Centers for Medicare & Medicaid Services
2015 Summary of Plan for Improvement
In the GAO High Risk Area

CMS Response to GAO Recommendations re: Medicare

The Government Accountability Office (GAO) has designated Medicare as a "high-risk" program because its complexity and susceptibility to improper payments, added to its size, have led to management challenges. CMS administers Medicare and is responsible for implementing payment methods that encourage efficient service delivery, managing the program to serve beneficiaries and safeguard it from loss, and overseeing patient safety and care.

CMS has made significant efforts to implement changes in the following areas delineated by GAO as opportunities for improvements:
1. Refine Medicare payment methods to encourage efficient provisions of services.
2. Improve program management.
3. Enhance program integrity.
4. Improve oversight of patient care and safety.

CMS Actions
Refine Medicare payment methods to encourage efficient provisions of services

CMS Response: CMS is committed to reforming the Medicare payment system to provide predictable payments that incentivize quality and efficiency in a fiscally responsible way. Our efforts are focused on two main goals: (1) ensuring physician payments emphasize high-quality, high-value care and (2) using proven payment models to improve accountability for the care furnished to Medicare beneficiaries. CMS believes that finding better approaches to reward quality care that results in improved health outcomes instead of quantity of services, while not increasing overall costs, remains an urgent priority. CMS is working to improve physician payment policy through CMS' rulemaking process including the Medicare Physician Fee Schedule, while testing new payments models and delivery system reforms that can help make physicians more accountable for the care they furnish.

CMS continues to make changes to the Medicare Physician Fee Schedule and other Medicare payment policies to improve efficiency and accuracy in Medicare payment and the quality of care for our beneficiaries. We have improved payment for primary care services, while enhancing our efforts to address payment for misvalued services under the physician payment system. We have begun to implement important delivery system reforms included in the Affordable Care Act, including the value-based payment modifier that provides incentives for physicians and physician groups to furnish high-quality, efficient care.

CMS issued a final rule that updates payment policies and payment rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2015. Medicare primarily pays physicians and other practitioners for care management services as part of face-to-face visits. Last year, CMS finalized separate payment outside of a face-to-face visit for managing the care for Medicare patients with two or more chronic conditions beginning in 2015. Through this year's rule, CMS provided more details relating to the implementation of the new policy, including payment rates. In addition, CMS adopted a new process for establishing PFS

payment rates that will be more transparent and allow for greater public input prior to payment rates being set. The final rule also makes some changes to several of the quality reporting initiatives that are associated with PFS payments – the Physician Quality Reporting System (PQRS), Medicare Shared Savings Program, and Medicare Electronic Health Record (EHR) Incentive Program, as well as changes to the Physician Compare website. Finally, the rule continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that would affect payments to physicians and physician groups, as well as other eligible professionals, based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program.

Additionally, in October 2014, CMS announced final rules that made changes for CY 2015 to the the payment policies and rates under the End-Stage Renal Disease (ESRD) Prospective Payment System (PPS) for renal dialysis services furnished to beneficiaries. CMS finalized the rebasing and revising of the ESRD bundled market basket for 2015 and introduced new quality and performance measures to improve the quality of care by outpatient dialysis facilities treating patients with end-stage renal disease.

CMS has made important strides to improve the accuracy of our physician payment system and to emphasize the value of primary care. Through the misvalued code initiative, CMS has taken a much more aggressive stance in evaluating potentially-misvalued payment codes and, when codes are found to be misvalued, acting to update and revise the payment accordingly. The agency has established a particular focus on those Physician Fee Schedule services that have not been reviewed recently and those where there is a potential for misuse. CMS has adopted appropriate work Relative Value Units (RVUs) and direct Physician Expense (PE) inputs for these services as a result of these reviews and continues aggressively to identify potentially misvalued services.

In recent years, CMS has begun testing several different payment models to help inform us as we begin to look for ways to improve physician payments in the long-term. Models such as Accountable Care Organizations, the Comprehensive Primary Care Initiative, the Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration and the Multi-payer Advanced Primary Care Practice Demonstration, can take different forms, but all have several common attributes such as encouraging care coordination and rewarding practitioners who furnish high-quality, efficient care. As experience with these models develops, CMS will also seek to hold practitioners increasingly accountable through the application of financial risk for consistently furnishing low quality care at excessive costs. HHS will continue to seek input from physicians and other professionals in designing these models. We will encourage practitioners to partner with Medicare by participating in a value based payment model. The Administration supports payment reform that would, over time, link the payment update for physicians' services to such participation. Those that successfully participate could receive higher payments under Medicare, while those who furnish lower quality, inefficient care would receive lower payments.

