

Center for Program Integrity Major Activities

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CMS/CPI Alphabet Soup

- **MACs** – Medicare Administrative Contractors
- **RACs** – Recovery Audit Contractors
- **UPICs** – Unified Program Integrity Contractors
- **SMRC** – Supplemental Medical Review Contractor
- **CERT** – Comprehensive Error Rate Testing Program
- **PERM** – Payment Error Rate Measurement
- **PECOS** – Provider Enrollment, Chain and Ownership System
- **FPS** – Fraud Prevention System

CPI'S STRATEGIC OBJECTIVES

<p>ADDRESS THE FULL SPECTRUM OF FRAUD, WASTE, AND ABUSE</p> 	<p>PROACTIVELY MANAGE PROVIDER SCREENING AND ENROLLMENT</p> 	<p>CONTINUE TO BUILD STATES' CAPACITY TO PROTECT MEDICAID</p> 
<p>EXTEND WORK IN MEDICARE PARTS C AND D, MEDICAID MANAGED CARE AND MARKETPLACE</p> 	<p>PROVIDE GREATER TRANSPARENCY INTO PROGRAM INTEGRITY ISSUES</p> 	

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 <h2 style="margin: 0;">ADDRESS THE FULL SPECTRUM OF FRAUD, WASTE, AND ABUSE</h2>	<ul style="list-style-type: none">• INTEGRITY CONTINUUM• MEDICAL REVIEW• DOCUMENTATION IMPROVEMENT PROJECT• TARGETED PROBE AND EDUCATE• FRAUD PREVENTION SYSTEM• RECOVERY AUDIT CONTRACTORS• UNIFIED PROGRAM INTEGRITY CONTRACTORS
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PROGRAM INTEGRITY 2.0

INTEGRITY CONTINUUM

- Individual provider risk
- Interventions that fit the risk
- Transparent billing, payment and compliance activity
- Best use of contractors (gain efficiencies/improve outcomes)
- PI early in program development and mature overtime
- Reduced audit burden for providers with compliant billing

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DOCUMENTATION REQUIREMENTS SIMPLIFICATION	
<p>GOAL:</p> <p>MAKE DOCUMENTATION REQUIREMENTS LESS BURDENSOME</p>	<p>CMS is leading an agency-wide documentation requirements simplification initiative to:</p> <ul style="list-style-type: none"> • Identify improvements needed in documentation requirements for all Medicare FFS • Identify statutes/regulations needing revision to decrease administrative denials • Work with external stakeholders to identify the greatest pain points • The first areas of focus are Proof of Delivery and some signature issues (initials)
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FRAUD PREVENTION SYSTEM (FPS)	
<p>GOAL:</p> <p>USING PREDICTIVE ANALYTICS APPROACHES TO FIGHT FRAUD, WASTE AND ABUSE IN THE MEDICARE FEE-FOR-SERVICE PROGRAM</p>	<ul style="list-style-type: none"> • Since inception (June 2011), CMS has systematically applied advanced analytics against 4.5 million (daily) Medicare FFS pre-paid claims on a nationwide basis. • For 2013 to 2015 FPS returned more than \$1 billion in savings identified from high risk providers • CY2015 results hold a first-ever national ROI of \$11.60 for each federal dollar spent on this game changing program integrity effort
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MEDICARE FEE-FOR-SERVICE RAC UPDATE

GOAL:

IDENTIFY AND COLLECT OVERPAYMENTS FROM PROVIDERS

- In FY 2016 the FFS Recovery Audit Contractors (RACs) corrected \$473.9 million in improper payments
 - \$404.4 million in overpayments
 - \$69.4 million in underpayments
- Over \$10 billion in program corrections since 2009
- CMS approves all audit areas prior to FFS RAC review
- CMS implemented program enhancements based on provider feedback:
 - Timeframe for medical record reviews reduced to 30 days
 - 30 day waiting period before sending the claim for adjustment to allow for discussion
 - Confirm receipt of discussion request or other correspondence within three days
 - Broaden review topics to all provider types and required review on CMS referrals
 - Revised medical record request limits for institutional providers

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MEDICARE FEE-FOR-SERVICE RAC UPDATE

On October 31, 2016, CMS awarded the next round of Medicare Fee-for-Service Recovery Audit Contractor (RAC) contracts to:

• **Performant Recovery, Inc.** (Regions 1 and 5); **Cotiviti, LLC** (Regions 2 and 3); and **HMS Federal Solutions** (Region 4).

