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

Introduction

The Government Accountability Office (GAO) has designated Medicare and Medicaid as high-risk programs. The Centers for Medicare & Medicaid Services (CMS) is strongly committed to program integrity efforts in Medicare and Medicaid and takes seriously its responsibility to protect taxpayer dollars and safeguard the Medicare Trust Funds by preventing and correcting improper payments.

In the 2015 High Risk report, GAO identified five criteria that a program must demonstrate to be removed from GAO's high-risk list: leadership commitment; capacity; action plan; monitoring; and demonstrated progress. The Medicare program has fully met the leadership commitment criterion and has partially met the remaining four criteria. The Medicaid program has partially met all five criteria.

Below are the criteria as defined by GAO and CMS' current efforts to address them as we strive to reduce improper payments and combat fraud, waste, and abuse in the Medicare and Medicaid programs.

Medicare

Criterion 1: Leadership Commitment

GAO determined that CMS has demonstrated strong commitment and top leadership support for removing Medicare from the high risk list, and fully met the Leadership Commitment criterion. CMS appreciates GAO's acknowledgement of our commitment and the efforts underway to improve program integrity and reduce improper payments. Our focus on improving program integrity is continuing, and we still sustain this high level leadership commitment to improvement as we work with the GAO and other stakeholders to further improve the integrity of our programs.

To continue our commitment to reducing improper payments, in 2015, CMS took steps to locate in one organizational component all offices whose primary mission is ensuring Medicare fee-for-service (FFS) claims payment integrity. This reorganization will help to reduce provider burden, improve staff productivity in determining possible actions to reduce improper payments, and bring program integrity efforts under one management chain. It also creates a more efficient organization for dealing with program integrity issues and simplifies the decision-making process.

Criterion 2: Capacity

GAO determined that CMS only partially met its capacity requirements, due in part to a lack of sustained funding. As GAO noted, Medicare program integrity efforts are funded through the Health Care Fraud and Abuse Control (HCFAC) program. In FY 2015, Congress, for the first time, appropriated the HCFAC discretionary full cap adjustment included in the Budget Control Act of 2011. This additional funding is being put toward new CMS investments in Medicare and Medicaid program integrity and is also supporting the Department of Justice and the Office of the Inspector General in the prosecution of health care fraud.

Consistent with GAO's statement that "sustained funding will be needed to maintain advances," in FY 2016, Congress appropriated additional funding for activities that will help CMS implement planned initiatives to protect Medicare dollars. The increase in funding is necessary to keep pace with the growth of federal health programs and increasingly complex fraud schemes, and reflects this Administration's commitment to fighting fraud and the belief that this investment will pay off in significant returns to the Medicare Trust Funds and the Treasury.

Criterion 3: Action Plan

GAO determined that CMS partially met its action plan requirements, because, while CMS does have an action plan in place, CMS has yet to address some areas where GAO has recommended action. The report provided examples of recommendations that CMS could implement, including requiring surety bonds for certain providers and suppliers and removing Social Security Numbers (SSNs) from Medicare cards.

Congress, as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), included a provision to require any home health agency (HHA) wanting to participate in the Medicare program to supply a surety bond in an amount that is commensurate with the volume of payments made by CMS to the HHA, but is no less than $50,000. This legislative change is consistent with CMS's proposal in the FY 2016 Budget. CMS is currently working to implement this home health surety bond requirement.

MACRA also provided resources for CMS to remove beneficiaries' SSNs from Medicare cards. CMS has begun the several year-long process by which Medicare cards will be redesigned and the current SSN-based identifier will be replaced with a Medicare Beneficiary Identifier (MBI). For the first time, CMS will be able to terminate a Medicare number as soon as we confirm that it has been compromised and issue a new number to a beneficiary, similar to how credit card companies address stolen card numbers.

Criterion 4: Monitoring

GAO determined that CMS partially met the requirement for monitoring and independently validating the effectiveness and sustainability of corrective measures. In its report, GAO noted that CMS continues to improve pre- and post-payment controls, and recommended that CMS take additional steps, including developing performance measures for its Zone Program Integrity Contractors (ZPICs).