CMS continues to aggressively work to effectively manage the physician fee schedule, strengthen primary care, and pursue efforts to test innovate delivery system models that may help

inform the development of new Medicare payment systems that reward high quality, high value care.

Improve program management

CMS Response: CMS continues to work toward reducing improper payments, prevent and respond to fraud, and operate a Medicare Fee-for-Service (FFS) Recovery Audit program to improve program management.

CMS calculates the Medicare FFS improper payment rate through the Comprehensive Error Rate Testing (CERT) program. Each year, CERT evaluates a statistically valid random sample of claims to determine if they were paid properly under Medicare coverage, coding, and billing rules. The fiscal year (FY) 2014 Medicare FFS program improper payment rate is 12.7 percent. The primary causes of improper payments are insufficient documentation and medical necessity errors. Insufficient documentation was particularly prevalent for home health claims. The improper payment rate for home health claims increased from 17.3 percent in FY 2013 to 51.4 percent in FY 2014 due to the implementation of documentation requirements to support the medical necessity of the services. Another reason for the increase is attributed to medical necessity errors for inpatient hospital claims, particularly short stays determined to not be medically necessary in an inpatient setting (i.e., services should have been billed as outpatient).

Each year, CMS outlines actions the agency will implement to prevent and reduce improper payments for all categories of error. While some corrective actions have been implemented, others are in the early stages of implementation. CMS believes these focused corrective actions will have a larger impact over time as they become integrated into business operations.

Of particular importance are four corrective actions that CMS believes will have a considerable effect in preventing and reducing improper payments:

1. CMS issued a final rule, Centers for Medicare & Medicaid Services (CMS) CMS-1611-F (79-FR 66031, issued on November 6, 2014) to update Medicare's Home Health Prospective Payment System payment rates and wage index for calendar year 2015. This final rule also included three changes to the face-to-face requirements for episodes beginning on or after January 1, 2015. Since implementation of the face-to-face requirements in April 2011, CMS observed that the provider community had difficulty complying with the documentation requirements and these errors have increased the improper payment rate. CMS believes clarifying the face-to-face requirements will lead to a decrease in these errors and improve provider compliance with regulatory requirements, while continuing to strengthen the integrity of the Medicare program.

2. CMS implemented two major policies in CMS 1599-F (78 FR 50495, issued on August 2, 2013 and effective on October 1, 2013) pertaining to inpatient hospital claims that are expected to reduce improper payments:

- Allowed all hospital participants to rebill, under Part B, denied Part A inpatient claims within one year from the service date when the service should have been billed as outpatient.
- Clarified and modified the policy regarding when an inpatient admission is generally appropriate for payment under Medicare Part A.

3. CMS expanded the prior authorization demonstration project for the durable medical equipment prosthetics orthotics and supplies (DMEPOS) from the original seven states to an additional twelve states. The initial demonstration led to a decrease for power mobility devices in both the demonstration and non-demonstration states. Specifically, based on claims submitted as of September 17, 2014, monthly expenditures for the power mobility devices included in the demonstration project decreased from $20 million in September 2012 to $5 million in March 2014 in the non-demonstration states; and from $12 million to $2 million in the demonstration states.
   - CMS also proposed to establish a prior authorization process for certain DMEPOS items that are frequently subject to unnecessary utilization. Through a proposed rule, HHS has solicited public comments on this prior authorization process, as well as criteria for establishing a list of durable medical items that are frequently subject to unnecessary utilization

4. In FY 2015 CMS will further test prior authorization for certain non-emergent services in certain states: 1) non-emergent hyperbaric oxygen therapy; and 2) repetitive, scheduled non-emergent ambulance transport.