• The RACs in Regions 1-4 will perform postpayment review to identify and correct Medicare claims that contain improper payments (overpayments or underpayments) that were made under Part A and Part B, for all provider types other than Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Home Health/Hospice.

• The Region 5 RAC will be dedicated to the postpayment review of DMEPOS and Home Health/Hospice claims nationally. These awards continue the implementation of many of the Recovery Audit Program enhancements designed to reduce provider burden, enhance program oversight, and increase transparency in the program.

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TARGETED PROBE AND EDUCATE

GOAL:

REDUCE IMPROPER PAYMENTS

REDUCE APPEALS

REDUCE PROVIDER BURDEN

- What?
 - The MAC chooses claim types and providers/suppliers based upon their data analysis
 - 20-40 claims per Probe Round
 - 1:1 Education, Intra-Probe and Post-Probe
 - Up to 3 Rounds
 - Providers who improve can be suspended from review
 - Providers who fail are referred to CMS for further action (e.g., RAC review, extrapolation, etc.)
- When?
 - Pilots began Sept 2016
 - National Expansion Fall 2017
- Preliminary findings:
 - 42% reduction in denials
 - 65% reduction in appeals
 - 22 provider types to date in Parts A & B
 - Almost 100% acceptance of 1:1 education

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IMPLEMENTING UNIFIED PROGRAM INTEGRITY CONTRACTOR

GOAL:

- **COORDINATE PROVIDER INVESTIGATION ACROSS MEDICARE AND MEDICAID;**
- **IMPROVE COLLABORATION WITH STATES BY PROVIDING A MUTUALLY BENEFICIAL SERVICE; AND**
- **INCREASED CONTRACTOR ACCOUNTABILITY THROUGH COORDINATED OVERSIGHT**

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UNIFIED PROGRAM INTEGRITY CONTRACTOR

The UPIC consolidates the Medicare and Medicaid program integrity functions currently performed by the Zone Program Integrity Contractors (ZPICs):

- including the Medicare-Medicaid Data Match (Medi-Medi) program,
- and the Medicaid Integrity Contractors (MICs)

Currently, CMS has contractors assigned to combat and prevent fraud, waste, and abuse in either the Medicare program or the Medicaid program. The UPIC seeks to merge these separate contracting functions:

- into a single contractor,
- in a geographic area,
- with responsibility to conduct program integrity audit and investigation work across Medicare and Medicaid operations

The UPIC IDIQ provides cms with a flexible contracting vehicle to address the complex landscape of program integrity

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UNIFIED PROGRAM INTEGRITY CONTRACTOR

MAJOR UPIC PROCUREMENT MILESTONES

May 2016 – IDIQ Awarded

May 2016 – 1st UPIC Task Order Awarded

- Midwest Jurisdiction formerly ZPIC Zone 3 & MIC Regions 5 & 7

October 2016 – 2nd UPIC Task Order Awarded

- Northeast Jurisdiction formerly Northeast Program Safeguard Contractors & MIC Regions 1 & 2

February 2017 – 3rd UPIC Task Order Awarded (currently under protest)

- Western Jurisdiction formerly ZPIC Zone 4 & MIC Regions 3 & 4 and 6 & 8

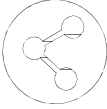
August 2017 – 4th UPIC Task Order Awarded (currently under protest)

- Southeastern Jurisdiction formerly ZPIC Zones 5 & 7 and MIC Regions 3 & 4

End of FY 2017

- Anticipate Award of 5th UPIC Task Order–Southwestern Jurisdiction
- Anticipate Re-Award of Western Jurisdiction

