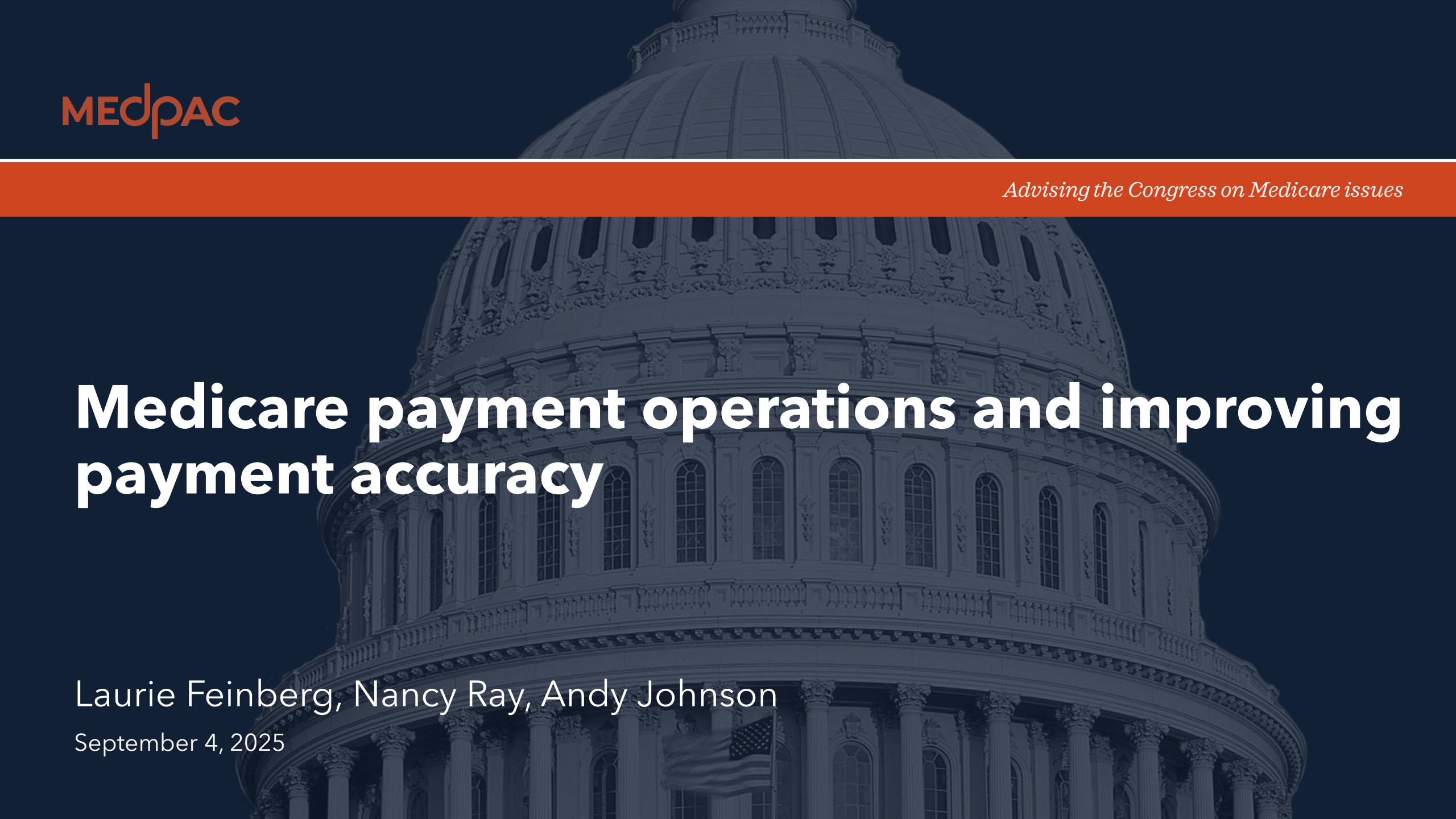
MEDPAC

Advising the Congress on Medicare issues



Medicare payment operations and improving payment accuracy

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Introduction

- Medicare spending (FY2024): $1.1 trillion
- Payment accuracy is important to help ensure good value for taxpayers and beneficiaries
- Most payments are accurate, but the size of the program means that even small share of improper payments has a large impact on spending

Source: Congressional Budget Office. 2025. The Budget and Economic Outlook: 2025 to 2035, Table B-4. https://www.cbo.gov/publication/60870