In addition, CMS' reported FY 2014 Medicare Part C gross improper payment estimate is 9.0 percent or $12.2 billion. The primary factor that drove this program's decrease from the prior year's reported error estimate was more accurate diagnoses submitted by Medicare Advantage (MA) organizations for payment. The Part C methodology estimates errors resulting from incorrect beneficiary risk scores. The primary component of a beneficiary's risk score is based on clinical diagnoses submitted by plans. If the diagnoses submitted to HHS are not supported by medical records, the risk scores will be inaccurate and result in payment errors. The Part C estimate is based on medical record reviews conducted under HHS's annual Risk Adjustment Data Validation (RADV) process, where unsupported diagnoses are identified and corrected risk scores are calculated.

Finally, the Medicare Part D gross improper payment estimate for FY 2014 is 3.3 percent or $1.9 billion. The primary factor that drove this program's decrease from the prior year's reported error estimate was a decrease in each component measure. As reported in the FY2014 Agency Financial Report, this improvement was driven, in part, by a reduction in the eligibility component of the FY 2012 Payment Error Rate Measurement (PERM) Medicaid eligibility component error rate and a change in the Part D benefit design that has reduced government liability for some claims.

CMS procured a Part D Recovery Audit Contractor (RAC) in 2011 to identify improper payments, prevent future improper payments and refer any potential findings identified to the

Medicare Drug Integrity Contractor (MEDIC). The Part D RAC has recovered approximately $1.3 million in improper payments in FY 2013 for payments made to exclude providers in 2007, and in FY 2014, the RAC identified improper payments made to excluded providers and other unauthorized prescribers in additional years.

The Medicare FFS Recovery Audit Program identifies and corrects Medicare improper payments through the efficient detection and collection of overpayments made on claims for items or services and the identification of underpayments to providers and suppliers so that the CMS can implement actions that will prevent future improper payments in all 50 states .In FY 2014, the Medicare FFS Recovery Audit program demanded approximately $1.9 billion and recovered approximately $2.3 billion. Recoveries can include amounts identified and demanded in prior fiscal years. The majority of collections continued to be from reviews of inpatient hospital and DME claims. This is consistent with CMS' focus to lower the Medicare error rate.

Enhance program integrity

CMS Response: CMS is using a multi-faceted approach to target all causes of waste, abuse, and fraud that result in inappropriate payments by shifting towards prevention-oriented activities. We are working closely with law enforcement, states, private insurers, and providers in our efforts. CMS must strike an important balance while overseeing the Medicare program. In 2014, as program integrity efforts matured, CMS applied three key operational principles to guide all of our initiatives. First, CMS aimed to achieve operational excellence in addressing the full spectrum of program integrity causes, in taking swift administrative actions, and in the performance of audits, investigations and payment oversight. Second, CMS will provide leadership and coordination in program integrity efforts across the healthcare system. Finally, we will focus on impacting the cost and appropriateness of care across healthcare programs. Fraud can inflict real harm to Medicare patients. When fraudulent providers steal a beneficiary's identity and bill for services or goods never received, the beneficiary may later have difficulty accessing needed and legitimate care. Medicare beneficiaries are at risk when fraudulent providers perform medically unnecessary tests, treatments, procedures, or surgeries, or prescribe dangerous drugs without thorough examinations or medical necessity. Our efforts are focused on ensuring that beneficiaries receive appropriate health care services, protecting both beneficiaries and taxpayers from unnecessary costs. We have instituted many program improvements since the passage of the Affordable Care Act and other legislation, and are continuously looking for ways to refine and improve our program integrity activities.

For example, first, CMS has used its moratoria authority provided to the Secretary in the Affordable Care Act to temporarily pause the enrollment of new Medicare, Medicaid, or CHIP providers and suppliers, including categories of providers and suppliers, if the Secretary determines certain geographic areas face a high risk of fraud. In July 2013, CMS announced temporary moratoria on the enrollment of new home health agencies (HHA) and ambulance companies in Medicare in three "fraud hot spot" metropolitan areas of the country: HHAs in and around Miami and Chicago, and ground‑based ambulances in and around Houston. In January 2014, CMS announced new temporary moratoria on the enrollment of HHAs in four metropolitan areas: Fort Lauderdale, Detroit, Dallas, and Houston, and on ground ambulances in

the metropolitan Philadelphia area. CMS also extended for six months the existing moratoria for HHAs in and around Chicago and Miami, and ground ambulance suppliers in the Houston area. CMS is required to re-evaluate the need for such moratoria every six months.