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 PROACTIVELY MANAGE PROVIDER SCREENING AND ENROLLMENT	<ul style="list-style-type: none">• PROVIDER ENROLLMENT• PECOS <p>15</p>
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PROVIDER ENROLLMENT	
GOAL: GATEWAY TO THE MEDICARE, MEDICAID AND OTHER CMS PROGRAMS	<ul style="list-style-type: none">• The National Plan & Provider Enumeration System (NPPES) and the Provider Enrollment, Chain and Ownership System (PECOS) serve as the systems of record for National Provider Identifier (NPI) and provider enrollment information• Provider enrollment also supports claims payment, fraud prevention programs, and law enforcement through the sharing of data <p>21</p>

<p>Medicare Enrollment Checks</p>	<ul style="list-style-type: none">Identity<ul style="list-style-type: none">• Name and NPI• Date of birth and/or death• TIN – SSN, EIN, ITINCredentials<ul style="list-style-type: none">• License and Certification• Survey & Certifications• Accreditation and DEA LicensesOperations<ul style="list-style-type: none">• Survey & Certifications• Banking Information• Practice LocationAssociations and Relationships<ul style="list-style-type: none">• Reassignments• Ownership and Business Structure• Managing ControlsCriminal and Adverse Actions<ul style="list-style-type: none">• Federal Exclusions• Fingerprint and FBI Check• Criminal BackgroundSpecial Processing Requirements<ul style="list-style-type: none">• Surety Bond• HHA and IDTF Operational Requirements• State & Local Specific Regulatory Requirements <p>17</p>
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PECOS 2.0

GOAL:

REDESIGN OF THE CURRENT PECOS SYSTEM THAT CONTROLS ENROLLMENT FOR ALL MEDICARE PROVIDERS AND SUPPLIERS


- Platform for Enrollment
- Streamlined Interface
- Modern APIs and Automation
- Increase agency and industry interoperability

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PECOS 2.0

- Support increased alignment between Medicare and Medicaid, and enhanced Part C and D oversight
- Support agency program integrity objectives through standardized processes, and allowing greater ability leverage enrollment data and verification controls
- Change workflow for users from complex non-intuitive process to simplified compartmentalized functions
- Extensive API hub allowing other systems to read, create and update records systematically in PECOS

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 <p>CONTINUE TO BUILD STATES' CAPACITY TO PROTECT MEDICAID</p>	<ul style="list-style-type: none"> • MEDICAID PROVIDER ENROLLMENT • PROGRAM INTEGRITY REVIEW AND PERM ASSESSMENT CYCLE SYNCHRONIZATION • STATE MEDICAID AGENCY ACCESS TO MEDICARE PROGRAM INTEGRITY DATA
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<p>MEDICAID PROVIDER SCREENING AND ENROLLMENT GUIDANCE</p>	
<p>GOAL:</p> <p>IMPROVE STATE PROVIDER ENROLLMENT PROCESSES AND FOCUS ON MEDICAID PROVIDER ENROLLMENT AS A PROGRAM INTEGRITY PREVENTION TOOL</p>	<p>Over the past year, CMS has:</p> <ul style="list-style-type: none"> • Released the Medicaid Provider Enrollment Compendium (MPEC) in March 2016. • Launched a data compare service to help states determine if: <ul style="list-style-type: none"> • Medicare screening can be relied upon in lieu of Medicaid screening • Any Medicaid providers “flag” when compared against a variety of data sources (OIE/LEIE, Medicare revocations, etc.) • Completed or planned 16 site visits with states to provide process and organizational guidance to achieve ACA provider screening and enrollment compliance • Aligned revalidation deadlines between Medicare and Medicaid (deadline for revalidation is September 25, 2016) • Established a dedicated CMS point of contact for provider screening and enrollment questions for each state

