Center for Program Integrity

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

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Center for Program Integrity (CPI)

Alec Alexander, Deputy Administrator and Center Director
Jonathan Morse, Deputy Director
George Mills Jr., 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**: 472
- **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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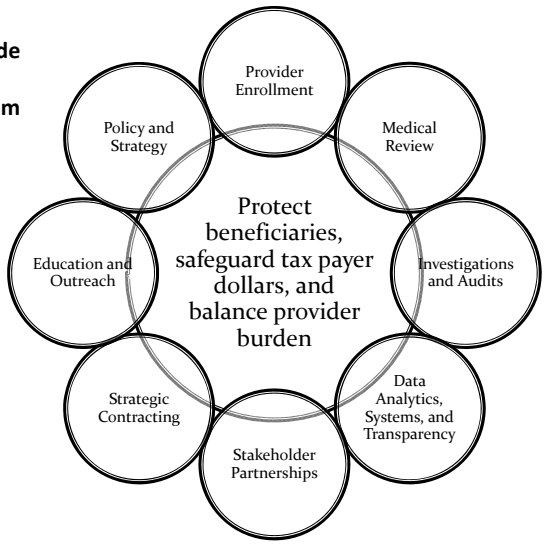
CMS Program Integrity Foundation and Functions

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



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CPI Priorities

CPI's priorities in 2018:

- Invest in data and analytics to support fraud detection and prevention efforts
- Reduce burdensome documentation requirements for providers
- Strengthen communication and collaboration with all our partners

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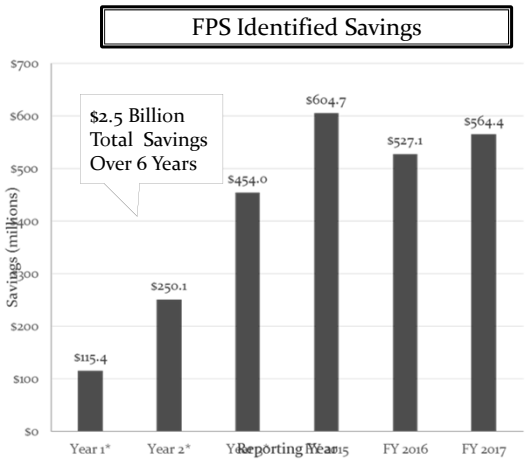
Center for Program Integrity (CPI)
Group Director Contact Information

Provider Enrollment and Oversight Group Zabeen Chong, Director Zabeen.Chong@cms.hhs.gov	**Provider Compliance Group** Melanie Combs-Dyer, Director Melanie.Combs-Dyer@cms.hhs.gov
Investigations and Audits Group Mark Majestic, Director Mark.Majestic@cms.hhs.gov	**Data Sharing and Partnership Group** Merri-Ellen James, Director Merri-Ellen.James@cms.hhs.gov
Executive Support Group Lisa Jarvis-Durham, Director	**Contract Management Group** Craig Gillespie, Director
Data Analytics and Systems Group Raymond Wedgeworth, Director	**Governance Management Group** Mary Greene, M.D., Director

Fraud Prevention System (FPS)

FPS is the 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
- Identify bad actors
- Deny claims not supported by Medicare Policy



*Years 1, 2, and 3 were determined by statutory mandate. Year 1 covered July 1, 2011 – June 30, 2012. Year 2 covered Oct 1, 2012 – Sep 30. 2013. Year 3 covered Jan 1, 2014 – Dec 31, 2014.

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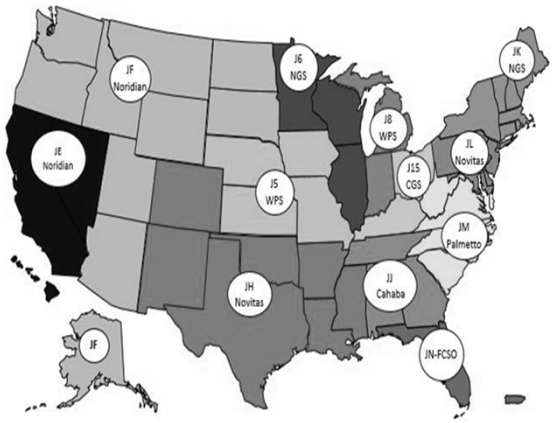
Medicare Administrative Contractors (MACs)

