CMS Program Integrity Contracting - The Changing Landscape

- Center for Program Integrity's 2015 Reorganization
- CPI Program Integrity Contract Programs
- UPIC
- Risk Adjustment Data Validation

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Washington, D.C.
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CPI Contracting Overview: Agenda

- CPI's organization & philosophy of 2015 reorganization
- High-level review of key CMS Program Integrity contract programs
- More detailed review of:
  - Medicaid Program Integrity history
  - ZPICs (Zone Program Integrity Contractors)
- The new CPI approach: UPIC
- Risk Adjustment Data Validation

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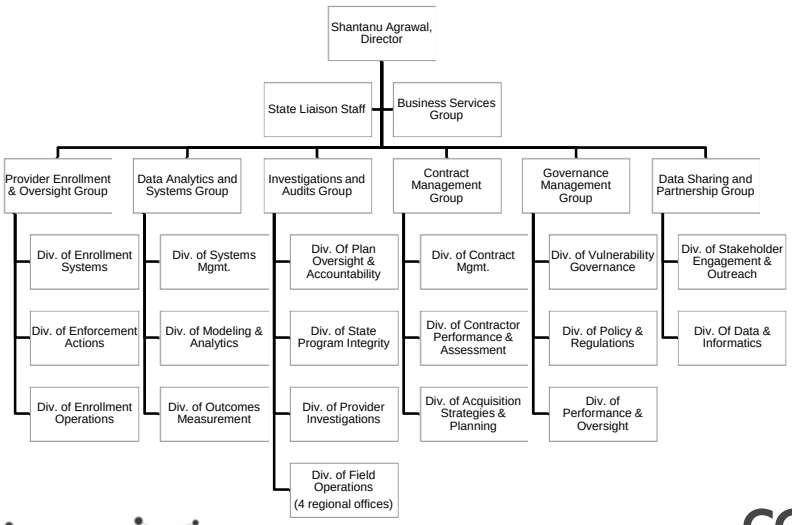
Center for Program Integrity 2015 Org Chart



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CPI's 2015 Reorganization

- Eighteen-month internal, HHS, and Congressional review (2013-2015)
- Announced Spring 2015
- Eliminated separate Medicare and Medicaid program integrity groups
- Shared services concept (i.e., new Contract Management Group)
- Added Governance Management Group
- Moved from program-specific to functional alignments
  - Example: Creation of new Investigations & Audits Group, while separating many contract management responsibilities
- New focus on measurement/outcomes
  - Gov. Mgmt. Group – Div. of Performance & Oversight
  - Data Analytics & Systems Group – Div. of Outcomes Measurement
- New organization is designed to support the new UPIC concept
- More to come? (George Mills)

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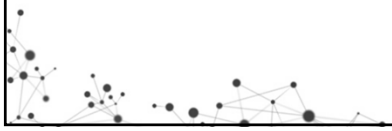
CPI Contracting Overview: Medicaid

- Review MICs (Medicaid Integrity Contractors)
- Audit MICs
- Education MICs
- Medicaid Integrity Institute (USDOJ runs MII under contract to CMS at the National Advocacy Center in Columbia, SC)



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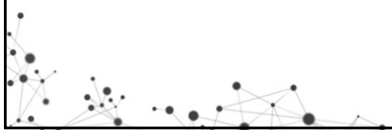
CPI Contracting Overview: Medicaid

- Less mature than Medicare
- Medicaid Integrity Group formed only in 2005
- Internal CPI review from 2012-2014 revealed low ROI for all federal Medicaid PI activities except MII
- CMS difficult relationship with states
  - CMS funds but does not run Medicaid agencies
  - Medicaid/states vocal lobby at CMS and on Capitol Hill
- Data issues



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CPI Contracting Overview: Medicaid

- Data issues
  - MSIS (Medicaid Statistical Information System)
  - T-MSIS (Transformed-MSIS) (2008 announced as MSIS Plus; 2013 re-announced as T-MSIS; work continues to the present)
- Issues are ongoing and include:
  - Onerous specifications – states required to perform a data extract
  - Lack of data – Not all states have all the data fields required by T-MSIS
  - Not a priority for Medicaid programs
  - Impractical error fixes – When state extracts are flawed, CMS must ask the states to correct (seldom happens)

