICs, or external entities (e.g., HHS-OIG and GAO). Each Medicare FFS RAC has the option to accept or decline these issues for review. CMS can also require the RACs to conduct specific reviews.

The Medicare FFS RACs identify overpayments and underpayments through claims data analysis and review of medical records, which they can request through ADR letters. If a provider does not submit the requested documentation in a timely manner, the Medicare FFS RAC denies the claims. CMS imposes limits on the number of ADRs Medicare FFS RACs may send within in a specified time frame as well as for each provider based on each provider's improper payment rate for past claims. CMS also sets an initial limit on the number of reviews the Medicare FFS RACs may conduct under each approved issue. Once a Medicare FFS RAC has reached this limit, CMS reassesses the approved issue before allowing the Medicare FFS RAC to conduct additional reviews

<sup>197</sup> In FY 2019, CMS updated the MAC post-payment review savings methodology to use overpayment transaction data from HIGLAS and VMS, instead of using reports submitted by the MACs. Due to data limitations, CMS reports collections on MAC-identified overpayments demanded on or after October 1, 2018. It is possible that the MACs tag some non-MAC-medical-review overpayments with the medical review tag, which would inflate savings.

<sup>198</sup> One Medicare FFS RAC reviews national DME, home health, and hospice claims, and four Medicare FFS RACs review other types of claims in four geographic regions.

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on the issue. In addition, the Medicare FFS RACs must assess each approved issue every six months to check for and report any necessary updates to CMS. Medicare FFS RACs are not allowed to identify improper payments more than three years after a claim was paid.

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

After the discussion period, the Medicare FFS RAC refers an identified improper payment to the MAC in the appropriate claims processing jurisdiction. The MAC then adjusts the associated claim(s) in order to recoup overpayments or reimburse underpayments. In the case of an overpayment, the MAC creates an accounts receivable and issues the provider a demand letter requesting repayment of the specific amount. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. Providers who disagree with a Medicare FFS RAC’s improper payment determination have the right to use the Medicare FFS appeals process.<sup>199</sup>

Both the Medicare FFS RACs and the MACs record information in the RACDW, as related to the claims review and transactional status of RAC-identified improper payments. The Medicare FFS RACs provide CMS with monthly reports of all amounts identified and demanded. The MACs provide CMS with data on all RAC-identified overpayments collected, and all underpayments reimbursed. There may be overpayments that a Medicare FFS RAC identified in a prior fiscal year for which collections occur in the current fiscal year. The MACs also record appeal outcome information in the RACDW. If an overpayment is fully or partially overturned on appeal, any offsets or recoupments that had been made are removed from savings in the fiscal year of the appeal decision. Thus, CMS calculates savings attributed to Medicare FFS RACs as the sum of Medicare FFS RAC-identified overpayment collections received from providers, minus 1) the sum of Medicare FFS RAC-identified underpayments reimbursed to providers and 2) the sum of collections that had been made on Medicare FFS RAC-identified overpayments overturned on appeal during the fiscal year.

### 5.5 Supplemental Medical Review Contractor Reviews

**Savings:** The amount of SMRC-identified overpayments that Medicare FFS collected.

**Data Source:** SMRC reports

<sup>199</sup> As required by Section 1893(h) of the Social Security Act, CMS pays Medicare FFS RACs on a contingency fee basis. A Medicare FFS RAC must return its contingency fee if an improper payment determination is overturned on appeal. CMS subtracts the amount of returned contingency fees from its program integrity obligations in the fiscal year during which a RAC returns the funds.

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

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

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

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

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

The SMRC provides CMS with quarterly data reports on project-specific amounts of collected overpayments. The MACs generate these reports for the SMRC based on data from HIGLAS, VMS, or the MACs’ internal reporting systems. CMS reports savings from SMRC reviews in the fiscal year during which overpayment amounts are collected. Therefore, there may be overpayments identified by the SMRC in a prior fiscal year for which collections occur in a later fiscal year. CMS does not currently report adjustments for collected overpayment amounts that may be later overturned on appeal.

## 5.6 Unified Program Integrity Contractor Post-Payment Reviews

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

**Data Source:** 1) HIGLAS and 2) VMS

During the course of an investigation, a UPIC may conduct post-payment reviews of suspect claims to identify instances of fraud. When conducting a post-payment review, a UPIC requests additional documentation from a provider. The provider must submit documentation within a specified time frame, though a UPIC has the discretion to grant extensions.<sup>200</sup> If a provider does not submit the requested documentation in a timely manner, the UPIC denies the claims.

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

Once a post-payment review is complete, the UPIC provides the results of the medical review to the provider<sup>201</sup> and refers the overpayment to the MAC in its jurisdiction for recovery. The MAC then adjusts the Part A, Part B, or DME claims associated with the overpayment in the respective shared claims processing system, and the provider is issued a demand letter requesting repayment of the overpayment. Providers have multiple payment options, such as directly sending CMS a payment-in-full, setting up an extended repayment schedule, or having the MAC offset future payments from CMS. The MAC may also recover overpayments from an escrow account when CMS terminates a payment suspension. Delinquent debts may be referred to the Department of the Treasury for further collection action. Providers have the right to appeal improper payment determinations through the Medicare FFS appeals process.

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

There may be instances when the MAC cannot collect on a UPIC-identified overpayment. In those instances, the receivable is closed in HIGLAS or VMS, and CMS does not include the amounts in the savings metric. To ensure unique attribution of savings, this metric also excludes UPIC-identified overpayments that are not referred to the MAC for recovery, per the request of law enforcement (see Appendix B-1 Section 9.1).

## 5.7 Overpayments from Retroactive Revocations

**Savings:** The amount of overpayments identified due to full, retroactive revocations, multiplied by a historical proportion that Medicare FFS expects to recover.

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<sup>200</sup> CMS Publication 100-08: Medicare Program Integrity Manual, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, § 3.2.3.2 – Time Frames for Submission.

<sup>201</sup> Depending on the status of investigations, UPICs have discretion regarding whether to send a provider a review results letter.