Goal: **Prevent** improper payments

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



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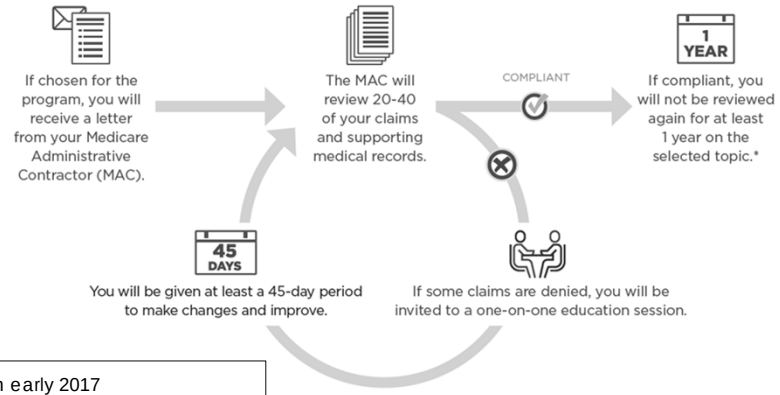
Targeted Probe & Educate



- Pilot began early 2017
- Nationwide began 10/2017
- Has been well received by Provider community.
- For Provider Questions write to:

ReducingProviderBurden@cms.hhs.gov

**MACs may conduct additional review if significant changes in provider billing are detected.*

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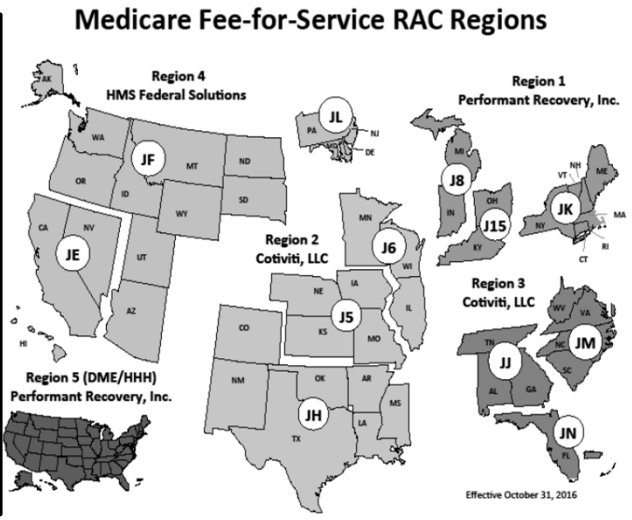
Recovery Audit Contractors (RACs)

Goal: Find and correct past improper payments

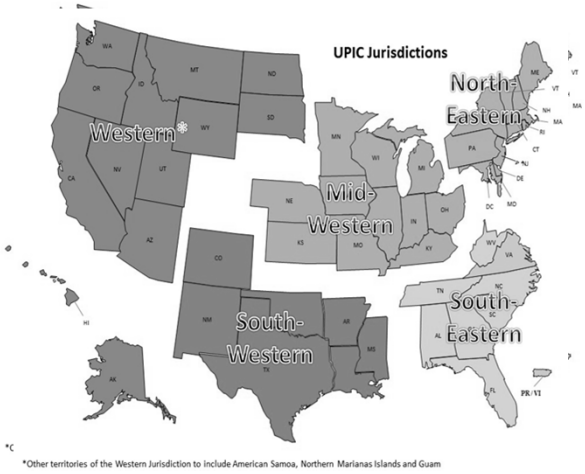
As part of the Recovery Audit Program, RAC auditors conduct post payment review of claims to identify potential underpayments and overpayments in Medicare FFS



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
- Refer fraud to law enforcement



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Medicare Drug Integrity Contractor (MEDIC)

Goal: Identify cases of suspected fraud, develop them thoroughly and in a timely manner, and take immediate action to ensure that Medicare Trust Fund monies are not paid inappropriately.

- Investigates Medicare Parts C and D prescriber, pharmacy and beneficiary suspected fraud, waste and/or abuse
- Develops investigations thoroughly and in a timely manner
- Recommends appropriate administrative actions to CMS
- Refers cases to HHS/OIG and other law enforcement entities if appropriate.

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Roles of the Various Medicare Improper Payment Review Entities

		Volume of Claims	Purpose of Review
MAC	Medicare Administrative Contractors (Targeted Probe & Educate)	20-40 cases x 3 rounds (60-120 cases)	To **prevent future** improper payments (pre-payment) - Targeted Probe & Educate (TPE)
RAC	Medicare FFS Recovery Auditors	Variable upon number of claims with improper payments for this provider	To **detect and correct past** improper payments (post-payment)
UPIC	Unified Program Integrity Contractors	Variable upon number of potentially fraudulent claims submitted by provider	To identify **potential fraud/ Improper payments**
MEDIC	Medicare Drug Integrity Contractor	Varies on the focus of the MEDIC	To identify **fraud** and **improper payments Part C & D**

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