In each moratorium area, CMS is taking administrative actions such as payment suspensions and revocations of HHAs and ambulance companies, as well as working with law enforcement to support investigations and prosecutions. In Miami alone, CMS has revoked the billing privileges of 101 HHAs in 2013; with 67 revocations occurring after the moratorium was put into place. Additionally, law enforcement made arrests in a $48 million Miami home health scheme, and secured guilty pleas against three home health recruiters in that scheme as well as guilty pleas from the owners of a clinic involved in an eight million dollar fraud scheme. In Texas, CMS has revoked the billing privileges of 179 ambulance companies since June 2013, and 92 revocations occurring after the moratorium was put into place in Houston.

Second, CMS has established Healthcare Fraud Prevention Partnership (HFPP) partnerships with the private sector to fight fraud, waste, and abuse across the health care system, as well as, with other federal government agencies. The ultimate goal of the HFPP is to exchange facts and information to identify trends and patterns that will uncover fraud, waste and abuse that could not otherwise be identified. The HFPP currently has 38 partner organizations from the public and private sectors, law enforcement, and other organizations combatting fraud, waste, and abuse. In 2013, the HFPP completed early proof-of-concept studies that have enabled partners, including CMS, to take substantive actions to stop payments from going out the door.

In CMS's partnership with other federal agencies, the Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS), acting through the Inspector General, is designed to coordinate Federal, state and local law enforcement activities with respect to health care fraud and abuse. These efforts recovered a record-breaking $4.3 billion in taxpayer dollars in FY 2013, up from $4.2 billion in FY 2012, from individuals and companies who attempted to defraud federal health programs serving seniors or who sought payments from taxpayers to which they were not entitled. Over the last five years, the administration's enforcement efforts have recovered $19.2 billion, up from $9.4 billion over the prior five-year period. Since the inception of the program in1997, the HCFAC Program has returned more than $25.9 billion to the Medicare Trust Funds and treasury.

The success of this joint DOJ and HHS effort was made possible in part by the Health Care Fraud Prevention and Enforcement Action Team (HEAT), created in 2009 to prevent fraud, waste and abuse in Medicare and Medicaid and to crack down on individuals and entities that are abusing the system and costing American taxpayers billions of dollars. . Since 2009, the Justice Department and HHS have improved their coordination through HEAT and increased the number of Medicare Fraud Strike Force teams. The strike force teams use advanced data analysis techniques to identify high-billing levels in health care fraud hot spots so that interagency teams can target emerging or migrating schemes as well as with chronic fraud by criminals masquerading as health care providers or suppliers. In Fiscal Year 2013, the strike force secured records in the number of cases filed (137), individuals charged (345), guilty pleas

secured (234) and jury trial convictions (46). Beyond these remarkable results, the defendants who were charged and sentenced are facing significant time in prison – an average of 52 months in prison for those sentenced in FY 2013, and an average of 47 months in prison for those sentenced since 2007.

Third, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis by using predictive algorithms and other sophisticated analytics to analyze billing patterns against every Medicare fee-for-service claim. When FPS models identify egregious, suspect, or aberrant activity, the system automatically generates and prioritizes leads for review and investigation by CMS's Zone Program Integrity Contractors (ZPICs). The ZPICs then identify administrative actions that can be implemented swiftly, such as revocation, payment suspension, or prepayment review, as appropriate. The FPS is also an important management tool, as it prioritizes leads for ZPICs to review and investigate Medicare fraud in their designated region, making our program integrity strategy more data-driven.

In its second year of operations, CMS' FPS identified or prevented more than $210 million in improper Medicare fee-for-service payments, double the previous year. It also resulted in CMS taking action against 938 providers and suppliers. The FPS is a key element of the anti-fraud strategy that has led to a record $19.2 billion in fraud recoveries over the previous five years. The FPS Building on its expert knowledge for investigators and analysts, CMS is leading the government and healthcare industry in systematically applying advanced analytics on a nationwide scale. The system also uses other data sources including compromised Medicare identification numbers and complaints made through 1-800-MEDICARE.

