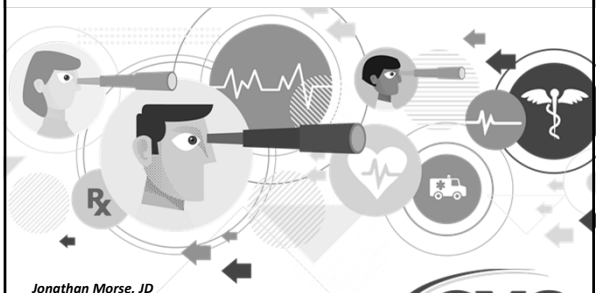
HCCA Managed Care Compliance Conference



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Deputy Director
CMS Center for Program Integrity

New Administration CMS Strategic Goals

CPI's program integrity objectives flow from CMS' strategic goals:

Balance program integrity initiatives aimed to protect beneficiaries and the Trust Fund while minimizing provider burden	**Empower patients and doctors to make decisions about their health care**	**Usher in a new era of state flexibility and local leadership**	Integrate, analyze, and share data to inform decision making
Share best practices with states and increase flexibility in program integrity approaches while improving accountability in Medicaid programs	**Support innovative approaches to improve quality, accessibility, and affordability**	**Improve the CMS customer experience**	Clarify and simplify program requirements through collaboration, transparency, outreach, and education

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Managed Care Program Integrity (PI) Review and Audits

CPI Medicaid Managed Care PI Reviews

CPI conducts **Program Integrity Reviews** which assess State PI efforts

Over the last few years **managed care** has been a **focus** of these reviews.

These managed care "focused" **reviews assess**:

- State oversight of plans
- Plan PI activities

2018 PI Managed Care Review Activity

In 2018 CPI will be conducting **6 Medicaid managed care focused reviews**

States being reviewed: **GA, ID, IL, KS, OR, WA**

CPI does not review every plan in a State but selects a **sample of 2-4 plans**

Draft reports are shared with States to **allow for review and comment**

Reports contain **findings** and **recommendations**

States are required to submit **corrective actions** related to any findings

Final reports can be found on the CMS website: https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html

Common Findings/Vulnerabilities from Managed Care PI Reviews

- Contracts in many states **do not require reporting** for-cause terminations and checks of federal databases for excluded parties.
- Contracts do not require MCEs to have SIUs dedicated specifically to **fraud, waste and abuse investigations.**
- Many States do not conduct onsite reviews of MCEs. **Compliance is monitored** only by a series of **reports submitted** to the State by the MCE.
- Contracts do not require MCEs to report cases of **suspected fraud, waste and abuse.**
- **Low numbers of investigations** and recoveries by MCEs.
- Many States **do not** contractually **require** that identified and collected **overpayments be reported** to the State.
- States that do receive encounter data from MCEs do not conduct data analytics necessary to identify **aberrant billing practices** of MCE providers.

Medicaid Managed Care Audits

CPI conducted

- a limited number of Medicaid managed care audits
- Audits have primarily focused on specific network providers
- Network provider audits have resulted in identifying simple overpayments

Summary of Medicaid Managed Care Plan Audit

Audit identified both **financial** and **clinical** findings

- Monthly reconciliations not performed or inaccurate, causing plan to pay claims and submit encounters for members not included on their member roster
- Medical loss ratio fell below 85 percent (contractually required level)
- Medical expenses overstated because of unallowable claims paid
- Lack of documentation regarding member care and authorizations
- Lack of primary care physician (PCP) oversight and coordination by the MCE, resulting in well care visits not being received
- Failure to meet prompt payment requirements

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Medicare Advantage Risk Adjustment Data Validation (RADV)

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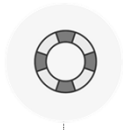
Risk Adjustment Data Validation (RADV)

Medicare Advantage Organizations **submit diagnoses** to CMS to support their enrollees risk adjusted payments.

RADV **validates that diagnoses** submitted for payment are supported by medical record documentation.



RADV **recovers improper payments** based on diagnoses submitted to CMS that are not supported by medical record documentation.

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RADV Goals

Identify all discrepancies by comparing risk adjustment diagnosis data submitted by MA organizations for payment against what MA organizations provided during medical record review.

Compute an improper payment estimate for audited MA organizations.

Recover the improper payment in compliance with federal statute (IPIA 2002, as amended by IPERA 2010, as amended by IPERIA 2013).

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CMS Data Analytics and Investigations Updates

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Fraud Prevention System (FPS)

State-of-the-art predictive analytic technology required under the *Small Business Jobs Act of 2010.*

Since June 30, 2011, the FPS has run **predictive algorithms and other analytics nationwide**; reviews all Medicare FFS claims.

WHAT IS FPS ?

CMS is systematically applying **advanced analytics** against Medicare FFS pre-paid claims on a streaming, nationwide basis for **program integrity** purposes.