Evaluating our initiatives' effectiveness is a high priority for CMS, and the results of our monitoring efforts continue to inform CMS's decisions regarding the Medicare program. We have taken steps to update the Program Integrity Manual with additional guidance regarding duplicative reviews among the different contractors that look at claims. To ensure greater consistency among contractors, we are looking for ways to better standardize the content of contractors' Additional Document Requests and results letters to providers and suppliers.

CMS has developed a new methodology for evaluating the effectiveness of the administrative actions taken by our ZPICs. As part of the Fraud Prevention System second year report, OIG certified this methodology, and CMS has determined that preventive actions are the most effective. For example, in revoking 48 Medicare providers and suppliers, CMS prevented $81 million from being paid. We are currently applying this methodology to all of CMS' work.

Criterion 5: Demonstrated Progress

GAO determined that CMS partially met the criteria of demonstrated progress, but said more work was needed to address the improper payment rate. The improper payment rate within the Medicare program is above CMS's target. CMS is working to identify and address the root causes of the improper payment rate, with a specific focus on home health services.

A contributing factor to the FY 2014 Medicare fee-for-service (FFS) improper payment rate was the implementation of new home health policies regarding documentation. The policy change will

ultimately strengthen the integrity of the program. However, it is not unusual to see changes in improper payment rates following implementation of new policies. To address errors that have resulted from the enforcement of these policies, CMS has eliminated the specific face-to-face narrative requirement and released a draft "template" home health certification form to reduce burden on physicians and practitioners who order home health services.

CMS has also implemented targeted demonstrations to reduce improper payments. For example, CMS implemented the Medicare Prior Authorization of Power Mobility Devices (PMDs) demonstration in September 2012 and expanded it to 12 additional states in October 2014. CMS used claims processed as of August 14, 2015 to calculate that monthly expenditures for the targeted PMDs decreased $12 million in September 2012 to $3 million in June 2015 in the original 7 demonstration states, $10 million in September 2012 to $2 million in June 2015 in the 12 additional expansion states, and $10 million in September 2012 to $3 million in June 2015 in the non-demonstration states.

Based on these promising results, CMS has implemented two new prior authorization models in targeted geographic regions, focusing on items and services that are frequently subject to unnecessary utilization. The President's FY 2016 Budget includes a proposal that would build on the success of the prior authorization demonstrations by giving CMS authority to require prior authorization for all Medicare FFS items that it determines are at the highest risk for improper payments.

Medicaid

Criterion 1: Leadership Commitment

GAO determined that CMS partially met the criteria for leadership commitment, but that improvements could be made to the oversight of Medicaid improper payments. GAO determined that CMS should ensure complete, reliable, and timely data to support program integrity efforts and noted that CMS is working to implement an enhanced claims data system to accomplish this goal.

In 2014, CMS underwent a reorganization to integrate the Medicare and Medicaid program integrity functions across CMS, align the audit and investigation functions for both programs under one reporting structure, and consolidate carrying out administrative actions in one unit. This new structure enhances CMS’s ability to coordinate its program integrity initiatives across programs and measure the return on investment of its key activities.

CMS is developing a methodology to determine the effectiveness of program integrity efforts in Medicare and Medicaid. CMS will calculate a return on investment for Medicare and Medicaid program integrity efforts CMS may use this information to ensure that program integrity efforts are cost effective and determine where CMS should focus its resources.

Criterion 2: Capacity

GAO determined that CMS partially met the criteria for capacity, but that expanded oversight was needed to ensure Medicaid managed care organizations (MCOs) are taking appropriate actions to identify and prevent improper payments. GAO also believes CMS could better deploy its audit resources to focus on states with identified vulnerabilities.

In June 2015, CMS published a Notice of Proposed Rulemaking (NPRM) that, if finalized as proposed, will require that state Medicaid programs enroll providers participating in Medicaid managed care.

Specifically, the NPRM would require that state Medicaid agencies apply the same risk-based screening standards and procedures that they currently apply to Medicaid FFS providers to managed care plan network providers. In addition, the proposed rule would require managed care plans to implement procedures to detect and prevent fraud and to promptly refer any cases of potential fraud, waste, or abuse that the plan identifies to the state Medicaid program integrity unit or directly to the state Medicaid Fraud Control Unit.