Fourth, CMS issued a final provider enrollment rule in December 2014 that will improve CMS' ability to deny or revoke the enrollment of entities and individuals that pose a program integrity risk to Medicare. Provider enrollment is the gateway that allows health care providers to bill for services provided to Medicare beneficiaries. CMS routinely evaluates its provider enrollment policies, and has implemented new safeguards as a result of provisions in the Affordable Care Act. CMS has finalized a number of additional provider enrollment provisions, including adding the ability to deny the enrollment of providers, suppliers, and owners affiliated with an entity that has unpaid Medicare debt, and the ability to deny the enrollment or revoke the billing privileges of a provider or supplier if a managing employee has been convicted of certain felony offenses. In addition, new provisions permit CMS to revoke billing privileges of providers and suppliers that have a pattern or practice of billing for services that do not meet Medicare requirements, and to make the effective date of billing privileges consistent across certain provider and supplier types.

In addition to CMS's ongoing program integrity efforts, the FY 2015 President's Budget reflects the Administration's commitment to strong program integrity initiatives, which includes investments that will yield $13.5 billion in gross savings for Medicare and Medicaid over 10 years. Such efforts targeting waste, abuse, and fraud have already helped extend the life of the Medicare Trust Fund, and are critical to protect Medicare for years to come.

Improve oversight of patient care and safety

CMS Response: Efforts to improve patient safety have resulted in 1.3 million fewer patient harms, 50,000 lives saved and $12 billion in health spending avoided through patient safety efforts undertaken by HHS, CMS and its partners.

An estimated 50,000 fewer patients died in hospitals and approximately $12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013. Preliminary estimates also show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period. In 2013 alone, almost 35,000 fewer patients died in hospitals, and approximately 800,000 fewer incidents of harm occurred, saving approximately $8 billion.

The efforts were due in part to provisions of the Affordable Care Act such as Medicare payment incentives to improve the quality of care and the Partnership for Patients initiative.

CMS Response to GAO Recommendations re: Medicaid

GAO designated Medicaid as a high-risk program due to its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. This federal and state program covered acute health care, long-term care, and other services for about 73 million low-income people in fiscal year 2013; it is one of the largest sources of funding for medical and health-related services for America's most vulnerable populations. Medicaid consists of more than 50 distinct state-based programs. The federal government matches state expenditures for most Medicaid services using the Federal Medical Assistance Percentage, a statutory formula based in part on each state's per capita income.

Medicaid is a significant expenditure for the federal government and the states, with total expenditures of $462 billion in 2013. CMS is responsible for overseeing the program at the federal level, while states administer their respective programs' day-to-day operations.

CMS has made significant efforts to implement changes in the following areas:
1. Improve oversight of Medicaid's fiscal and program integrity
2. Reduce improper payments to providers
3. Improve oversight of Medicaid managed care payment rate-setting and supplemental payments
4. Improve criteria and methods used to ensure that the budget neutrality of Medicaid demonstrations remains valid

CMS Actions

Improve oversight of Medicaid's fiscal and program integrity

CMS Response: Medicaid is a federal-state partnership, and that partnership is central to the program's success. CMS provides states with interpretive guidance to use in applying statutory and regulatory requirements, technical assistance including tools and data, federal match for their expenditures, and other resources. CMS carries out its obligations to states while being mindful of the uniqueness of each state's size, resources, delivery systems, and level of risk for the integrity of the program. States fund their share of the program, and, within federal and state guidelines, operate their individual programs, including setting rates, paying claims, enrolling providers and beneficiaries, contracting with plans, and claiming expenditures. State Medicaid programs and CMS share responsibility for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible individuals and are not diverted into fraud, waste, or abuse.

To meet the program integrity challenges created by the transformation and expansion of Medicaid, CMS will implement the following strategies to work more effectively with states to safeguard federal and state Medicaid funds:[1]

- Eliminate duplication of efforts by integrating Medicare and Medicaid audits and investigations;
- Improve financial accountability of Medicaid managed care organizations;
- Improve safeguards for Medicaid fee-for-service claims;
- Expand reporting and controls for provider rate setting;
- Enhance beneficiary eligibility safeguards;
- Improve the accuracy of state claiming and grant management;
- Execute safeguard strategies for new forms of payment and new delivery systems; and
- Revise measurement of error rates to align with program changes.

CMS' Medicaid Integrity Program also provides the assistance of federal staff specializing in program integrity and contractor support to bolster state activities. Based on states' quarterly reports to HHS, this assistance supported state efforts to collect $944.4 million in total collections in FY 2014.

Moving forward, CMS will continue efforts to work productively to identify and resolve fiscal and program integrity issues in the Medicaid program.

