CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR PROGRAM INTEGRITY

Program Integrity and COVID-19

Medical Education Program Event

September 30, 2020

Kathleen McGinty

Acting Deputy Director

CMS Center for Program Integrity,
Investigations and Audits Group

Center for Program Integrity

Purpose:	The Department of Health and Human Services (HHS) Secretary created CPI to align Medicare, Medicaid, and Exchanges program integrity activities in March 2010.
Mission:	Hold the healthcare system accountable, protect beneficiaries from harm and safeguard taxpayer dollars while minimizing unnecessary provider burden
Budget:	FY 2020: 14 funding sources totaling $1 billion
Workforce:	479 Employees onboard - 8 Groups - 27 Divisions including 4 field offices & Private Plans Team

CPI Functions

Promotes the integrity of the Medicare and Medicaid programs and CHIP through provider/contractor audits and policy reviews, identification and monitoring of program vulnerabilities, and providing support and assistance to States

Recommends modifications to programs, policies and operations to deter, reduce, and eliminate fraud, waste and abuse

Collaborated with key stakeholders relating to program integrity (i.e., U.S. Department of Justice, DHHS Office of Inspector General, State law enforcement agencies, other Federal entities) for combating fraud and abuse, as well as taking action against those that participate in fraudulent or unlawful activities

Develops and implements comprehensive strategic plans, objectives and measures to carry out CMS' Medicare, Medicaid and CHIP program integrity mission and goals, and ensure program vulnerabilities are identified and resolved

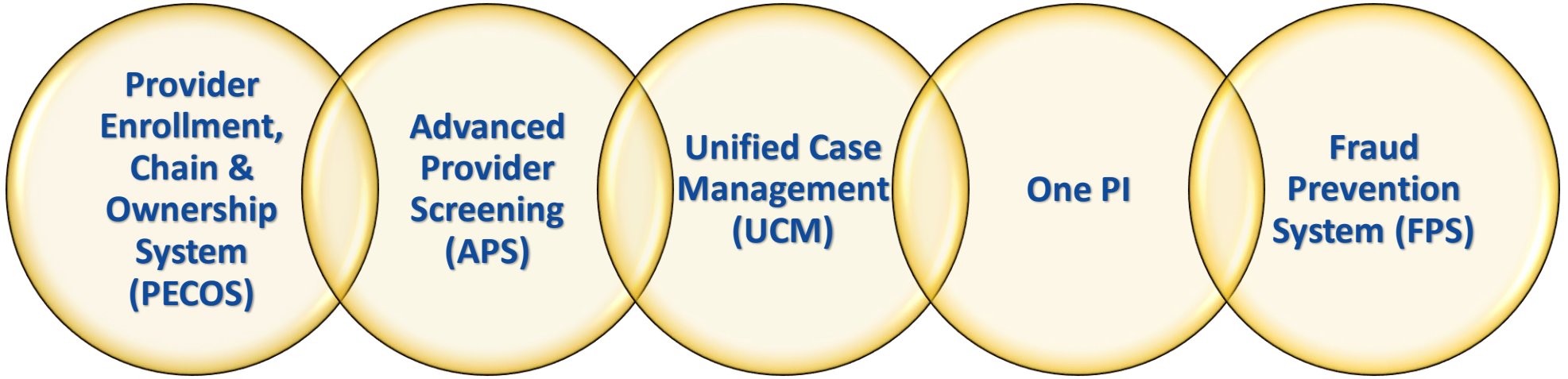
CPI Priorities

- **Leverage new and emerging technology** to modernize our program integrity tools
- **Prevent and deter fraud** by adding protections to ensure that legitimate providers are enrolled while taking aggressive actions to keep out those who seek to defraud the programs
- **Enhance vulnerability identification** using data analytics and **mitigate emerging program integrity risks** by addressing key risk drivers
- **Utilize demonstration authority to target high risk areas** for Medicare fraud while **reducing provider burden**
- **Apply program integrity safeguards to value-based payment programs** to mitigate and prevent potential fraud and abuse

Data and Analytics

Data analytics, systems, and transparency are foundational to CPI programs:

- Focuses on analytics related to fraud, waste, and abuse in CMS
- Provides program integrity statistical and data analysis for providers and service trends
- Identifies emerging fraud trends through data mining and other advanced analytical techniques