Introduction *(continued)*

- Each year MedPAC examines aggregate FFS and MA payments and makes recommendations to improve accuracy within payment systems by:
  - Better aligning payments with costs for efficient providers
  - Improving accuracy of payments across case types and providers
- Other government entities and contractors examine individual claims and identify improper payments
  - GAO reported that improper Medicare payments were estimated at $54.3 billion in FY 2024
- At the April meeting, commissioners asked for more information about CMS's claims processing and program integrity activities

Note: FFS (fee-for-service), MA (Medicare Advantage)
Source: GAO-25-107753

Presentation roadmap

1. What are improper payments?
2. CMS efforts to ensure proper payments in FFS Medicare
3. CMS efforts to ensure proper payments in MA and Part D
4. MedPAC's work to improve payment accuracy and value of Medicare's payments
5. Discussion

What are improper payments?

- Improper payments may include:
  - Overpayments or underpayments
  - Payments for an ineligible recipient
  - Payments for ineligible services or items
  - Duplicate payments
  - Payments lacking documentation to determine their appropriateness

➢ Note: Improper payments are not necessarily fraudulent

CMS efforts to ensure proper payments in FFS Medicare

CMS efforts to ensure proper payments in FFS Medicare: Overview

- Medicare Administrative Contractors (MACs):
  - Enroll providers and process claims
  - Perform prior authorization and pre-claims approval in certain circumstances
- Other contractors perform post-payment reviews
- Improper FFS payments reported in FY2024: $32 billion (7.7% of payments)

Note: FFS (fee-for-service).
Source: Centers for Medicare & Medicaid Services, Comprehensive error rate testing, https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/comprehensive-error-rate-testing-cert

Medicare administrative contractors (MACs)

- MACs are private contractors that:
  - Enroll and educate providers
  - Process Part A and Part B claims
  - Audit cost reports
  - Develop local coverage decisions
  - Perform the first level of appeals
- 12 MACs process claims in specified regions; 4 DME-MACs process claims for DMEPOS
- MACs processed more than 1.1 billion FFS claims in FY2023

Note: DMEPOS (durable medical equipment, prosthetics, orthotics, and supplies), FFS (fee-for-service).
Source: Centers for Medicare & Medicaid Services, What's a MAC?, https://cms.gov/medicare/coding-billing/medicare-administrative-contractors-macs/whats-mac

Enrollment of providers

- Enroll using Provider Enrollment, Chain, and Ownership System (PECOS)
- Obtain an NPI and fill out an application
  - Practitioners and most suppliers: Application goes to MAC for approval
  - DME suppliers: Must obtain accreditation before applying; once approved, must post a surety bond
  - Facilities: Must be licensed and meet Conditions of Participation; reviewed by CMS

Note: NPI (National Provider Identification), DME (durable medical equipment), MAC (Medicare administrative contractor). NPIs are unique identifiers for each provider.
Source: Centers for Medicare & Medicaid Services, Become a Medicare Provider or Supplier, https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers

FFS Medicare claims are sent to the MAC

- When providers furnish an item or service, they submit an electronic claim to the MAC
- MACs have 3 levels of automated review:
  - "Front-end edits" to verify the beneficiary, provider, and date of service
  - "Implementation guide" reviews, including checks for duplicate claims
  - Specific edits to screen for items and services that should not be billed together or have an unreasonable number of units and to check for compliance with national and local coverage determinations
- "Clean claims" are required to be paid within 30 days of receipt
- MACs may perform targeted prepayment and post-payment reviews

Note: MAC (Medicare Administrative Contractor).
Source: Centers for Medicare & Medicaid Services, National Correct Coding Initiative (NCCI) edits, https://www.cms.gov/medicare/coding-billing/ncci-medicare

MAC prior authorization and pre-claims review

- MACs perform prior authorization for some outpatient procedures, for some DME, and for non-emergency transports
  - Provider submits a request and receives the decision before services are rendered
- MACs also will perform prior authorization in the new WISeR model, in which private contractors will use AI and data analytics to identify services for review; scheduled to start in January 2026
- MACs conduct some pre-claim reviews for HHAs and IRFs in some states
  - Provider submits the request and receives the decision prior to claim submission, but can render services before submission/decision

Note: MAC (Medicare administrative contractor), DME (durable medical equipment), WISeR (Wasteful and Inappropriate Service Reduction), AI (artificial intelligence), HHA (home health agency), IRF (inpatient rehabilitation facility).