Reduce improper payments to providers

CMS Response: The national FY 2014 Medicaid improper payment rate is based on measurements conducted in FYs 2012, 2013, and 2014. Medicaid improper payments are estimated on a federal fiscal year basis and measure three component error rates: FFS, managed care, and eligibility. The national Medicaid gross improper payment estimate for FY 2014 is 6.7 percent or $17.5 billion. The increase in the FY14 National Medicaid error rate was due to the

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[1] These and other strategies are outlined in the Comprehensive Medicaid Integrity Plan for FYs 2014-2018, available at http://www.cms.gov/Regulations-and-Guidance/Legislation/DeficitReductionAct/Downloads/cmip2014.pdf

increase in the FFS component rising from 3.6 percent to 8.8 percent. However, the eligibility component reported and the managed care components reported decreases.

CMS works closely with all states to develop State-specific Corrective Action Plans (CAPs). All states are responsible for implementing, monitoring, and evaluating the effectiveness of their CAPs, with assistance and oversight from CMS. CMS received CAPs from all states whose Medicaid programs were previously measured, and all states measured in FY 2014 are developing CAPs for submission to CMS. When developing the CAPs, states focus their efforts on the major causes of improper payments where the state can clearly identify patterns.

Through the PERM program, CMS identified $631,595 in Medicaid overpayments eligible for recovery for FY 2014. CMS has encouraged and supported states in their efforts to modernize and improve State Medicaid Management Information Systems (MMIS), which will produce greater efficiencies in the PERM measurement and strengthen program integrity.

CMS also developed the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS will facilitate state submission of timely claims data to HHS, expand the MSIS dataset, and allow CMS to review the completeness and quality of State MSIS submittals. CMS will use this data for the Medicaid improper payment measurement and to satisfy other HHS requirements. Through the use of T-MSIS, CMS will not only acquire higher quality data, but will also reduce state data requests. States will move from MSIS to T-MSIS on a rolling basis with the goal of having all states submitting data in the T-MSIS file format in 2015.

Federal and state governments have invested heavily in the development and operations of claims systems that engage in high volume transactions. Proper adjudication of these transactions is dependent on technical designs and investments, implementation of effective claims edits and predictive modeling approaches, efficient suspense resolution procedures, proper use of payment suspension authorities, and referral and information sharing practices. CMS will be expanding our assessment of these systems and operations to ensure that our investments are producing timely and accurate claims payment results, processing State Plan Amendments implementing required safeguards (such as the National Correct Coding Initiative), and supporting new investments (such as those in predictive modeling) that can help detect claims anomalies and relationships of interest.

Improve oversight of Medicaid managed care payment rate-setting and supplemental payments

CMS Response: CMS is implementing a broad set of initiatives to strengthen its oversight and compliance of managed care services and to ensure access to services and quality of care for all Medicaid beneficiaries. As part of these oversight efforts, CMS established and implemented a managed care oversight team that developed Standard Operating Protocols (SOP) for the review and approval of Medicaid and CHIP managed care contracts and SOPs for the review and approval of managed care rates; Medicaid contract review checklist; CHIP contract review checklist; and an online contract tracking system to support the review and approval of managed care contracts. CMS staff is maintaining and updating these SOPs, checklists and tools as

needed.   Currently, CMS works with staff from the Office of the Actuary (OACT) to review and approve state managed care rates.

At the same time, CMS worked to develop additional elements of CMS' managed care oversight improvement plan, including guidelines for interpreting and enforcing regulatory requirements (e.g., 2014 and 2015 Managed Care Rate Setting Consultation Guides), providing additional guidance for States, and training for CMS staff. CMS is also working on revised Medicaid managed care regulations which are expected to align FFS and managed care provider enrollment, screening and disclosure requirements as well as program integrity requirements much more closely than they have been in the past. These regulations will have the effect of creating more uniform standards of practice in state managed care programs. They will help standardize the approaches used to managed care rate-setting as well. The agency expects to issue the new regulations for public comment in FY 2015.

In addition, in FY 2014, CMS also undertook a series of focused program integrity reviews targeting 10 states which were expected to have significant Medicaid expansion populations under health care reform. In 8 of these states, one part of the review focused on the program integrity activities of Medicaid managed care plans and their Special Investigation Units in particular. Information obtained from these reviews is expected to help states in developing future managed care contract requirements that will strengthen state oversight of plan program integrity activities and improve fee-for-service and managed care coordination in cases of provider fraud and abuse.