**Data Source:** 1) PECOS, 2) CMS revocations log, and 3) CWF claims data

When a provider is revoked from Medicare, the effective date is 30 days from the mailing of the letter notifying the provider of the revocation, except for those revocation reasons applied retroactively as specified in regulation. For example, if an investigator determines that a provider's license is suspended, CMS sets the effective date of that provider's revocation as the date the license was suspended. CMS has the authority to recover payments made to an ineligible provider. As part of their standard operating procedures, the MACs attempt to recover overpayments when a provider is retroactively revoked.

Providers are afforded the same CAP and appeal opportunities (see Appendix B-1 Section 3.1), whether the revocation effective date is retroactive or not.

The MACs do not currently track overpayment recoveries specifically related to retroactive revocations; thus, CMS estimates savings as follows:

1. *Identify overpayments associated with full, retroactive revocations:* CMS sums the amounts paid to fully,<sup>202</sup> retroactively revoked providers for dates of service between the effective date and implementation date of the revocation. For a given full, retroactive revocation, CMS attributes estimated savings to the fiscal year in which the revocation was implemented.<sup>203</sup>
2. *Adjust for historical recovery experience:* To estimate actual recoveries, CMS multiplies the amount of identified overpayments by a proxy, provider-type-specific adjustment factor based on the MACs' historical recovery rate of overpayments identified by previous Medicare FFS program integrity contractors. Based on a historical sample, each provider-type-specific adjustment factor is the ratio of the total amount of overpayments recovered by the MAC to the total amount of overpayments referred by previous Medicare FFS program integrity contractors.<sup>204</sup>

## 5.8 Overpayments Related to Risk Adjustment Data

**Savings:** The amount of overpayments that Medicare recovered from plan sponsors, due to the retrospective elimination of invalid diagnosis codes in risk-adjusted payments.

**Data Source:** Medicare Advantage and Prescription Drug System

As required by the Social Security Act, MA organizations and Part D sponsors are required to report and return identified overpayments. CMS risk adjusts per capita payments to MA organizations, Part D plan sponsors, Program of All-Inclusive Care for the Elderly (PACE) organizations, and

<sup>202</sup> CMS defines a full, retroactive revocation at the professional identifier level where there is at least one revoked enrollment, no other approved enrollments, and no active billing privileges.

<sup>203</sup> This metric excludes retroactive revocations submitted by UPICs to prevent possible overlap with the UPIC post-payment reviews metric, which quantifies recoveries of UPIC-identified overpayments.

<sup>204</sup> In FY 2019, CMS calculated an updated set of provider-type-specific adjustment factors.

some demonstration plans. HHS believes that overpayment statute contributed to increased attention to data accuracy and more accurate payment information submissions. In FY 2019, plan sponsors self-reported and returned approximately \$46.1 million in overpayments.

## 5.9 Medicare Part D Plan Sponsor Audits

Medicare Part D Plan Sponsor Audits include the following activities:

- National Benefit Integrity (NBI) Medicare Drug Integrity Contractor (MEDIC) Part D Data Analysis Projects
- Medicare Part D Plan Sponsor Self-Audits

In the FY 2019 Report to Congress on the Medicare and Medicaid Integrity Programs, *Table 3: Medicare Savings* provides the sum of savings from both initiatives.

### *National Benefit Integrity Medicare Drug Integrity Contractor Part D Data Analysis Projects*

**Savings:** The amount of overpayments that Medicare recovered from Part D plan sponsors, as related to NBI MEDIC data analysis projects.

**Data Source:** NBI MEDIC data analysis report for each project

CMS contracts with the NBI MEDIC, a program integrity contractor that assists with detecting and preventing fraud, waste, and abuse in the Medicare Part D program. The NBI MEDIC conducts data analysis projects related to specific Part D vulnerabilities in order to identify inappropriate payments. Data sources used to conduct data analysis include PDEs, Medicare FFS claims, plan formularies, and drug prior authorization information.

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

CMS reports data analysis project savings in the fiscal year during which plan sponsors delete the inappropriate PDE records.

### *Medicare Part D Plan Sponsor Self-Audits*

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

**Data Source:** Self-audit attestations and close-out letters

CMS uses Medicare Part D plan sponsor self-audits to evaluate the appropriateness of questionable payments for Part D covered drugs identified through data analysis. CMS contracts with the NBI MEDIC to conduct data analysis that identifies high-risk areas for inappropriate Medicare Part D

payments and plan sponsors with potential overpayments for recovery. CMS provides notification to Part D plan sponsors to conduct a self-audit. Upon completion of the plan sponsor self-audit review, CMS and the NBI MEDIC validate whether plan sponsors have deleted the identified inappropriate PDE records. CMS reports self-audit savings in the fiscal year during which the PDE records are deleted.

### 5.10 Medicare Part D Recovery Audit Contractor Reviews

**Savings:** The amount of Medicare Part D RAC-identified overpayments that Medicare recovered from Part D plan sponsors.

**Data Source:** Plan payment adjustment forms

The Medicare Part D RAC<sup>205</sup> reviewed post-reconciliation PDE records to identify improper payments made under the Medicare Part D benefit.<sup>206</sup> CMS authorized the RAC to conduct audits of specific topics during particular plan years of interest. The Medicare Part D RAC could also propose new audit issues, which were subject to CMS's review and approval. Example audit topics included improper payments made to excluded providers<sup>207</sup> or unauthorized prescribers<sup>208</sup> and inappropriate refills of certain drugs regulated by the Drug Enforcement Administration under the Controlled Substances Act. The Medicare Part D RAC could only identify improper payments on PDE records within the four years prior to a plan sponsor's current plan year.

The Medicare Part D RAC conducted automated, algorithm-based reviews as well as complex reviews using additional documentation requested from the plan sponsor. In addition to PDE records, the Medicare Part D RAC could also use other data sources, such as CMS's Medicare Exclusion Database, HHS-OIG's List of Excluded Individuals and Entities, or the General Services Administration's System of Award Management. The Medicare Part D RAC referred cases of suspected fraud directly to the NBI MEDIC.

The Medicare Part D RAC's improper payment findings underwent an independent quality check by CMS's Data Validation Contractor and then had to receive approval from CMS. If the Medicare Part D RAC's findings were approved, the plan sponsor received a Notification of Improper Payment, which was determined by an improper payment calculation. Medicare Part D plan sponsors were given the opportunity to appeal improper payment determinations.