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CPI Contracting Overview: Medicare

- ZPICs (Zone Program Integrity Contractors)
- FPS (Fraud Prevention System)
- Part C RAC (Recovery Audit Contractors)
- Part D RAC
- Part A & B RAC (non-CPI; OFM/George Mills)
- NBI MEDIC (National Benefit Integrity Medicare Drug Integrity Contractor) – Part C & D data analytics contract
- HPMS (Health Plan Management System) – determines whether an entity is qualified to contract with Medicare (Part C & Part D; non-CPI)
- UCM (Unified Case Management System)

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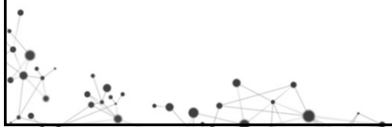
CPI Contracting Overview: Medicare

- FPS (Fraud Prevention System)
- Initial contract ending
- Procurement for “FPS2” currently active; updated May 20, 2015; response date was June 5, 2015
- Incumbents: NGS/Verizon team; and IBM (modeling/algorithm development only)
- CMS:

  “The purpose of this requirement is to acquire a second generation of the Fraud Prevention System (“FPS2”) and associated operational services to support the workload of Centers for Medicare & Medicaid Services (“CMS”) program integrity (“PI”) contractors across the Medicare and Medicaid programs. ”



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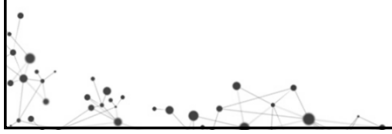
CPI Contracting Overview: Medicare

- Part C RAC (Recovery Audit Contractors)
- Part D RAC
- Part A & B RAC (non-CPI; OFM/George Mills)



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CPI Contracting Overview: Medicare

- NBI MEDIC (National Benefit Integrity Medicare Drug Integrity Contractor) – Part C & D data analytics contract
- The purpose of the NBI MEDIC is to detect and prevent fraud, waste, and abuse in the Part C (Medicare Advantage) and Part D (Prescription Drug Coverage) programs on a national level. (Health Integrity)

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CPI Contracting Overview: Medicare

- HPMS (Health Plan Management System) – determines whether an entity is qualified to contract with Medicare, and whether providers and facilities proposed to be used by a Part C plan are appropriate and qualified; and is plan submitting accurate data to CMS (Part C & Part D; non-CPI)
- CMS:

  "The Centers for Medicare & Medicaid Services' (CMS) Health Plan Management System (HPMS) is a web-enabled information system that serves a critical role in the ongoing operations of the Medicare Advantage (MA), Part D, and Accountable Care Organization (ACO) programs.

  "HPMS services the MA and Part D programs in two central ways. First, HPMS functionality facilitates the numerous data collection and reporting activities mandated for these entities by legislation. Second, HPMS provides support for the ongoing operations of the plan enrollment and plan compliance business functions as well as for longer-term strategic planning and program analysis."

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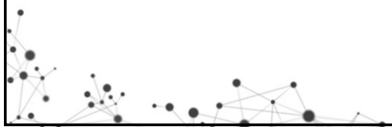
CPI Contracting Overview: Medicare

- UCM (Unified Case Management System)
  - IBM; awarded Fall 2014; brief protest by Deloitte; began work Spring 2015
  - Working internally; unclear when product will be rolled out; expectation is late 2015/early 2016



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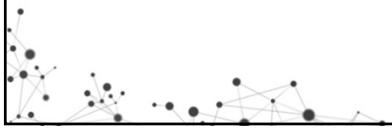
Medicare:

- ZPICs
  - Seven Zones
  - Functions:
    - “Detective Agency” for health care fraud
    - Analytics
    - Site visits