In 2014, CMS began conducting focused program integrity reviews on state Medicaid programs. Focused reviews examine specific areas of program integrity concern such as managed care, Affordable Care Act implementation and personal care services. CMS believes the focused reviews allow for more in depth reviews of key areas and provide CMS and states with quicker feedback on identified vulnerabilities.

Criterion 3: Action Plan

GAO determined that CMS partially met its action plan criteria, because, while CMS has taken steps to develop action plans to address improper payments, it has not provided some legally required action plans to Congress. CMS has not reported on the use and effectiveness of funds appropriated for the Medicaid Integrity Program for FYs 2013 and 2014.

CMS is currently drafting the Medicare and Medicaid Integrity Program Report to Congress for FY 2013 and 2014, and plans to release this report in the second quarter of 2016.

In the Comprehensive Medicaid Integrity Plan (CMIP) for FYs 2014-2018, CMS established goals to expand CMS's capacity to protect the integrity of the Medicaid program and manage risk in the administration of federal grants to states. Since the CMIP's publication, CMS has worked to fulfill its goals by increasing access to Medicare program integrity data; streamlining assessments of Medicaid program integrity activities; and expanding training through the Medicaid Integrity Institute. CMS will continue to implement work towards achieving the goals outlined in the CMIP over the coming years.

Criterion 4: Monitoring

GAO determined that CMS partially met its monitoring criteria for monitoring and evaluating the effectiveness of corrective measures, because, while CMS has eliminated duplicative improper payment monitoring activities, it is difficult for CMS to determine which audit activities should be adjusted or discontinued with its current monitoring activities.

As discussed, CMS recently began conducting focused program integrity reviews on State Medicaid programs. These reviews allow us to tailor our monitoring activities to the needs of individual States and concentrate our efforts on the biggest program integrity issues facing Medicaid. In addition, CMS is working to calculate a return on investment for Medicaid program integrity efforts.

Criterion 5: Demonstrated Progress

GAO determined that CMS partially met the criteria for demonstrated progress. GAO noted that CMS has taken steps in recent years to improve the process for coordinating Medicaid provider terminations among States and calculating improper payments. However, it recommended that CMS improve its oversight of MCOs and provide states with additional support for managed care oversight.

As discussed previously, CMS recently issued an NPRM that, if finalized, will enhance CMS oversight of MCOs by requiring managed care plan network providers to undergo the same risk-based screening

standards and procedures currently applied to Medicaid FFS providers. In addition, the proposed rule would require managed care plans to implement procedures to detect and prevent fraud and to promptly refer any cases of potential fraud, waste, or abuse that the plan identifies to the proper authorities.

In addition, CMS is performing Focused Managed Care Program Integrity Reviews, by which CMS identifies deficiencies in MCO oversight and highlights best practices across states, on all states with managed care programs. These reviews are customized to address the specific high-risk areas of concern particular to each State's Medicaid program after discussions with the state and identification of national Medicaid issues of concern.

States are required to terminate a provider's participation in their respective State Medicaid programs if that provider is terminated for cause (i.e., for reasons of fraud, integrity, or quality) from another State Medicaid program or Children's Health Insurance Program, or has been denied or revoked from Medicare. As GAO notes in its report, in 2013 CMS developed and launched an enhanced voluntary collection, storage, and delivery process for Medicaid termination notifications, which helps states share and access information about providers that are terminated from Medicaid and Medicare providers and suppliers in a revoked status. In 2014, CMS implemented improvements to the Medicaid termination notification system to enhance this process. In addition, CMS consolidated provider enrollment guidance and enhanced technical resources targeted to help states address improper payments triggered by recent and more rigorous risk-based provider screening and enrollment requirements. This includes requirements for NPI identification on claims and enrollment of ordering, prescribing and referring providers.

CMS has made impressive gains in these areas, but more work remains to be done. Strengthening and improving upon programs that provide vital services to millions of Americans, such as Medicare and Medicaid, is a continuous process, and at CMS we take seriously our responsibilities to taxpayers and beneficiaries. We will continue to work with stakeholders to establish new initiatives and expand upon our existing programs to fight fraud, reduce improper payments, and improve oversight. CMS appreciates GAO's work in this area and will continue to address the issues GAO has identified as we work to remove our programs from the GAO High Risk List.