<sup>205</sup> The Medicare Part D RAC contract ended on December 31, 2015. However, an administrative and appeals option period was exercised through December 2017 to allow the Medicare Part D RAC to complete outstanding audit issues that were initiated prior to the end of the contract period and receive payment.

<sup>206</sup> During FY 2019, Medicare Part D RAC activities included the appeals and recoupment process. The audits, validations, and Notification of Improper Payments issuance were all completed during FY 2016.

<sup>207</sup> Excluded providers are not allowed to receive payment from Medicare or other federal health care programs. HHS-OIG has multiple authorities under which to exclude providers, such as a convictions related to patient abuse, health care fraud, or the misuse of controlled substances.

<sup>208</sup> An unauthorized prescriber is a provider who orders drugs for Medicare beneficiaries despite not being allowed to do so. The provider types with prescribing authority may vary by state, but some provider types do not have the authority to prescribe in any state.

Inappropriately-paid PDE records had to be deleted by the Part D plan sponsor after the final appeal decision or within a specified time period if no appeal was filed. CMS recoups overpayments through offsets to Medicare’s monthly prospective payments to plan sponsors and reports these amounts as savings in the fiscal year during which the offsets occur.

## 6 Cost Report Payment Accuracy

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

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

### 6.1 Provider Cost Report Reviews and Audits

<b>Savings:</b>	The difference between as-submitted or revised reimbursable cost requests submitted by providers and the settlement amounts, as determined through audits or desk reviews, for each cost item submitted in Medicare FFS provider cost reports.
<b>Data Source:</b>	System for Tracking for Audit and Reimbursement Reports 104 and 106, as entered by the MACs

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

- Pass-through costs for hospitals paid under a PPS<sup>209</sup>
- All costs for critical access hospitals reimbursed on a cost-basis
- All costs for cancer hospitals reimbursed under the Tax Equity and Fiscal Responsibility Act
- Bad debts<sup>210</sup> claimed by all provider types

A provider must file its annual cost report with its respective MAC either five months after the end of the provider’s fiscal year or 30 days after the Provider Statistical and Reimbursement (PS&R)<sup>211</sup>

<sup>209</sup> Pass-through costs refer to amounts paid outside of the PPS. Examples of Medicare’s pass-through payments to hospitals include amounts for DSH qualification, graduate medical education, indirect medical education, nursing and allied health, bad debt, and organ acquisition.

<sup>210</sup> Bad debt refers to Medicare deductibles and coinsurance amounts that are uncollectible from beneficiaries. In calculating reimbursement, CMS considers a provider’s bad debt if it meets specific criteria.

<sup>211</sup> CMS’s PS&R system accumulates statistical and reimbursement data for processed and finalized Medicare Part A paid claims. The system generates various summary reports used by providers to prepare Medicare cost reports and by the MACs during the audit and settlement process.

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reports are available, whichever date is later.<sup>212</sup> The annual cost report contains provider information such as facility characteristics, utilization data, costs, charges by cost center (in total and for Medicare), accumulation of Medicare claims data (e.g., days, discharges, charges, deductible and coinsurance amounts, etc.), and financial statement data.

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

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

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

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

A provider may appeal disputed adjustments if the Medicare reimbursement amount in controversy is at least \$1,000. An appeal request must be filed within 180 days of receiving the NPR. Appeals disputing amounts of at least \$1,000 but less than \$10,000 are filed with the MAC and the CMS Appeals Support Contractor. Appeals disputing amounts of \$10,000 or more are filed with the Provider Reimbursement Review Board.

In addition, a final settled cost report may be reopened to correct errors, comply with updated policies, or reflect the settlement of a contested liability. A provider may submit a request for reopening, or the MAC may reopen a cost report based on its own motion or at the request of CMS. A reopening is allowed within three years of an original NPR or a revised NPR concerning the same issue for reopening.<sup>213</sup>

CMS determines savings from the settlement of provider cost reports by calculating the difference between reimbursable costs per the providers' initial or revised cost reports and the settlement

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<sup>212</sup> Provider Reimbursement Manual, Part II (PRM-II), § 104. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, § 110.A.

<sup>213</sup> In the case of fraud, the MAC can reopen a cost report at any time.

amounts resulting from audits or desk reviews. CMS reports savings in the fiscal year during which an NPR is issued. If a successful appeal results in a revised NPR, CMS reports adjustments to savings in the fiscal year the revised NPR is issued.

## 6.2 Cost-Based Plan Audits

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

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

CMS reimburses Medicare cost-based plans based on the reasonable costs incurred for delivering Medicare-covered services to enrollees.<sup>214</sup> Medicare cost-based plans include Health Maintenance Organizations (HMO) and Competitive Medical Plans operated under Section 1876 of the Act and Health Care Prepayment Plans (HCPPs) established under Section 1833 of the Act.

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

Based on the reconciliation of the CMS-determined Medicare reimbursable amounts and interim payments to the plan, CMS issues the plan an NPR indicating a balance due to the plan or to CMS. If the plan owes money to CMS, the plan has 30 days to provide payment, otherwise, interest is due. If CMS owes money to the plan, reimbursement is provided in a subsequent monthly payment to the plan.

Plans may appeal cost report adjustments that are greater than \$1,000. Plans have 180 days to submit a formal written appeal.

CMS determines savings from cost-based plan audits by calculating the difference between Medicare reimbursable amounts determined through cost report audits and reimbursable amounts claimed by cost-based plans.<sup>215</sup> CMS attributes savings to the fiscal year in which NPRs are processed. If a plan receives a settlement refund or favorable appeal decision, CMS subtracts the

<sup>214</sup> Some Medicare cost plans provide Part A and Part B coverage, while others provide only Part B coverage. Some cost plans also provide Part D coverage. An HCPP operates like a Medicare cost plan but exclusively enrolls Part B only beneficiaries and provides only Part B coverage.

<sup>215</sup> The cost-based plan audits metric quantifies savings as the truing-up of plan payments. Year-over-year savings may fluctuate depending on the number of audited plans, membership size, and contract years of plans subject to audit, plan adherence to payment regulations, settlement decisions, and other factors.

refund or amount overturned on appeal from savings in the fiscal year during which the settlement refund or appeal is processed.

