



Office of External Affairs

CMS FACT SHEET

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CMS EXPANDS PAYMENT OVERSIGHT EFFORTS TO INCLUDE MEDICAID, SCHIP

Background: Aggressive oversight and new improvement efforts have reduced the number of improper Medicare claims payments by half in one year, from 10.1 percent in 2004 to 5.2 percent in 2005. These successful efforts are built on a comprehensive oversight strategy that includes getting additional, specific information about the accuracy of payments in each part of the Medicare program, and using this information to target oversight initiatives to where they can have the most impact. CMS is expanding key features of this strategy to Medicaid and the State Children's Health Insurance Program (SCHIP) with the implementation of a program to measure improper Medicaid and SCHIP payments at the state and national level.

The Federal share for spending for health care services under Medicaid in 2005 is expected to be more than \$188 billion. In 2003, the Centers for Medicare & Medicaid Services conducted the Payment Accuracy Measure (PAM) pilot project to measure the accuracy of state payments for Medicaid and SCHIP. In October, 2005, CMS issued a final regulation with comment implementing a national program to identify and reduce improper payments in Medicaid and SCHIP. 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 and SCHIP. CMS will then calculate state-specific error rates upon which a national Medicaid and SCHIP error rate can be estimated.

Medicaid and SCHIP Oversight

The Centers for Medicare & Medicaid Services is implementing a national strategy to estimate the amount of improper paid by each of the states. CMS has been proactively testing the methods to estimate improper payments in Medicaid through pilot projects initiated in fiscal year 2002. These projects have led to a national contracting strategy that CMS will implement in 2006.

- In 2006, CMS will review Medicaid fee-for-service component;
- In 2007, CMS will review Medicaid fee-for-service, managed care and beneficiary eligibility; and
- Late in 2007, CMS will calculate a national Medicaid error rate based on the state-specific error rates from 2006.

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Each state Medicaid program will be reviewed once every three years.

The Medicaid improper payment review will include such state-specific information as:

- Claims and expenditures data,
- Medical policies in effect and quarterly medical policy revisions needed to review claims, and
- Verified or updated current provider contact information.

Using this information, CMS will select a statistically valid random sample of claims, each quarter. The average total sample size per state is expected to be 1,000 claims (based on analyses showing a range of 800 to 1,200 claims per state to obtain the required degree of statistical precision). States selected for review also will provide technical assistance as needed to allow the contractor to fully and effectively perform all functions necessary to produce the program error rates..

Based on the results of the analysis, the states will develop and implement corrective action plans to address the source of the payment errors, In addition, CMS will be able to provide more effective guidance to states on specific areas where payment accuracy can be improved, and CMS will help guide the states to implement best practices. Such specific, evidence-based evaluation of payment accuracy has been an important contributor to the substantial reductions in Medicare payment error rates and CMS expects similar savings in Medicaid and SCHIP in the future.

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