

CMS FACT SHEET

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CMS Announces New Demonstrations to Help Curb Improper Medicare, Medicaid Payments *Efforts will Build on 2011 Decreases in Medicare, Medicaid Improper Payments*

In 2010, the President announced three goals for cutting improper payments by 2012: reducing overall payment errors by \$50 billion, cutting the Medicare fee-for-service error rate in half, and recovering \$2 billion in improper payments.

To help achieve these goals, the Centers for Medicare & Medicaid Services (CMS) has announced it will launch demonstration programs beginning in January 2012 targeting some of the most common factors that lead to improper payments.

Cost Saving Projects will Help Protect Medicare and Medicaid

Beginning on January 1, 2012, CMS will conduct demonstration projects that will strengthen Medicare by aiming at eliminating fraud, waste, and abuse. Reductions in improper payments will help ensure the sound future of the Medicare Trust Fund and protect Medicare beneficiaries who depend upon it.

- **Recovery Audit Prepayment Review:** The Recovery Audit Prepayment Review demonstration will allow Medicare Recovery Auditors (RACs) to review claims before they are paid to ensure that the provider complied with all Medicare payment rules. The RACs will conduct prepayment reviews on certain types of claims that historically result in high rates of improper payments. These reviews will focus on seven states with high populations of fraud- and error-prone providers (FL, CA, MI, TX, NY, LA, IL) and four states with high claims volumes of short inpatient hospital stays (PA, OH, NC, MO) for a total of 11 states. This demonstration will also help lower the error rate by preventing improper payments rather than the traditional “pay and chase” methods of looking for improper payments after they have been made.
- **Prior Authorization for Certain Medical Equipment:** The second demonstration announced today will require Prior Authorization for certain medical equipment for all people with Medicare who reside in seven states with high populations of fraud- and error-prone providers (CA, FL, IL, MI, NY, NC and TX). This is an important step toward paying appropriately for certain medical equipment that has a high error rate. This demonstration will help ensure that a beneficiary’s medical condition warrants their medical equipment under existing coverage guidelines. Moreover, the program will assist in preserving a Medicare beneficiary’s right to receive quality products from accredited suppliers.

The Prior Authorization demonstration will be implemented in two phases. During the first phase (the first three to nine months), the Medicare Administrative Contractors will conduct prepayment reviews on certain medical equipment claims. The second phase, for the remainder of this three-year demonstration, will implement prior authorization, a tool utilized by private-sector health care payers to prevent improper payments and deter the fraudulent provision of items or services.

- *Part A to Part B Rebilling:* The third initiative will allow hospitals to rebill for 90 percent of the Part B payment when a Medicare contractor denies a Part A inpatient short stay claim as not reasonable and necessary due to the hospital billing for the wrong setting. Currently, when outpatient services are billed as inpatient services, the entire claim is denied in full.

This demonstration will be limited to a representative sample of 380 hospitals nationwide that volunteer to be part of the program. This demonstration will allow hospitals to resubmit claims for 90 percent of the allowable Part B payment when a Medicare Administrative Contractor, Recovery Auditor, or the Comprehensive Error Rate Testing Contractor finds that a Medicare patient met the requirements for Part B services but did not meet the requirements for a Part A inpatient stay. In addition, this demonstration is expected to lower the appeals rate which will protect the trust fund and reduce hospital burden. Beneficiaries will be held harmless with respect to changes in hospital coinsurance liability.

This past May, HHS announced a pilot project under the [Partnership Fund for Program Integrity Innovation](http://partner4solutions.gov/) (<http://partner4solutions.gov/>) to test an automated tool to screen providers for the risk of fraud. Currently, HHS and States lack standardized Medicaid provider data, which hampers detection of potential fraud. If successful, this tool will not only help prevent improper payments by weeding out fraudulent providers, but it will help States focus their resources where fraud is most likely to occur.

New Projects Build on 2011 Savings

The 2012 projects announced today will build on accomplishments in 2011 to reduce Medicare and Medicaid improper payment rates.

For example, the Medicare fee-for-service improper payment rate dropped to 8.6 percent, or \$28.8 billion in estimated improper claims payments. This rate was calculated using a refined methodology, after consulting with the Office of the Inspector General, that reflects the impact of late documentation and the results of appeal activities that typically occur after the cut-off date. For consistency and comparison purposes, CMS adjusted the 2010 error rate to 9.1 percent or \$29.7 billion. When comparing the adjusted rates, the 8.6 percent error rate for 2011 represents a 0.5 percentage point reduction in the improper payment rate from 2010. [\[1\]](#)

In addition, for 2011:

- The Medicare Advantage (Part C) improper payment rate, based on the 2009 payment year, is 11.0 percent, or \$12.4 billion, a reduction from last year's rate of 14.1 percent, or \$13.6 billion. The Part C improper payment rate dropped 3.1 percentage points (or 21 percent) from 2010, a result of the Administration's aggressive corrective actions, including ongoing audits - with an emphasis on contract-level risk adjustment data validation audits - designed to recover overpayments to Part C plans.
 - The Medicaid improper payment rate is 8.1 percent, or \$21.9 billion in estimated improper payments. This rate reflects a three-year average of the 2009, 2010, and 2011 cycle rates. The Medicaid improper payment rate

declined by 1.3 percentage points, reflecting ongoing efforts by the States and the Department of Health and Human Services (HHS) to educate providers on the root causes of improper payments.

CMS is also reporting for the first time a composite improper payment rate for the Medicare Part D prescription drug program. Based on payment year 2009, the improper payment rate is 3.2 percent, or \$1.7 billion. The Part D payment improper payment rate combines five component payment error measures: Medicare Advantage prescription drug payment system error; payment error related to low income subsidy status; payment error related to incorrect Medicaid status; payment error related to prescription drug event data validation; and payment error related to direct and indirect remuneration.

The improper payment rate for the Children's Health Insurance Program (CHIP) will not be published until 2012. CMS was prohibited from calculating or publishing a rate until six months after the August 2010 Payment Error Rate Measurement (PERM) program rules went into effect. Due to the timing, HHS began measuring CHIP improper payments under the new program rules in 2011, and will publish the results in 2012.

While improper payment rates are not necessarily an indicator of fraud in Medicare, Medicaid or CHIP, they do provide HHS, CMS and States with a more complete assessment of factors leading to error rates and new ways to help prevent them.

CMS is continuing to invest time and resources to work with providers across the country and eliminate errors through increased and improved training, education, and outreach.

Additional Fact sheets issued today (11/15/11):

- CMS Prior Auth Fact Sheet- <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4168>
- CMS Rebilling Fact Sheet - <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4169>
- CMS Recovery Audit (RAC) Demo Fact Sheet- <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4170>
- CMS Medicaid Fact Sheet- <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4171>
- CMS Medicare D fact sheet <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4172>
- CMS Medicare C fact sheet and <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4175>
- CMS Medicare FFS Improper payments Fact Sheet : <https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4174>

Also, please see the White House Press Release- *We Can't Wait: Agencies Cut Nearly \$18 Billion in Improper Payments, Announce New Steps for Stopping Government Waste*- <http://www.whitehouse.gov/the-press-office/2011/11/15/we-can-t-wait-agencies-cut-nearly-18-billion-improper-payments-announce->

- Agency improper payment data is being updated Tuesday afternoon at www.paymentaccuracy.gov

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