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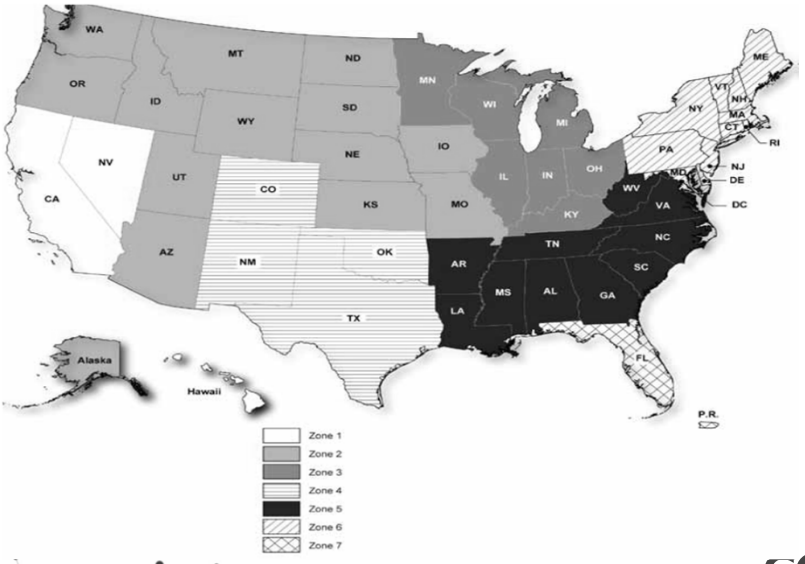
Medicare ct'd: ZPIC regions



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Medicare *ct'd*:

- ZPICs
  - Part A & B, Home Health, Hospice, Part B, DME; Prosthetics, Orthotics, and Supplies (DMEPOS)
  - Medicare and Medicaid Data Matching
  - Seven Zones
  - Functions:
    - "Detective Agency" for health care fraud
    - Analytics
    - Site visits
    - Administrative actions
      - payment suspension
      - revocation
    - Criminal referrals

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Medicare *ct'd*:

- The next phase for CPI contracting: UPICs
  - CMS:

    "The UPIC will combine and integrate existing CMS program integrity functions carried out by multiple contractors and contracts into a single contractor to improve its capacity to swiftly anticipate and adapt to the ever changing and dynamic nature of those involved in health care fraud, waste, and abuse across the Medicare and Medicaid program integrity continuum."

    "[UPIC will:] Integrate Medicare and Medicaid program integrity activities to support a holistic and coordinated Medicare and Medicaid program integrity strategy"

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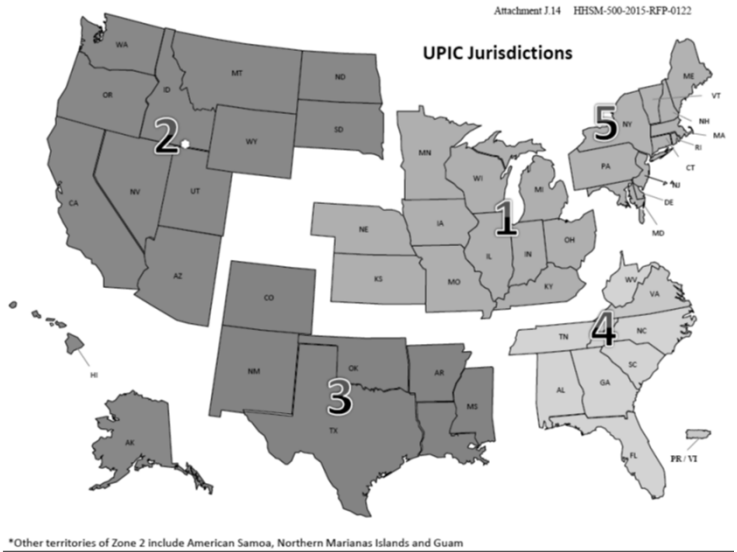
Medicare *ct'd*:



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Medicare *ct'd*:

- UPICs
  - CMS:

    "CMS anticipates award of a Multiple Award (MA) Indefinite Delivery Indefinite Quantity (IDIQ) contract for a 12-month Base Period and nine (9) 12-month Option Periods that can be exercised at the unilateral discretion of the Government.

    In addition, CMS anticipates awarding a Cost-Plus-Award-Fee task order for Jurisdiction 1 for a 12-month Base Period and four (4) 12-month Option Periods that can be exercised at the unilateral discretion of the Government. Jurisdiction 1 includes the states of Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky, Iowa, Missouri, Nebraska and Kansas."