Analyzes 4.5 million claims each day using a variety of analytic algorithms to generate alerts and identify suspicious patterns for further investigation.

FPS is one way PI Contractors get their **leads**. FPS 2.0 **launched** in March 2017.

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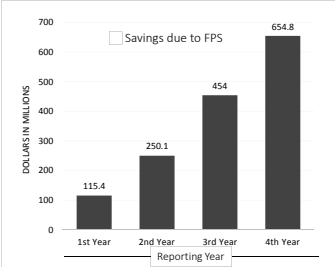
Fraud Prevention System (FPS)



$1.5 Billion total savings over 4 years

CY 2015 ROI $11.5 to $1

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Unified Program Integrity Contractor (UPIC)

About UPIC:

- **Coordinates provider investigations across Medicare and Medicaid;**
- **Improves collaboration with States by providing a mutually beneficial service; and**
- **Increases contractor accountability through coordinated oversight**

UPIC AWARDS:

- **MIDWESTERN JURISDICTION** AdvanceMed Corporation
- **NORTHEASTERN JURISDICTION** SafeGuard Services, LLC
- **WESTERN JURISDICTION** Health Integrity, LLC
- **SOUTHEASTERN JURISDICTION** SafeGuard Services, LLC*
- **SOUTHWESTERN JURISDICTION** Health Integrity, LLC

*Currently under protest.

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Investigations and Audits

- CPI develops a risk-based and location-specific targeted investigation/audit approach, which is operationalized by the UPICs
- National investigative priorities (2017): Home Health, Hospice, Laboratory Services
- Provides oversight of CMS program integrity contractors (UPICs and ZPICs for Medicare Parts A and B and National Benefit Integrity Medicare Drug Integrity Contractor [NBI MEDIC] for Medicare Parts C and D)
- Partners across CMS components to provide program integrity oversight of Medicare Advantage and Prescription Drug Plans
- Has approval authority for all Medicare payment suspensions
- Serves as CMS' liaison with law enforcement on investigative activities

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Targeting Potential Fraud & Abuse: No Prior Relationship Data Analysis

"No Prior Relationship" (NPR) signifies a potential scheme in which data analysis suggests that a **physician has not had a clinical interaction** with a Medicare beneficiary.

This is evidenced by **no Part B billing**, even though the physician has ordered/referred the beneficiary for a large amount of Medicare covered services.

NPR can be an **indicator** of the following:

- "Robo" signing of medical documentation
- Potential fraudulent or abusive behavior
- Potential payment of kickbacks
- The Physician's Medicare number and National Provider Identification Number (NPI) have been compromised

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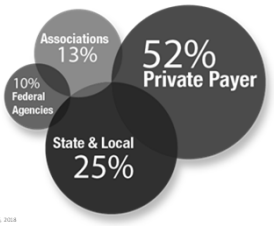
Healthcare Fraud Prevention Partnership

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



91 Partners*

9 Federal Agencies

12 Associations

22 State and Local

47 Private Payers

* As of February 1, 2018

HFPP Mission and Strategies

Mission Statement: *Position the HFPP as a leading body of empowerment for the healthcare industry to reduce fraud, waste and abuse.*

Benefits of HFPP Membership

ENHANCED ANALYTICS

With the use of public and private data – including CMS

COLLABORATION

Partners leverage collective experiences to shape the Partnership and combat healthcare fraud

CONFIDENTIALITY AND SECURITY

No Partner has access to the data of other Partners

EXPAND RESEARCH

Inform HFPP study design and join forces to address emerging trends

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Patients Over Paperwork

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Patients Over Paperwork Project Objectives

Explore provider perception of challenges presented by CMS programs, especially those related to compliance, enrollment, and auditing

Develop recommendations for program and process improvements and enhanced communications with key stakeholders, with a focus on CPI programs and initiatives

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Patients Over Paperwork Project Background

In working to address the **Administrator's goal** to **ease regulatory burden**, the Center for Program Integrity conducted nationwide **provider research** to understand the **current challenges** facing providers when **working with CMS**.

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Patients over Paperwork: Addressing Provider Burden

Guiding Principle: Reduce provider burden while maintaining consistency in process and oversight

Providers are the **heart and soul** of Medicare

The largest overall burden across all providers is **financial pressures** and meeting **insurance requirements**

Currently, there is **hesitancy to engage** CMS due to fears and lack of efficient interactions

"During my visits with clinicians across the country, **I've heard many concerns about the impact burdensome regulations have on their ability to care for patients**," - Seema Verma, Administrator of CMS.

