Center for Program Integrity

Alec Alexander
Deputy Administrator and Director of the Center for Program Integrity

Health Care Compliance Association's Healthcare Enforcement Compliance Conference

November 6, 2018

Center for Program Integrity (CPI)

Alec Alexander, Deputy Administrator and Center Director
George Mills Jr., Deputy Director
Melanie Combs-Dyer, Acting Deputy Director

- **Created**: Department of Health and Human Services (HHS) Secretary created CPI to align Medicare and Medicaid program integrity activities in March 2010
- **Allocated FTEs**: 492
- **Current Organization**:
  - 8 Groups
  - 24 Divisions, including four field offices
- **Budget**: 20 funding sources totaling $1.3 billion
- **Work**: Serves as CMS's focal point for all national and statewide Medicare and Medicaid program integrity functions and the establishment of an integrated and coordinated national framework for program integrity-related policies and procedures

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CPI - Group Directors

Provider Enrollment and Oversight Group
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Investigations and Audits Group
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Governance Management Group
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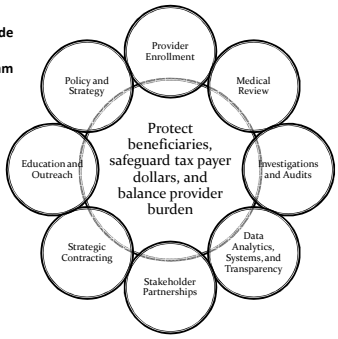
CMS Program Integrity Foundation and Functions

CPI is responsible for national and state-wide Medicare, Medicaid, and Exchanges program integrity functions.



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Impact of Current PI Programs

Administrative Actions

Payment Suspensions	**Enrollment Moratoria**
Revocations	**Medical Review**
Deactivations	**Overpayment Recovery**
Auto-denial Edits	**Law Enforcement Referrals**

Program Integrity Savings

Program	FY 2015 Savings	FY 2016 Savings
Medicare FFS RAC	$237.7 M	$274.0 M
Medicare Secondary Payer	$8.6 B	$8.7 B
Medicare FFS Medical Review	$5.0 B	$6.1 B
Revocation of FFS Providers	$886.2 M	$629.6 M
Fraud Prevention System	$604.7 M	$527.1 M
National Correct Coding Initiative	$877.7 M	$815.2 M
Medicaid RAC	$65.5 M	$49.2 M

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CPI Priorities

CPI's priorities in 2018/2019:

- Invest in data and analytics to support fraud detection and prevention efforts
- Reduce provider burden
- Strengthen collaboration with all our partners
- Enhance Medicaid oversight
- Combat opioid crisis
- Integrate vulnerability management

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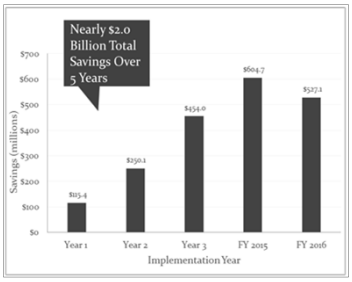
Data Analytics Fraud Prevention System (FPS)

FPS is a state-of-the-art predictive analytics system that is part of CMS's comprehensive Program Integrity strategy.

- Identify leads for early intervention by MAC/UPIC/LE
- Identify bad actors/MCC
- Deny claims not supported by Medicare Policy



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Reducing Burden

- **Simplifying Paperwork**
  - Documentation Requirement Simplification
- **Making Required Paperwork Easier to Find**
  - Provider Documentation Manual
  - Documentation Requirement Look Up Service "Da Vinci"
- **Improving the Audit Process**
  - MAC (TPE)
  - RAC (Enhancements)
  - UPIC (MCC) Escalation-De-Escalation
  - MEDIC (NEW Contract)
  - MPIC (Fraud Schemes)

- **Streamlining Provider Enrollment** (PECOS 2)

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CPI Contractor Roles to Identify and Prevent Fraud