Provider Enrollment

Provider enrollment is the gateway to the Medicare and Medicaid programs and the provider's first interaction with CMS and the State Medicaid Agencies:

- Oversees the Medicare Administrative Contractors (MACs)
- Collaborates with states to develop Medicaid enrollment policy and to leverage Medicare provider data
- Oversees and develops Medicare provider enrollment and screening systems
- Analyzes and implements Medicare administrative actions such as denials, revocations and deactivations

Recent Provider Enrollment Initiatives:

- Stop Bad Actors – Issued the Program Integrity Enhancements to the Provider Enrollment Process Final Rule - applies proactive methods to act-on and keep unscrupulous providers and suppliers out of Medicare and Medicaid from the outset

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

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

Audits and Investigations

CPI's risk-based and targeted regional and national investigations and audits approach:

- Serves as CMS' liaison with law enforcement on investigative activities
- Collaborates with State Medicaid Agencies to provide support and assistance in program integrity oversight of the Medicaid program, including both fee-for-service and managed care
- Conducts State Program Integrity Reviews which assess the effectiveness of the state's program integrity efforts, including its compliance with Federal statutory and regulatory requirements
- Provides business function lead support to CMS program integrity contractors who conduct investigative activities
- Conducts focused audits related to plan oversight pertaining to the Medicare Part C and Part D program integrity initiatives

Major Case Coordination

Major Case Coordination: Forum designed so that CMS and law enforcement partners can quickly and systematically collaborate on fraud health care schemes. Through this collaboration, CMS is able to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on federal programs.

Goal:** To use the **right tool** at the **right time** in the **right order

Since April 2018:
• 2,110 Unique Case Reviews • 1,409 Law Enforcement Referrals • 1,141 Potential Payment Suspensions* • 454 Potential Revocations*

** Potential path to payment suspension and/or revocation identified.*

Healthcare Fraud Scheme Takedowns
• Operation Brace Yourself *(April 9, 2019)* • Appalachian Region Prescription (ARPO) Opioid Strike Force Takedown *(April 17, 2019)* • PSTIM *(September 17, 2019)* • Second ARPO Strike Force Takedown *(September 24, 2019)* • NE DME/Opioid Strike Force Takedown *(September 26, 2019)* • Home Health RAP Fraud *(September 27, 2019)* • Genetic Testing Strike Force Takedown *(September 27, 2019)*

***Result:** Increase in the **number** and **quality** of law enforcement referrals*

PI in Medicare Advantage and Part D

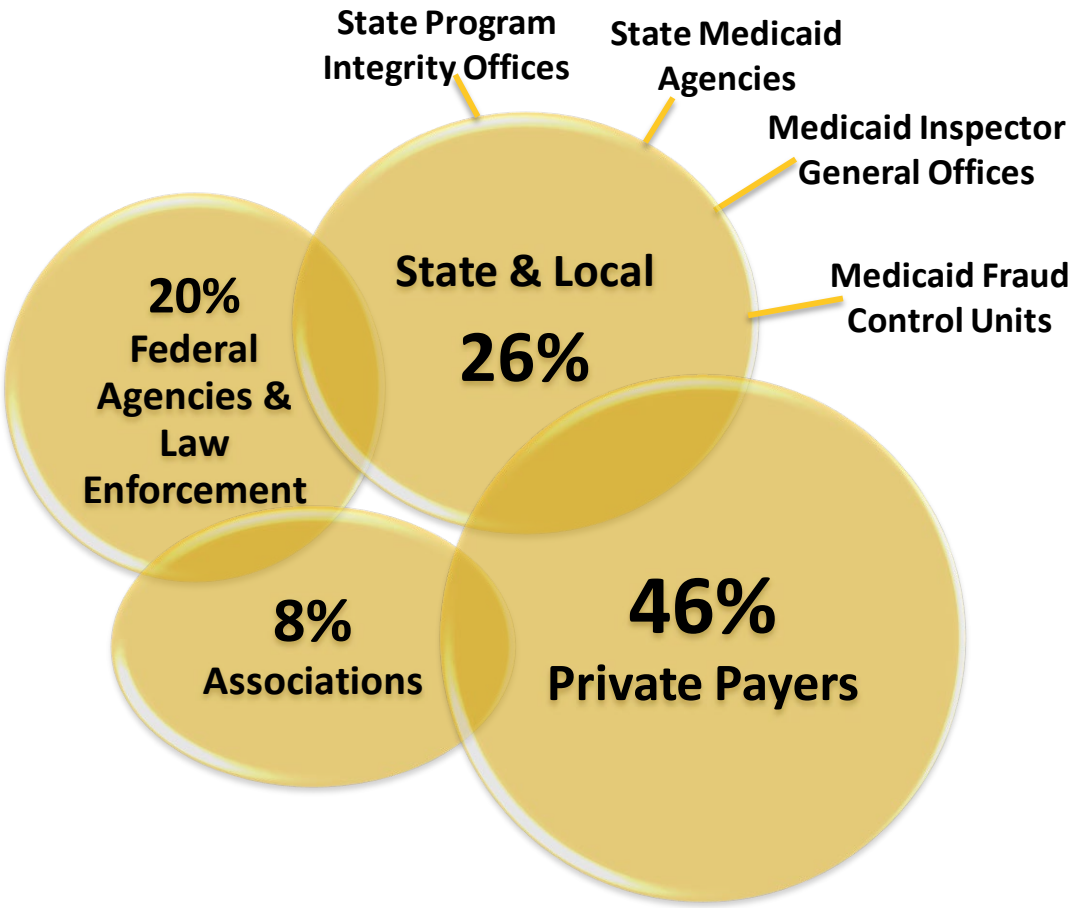
CMS continues to work to modernize the Medicare Advantage and Part D programs:

- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)
  - Section 6065: Annual notification of prescribers identified as outlier prescribers of opioids
  - Section 2008: Proposed provisions require plans sponsors to notify the Secretary of the imposition of a payment suspension based on a credible allegation of fraud
  - Section 6063:
    - Proposed provisions require the Secretary to establish a secure internet website portal to enable the sharing of data among MA plans, prescription drug plans, and the Secretary
    - Proposed provisions require plan sponsors to submit information on investigations, credible evidence of suspicious activities related to fraud, and other corrective actions related to inappropriate opioid prescribing
    - Proposed provisions require the Secretary to share information and quarterly reports with plan sponsors

- Risk Adjustment Data Validation (RADV) Audits
  - Completed the medical record submission phase for 2014 contract level audit
  - Launched medical record submission phase for 2015 contract level audit
  - Reviewed all comments received on the RADV proposed rule and working to finalize the rule in FY20

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



170 Partners

5 Federal Agencies

29 Law Enforcement

13 Associations

44 State and Local

79 Private Payers

HFPP Process

Medicaid PI Strategy

The Medicaid Program Integrity Strategy was released in June 2018 and included several new and enhanced initiatives, such as:

- Stronger audit and oversight functions
- Increased data sharing and partnerships
- Additional education, technical assistance, and collaboration

CMS continues to collaborate with states in implementing these initiatives and looks for new areas of vulnerability and opportunity to support state efforts to meet high program standards.

Medicaid PI Updates

Accountability and Education:

- Comprehensive Medicaid Integrity Plan (CMIP): Released CMS' plan to protect taxpayer dollars by combatting fraud, waste, and abuse in Medicaid and CHIP in June 2020
- Sub-Regulatory Guidance: Working to release sub-regulatory guidance related to the PI provisions of the 2016 Medicaid Managed Care Final Rule
- Medicaid Major Case Coordination: Implementing a forum designed so that CMS, state partners, UPICs and law enforcement can quickly and systematically collaborate on fraud health care schemes and maximize efforts to identify, investigate, and pursue providers who might otherwise endanger the program

Audits & Oversight:

- Medical Loss Ratio (MLR) Audits: CMS is continuing targeted audits of states Medicaid managed care organization (MCO) financial reporting and MLR
- Unified Program Integrity Contractor (UPIC) Audits: CMS is increasing UPIC audits in the managed care space
- Beneficiary Eligibility Audits: Conducted beneficiary eligibility audits for New York, Louisiana, and Kentucky
- Payment Error Rate Measurement (PERM) Corrective Actions Plans (CAPs): Reviewing and assisting states to address the state-specific drivers of improper payments

Data Sharing:

- Optimize State-Provided Claims & Provider Data: CMS is working closely with states to ensure that CMS and oversight bodies have access to the best, most complete and accurate Medicaid data
- Transformed Medicaid Statistical Information System (TMSIS): For the first time, all 50 states, D.C. and Puerto Rico are now submitting data on their programs