Source: Centers for Medicare & Medicaid Services, Prior Authorization and Pre-Claim Review Initiatives, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-and-pre-claim-review-initiatives; Centers for Medicare & Medicaid Services, WISeR model, https://www.cms.gov/priorities/innovation/innovation-models/wiser

Other contractors do post-payment reviews

- UPICs
  - Investigate suspicious claims referred by CMS and MACs
  - Review medical documentation and conduct interviews and on-site visits
  - Refer to law enforcement as appropriate
- RACs
  - In-depth review of topics approved by CMS
  - Request medical documentation from providers as needed
  - Identify both over and underpayments
  - Retain a portion of their recoveries as payment for the activities

Note: UPIC (unified program integrity contractor), MAC (Medicare administrative contractor), RAC (recovery audit contractor).
Source: Noridian, Unified Program Integrity Contractor (UPIC), https://med.noridianmedicare.com/web/jadme/cert-reviews/upic; Centers for Medicare & Medicaid Services, Medicare Fee for Service Recovery Audit Program, https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medicare-fee-service-recovery-audit-program

CMS efforts to ensure proper payments in MA and Part D

Ensuring proper payments in MA

- CMS pays MA plans capitated monthly amounts that are risk-adjusted using demographic and diagnostic information for each beneficiary
  - Improper payment estimates assess whether diagnostic data used for payments are supported by a beneficiary's medical record
- Improper payment error rate was reported in FY2024 to be 5.6%, or $19 billion
- RADV audits are ongoing to recover improper payments
- Improper payments in MA are conceptually different from estimates of increased MA coding intensity

Note: MA (Medicare Advantage), RADV (risk adjustment data validation).
Source: Centers for Medicare & Medicaid Services, Medicare Part C improper payment measurement, https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/medicare-part-c-ipm

Ensuring proper payments in Part D

- CMS pays Part D plans through capitated monthly payments and cost-based reimbursement
  - Improper payment estimates assess the appropriateness of the prescription drug event data used for payments
- Improper payment error rate was reported for FY2024 to be 3.7%, or about $4 billion, mainly due to missing documentation

Source: Centers for Medicare & Medicaid Services, Medicare Part D improper payment measurement, https://www.cms.gov/data-research/monitoring-programs/improper-payment-measurement-programs/medicare-part-d-ipm

MedPAC's work to improve payment accuracy and value of Medicare's payments

MedPAC's work to improve payment accuracy and value of Medicare's payments

- MedPAC's role is to provide recommendations and advice to improve the accuracy and value of Medicare's payments
- This work is distinct from identifying improper payments but can help reduce improper payments
- MedPAC's work has included:
  - Recommendations to align Medicare's payments with costs of efficient care in a payment system
  - Identification of other opportunities to improve efficiency

Selected MedPAC work to align Medicare's payments with costs of efficient care

- Annual assessment of FFS payment adequacy in 7 payment systems considers:
  - Beneficiaries' access to care
  - Providers' quality of care and access to capital
  - How Medicare payments compare with providers' costs
- Recommendation: Payments for post-acute care are high relative to costs and should be reduced
- Recommendation: ASCs should submit cost data to ensure that payments are aligned with the cost of efficient care

Note: FFS (fee-for-service), ASCs (ambulatory surgery centers).

Selected MedPAC work to identify other opportunities to improve efficiency

- Increase bundling of similar drugs in the OPPS
- Improving payment for non-emergency ambulance transports
- Evaluating alternative approaches for addressing potentially low-value care
- Evaluate rapid growth of Medicare spending on skin substitutes to determine if payment reforms are needed
- Expand competitive bidding
- Better align payments across ambulatory settings
- Improve the validity of MA encounter data and diagnoses submitted for risk adjustment

Note: OPPS (outpatient prospective payment system), MA (Medicare Advantage).

Alignment of payments across ambulatory settings

- MedPAC has discussed aligning payment rates across ambulatory settings since 2014
- Recommended that Medicare move toward more site-neutral payments for ambulatory services when doing so does not pose a risk to access (June 2023)
  - For 57 APCs where freestanding offices had the highest volume of services, OPPS rates could be more closely aligned to PFS rates
  - For 9 APCs where ASCs had the highest volume, OPPS rates could be more closely aligned to ASC rates
  - Budget neutrality would increase the payment for the unchanged APCs
- GAO has recommended site-neutral payments for E&M services across settings (2016)

Note: APC (ambulatory payment classification), OPPS (outpatient prospective payment system), PFS (physician fee schedule), ASC (ambulatory surgical center), E&M (evaluation and management).

Sources: MedPAC March 2014 Report, Chapter 2; MedPAC June 2023 Report, Chapter 8; GAO-16-189.