Know:
CMS is **actively improving** processes to **reduce provider burden.**

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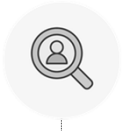
Assessing Provider Burden: Research Methods

Physicians, non-physician practitioners, and administrative staff were **engaged to provide a holistic view** of clinical practice



Blend of three distinct qualitative methods to **compare and contrast input**, enhancing the relevance of findings:

- Triad focus groups: **19 groups**
- Ethnographic interviews: **12 observations**
- Online community: **207 providers**

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Research Findings

Providers perceive a high level of burden because of:

Excessive requirements that…

- do not directly relate to quality care
- take valuable time away from patients
- are perceived to have significant financial impact on their practice

A perceived lack of customer service that allows providers to resolve their problems quickly and easily

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Theme 1: Excessive Requirements

Provider Insight:

- CMS requirements are excessive and take time and resources away from patient care
- It should not be CMS' role to oversee how they practice medicine
- Providers shield themselves with layers of staff to avoid non-care delivery work
- Providers have a fear of CMS audits and don't understand the purpose or processes involved
- Providers' concerns span further than simply interacting with CMS systems. They want more transparency in processes to understand when they have been completed successfully, or may require more input

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What Can CPI Do?

Incorporate providers' input and expertise on the reality of clinical practice to simplify and streamline requirements while continuing to ensure the integrity of our programs

30

Specific Actions to Incorporate Provider Input

1 Streamline Our Documentation Requirements

- Documentation Requirements Simplification (DRS) Project
- Creating a Provider Documentation Manual, where all documentation requirements will be in one place
- Making information available to providers the way they want to receive it (we are currently soliciting feedback through the online provider community regarding preferences around communication methods, features and frequency)

2 Incorporate Provider Input Into Our Decision Making

- Introducing new ways to solicit provider expertise (hosting provider compliance focus groups, provider enrollment conferences, and including providers in testing new processes, interfaces, and materials)
- Strengthening relationships with industry groups, such as AMA, AHA, AAMC, etc.

3 Simplify Our Provider Enrollment Systems & Processes

- Updating Enrollment Processes and System
- Consolidating Medicare and Medicaid Provider enrollment screening
- Developing National Provider Record for Medicare and Medicaid

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Specific Actions to Incorporate Provider Input (Cont'd)

4 Target Our Compliance Efforts

- Targeted Probe and Education (TPE)
- Utilizing risk scoring to inform provider selection for review
- Deprioritizing certain providers for review, such as those providers participating in certain Advanced Alternative Payment Models (APMs) and certain rural providers

5 Reduce Our Audit Burden

- Developing user-friendly information on types of audits and what to expect
- Providing detailed denial reason codes
- Ending routine reviews
- Disclosing proposed Recovery Audit Contractor review topics
- Enhancing provider portals

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Theme 2: Customer Service

Provider Insight:

- The primary goal when it comes to Medicare is timely and appropriate payment, with as little hassle as possible
- Because there is no ongoing relationship, providers have a hard time getting the answers they need; consistency or a single point of contact is important
- Practice administrators complete most compliance and enrollment work for providers. Sometimes, these employees have no training in compliance or CMS processes other than on-the-job experience
- CMS tools, training materials, and systems are difficult to use and understand
- Greater transparency and communication around the rules and processes would be valued by providers and their staff

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What Can CPI Do?

Improve CMS customer service by delivering individualized support and providing clear and consistent messaging through trusted channels

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Specific Actions to Improve Customer Service

1

Reframe Ourselves As a Partner, Not an Adversary

- Build trust that CMS is a resource to support their practice, not to catch them making a mistake so we can take money back
- Streamline points of contacts to provide consistency and accountability of information shared
- Increase engagement with practice administrators across all program areas

2

Improve Our Communications

- Perform a comprehensive review of CPI and contractor communication materials
- Develop plain language resources that meet provider needs and encourages their active involvement
- Provide opportunities for interactive learning to avoid common mistakes
- Develop industry-focused conferences that allow CMS to interact with providers directly

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Specific Actions to Improve Customer Service

3

Work Toward Accountability

- Build trust that CMS is a resource to Develop metrics for customer service to allow for continuous improvement
- Medical review contractor accuracy rates
- Consider a 5 point efficiency program (call backs vs. on hold, system upgrades, regional relationships, website optimization)

4

Develop Strategic Collaborations

- Collaborate with internal stakeholders, State agencies, other government programs, and private sector to unify language around common processes
- Collaborate with professional societies so information has a trusted messenger
- Encourage/ask professional societies to do their own web pages "so, you're about to be audited…" that drive members to our information

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Addressing Provider Burden: What Can CPI Do?

- Incorporate providers' input and expertise on the reality of clinical practice to simplify and streamline requirements, while continuing to ensure the integrity of CMS programs.
- Improve CMS customer service by delivering individualized support and providing clear and consistent messaging through trusted channels

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In Summary

- New CMS Strategic Goals and CPI Objectives
- Managed Care Program Integrity (PI) Reviews
- Medicaid Managed Care Audits
- CMS Investigations and Audits
- Healthcare Fraud Prevention Partnership
- Risk Adjustment Data Validation (RADV)
- Patients Over Paperwork

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Now We Want Your Feedback

What do you want to see from CMS

?

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