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Medicare *ct'd*:

- UPICs
  - Procurement currently active
  - Solicitation issued in June 2015, changed several times (last time August 14, 2015)
  - Responses were due August 25, 2015
  - Solicitation is for Jurisdiction 1, but also to get on the IDIQ list, so any organization that wants to be a UPIC in a future zone had to submit

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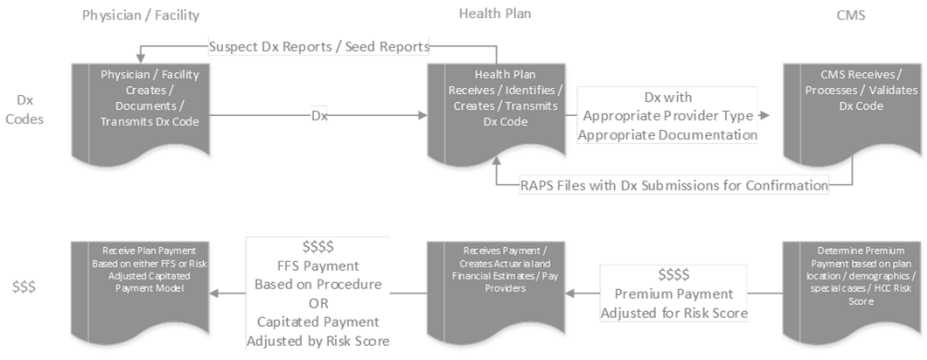
Risk Adjustment Data Validation Audits

Risk Adjustment Transaction Flow Diagnosis and Funds – Medicare Advantage



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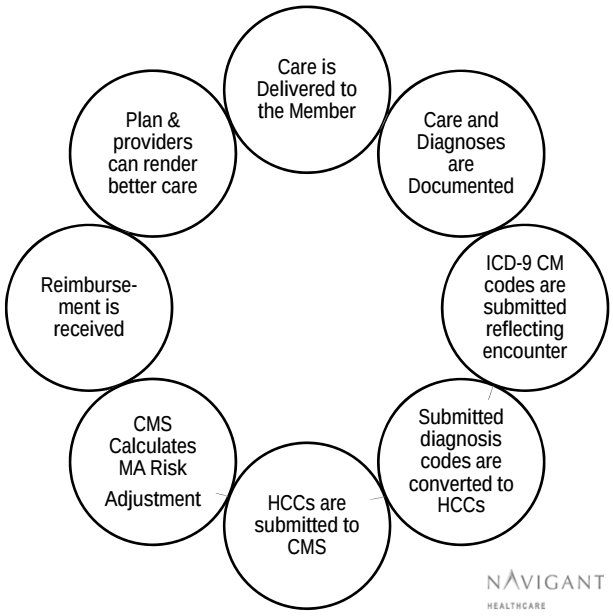
Risk Adjustment Process Cycle

Public Policy Benefits

- Improved Alignment of Reimbursement and Incentives
- Improved Population Health Management
- Improved Health Research Data



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Risk Adjustment Impact to Payers and Providers

- Payers continue to face the largest exposure to inaccurate and/or non-comprehensive coding practices, however;
- Providers are now facing new risk adjustment challenges including:
  - Integrating incentives / penalties in contracts for coding and medical record documentation accuracy
  - Moving to at-risk arrangements where coding and documentation accuracy will now impact their top line revenue

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Multiple Risk Adjustment Models

Different risk adjustment models are employed across sectors

Models change periodically

Medicare Advantage: Payments are adjusted using the CMS-HCC model

Medicaid: States can opt to use various models to risk adjust payments including CDPS, ACG, and Medicaid Rx

Commercial: Individual and small group exchange payments are adjusted using the HHS-HCC models

Regulatory Monitoring, Oversight, and Expectations are Increasing in all Sectors

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Broad Evaluation of Processes

Coding & Documentation	Population Health	Compliance
• Provider profiling (e.g. prescriptions w/o corresponding dx) • Provider outreach and education opportunities (e.g. scorecards) • End-to-end data flow integrity (from physician to CMS submission)	• Population segmentation for tailored outreach • Member outreach and education opportunities • Gaps in care (follow-up visit scheduled, outreach w/in 2 days of discharge, etc.)	• Accuracy of data fields for submission • Timeline adherence with contract standards • Controls and policies & procedures in place • Chart reviews (random or targeted sample)

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Multiple Functional Areas within Health Systems, Physician Organizations and Health Plans are Involved in Mitigating the Risk of Inappropriately Under Reporting or Over Reporting