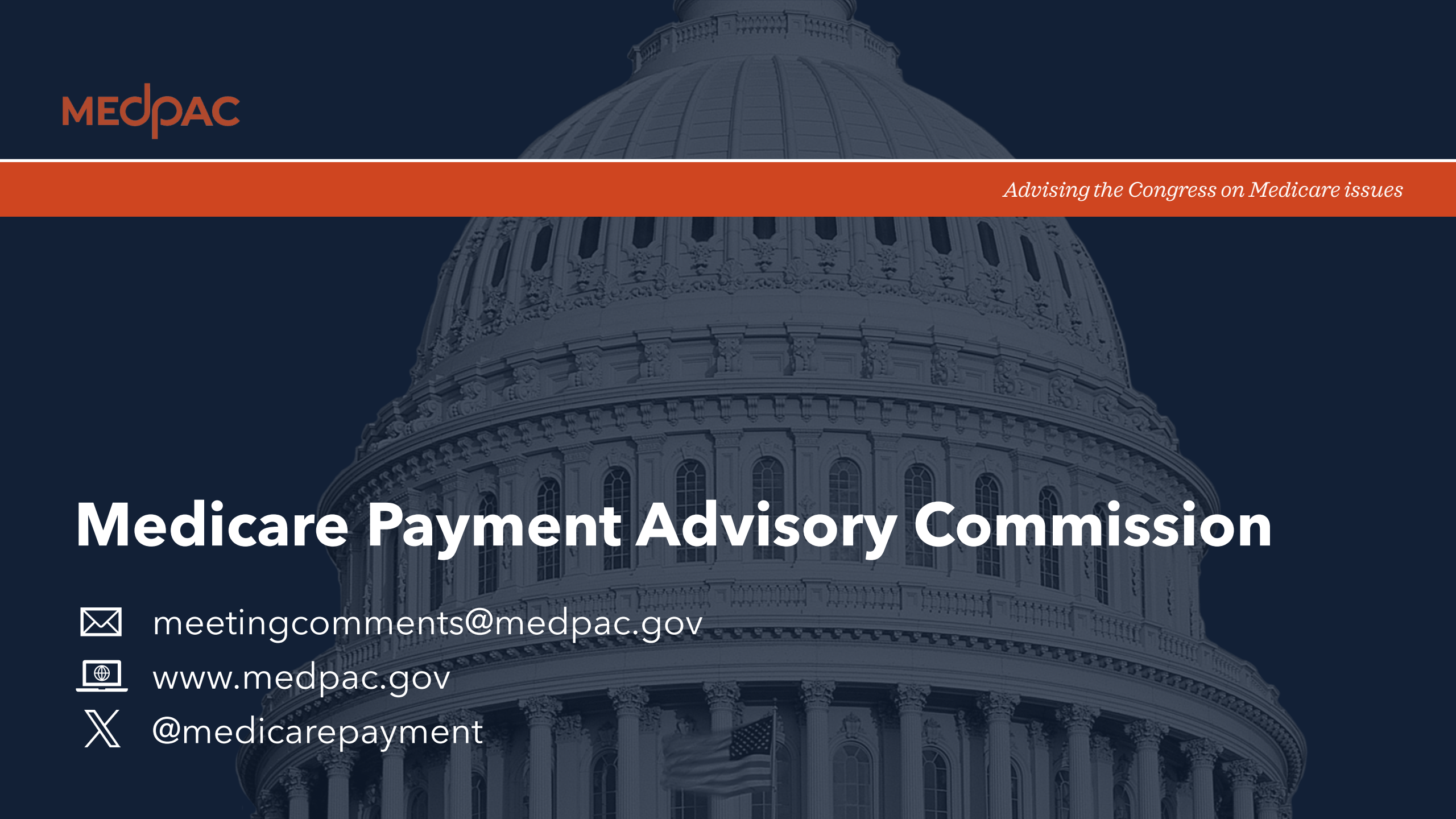
Improve the validity of MA encounter data and diagnoses submitted for risk adjustment

- Despite recent improvements, incomplete MA encounter data continues to be an issue, as was most recently documented in our June 2024 report
- MedPAC has estimated overall increased intensity of diagnosis coding in MA and recommended that the Secretary fully address the effects of coding intensity (March 2016)
- GAO has recommended improving the completeness and validation of MA encounter data (2014 & 2017) and verification of diagnostic codes used to determine the payments to plans (2016)

Sources: MedPAC June 2024 Report, Chapter 3; MedPAC March 2016 Report, Chapter 12; GAO-14-571; GAO-17-223; GAO-16-76.

Discussion

- Questions?
- Ideas for future work?



MEDPAC

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Medicare Payment Advisory Commission

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