## 7 Plan Penalties

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

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

### 7.1 Medicare Part C and Part D Program Audits

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

**Data Source:** CMS enforcement action records

CMS conducts program audits of MA organizations, Part D plan sponsors, and organizations offering Medicare-Medicaid plans (MMPs), hereafter, collectively referred to as plan sponsors. Program audits evaluate plan sponsors' compliance with core program requirements and ability to provide enrollees with access to health care services and prescription drugs. A routine program audit covers all of a plan sponsor's MA, MA-Prescription Drug (MA-PD), PDP, and MMP contracts with CMS. CMS annually determines the plan sponsors to be audited. CMS relies on a number of factors when selecting plan sponsors for audit, including performance data collected by or reported to CMS, complaints, and other factors that could increase a sponsor's risk of non-compliance (e.g., significant increases in enrollment, a large number of changes to a sponsor's drug formulary for a new plan year, or switching to a new pharmacy benefit manager close to the beginning of a new plan year). Other factors that affect plan sponsor selection include audit referrals from CMS central and/or regional offices and time since last audit. CMS initiates audits of plan sponsors throughout the year.

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

- Compliance Program Effectiveness
- Part D Formulary and Benefit Administration
- Part D Coverage Determinations, Appeals, and Grievances
- Part C Organization Determinations, Appeals, and Grievances
- Special Needs Plans Model of Care
- MMP Service Authorization Requests, Appeals, and Grievances
- MMP Care Coordination and Quality Improvement Program Effectiveness

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If audits or other monitoring activities determine compliance violations that adversely affected or have the substantial likelihood of adversely affecting enrollees,<sup>216</sup> CMS has the authority to impose CMPs against plan sponsors. Other enforcement actions include intermediate sanctions (e.g., suspension of marketing, enrollment, or payment) and terminations. The number of violations and history of noncompliance are factored into the enforcement action taken. All enforcement actions may be appealed. CMP appeal requests must be filed no later than 60 days after receiving a CMP notice.

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

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

## 7.2 Medical Loss Ratio Requirement

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

**Data Source:** MA organizations' and Part D sponsors' annual reports provided to CMS

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

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<sup>216</sup> Examples of compliance violations that result in enforcement actions include the following: 1) inappropriate delay or denial of beneficiary access to health services or medications, 2) incorrect premiums charged to or unnecessary costs incurred by beneficiaries, and 3) inaccurate or untimely information provided to beneficiaries about health and drug benefits.

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in 2014 or later are subject to this statutory requirement.<sup>217</sup> The minimum MLR requirement is intended to create incentives for MA organizations and Part D sponsors to reduce overhead expenses, such as marketing, profits, salaries, administrative expenses, and agent commissions, in order to help ensure that taxpayers and enrolled beneficiaries receive value from Medicare health plans.

A MLR is calculated as the percentage of Medicare contract revenue spent on the following:

- Incurred claims for clinical services\*
- Incurred claims for prescription drugs
- Quality improving activities
- Direct benefits to beneficiaries in the form of reduced Part B premiums\*

*\*Not applicable to Part D stand-alone contracts.*

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

If a MA organization or Part D sponsor has a MLR for a contract year that is less than 85 percent, the MA organization or Part D sponsor owes a remittance to CMS. CMS deducts the remittance from the regular monthly plan payments to the MA organization or Part D sponsor. Further MLR-related sanctions on MA organizations and Part D sponsors include a prohibition on enrolling new members after three consecutive years and contract termination after five consecutive years of failing to meet the minimum MLR requirement.

In general, MA organizations and Part D sponsors are required to report a contract's MLR in December following the contract year, and any payment adjustments are implemented the following July. The reporting deadline is earlier in the year for contracts that fail to meet the MLR threshold for two or more consecutive years, so that CMS has time to implement, prior to the open enrollment period, an enrollment sanction for any contract that fails to meet the MLR threshold for three or more consecutive years and contract termination for any contract that fails to meet the MLR threshold for five consecutive years. Once reported and attested by an insurer and reviewed by CMS, a MLR is considered final and may not be appealed. Savings are reported in the fiscal year during which remittances are recovered.<sup>218</sup>

CMS applies credibility adjustments to the MLRs of contracts with relatively low enrollment. A credibility adjustment is a method to address the impact of claims variability on the experience of smaller contracts by adjusting the MLR upward. CMS defines the enrollment levels for credibility

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<sup>217</sup> MLR requirements apply to all MA organizations and Part D sponsors offering Part C and/or D coverage, including the following: 1) MA organizations with contract(s) including MA-PD plans (all MA contracts must include at least one MA-PD plan; some contracts may also include MA-only plans); 2) Part D stand-alone contracts; 3) Employer Group Waiver Plans with contracts offering MA and/or Part D; 4) Part D portion of the benefits offered by Cost HMOs/Competitive Medical Plans and employers/unions offering HCPPs; and 5) Dual Eligible Special Needs Plans. MA organizations report one MLR for each contract with MA-PD plans, instead of one MLR for nondrug benefits and another for prescription drug benefits. As discussed in the May 23, 2013 Medicare MLR final rule (78 FR 31284, 31285), CMS has waived the MLR requirement for PACE organizations.

<sup>218</sup> MLR remittances are transferred to the General Fund of the Treasury.

adjustments separately for MA and Part D stand-alone contracts. A contract with enrollment at or between specified levels (i.e., a partially credible contract) may add a scaled credibility adjustment (between 1.0 percent and 8.4 percent) to its MLR. This adjusted MLR is used both to determine whether the 85 percent requirement has been met and to calculate the amount of any remittance owed to CMS. Contracts with enrollment levels above the full-credibility threshold do not receive a credibility adjustment. For contracts with enrollment below a specified level (i.e., non-credible contracts), MLR sanctions do not apply.

## 8 Other Actions

### 8.1 Party Status Appeals

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

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

The Medicare FFS appeals process includes five levels:<sup>219</sup>

- *Level 1:* Redetermination by a MAC is a review of the claim and supporting documentation by an employee who did not take part in the initial claim determination.
- *Level 2:* Reconsideration by a QIC<sup>220</sup> is an independent review of the initial determination, including the MAC's redetermination. For decisions made as to whether an item or service is reasonable and necessary, a panel of physicians or other health care professionals conducts the review.
- *Level 3:* Hearing before an ALJ or a review of the administrative record by an attorney adjudicator within the HHS Office of Medicare Hearings and Appeals (OMHA).<sup>221</sup> The amount remaining in controversy must meet the threshold requirement for this appeal level.
- *Level 4:* Review by the Medicare Appeals Council within the HHS DAB.<sup>222</sup> There are no requirements regarding the amount remaining in controversy for this appeal level.
- *Level 5:* Judicial review in U.S. District Court. The amount remaining in controversy must meet the threshold requirement for this appeal level.