MEDICAID PROVIDER SCREENING AND ENROLLMENT – INFORMATION SHARING	
<p>Continued to provide data to states on:</p> <ul style="list-style-type: none"> • Medicare provider file (Provider Enrollment, Chain and Ownership System (PECOS) “extract” data) • LEIE data (CMS MED file) • Medicare “for cause” revocations • State “for cause” Terminations • Coming soon: Death Master File data • Increased offerings on PECOS training to state users three times per year • Developed database for sharing information to all States about providers that each State has terminated from its Medicaid program, or that CMS has revoked from the Medicare program 	<p>Operationalizing ACA Fingerprint-based criminal background check (FCBC) for high-risk providers:</p> <ul style="list-style-type: none"> • Held a webinar for state Medicaid agencies in April to provide technical guidance on operationalizing the FCBC requirement • Issued FCBC compliance plan approval letters to 40 state Medicaid agencies

COMPLIANCE STRATEGIES FOR PERM	
PERM AND STATE PI REVIEWS	<ul style="list-style-type: none"> • CPI is amending state program integrity to align with the PERM review cycle to the greatest extent possible. • State program integrity reviews will include an assessment of states’ implementation of PERM corrective action plans. In FY 2016, this work will encompass reviewing CAPs submitted by the cycle 2 PERM state.
INTEGRATED COMPLIANCE APPROACH	<ul style="list-style-type: none"> • Communication strategy with state Medicaid agencies to target improper payment rate drivers. • Aligning state program integrity reviews with off cycle PERM beginning in 2016. • Conducting outreach to state Medicaid agencies during off-cycle PERM time frames to follow up with corrective action plans regarding provider enrollment.
GUIDANCE	<ul style="list-style-type: none"> • CMS is providing guidance to state Medicaid agencies to rely on Medicare’s provider enrollment screening to help prevent PERM-related enrollment errors. • Providing ongoing outreach and education to state Medicaid agencies on Medicaid enrollment and screening Federal requirements. • National best practice calls to facilitate idea sharing and lessons learned among state Medicaid agencies to decrease improper payments.

 <p>EXTEND WORK IN PARTS C AND D, MEDICAID MANAGED CARE AND MARKETPLACE</p>	<ul style="list-style-type: none">• MEDICAID MANAGED CARE PROGRAM INTEGRITY• MARKETPLACE PROGRAM INTEGRITY <p>30</p>
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<p>MARKETPLACE PROGRAM INTEGRITY</p>	
<p>GOAL:</p> <p>PROTECT CONSUMERS ENROLLED IN THE MARKETPLACES AND SAFEGUARD TAXPAYER DOLLARS</p>	<ul style="list-style-type: none">• CMS reviews complaints and allegations of fraud and abuse from consumer calls to the Marketplace call center and from issuers, law enforcement and states.• CMS shares information with federal and state partners (e.g. OIG, DOIs) and the private sector through the Healthcare Fraud Prevention Partnership.• We are proactively identifying issues through analytics and sharing information with health plans.• We are identifying new schemes and vulnerabilities and recommending administrative actions to stop bad actors and protect consumers. <p>26</p>

ELIGIBILITY AND ENROLLMENT PI TEAM

- CMS launched a Special Enrollment Periods (SEP) verification process for consumers who enroll in Marketplace coverage through the Federal Marketplace.
- Beginning in March 2016, consumers who applied for Marketplace coverage were required to acknowledge that they might be asked to provide documentation to verify eligibility for a special enrollment period.
- Beginning June 18, all consumers who qualify for one of the five SEPs will be notified on their eligibility results page that they are required to submit documents to prove their eligibility.
- CMS is modeling the process after approaches used by the Internal Revenue Service, and we are reviewing documents to ensure consumers qualify for an SEP.
- Consumers who do not respond, or are determined to be ineligible may lose their coverage.

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INSURANCE AGENT MISCONDUCT

- The majority of fraud complaints CMS receives from consumers are about **alleged misconduct by insurance agents who have the incentive to receive commissions from Marketplace plans.**
- Enrollment without consent (identity theft) for agent's financial gain.
 - Impact for consumer: Tax liability for Advanced Premium Tax Credit (APTC).
- Changes to application or coverage without consumer's consent such as changes to contact information so the insurance agent gets notices, and changes to income to make an individual eligible for 100% APTC.
 - Impact for consumer: Tax liability for APTC; loss of coverage.
- Steering consumers to the Marketplace from Medicaid or Medicare to get a commission for Marketplace coverage.
 - Impact for consumer: declining Medicare can result in late enrollment penalties, Medicaid can cause changes to access.