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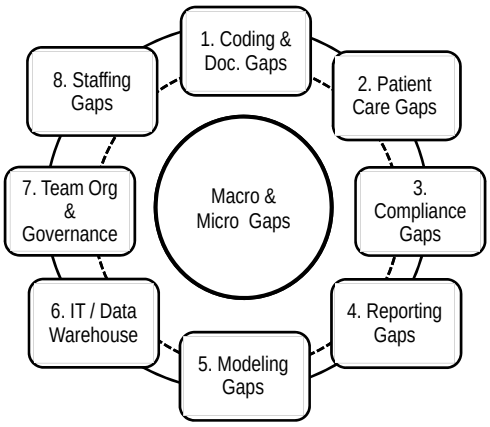
A. Claims Processing
Data sources & feeds
Data validation checks
Payer data considerations

B. Clinical / Provider
Pop. health innovation
Member outreach
Provider education

C. Coding / ICD-10
Chart reviews
Audit readiness
ICD-10 readiness

D. Contacting
Physician incentives
Payer relations
Uniform provisions



E. Finance
Strategic initiatives
Cross collaboration
Vendor performance

F. Information Technology
Data warehouse
Data infrastructure
Data submissions

G. Decision Support
Reporting & modeling
Population segmentation
Predictive analytics

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Risk Adjustment Principles

- Clear focus on the quality of disease state diagnosis and medical record coding
- Clear focus on data integrity and data submission requirements
- Correlate data across diagnosis submission and disease management programs
- When interacting with data / process – balance the interaction (identification of missing or inaccurate code submission)
- Assume some errors exist – create the analytics to look for and analyze outliers
- All stakeholders are realizing the impact of risk adjustment to government payment streams (DOJ / OIG / CMS / Other Plans / State Managed Care Agencies / Your Associates)
- Continuously scan for areas of concern and new areas of regulatory and enforcement focus.

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Risk Adjustment Process Components

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Physician/Hospital	Health Plan	CMS

• Documents member diagnoses during face-to-face encounter
• Codes diagnoses:
  • Manually
  • Automatically by EMR.
• Predictive software:
  • Maximizes diagnoses capture
  • Messages physician to consider certain diagnoses
  • Suspect reporting from plan
  • Queries: coder must follow coding standard (non-leading queries)
• EMR
  • Rolls forward diagnosis to history
• Risk Sharing Agreements between Provider and Payer
  • Higher Diagnosis = Higher Reimbursement
  • Joint Ventures / Partnerships
• Path to Risk Contracting
• Clinically Integrated Networks
	• Collect Dx from claims data
	• Collect Dx from encounters
	• Pay risk shares, path to risk bonuses
	• Support joint ventures / partnerships
	• Proactive physician training
	• Creates predictive models to identify missing Diagnoses.
	  • Supply suspect reports to physicians
	  • Employ coders to requests charts and re-code Dx
	  • Create predictive engines
	• Submit Dx via CMS RAPS
	• Reconcile RAPS returns
	• Creates financial projections
	  • Expected RA premium
	  • Contingent payback due to RADV Audits
	  • Overall error projection vs. Fee-for-service error rate
	• Optimize processes for chart capture, Dx tracking
	• Dx interface with disease management, STARS, HEDIS
	• Fraud Identification and Mitigation
		• Sets Dx / RA submission expectations
		• Tracks diagnosis submission and confirms receipt
		• Conducts Audits
		  • National Audits
		  • RADV Audits
		  • Plan specific audits with findings extrapolated
		• Provider, home health focused inquires / audits
		• Recovers funds from plans where errors are identified
		• Captures hotline complaints
		• OIG audit focus on Dx risk coding
		  • Prescribes coding standard expectations through their work

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Risk Adjustment Data Validation Audits for MA

CMS has indicated that they will undertake audits of selected Medicare Advantage Health Plans.

- CMS expected to follow their announced audit methodology
- Random selection of beneficiaries
- Request for one best medical record to support the HCC relevant diagnosis
- Coding audit of the medical records
- Review of errors and determination of payment impact
- Extrapolation of errors
- FFS error factor evaluation
- Potential payment liability to CMS

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Questions / Discussion

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