If an appellant disagrees with the decision made at one level of the process, they can file an appeal to the next level. Each level of appeal has statutory time frames for filing an appeal and issuing a decision. The entities adjudicating the respective appeal conduct a new, independent review of the

<sup>219</sup> Pursuant to statutory requirements, CMS begins recouping overpayment amounts after Level 2. If the appellant receives a favorable decision in a subsequent level of appeal, CMS reimburses the amount collected with interest.

<sup>220</sup> CMS currently contracts with two Part A QICs, two Part B QICs, and one DME QIC.

<sup>221</sup> OMHA is independent of CMS.

<sup>222</sup> The Medicare Appeals Council within the DAB is independent of CMS.

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case at each level, and are not bound by the prior levels' findings and decision. The same appeal rights apply for claims denied on either a prepayment or post-payment basis.

In support of Medicare program integrity efforts, CMS funds QICs' participation as a party in ALJ hearings in accordance with party status appeals regulatory provisions in 42 CFR § 405.1012.<sup>223</sup> In addition to QICs' performance of Level 2 appeals, a QIC may elect to participate in Level 3 appeals, either as a non-party participant in the proceedings on a request for an ALJ hearing, a witness, or as a party to an ALJ hearing. As a non-party participant, a QIC may file position papers and/or submit written testimony to clarify factual or policy issues in a case.<sup>224</sup> As a witness, the QIC's activities are limited to supporting a party in responding to policy or factual issues related to a particular case. As a party to an ALJ hearing, a QIC can better defend the Level 2 decision by filing position papers, submitting evidence, providing testimony to clarify factual or policy issues, calling witnesses, or cross-examining the witnesses of other parties. The additional rights afforded to parties are extremely beneficial to the ALJ hearing and the QIC's ability to successfully defend a claim denial.

Each fiscal year, CMS determines the funding for and number of hearings in which the QICs are able to participate as a party. The QICs receive the ALJ Notices of Hearing and identify hearings in which they elect to participate as a party. Within ten days of a QIC receiving a hearing notice, a QIC must notify the ALJ, the appellant, and all other parties that it intends to participate as a party.<sup>225</sup> Generally, the QICs elect party status when there are significant amounts in controversy, national policy implications, or particular areas of interest for CMS.

When CMS uses program integrity funding for a QIC to participate as a party and the ALJ either fully upholds the prior decision or dismisses the case,<sup>226</sup> CMS considers the estimated amount in controversy for upheld and dismissed cases as savings.<sup>227</sup> Savings are based on the "item original amount" field from the MAS. For both prepayment denials and overpayment determinations, this field represents the billed amount submitted by the provider for claims or claim lines under appeal. CMS reports savings in the fiscal year during which the QIC receives notice of the ALJ or attorney adjudicator's ruling to uphold the prior decision or dismiss the case. CMS does not currently adjust reported savings if the appellant pursues further appeal rights and receives a favorable decision at Level 4 or Level 5.

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<sup>223</sup> CMS or one of its contractors (e.g., a MAC, QIC, RAC, UPIC, etc.) may elect to participate as a party in ALJ appeals, except when an unrepresented beneficiary files the hearing request.

<sup>224</sup> The QICs may elect non-party participation in accordance with 42 CFR § 405.1010. Non-party participation is incorporated into the QICs' operational activities and is not part of this savings metric.

<sup>225</sup> If multiple entities, i.e., CMS and/or contractors, file an election to be a party to a hearing, the first entity to file its election is made a party to the hearing (42 CFR § 405.1010).

<sup>226</sup> A case is dismissed when the ALJ or attorney adjudicator determines that the appellant or appeal did not meet certain procedural requirements. Appellant withdrawals are also counted under case dismissals.

<sup>227</sup> Due to data system limitations, there may be overlap across fiscal years with other Medicare FFS savings metrics that quantify savings from prepayment denials and overpayment recoveries.

## 9 Law Enforcement Referrals

UPICs (see Appendix B-1 sections 1.6, 2.3, and 5.6) and the Investigations MEDIC (I-MEDIC)<sup>228</sup> identify and investigate cases of suspected fraud related to Medicare FFS and Medicare Part C and Part D, respectively. UPIC and I-MEDIC investigations may involve providers, beneficiaries, and/or other entities. Once a UPIC or the I-MEDIC has gathered evidence to substantiate allegations of suspected fraud, CMS requires the contractor to refer such cases to law enforcement (e.g., HHS-OIG DOJ) for consideration of civil or criminal prosecution.

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

When a UPIC or the I-MEDIC refers a case to law enforcement for criminal or civil investigation, it reports the estimated value of the case to CMS, typically based on total paid amounts for the alleged fraudulent activities.<sup>229</sup> If law enforcement accepts the referral, the UPIC or the I-MEDIC remains available to assist and provide information at the request of law enforcement. When cases result in restitution, judgments, fines, and/or settlements, the DOJ routes Medicare recoveries to CMS or the plan sponsor. The following sections describe how CMS reports savings attributable to UPICs' and the I-MEDIC's law enforcement referrals.

### 9.1 Unified Program Integrity Contractor Law Enforcement Referrals

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

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

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

<sup>228</sup> In January 2019, CMS split the work of the NBI MEDIC into two contracts. Under this new set of contracts, the I-MEDIC performs Medicare Part C and Part D investigations of prescribers, pharmacies, and beneficiaries, while the NBI MEDIC continues to conduct specific Part D data analysis projects to support plan sponsor oversight. FY 2019 estimated savings include law enforcement referrals made by the NBI MEDIC and the I-MEDIC.

<sup>229</sup> Effective July 30, 2019, CMS requires contractors to estimate the value of the case based on a three-year lookback paid amount for claims associated with the alleged fraudulent activities.