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OVERSIGHT RESPONSIBILITIES

- CMS requires agents to register and sign agreements with **the FFM** to receive commissions for enrollments in the Marketplace.
 - CMS requires agents to complete Marketplace training.
 - Agreements have specific security and privacy standards for using consumer personally-identifiable information.
 - CMS can terminate or suspend an agent's agreement with Marketplace, and refer to state DOI for any appropriate license action and to law enforcement.
- Health plans have oversight responsibilities of agents as downstream entities in the Marketplace, like Medicare Part C and Part D.
 - Verify agents' license and compliance with other state laws.
 - Health plans are also required to verify that agents are registered with CMS.


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INAPPROPRIATE STEERING

- Recent reports from health plans of alleged collusion between a health care provider and someone assisting consumers (agent or patient recruiter) to steer people to the Marketplace from Medicare and/or Medicaid for the provider's financial gain.
- These situations typically include one or more of these elements:
 - Taking advantage of vulnerable consumers (e.g., homeless, recently released from incarceration).
 - Billing for service not rendered or excessive out-of-network services.
 - Third party payments of premiums.
- CMS issued a request for information (RFI) for public comment on providers steering patients to the Marketplace, and comments were due September 22, 2016.

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PARTS C & D RAC UPDATE	
GOAL:	
PROCURE A RAC FOR THE MEDICARE PART C AND PART D PROGRAMS	<ul style="list-style-type: none">• Development of the Acquisition Strategy is in process• Development of Statement of Work (SOW) underway• Discussion on possible contract vehicles for RAC
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PROVIDE GREATER TRANSPARENCY INTO PROGRAM INTEGRITY ISSUES	<ul style="list-style-type: none">• HEALTHCARE FRAUD PREVENTION PARTNERSHIP (HFPP)• RETURN ON INVESTMENT (ROI)
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HEALTHCARE FRAUD PREVENTION PARTNERSHIP

GOAL:

DETECTING AND PREVENTING HEALTHCARE FRAUD THROUGH DATA AND INFORMATION SHARING WITH A PUBLIC-PRIVATE PARTNERSHIP

- As of August 2016, the partnership has reported \$294 million in shared savings and recoveries
- One Billion Dollar Campaign initiative
- HFPP Opioids White Paper
- Partnership continues to increase

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HFPP OPIOIDS WHITE PAPER

PROJECT GOALS

To develop a HFPP-branded White Paper that identifies best practices that payers can take to effectively address and minimize current and future opioid abuse and inappropriate payments, while ensuring access to medically necessary therapies

To gain Partner commitment to socialize and implement recommendations within their own organizations

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HFPP - MORE THAN 65% COVERED LIVES REPRESENTED

- The HFPP began in 2012 with 20 members
- Today, the partnership is made up of 82 members, including federal and state agencies, private payers, and anti-fraud, waste, and abuse associations

The HFPP represents 261,994,220 covered lives in the U.S., equating to 65% of U.S. covered lives

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IMPACT OF CURRENT PI PROGRAMS

ADMINISTRATIVE ACTIONS:
Program integrity savings

CMS deactivated 543,163 providers and suppliers and revoked 34,888 providers and suppliers since March 2011 ⁴	About \$2.4 billion was or will be prevented in payment to the revoked providers since 2011	CMS saved >\$25 billion through recoveries and prepayment denials since 2011 ⁵
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⁴ Deactivated providers have their billing privileges stopped; however, their billing privileges can be restored upon the submission and approval of an updated enrollment application. Revoked providers have their billing privileges terminated and are barred from re-entering the Medicare program for a period of one to three years, depending on the severity of the revocation.
⁵ Through Medicare Administrative Contractors and Recovery Audit Contractors in Medicare FFS

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QUESTIONS

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