Prior Authorization

CMS is leading Prior Authorization (PA) and Pre-Claim Review initiatives to prevent improper payments and decrease appeals in the Medicare fee-for-service program:

PA of Certain DMEPOS Items: Master list of items for potential PA that CMS chooses based on potential FWA

- As of May 2020, CMS requires PA on 40 Power Mobility Devices (PMD), 5 Pressure Reducing Support Surfaces (PRSS), and 6 high cost Lower Limb Prosthetics (LLP)

Repetitive Scheduled Non-Emergent Ambulance Transports Model: Tests whether PA helps reduce expenditures and improper payments, while maintaining or improving access to and quality of care

- Currently in 8 states and Washington, D.C.
- Since implementation, spending has decreased on average approximately $9 million per month, resulting in savings of approximately $710 million while maintaining and improving access to and quality of care

Home Health Review Choice Demonstration: Provides flexibility, provider choice, and risk-based changes to providers who bill accurately

- Includes HHAs in IL, OH, TX, NC, and FL
- Initial analysis of the demonstration indicates that HHAs have a good understanding of the medical necessity and documentation requirements for the home health benefit

PA of Certain Hospital Outpatient Department (OPD) Services: Nationwide PA process and requirements for certain hospital OPD services

- As of July 2020, CMS requires PA for 5 groups of services: Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation

Provider Compliance Outreach and Education

Prevent improper payments and decrease appeals in the Medicare fee-for-service program through:

Comparative Billing Reports (CBRs): Compare an individual provider's billing and/or prescribing practices for a specific billing code, policy group, or service with the billing and/or prescribing practices of that provider's peers in the same state and/or specialty, and national averages

- Provides insight into Medicare policy and regional billing trends to increase provider utilization awareness

Program for Evaluating Payment Patterns Electronic Reports (PEPPERs): Provider-specific Medicare statistics for target areas often associated with Medicare improper payments due to billing, diagnosis related group (DRG) coding, and/or admission necessity issues to facilities

- Encourages providers to review data about their billing practices to help ensure accurate claims are submitted for payment

Medical Review: Review claims and medical records for providers who have a high propensity for improper payments

- Ensures that payment is made only for services that meet all Medicare requirements

Targeted Probe and Educate (TPE): Conducts data analyses on spending and conducts a probe sample to determine adherence to policies, then provides individual education to providers with high denial rates

- Designed to help providers and suppliers reduce claim denials and appeals through one-on-one help

Vulnerability Collaboration Council

Vulnerability Collaboration Council (VCC): CMS' centralized, enterprise-level process that is used to manage vulnerabilities and mitigations associated with the integrity of CMS programs

- Incorporates the Government Accountability Office (GAO) fraud risk framework for the prevention, identification, and mitigation of fraud, waste, and abuse
- Determines program risks and associated mitigations
- Promotes cross-collaboration within CMS to:
  - Conduct detailed fraud risk assessment of programs
  - Coordinate various key players to identify, prioritize, assign, manage, track, and evaluate mitigations
  - Facilitate the identification, scoring, prioritization and assessment of vulnerabilities that can lead to monetary loss or potential beneficiary harm
  - Develop comprehensive PI Strategies to address related vulnerabilities

COVID-19 Analysis

Program Integrity Challenge: The COVID-19 PHE has created additional opportunities for those who are intent on defrauding CMS programs

Actions Taken: CMS is analyzing the waivers and flexibilities issued across all CMS programs – Medicare fee-for-service (FFS), Medicare Part C and Part D, the Exchanges, and Medicaid, as well as accelerated and advanced payments and provider relief fund payments – for potential vulnerabilities

Findings: The identification of greatest concern is reliant on a combination of data analytics, payment integrity issues, and our historical knowledge of problematic fraud schemes. Top risk categories include:

- Hospitals
- Skilled Nursing Facilities
- Durable Medical Equipment
- Telehealth
- Laboratories

Monitoring and Mitigation Strategy: CPI is engaged in the execution and development of program integrity activities to ensure sufficient oversight of Medicare and Medicaid during and after the PHE. Our data monitoring efforts will continue as additional claims are submitted and will evolve as we learn more about the impact of each waiver and flexibility.

Questions?