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

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

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

CMS reports on the value of the I-MEDIC's Part C and Part D referrals accepted by law enforcement during the fiscal year, regardless of when the case concludes. Because the timeline of case resolution varies, CMS estimates the amount Medicare<sup>230</sup> expects to recover by multiplying the value of the referrals by a Part-C-specific, Part-D-specific, or combined Part C and Part D law enforcement adjustment factor depending on the nature of each case. Each factor reflects the historical ratio of court-ordered restitutions, judgments, fines, and settlements to the amounts referred by the previous NBI MEDIC.

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<sup>230</sup> The court may order funds be returned to Medicare and/or plan sponsor(s).

## Appendix B-2 – Medicaid and Children's Health Insurance Program Savings Methodology

### Introduction

Medicaid and Children's Health Insurance Program (CHIP) costs are shared between states and the federal government. To receive federal Medicaid and CHIP funds, states provide an estimated budget of their prospective costs, and the federal government contributes a specific percentage of these costs as a grant to the state. CMS determines the federal contribution amount using the Federal Medical Assistance Percentage (FMAP).<sup>231</sup> States then submit actual expenditure reports,<sup>232</sup> which CMS uses to reconcile grant amounts. States are required to report their expenditures to CMS within 30 days of the end of each quarter and may adjust their past reporting for up to two years after an expenditure was made.<sup>233</sup>

States and CMS share accountability for Medicaid and CHIP program integrity and ensuring proper use of both federal and state dollars. As such, CMS and the states collaborate to combat improper payments through multiple strategies. In *Table 4: Medicaid and CHIP Savings* of the FY 2019 Report to Congress on the Medicare and Medicaid Integrity Programs, CMS quantifies the federal share of Medicaid and CHIP program integrity savings stemming from Medicaid and CHIP financial management and state-reported Medicaid overpayment recoveries due to collaborative federal-state programs and state-level initiatives. The following sections describe the methodologies used to determine these savings.

### 1 Medicaid and CHIP Financial Oversight

CMS financial management staff<sup>234</sup> engages in financial oversight to ensure that state expenditures claimed for federal matching under Medicaid and CHIP are programmatically reasonable, allowable, and allocable in accordance with federal laws, regulations, and policy guidance. Federal funds paid to the state are referred to as the Federal Financial Participation (FFP). States are required to submit Medicaid and CHIP budget and expenditure data through the Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES), which applies the appropriate FMAP to each expenditure to determine the FFP. CMS reports Medicaid and CHIP financial management savings as improper FFP that was either 1) averted due to financial management staff intervention or 2) recovered following financial management staff review or assistance in response to and resolution of financial issues.

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<sup>231</sup> Congressional Research Service Report R43847, *Medicaid's Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell

<sup>232</sup> States submit quarterly expenditure reports on forms CMS-64 and CMS-21 for Medicaid and CHIP, respectively. The CMS-64 and CMS-21 are records of actual costs of running Medicaid and CHIP. States are responsible for maintaining supporting documentation for all reported expenditures.

<sup>233</sup> 42 CFR § 430.30

<sup>234</sup> CMS stations financial management staff, including accountants and financial analysts, at CMS regional offices, in states, and in the CMS central office.

## 1.1 Averted Medicaid and CHIP Federal Financial Participation

**Savings:** The total amount of FFP for which states agree to voluntarily 1) enter a credit adjustment on their expenditure report, 2) retract from their expenditure report, or 3) make a prior period credit adjustment on the current or a future expenditure report.

**Data Source:** CMS's Medicaid regional office averted FFP at-risk form

The CMS financial management staff works to ensure that states submit Medicaid and CHIP claims only for allowable expenditures. CMS uses the following activities to identify potentially improper, i.e., “at-risk,” FFP:

- Review of quarterly expenditure reports
- Technical assistance to states on financial management issues

If at-risk FFP is identified prior to finalizing the quarterly expenditure report, the state may make a credit adjustment on their expenditure report for the amount in question or retract the claim associated with the at-risk FFP. If identified after finalizing the expenditure report, the state agrees in writing and makes a prior period credit adjustment,<sup>235</sup> which retroactively adjusts the claim in question and offsets the at-risk FFP for which the state already received reimbursement. Averted Medicaid and CHIP FFP represents the total dollar amount of at-risk FFP that was prevented or offset due to CMS financial management staff intervention and oversight during the fiscal year.

The CMS financial management staff submits the averted FFP at-risk form to their division management for validation. CMS only reports approved amounts in the total averted Medicaid and CHIP FFP.

## 1.2 Recovered Medicaid and CHIP Federal Financial Participation

**Savings:** The total amount of at-risk FFP that the states returned to CMS as a result of CMS financial oversight activities.

**Data Source:** CMS's financial performance spreadsheet

The CMS financial management staff identifies potential improperly paid FFP through:

- Quarterly expenditure report reviews
- Annual financial management reviews
- Department of Health and Human Services Office of Inspector General (HHS-OIG) audits

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<sup>235</sup> States may adjust claims from prior quarters by either increasing or decreasing the amount of the claim, and therefore increasing or decreasing the FFP. These adjustments often reflect resolved disputes between CMS and the state or reclassifications of expenditures.

If CMS and the state cannot resolve the issue and the state does not agree to return the improperly paid FFP, CMS initiates a disallowance action requiring the state to return the FFP.<sup>236</sup>

States have the right to request administrative reconsideration and/or DAB review to appeal a disallowance action within 60 days of receiving a disallowance letter. CMS may recover the disallowance amount if, following the DAB appeal, a decision has been rendered in CMS's favor or if the state did not appeal the disallowance and the 60-day filing period for an appeal has lapsed. CMS counts a disallowance as recovered once the state returns the associated FFP to CMS.

The total recovered Medicaid and CHIP FFP includes all at-risk FFP that has been recouped or returned to CMS within the fiscal year; thus, some amounts may be associated with financial issues identified in prior fiscal years. The total recovered Medicaid and CHIP FFP does not include any amounts actively under appeal.<sup>237</sup>

## 2 State-Reported Medicaid Overpayment Recoveries

States report Medicaid overpayment recoveries made through collaborative federal-state programs and state-level initiatives, including 1) UPICs, 2) state Medicaid RACs, 3) HHS-OIG-compliant false claims acts, and 4) other state program integrity activities.

