U.S. SENATE COMMITTEE ON
Finance
SENATOR CHUCK GRASSLEY, OF IOWA - CHAIRMAN
http://finance.senate.gov

M E M O R A N D U M

To: Reporters and Editors
Re: New Report on Improper Medicare Payments
Da: Thursday, Nov. 10, 2005

Sen. Chuck Grassley issued a comment today about the just-released November 2005 Report on Improper Medicare Fee-for-Service Payments. The report shows the improper rate has been cut in half, reducing improper payments by $9.5 billion. As chairman of the Committee on Finance, Sen. Grassley is responsible for Medicare legislation and oversight. He has put continued pressure on Medicare program administrators to reduce improper payments. His statement follows here.

"It's remarkable that better management of the Medicare program has achieved the same level of savings in just one year as the Senate did in a five-year budget bill passed just last week. Congressional oversight plus a commitment to addressing the problem from Administrator McClellan are having a very positive effect. Taxpayers and beneficiaries deserve continued efforts by Medicare officials to reduce improper payments. Every dollar not wasted is another dollar for beneficiaries."

Following is today's news release from the Center for Medicare and Medicaid Services.

CMS NEWS

FOR IMMEDIATE RELEASE
CMS Media Affairs
November 10, 2005

MEDICARE REDUCES IMPROPER CLAIMS PAYMENTS BY HALF
CMS Expands Oversight to Include Medicaid, SCHIP and Prescription Drug Plans

Aggressive oversight and new improvement efforts have cut the number of improper fee-for-service Medicare claims payments by half in one year, from 10.1 percent in 2004 to 5.2 percent in 2005, a $9.5 billion reduction in improper payments, Centers for Medicare & Medicaid Services (CMS) Administrator Mark B. McClellan, M.D., Ph.D., announced today. Dr. McClellan also announced the first year of the national implementation to measure state-level Medicaid improper payments and a comprehensive strategy to assure appropriate payments to prescription drug plans.

"The unprecedented, $9.5 billion reduction in improper Medicare payments reflects our commitment

to careful measurement and targeted oversight, and we intend to keep building on these efforts," said Dr. McClellan. "We are measuring the accuracy of payments more closely, and that enables us to target our efforts more effectively with Medicare contractors and providers."

The Medicare fee-for-service error rate has declined from 14.2 percent in 1996, when the Medicare improper payment rate was first reported, to the current 5.2 percent. The unprecedented reduction in the error rate has occurred despite a growing volume of claims and complexity of payment processing at CMS. CMS pays more than 1 billion fee-for-service claims each year, and provides oversight to state payments for services provided by health care professionals under Medicaid and the State Children's Health Insurance Program (SCHIP). In 2005, Medicare also made monthly payments to more than 450 Medicare health plans across the U.S.

Building on the success of the Medicare Integrity Program for Medicare Parts A and B, CMS is developing a comprehensive plan for a similar oversight program for payments to Medicare health and prescription drug plans and Medicaid, all of which is reflected in the President's 2006 budget request. CMS has requested $720 million for the Medicare Integrity Program and an additional $80 million to continue to expand its oversight to the other programs.

"Much of the success we've achieved so far in our oversight of the fee-for-service Medicare program is due to Congress' support and we expect that will continue for our oversight of the managed care and Medicaid efforts," said Dr. McClellan.

CMS reviewed approximately 160,000 fee-for-service Medicare claims in 2005 as part of its Medicare error rate testing program. These detailed reviews, which span all types of Medicare payments, were first conducted at the level of individual contractors last year. By providing accurate statistical information at the level of particular contractors and types of medical services, CMS can now identify where problems exist and target improvement efforts to address the problems. This effort reflects the agency's increased commitment to use more detailed data and analysis to identify and eliminate improper payments and as a tool to better manage the Medicare contractors.

The significant reduction in the Medicare FFS error rate from 2004 to 2005 can be attributed largely to marked improvement in the no documentation and the insufficient documentation error rates. Since the CERT program began, CMS and the Medicare contractors focused a large part of their efforts on educating providers about CERT and the importance of responding to CERT requests for medical records which has dramatically reduced the number of no documentation errors. Provider education also helped reduce the insufficient documentation error rate to just over one percent:

0.7 percent had errors due to non-responses to request for medical records (3.1 percent in 2004);

1.1 percent of payments had errors due to insufficient documentation being submitted (4.1 percent in 2004);

1.6 percent due to medically unnecessary services (1.6 percent in 2004);

1.5 percent due to incorrect coding (1.2 percent in 2004); and

0.2 percent due to other errors (0.2 percent in 2004).

As part of the efforts to further reduce the Medicare error rate, CMS is requiring its fee-for-service contractors to:

Develop corrective action plans that include efforts to educate providers about the importance of submitting thorough and complete medical records;

Identify which providers or contractors need to review their submission of claims and improve their educational efforts, based on information that shows where the highest percentage of errors on overused billing codes are occurring; and

Use the performance results to develop local efforts to lower their error rates by addressing the cause of the errors and outlining corrective steps.

"We've taken major steps to get more accurate information about the payments we make in Medicare, and those steps will help us reduce the error rates for Medicare," said Dr. McClellan. "We are now taking the successes we've achieved with our evidence-based strategies to cut the Medicare error rate to help us achieve similar results for payments in Medicaid, SCHIP and Medicare managed care and prescription drug plans."

Taking similar steps to identify and measure errors and weaknesses at a provider and geographic level, CMS will develop better, comparable information on the accuracy of payments in Medicaid. These efforts will allow CMS to collect consistent information on error rates in Medicaid payments across all states. Under the review program, states will be reviewed once every three years.

In addition, 2005 was the third year of the Payment Accuracy Measure (PAM) pilot project which CMS used to measure the accuracy of state payments for Medicaid and SCHIP. In October, CMS issued an interim final regulation with comment that will implement a national program to identify and reduce improper payments in Medicaid. In 2006, CMS will review Medicaid fee-for-service medical claims and in 2007, CMS will measure improper payments in the fee-for-service, managed care and eligibility aspects of Medicaid. CMS will then calculate state-specific error rates upon which a national Medicaid error rate can be estimated. CMS will work with states to develop and review the data, to identify the state programs that keep error rates down, and to expand the use of effective approaches.

Also beginning in FY 2007, CMS will begin to measure improper payments in SCHIP programs and will begin to select states for measurement once every three years, similar to the selection in the Medicaid improper payment effort.

CMS is developing a comprehensive strategy to measure improper payments for the new prescription drug benefit as it is implemented in the coming months. In 2005, CMS began an assessment of the risk for improper payments to Medicare Advantage plans. In 2006, CMS will take a series of steps to measure the accuracy of these payments in detail and address potential risks. CMS will begin by reviewing the monthly payments made to the plans and conduct a review of all the data required for plan payments. Managed care payment reviews will examine whether beneficiaries are eligible to enroll in a plan, how payments are made and what occurs when a beneficiary's enrollment is terminated.

Those efforts will be complemented through the work of the Medicare Rx Integrity Contractors (MEDICs) who will help identify and prevent fraud and abuse in the Medicare prescription drug

program.

“Program and fiscal integrity oversight is an integral part of CMS's financial management strategy and we place a high priority on detecting and preventing improper or fraudulent payments,” said Dr. McClellan.

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