	CMS Medicare Contractors	Purpose
MAC	Medicare Administrative Contractors (Targeted Probe & Educate)	To **prevent future** improper payments (pre-payment) - Targeted Probe & Educate (TPE)
RAC	Medicare FFS Recovery Auditors	To **detect and correct past** improper payments (post-payment)
UPIC	Unified Program Integrity Contractors	To identify **potential fraud/ Improper payments**
MEDIC	Medicare Drug Integrity Contractor	To identify **fraud** and **improper payments Part C & D**
MPIC	Marketplace Program Integrity Contractors	To identify **fraud** in the Marketplace **Exchange**

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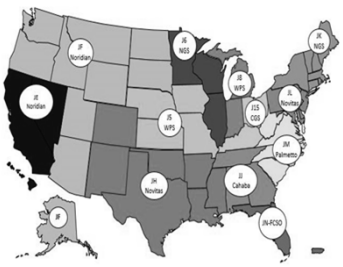
Medicare Administrative Contractors (MACs)

Goal: **Prevent** improper payments

- Targeted Probe and Educate - Three rounds of Prepayment Probe Reviews
- Prior Authorization- Request submitted by provider prior to services beginning
- Pre-Claim review occurs after services start but prior to the final claim being submitted



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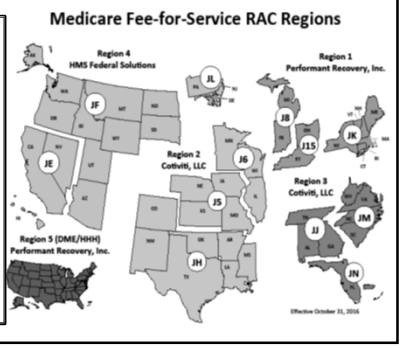
Targeted Probe and Educate (TPE)

The Old Way To Do Medical Review	The New Way To Do Medical Review: Targeted Probe and Educate (TPE)
• MAC can request /review an **unlimited number** of medical records (within their budget) • After reviews are completed, MAC sends an (often **vague**) **denial code** • MAC can keep a topic/provider on review for **years/decades**	• MAC chooses claim types and providers/suppliers based on their data analysis • MAC typically selects **20-40** pre-pay claims per round (for special circumstances, can be fewer or post-pay) • **Educational intervention** is the same, with 1:1 education being offered at the conclusion of the 20-40 claim probe • MAC performs up to 3 rounds of "Probe & Educate"

Recovery Audit Contractors (RACs)

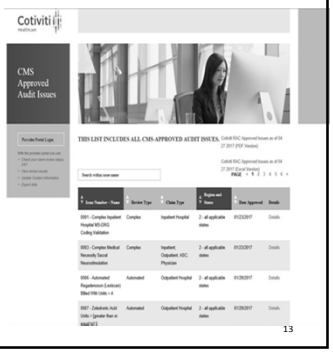
Goal: Find and correct past improper payments

As part of the Recovery Audit Program, RAC auditors conduct post payment review of claims to identify potential underpayments and overpayments in Medicare FFS



RAC Program Enhancements

- RACs must have CMS approval before doing reviews
- Each RAC is required to post all CMS-approved review topics, for their respective region, to their website to notify providers



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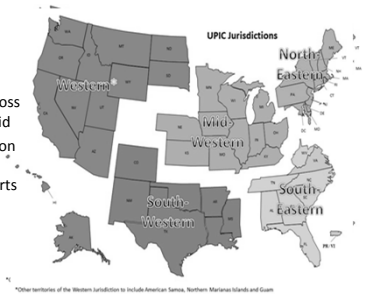
Unified Program Integrity Contractors (UPICs)

Goal: To identify fraud and improper payments:

- Integrate audit and investigation program integrity functions across Medicare and Medicaid
- Strengthen coordination of Federal and State program integrity efforts (MCC)
- Refer fraud to law enforcement



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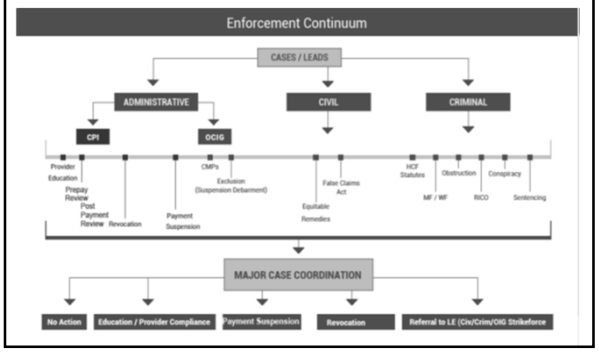
Strengthen Collaboration with All Partners