As states and the federal government share in the cost of Medicaid, so too do the states and federal government share in overpayment recoveries. States have one year to return the federal share of an identified overpayment;<sup>238</sup> thus, some of the recovered amounts reported in the current fiscal year may be related to amounts identified in the previous fiscal year.

### 2.1 Unified Program Integrity Contractor Recoveries

**Savings:** The total recovered federal share of Medicaid overpayments identified by UPICs.

**Data Source:** State Medicaid program integrity quarterly reports, specifically:

- Form CMS 64.9C1, Line 5
- Form CMS 64.9OFWA, Line 5

In collaboration with states, CMS's UPICs conduct post-payment investigations and audits of Medicaid providers throughout the country and report identified overpayments to the states for recovery. CMS and the states collaborate to select issues and providers for audits. Any Medicaid provider, including FFS providers, managed care entities, and managed care network providers,

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<sup>236</sup> 42 CFR § 430.42

<sup>237</sup> If FFP is appealed beyond the HHS DAB, CMS does not include these amounts in the total recovered Medicaid and CHIP FFP, even when the ultimate ruling is in CMS's favor.

<sup>238</sup> States have one year from the date of discovery to return the full federal share of an identified overpayment, regardless of the amount the state succeeds in collecting from the associated provider(s) (42 CFR § 433.300-316). If a state is unable to collect an overpayment because the provider is bankrupt or out of business, the state is not required to refund the federal share (42 CFR § 433.318).

may be subject to audit. After the associated states and providers have the opportunity to comment on any identified overpayments, CMS sends the states the final audit reports/final findings reports documenting total overpayments for recovery. States are responsible for sending demand letters to the appropriate providers, collecting overpayments, and remitting the federal share to CMS. Providers may appeal the findings of a final audit report through their state's administrative process.

CMS reports the recovered federal share of Medicaid overpayments identified by UPICs in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit.

### 2.2 State Medicaid Recovery Audit Contractor Recoveries

<b>Savings:</b>	The total recovered federal share of Medicaid overpayments identified by state Medicaid RACs, after subtracting contingency fees.
<b>Data Source:</b>	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Lines 9E and 10E

Unless CMS grants an exception, states must contract with one or more Medicaid RACs to identify and recover overpayments as well as identify underpayments made to Medicaid providers. States determine the operations and focus areas for Medicaid RAC audits. CMS requires states to have an appeals process for providers seeking review of Medicaid RAC findings.

CMS reports the recovered federal share of Medicaid overpayments identified by Medicaid RACs in the fiscal year during which the recovery occurred. The calculation of the recovered federal share includes 1) the federal share of amounts collected by states within the one-year time limit, plus 2) the federal share of amounts refunded by states in cases when a state was not able to fully collect an identified overpayment within the one-year time limit, less 3) the federal share of Medicaid RAC fees.<sup>239</sup> The recovered federal share includes any necessary adjustments to previously-reported federal share amounts. For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

### 2.3 Office of Inspector General Compliant False Claims Act Recoveries

<b>Savings:</b>	The net federal share of Medicaid false or fraudulent payments recovered as a result of state action under an HHS-OIG-compliant false claims act, after subtracting the state financial incentive.
<b>Data Source:</b>	State Medicaid program integrity quarterly reports, specifically Form CMS 64 Summary, Line 9C2

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<sup>239</sup> CMS contributes the federal share of Medicaid RAC fees in the same proportion as the FMAP, up to the highest contingency fee rate of Medicare RACs.

Many states have false claims acts that establish civil liability to the state for individuals and entities that knowingly submit false or fraudulent claims under the state Medicaid program. If a state obtains a recovery related to false or fraudulent Medicaid claims, the federal government is entitled to a share of the recovery, in the same proportion as the FMAP. To encourage states to pursue civil Medicaid fraud, Section 1909 of the Act includes a financial incentive for states if their false claims acts meet certain requirements.<sup>240</sup> HHS-OIG, in consultation with the U.S. Attorney General, determines if a state's false claims act qualifies for the incentive, which is a 10-percentage-point increase in a state's share of recovered amounts.

CMS reports the net federal share of Medicaid false or fraudulent payments recovered under states' HHS-OIG-compliant false claims acts in the fiscal year during which the recoveries occurred. A state's compliance is subject to review before CMS awards a state the financial incentive; thus, the financial incentive does not appear in Form CMS 64 Summary, Line 9C2. Instead, CMS gives states the financial incentive on a finalization grant award. To report savings, CMS conservatively estimates the net federal share of recovered Medicaid false or fraudulent payments by subtracting out the state financial incentive for all states that report in Form CMS 64 Summary, Line 9C2.

### 2.4 Other State Program Integrity Recoveries

**Savings:** The total recovered federal share of Medicaid overpayments identified through other state-level program integrity activities.

**Data Source:** State Medicaid program integrity quarterly reports, specifically:

- Form CMS 64.9C1, Lines 1A, 1B, 1C, 2, 3, 4, 6, and 8
- Form CMS 64.9OFWA, Lines 1A, 1B, 1C, 2, 3, 4, 6, 8, and 9

The states undertake a variety of program integrity activities to identify and recover improper payments, including the following:

- Provider audits
- Medicaid Fraud Control Unit (MFCU) investigations<sup>241</sup>
- Data mining activities conducted by state Medicaid agencies as well as MFCUs
- Settlements and judgments
- Civil monetary penalties

CMS reports the recovered federal share of Medicaid overpayments identified through state-level program integrity activities in the fiscal year during which the recovery occurred. The recovered federal share includes 1) amounts collected by states within the one-year time limit and 2) amounts refunded by states in cases when a state was not able to fully collect an identified overpayment

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<sup>240</sup> Refer to <https://oig.hhs.gov/fraud/state-false-claims-act-reviews> for more information on HHS-OIG's requirements for states to receive the financial incentive.

<sup>241</sup> Refer to <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu> for more information on MFCUs.

## Appendix B - Program Integrity Savings Methodology

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within the one-year time limit. The recovered federal share includes any necessary adjustments to previously-reported federal share amounts.<sup>242</sup> For example, credit may be due back to the state for overpayment amounts previously refunded to CMS due to the expiration of the one-year time limit, but where the provider was subsequently determined as bankrupt or out of business.