Next, CMS is undertook a fundamental redesign of Medicaid data collection and the development of robust analytical functionality that will offer strategic programmatic insights of use to States, Federal partners, and other stakeholders. CMS will be setting standards for the type and frequency of managed care data submissions by States in order to expand the type and consistency of data on managed care programs. With more complete data at its disposal, CMS will be able to implement more rigorous analysis to assess the underlying quality of data submissions. More specifically, a CMS contractor developed a managed care "Encounter Data Toolkit," published in November 2013. The toolkit is a practical guide to collecting, validating, and reporting Medicaid managed care encounter data" which will help states significantly in improving the quality of the encounter data they obtain from Medicaid managed care plans. It should assist states greatly in efforts to develop a more rigorous managed care rate setting process.

In addition to the oversight efforts for Medicaid managed care payment rate-setting, CMS has also implement more robust oversight of supplemental payments. It is important to note that any supplemental payment that is newly proposed or modified under a state plan amendment (SPA) is subject to CMS' oversight through its SPA review and approval process. This requires that the state respond to detailed questions regarding how the state will finance its share of the payment. Supplemental payment proposals will not be approved until CMS has determined that the state is securing appropriate non-federal funding to finance its share of its Medicaid program. In addition, for any supplemental payment proposal, a state must demonstrate that the aggregate payment amount will be within the state's applicable upper payment limit (UPL). The UPL

requires that a total Medicaid payment (which includes base rate payments and any supplemental payments) cannot exceed a reasonable estimate of what Medicare would pay for similar services.

In order to ensure a consistent policy across states and over the years, and to evaluate the need for further guidance and oversight, CMS is undertaking a comprehensive review of all approved SPAs to scrutinize supplemental payment methodologies. As part of this activity, CMS is identifying any states that are failing to report supplemental payments through the Medicaid Budget and Expenditure System (MBES) as required, and taking necessary steps to ensure compliance with the requirement and address methodologies that are not compliant with the Medicaid statute and federal regulation. This analysis will assist us in determining the need for more guidance or definition of formulas, data sources, validation, and updates of UPL demonstrations and payments.

Additionally, CMS has embarked on new initiatives to improve analytic capacity and provide a more regular process for state financing and upper payment limit data reporting. CMS issued a policy letter on March 18, 2013 that discusses the mutual obligations of states and CMS to apply safeguards to ensure the proper use of federal and state Medicaid funds. As part of the letter, CMS instituted a new policy to require annual submissions that demonstrate compliance with federal upper payment limits (UPL) and information on the source of the non-federal share that is used to fund in some cases facility specific "UPL" supplemental payments. We have engaged with our regional offices to analyze the first state UPL submissions and have engaged with a contractor to aid in the ongoing effort.

Improve criteria and methods used to ensure budget neutrality of Medicaid demonstrations remains valid

CMS Response: CMS has taken new steps to make the approach to budget neutrality more transparent. On October 5, 2012 CMS released a section 1115 template for states to use in order to clarify the requirements and simplify the application process. This template includes instructions and an accompanying budget worksheet that provides guidance on some of the most commonly used data elements for demonstrating budget neutrality. Consistent with CMS' policy that budget neutrality calculations should be based on the best available data, states must provide an explanation of how the demonstration program will achieve budget neutrality and include data that supports the state's rationale. This guidance had not previously been communicated in this format and is part of the agency's broader effort to increase transparency in section 1115 demonstrations.

The section 1115 demonstration template is only one component of a broader set of recent initiatives that CMS has undertaken to improve transparency and the quality of care provided under demonstrations, while at the same time ensuring accountability for demonstration expenditures.

CMS launched a new section on the Medicaid.gov website to receive public comments on demonstration applications and renewals and provide the public with all relevant demonstration documents, including budget neutrality agreements. Another example of CMS' focus on quality

and accountability is the recently released series of tools and guidance on implementing managed care amendments to 1115 demonstrations that include long-term services and supports.

These changes and additional tools have assisted CMS in its consistent application of budget neutrality policy by adding to the transparency of the process and enhancing understanding between CMS and the states.