Major Case Coordination

Implemented	April 2018
Stakeholders	OIG, DOJ, UPICS AND ALL COMPONENTS OF CPI
Goal	"RIGHT TOOL, RIGHT CASE, RIGHT TIME, AND RIGHT ORDER"
MCC Stats as of 10/5/18	**726 Cases Reviewed** • LE referrals (354) • Revocations (167) • Payment Suspensions (225) • TPE/ Education (18)
Success Story	LESS THAN 45 DAYS FROM MCC MEETING TO INDICTMENT • 5/16 MCC MEETING • 6/26 DATE OF INDICTMENT

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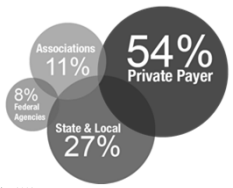
Healthcare Fraud Prevention Partnership (HFPP)

Voluntary, public-private partnership between the federal government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector

Make-up of the Partnership



112 Partners*

9 Federal Agencies
12 Associations
30 State/Local Partners
61 Private

* As of October 2018

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CPI Program Integrity Efforts for the New Medicare Card Rollout

CMS is using several strategies to prevent fraud related to the use of Medicare Beneficiary Identifiers (MBIs) and the new Medicare card rollout, including:

- Comprehensively verifying beneficiaries' addresses*
- Monitoring MBI billing
- Using data from beneficiary complaints and reports of potential identify theft
- Engaging the United States Postal Service (USPS)*

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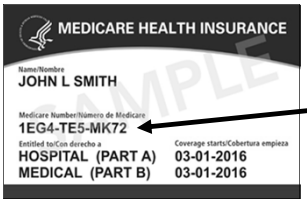
New Unique Medicare Number



New Medicare Number

- New Non-Intelligent Unique Identifier
- 11 bytes

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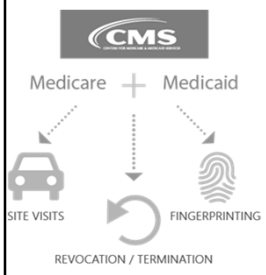
Provider Enrollment & Oversight

The Center for Program Integrity manages Medicare and Medicaid enrollment:



Less Burden for States and Providers - States can screen Medicaid providers using our Medicare enrollment data (site visits, revalidation, application fees, fingerprinting)

Greater Support for States - Training on systems, best practice screening, clearer sub-regulatory guidance and direct data matching with Medicare

Increase Guidance - Medicaid Provider Enrollment Compendium (MPEC)is similar to the Medicare Program Integrity Manual

Streamline Enrollment - PECOS 2.0 works to consolidate Medicare & Medicaid Screening and Enrollment

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Medicaid PI Strategy

Improve Accountability in Medicaid Programs

- Conduct PI-focused audits of state improper claiming of the federal match
- Conduct PI-focused audits of Medicaid managed care, including Medical Loss Ratio (MLR)
- Conduct new audits of state beneficiary eligibility determinations
- Adding PI performance measures to the new Medicaid scorecard
- Collaborate with states to ensure compliance with the Medicaid managed care final rule and implementation of PI safeguards
- Optimize PI use of T-MSIS data, conduct data analytics pilots with states, and improve state access to data sources that are useful for PI
- Expand state Medicaid data compare service to additional states and implement criminal screening of Medicaid-only providers pilot for states

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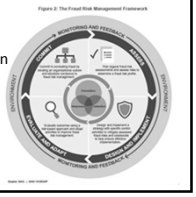
Vulnerability Management

- Enterprise risk management that fits into the **GAO Fraud Risk** framework
  - Increase CPI efforts to evaluate vulnerabilities across programs and components
  - Prioritize and mitigate the highest risk vulnerabilities
  - Promote a risk management culture with an increased level of engagement and collaboration by utilizing the PI Board



Questions?