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<sup>242</sup> States report total adjustments, which could be related to UPIC and/or other state program integrity activities.

## Appendix C – Acronyms and Abbreviations

Acronym	Description
ACO	Accountable Care Organization
ADR	Additional Documentation Request
AFR	[HHS] Agency Financial Report
ALJ	Administrative Law Judge
ANOC	Annual Notice of Change
APS	Advanced Provider Screening [system]
AREMAC	Analytic and Reporting Environment for Medicaid & CHIP
BCRC	Benefits Coordination & Recovery Center
CAP	Corrective Action Plan
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CHIP	Children’s Health Insurance Program
CMP	Civil Money Penalty
CMS	Centers for Medicare & Medicaid Services
COB&R	Coordination of Benefits & Recovery
CPI	[CMS] Center for Program Integrity
CPT	Common Procedural Terminology
CRC	Commercial Repayment Center [Recovery Auditor]
CROWD	Contractor Reporting of Operational and Workload Data
CWF	Common Working File
DAB	Departmental Appeals Board
DDPS	Drug Data Processing System
DIR	Direct and Indirect Remuneration
DME	Durable Medical Equipment
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics and Supplies
DOJ	Department of Justice
DOS	Date of Service
DRA	Deficit Reduction Act of 2005
DSH	Disproportionate Share Hospital
EIN	Employee Identification Number

## Appendix C - Acronyms and Abbreviations

<b>Acronym</b>	<b>Description</b>
EOC	Evidence of Coverage
FCBC	Fingerprint-based Criminal Background Check
FFP	Federal Financial Participation
FFS	Fee-for-Service
FISS	Fiscal Intermediary Shared System
FMAP	Federal Medical Assistance Percentage
FPS	Fraud Prevention System
FY	Fiscal Year
GAO	Government Accountability Office
GHP	Group Health Plan
GPO	Group Purchasing Organization
HCFAC	Health Care Fraud and Abuse Control Program
HCPCS	Healthcare Common Procedural Coding System
HCPP	Health Care Prepayment Plan
HEAT	Healthcare Enforcement and Action Team
HFPP	Healthcare Fraud Prevention Partnership
HHA	Home Health Agency
HHS	Department of Health & Human Services
HIGLAS	Healthcare Integrated General Ledger Accounting System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPMS	Health Plan Management System
IDR	Integrated Data Repository
I-MEDIC	Investigations MEDIC
IPERA	Improper Payments Elimination and Recovery Act of 2010
IPERIA	Improper Payments Elimination and Recovery Improvement Act of 2012
IPIA	Improper Payments Information Act of 2002
MAC	Medicare Administrative Contractor
MACBIS	Medicaid and CHIP Business Information Solutions
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MA	Medicare Advantage
MA-PD	Medicare Advantage Prescription Drug

## Appendix C - Acronyms and Abbreviations

<b>Acronym</b>	<b>Description</b>
MAS	Medicare Appeals System
MCS	Multi-Carrier System
MDP	Medicaid Drug Program
MEDIC	Medicare Drug Integrity Contractor
Medi-Medi	Medicare-Medicaid Data Match
MFCU	Medicaid Fraud Control Unit
MII	Medicaid Integrity Institute
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MLN	Medicare Learning Network®
MLR	Medical Loss Ratio
MMIS	Medicaid Management Information System
MMSEA	Medicare, Medicaid and SCHIP Extension Act of 2007
MPEC	Medicaid Provider Enrollment Compendium
MSIS	Medicaid Statistical Information System
MSP	Medicare Secondary Payer
MUE	Medically Unlikely Edit
NBI	National Benefit Integrity
NCCI	National Correct Coding Initiative
NPI	National Provider Identifier
NPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
OEOCR	Office of Equal Employment Opportunity & Civil Rights
OIG	Office of Inspector General
OMHA	Office of Medicare Hearings and Appeals
One PI	One Program Integrity
OPPS	Outpatient Prospective Payment System
ORM	Ongoing Responsibility for Medicals
O&R	Ordering and Referring [Edit]
PACE	Program of All-Inclusive Care for the Elderly
Part C	Medicare Advantage Part C Program
Part D	Medicare Prescription Drug Program

## Appendix C - Acronyms and Abbreviations

<b>Acronym</b>	<b>Description</b>
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PECOS	Provider Enrollment, Chain and Ownership System
PERM	Payment Error Rate Measurement
PMD	Power Mobility Device
PPS	Prospective Payment System
PS&R	Provider Statistical and Reimbursement [System or Report]
PTP	Procedure-to-Procedure [Edit]
QIC	Qualified Independent Contractor
RAC	Recovery Audit Contractor
RADV	Risk Adjustment Data Validation
RAPS	Risk Adjustment Processing System
ROI	Return on Investment
SBJA	Small Business Jobs Act of 2010
SMA	State Medicaid Agency
SMART	Medicare IVIG Access and Strengthening Medicare and Repaying Taxpayers Act of 2012
SMRC	Supplemental Medical Review Contractor
SOW	Statement of Work
TDD	Telecommunication Device for the Deaf
T-MSIS	Transformed-Medicaid Statistical Information System
TTY	Text Telephone
UCM	Unified Case Management [system]
UOS	Unit of Service
UPIC	Unified Program Integrity Contractor
UPL	Upper Payment Limit
USC	United States Code
VMS	Viable Information Processing Systems (VIPS) Medicare System
WC	Workers' Compensation
WCMSA	Workers' Compensation Medicare Set-Aside Agreement

## Appendix D - Statutes Referenced in this Report

Public	Title	Short Title
74-271	The Social Security Act	The Act
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	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
111-148	Patient Protection and Affordable Care Act	
111-204	Improper Payments Elimination and Recovery Act of 2010	IPERA
111-240	Small Business Jobs Act of 2010	SBJA
111-3	Children’s Health Insurance Program Reauthorization Act of 2009	CHIPRA
112-242	Medicare IVIG Access and Strengthening Medicare and Repaying	SMART Act
112-248	Improper Payments Elimination and Recovery Improvement Act of 2012	IPERIA
114-10	Medicare Access and CHIP Reauthorization Act of 2015	MACRA