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The Future of Medicare Program Integrity

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Fraud, waste, & abuse **Medicare Parts A & B** **Safety**

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Earlier this month, President Trump announced an Executive Order charging CMS to propose annual changes to combat waste, fraud, and abuse in the Medicare program. That's why I'm proud to announce our vision to modernize our program integrity methods to better protect taxpayers from fraud, waste and abuse in Medicare. Every dollar spent on Medicare comes from American taxpayers and must not be misused.

CMS defines program integrity very simply: "pay it right." Program integrity must focus on paying the right amount, to legitimate providers, for covered, reasonable and necessary services provided to eligible beneficiaries while taking aggressive actions to eliminate fraud, waste and abuse. Our health care programs are quickly evolving; therefore our program integrity strategy must keep pace to address emerging challenges.

Government watchdogs routinely identify concerns about waste and abuse within our programs. The Government Accountability Office (GAO) has designated Medicare as a High Risk program since 1990 because of its size, complexity and susceptibility to improper

payments. In 2018, improper payments accounted for 5% of the total $616.8 billion of Medicare's net costs. While CMS regularly implements GAO recommendations, sometimes we lack the tools or capabilities to integrate worthy suggestions. The Medicare Fee-For-Service (FFS) program is limited by statute as to what methods can be used to prevent fraud, waste, and abuse. For example, last year's President's budget contained a legislative proposal to expand review of high risk areas in FFS. Under current statute, review is limited to durable medical equipment like wheelchairs. In contrast, other programs like Medicaid, Medicare Advantage, Medicare Prescription Drug Plans (PDPs), Tricare, Marketplace plans, and private insurers all have broad authority to review procedures for medical necessity and appropriateness. GAO has also recommended that Congress expand prior authorization in FFS.

As our programs become more complex, program integrity risks become increasingly difficult to recognize. New provider types have entered the program, including hospices, home health agencies, and federally qualified health centers. CMS has implemented a number of value-based payment programs that have improved quality and managed cost, but also bring new challenges in identifying improper payments, beneficiary safety and quality issues, and other program integrity concerns. More challenging cross-ownership issues have emerged, such as one corporate parent owning various providers and provider types. Increasingly complex webs of affiliations can allow unscrupulous providers to simply appear, disappear if they come under scrutiny, and then re-appear as "new" entities.

Medicare's transformation has raised the stakes of program integrity to historically high levels -- taxpayers have more to lose than ever before from those who would, whether by negligence or by intent, improperly seek payment from our programs. They necessitate a paradigm shift in how we approach program integrity.

When Medicare was signed into law 54 years ago, there were only 19 million beneficiaries. Today, there are almost 61 million and we are adding 10,000 new enrollees every day. When the programs began, Medicare and Medicaid accounted for only 2.3% of Federal spending. These government programs now account for 23.5% of Federal spending. We have witnessed exponential growth in the number and types of providers included, the types of benefits available, the number of claims processed and paid, and, perhaps most importantly, the number of dollars involved.

Medicare's improper payment rates have declined but remain too high. That's why CMS is developing a five-pillar program integrity strategy to modernize our approach and protect Medicare for future generations.

- **Stop Bad Actors**. We work with law enforcement agencies to identify and take action on those who defraud the Medicare program. CMS, Office of the Inspector general (OIG), Department of Justice (DOJ), and the Unified Program Integrity Contractors (UPICs) jointly deliberate on potential healthcare fraud cases, quickly direct them to law enforcement, and take appropriate administrative action such as payment suspensions and revocations. This collaboration allows CMS is to maximize efforts to identify, investigate, and pursue providers who might otherwise endanger program beneficiaries or commit fraud on Federal programs. It has led to some of the biggest healthcare fraud takedowns ever -- including two in just the past few months involving orthotic braces and genetic testing that saved taxpayers $3.3 billion dollars. In one recent takedown, it took only six months from identification of the fraud scheme to law enforcement action. We are taking steps to make such prompt enforcement the norm.

- **Prevent Fraud**. We continue to focus on moving away from an expensive and inefficient “pay and chase” model. Instead we are improving infrastructure that prevents fraud, waste and abuse on the front end. After we identify bad actors and their schemes, we make system changes to avoid similar fraudulent activities in the future. CMS’s oversight, audit and investigative activities allow us to analyze data to identify potential problem areas. We then work with our law enforcement partners to develop policies, regulations, and processes to prevent vulnerabilities from being exploited before claims are paid. This close collaboration between enforcement entities stops payments to known or suspected bad actors without adversely impacting sensitive and critical law enforcement operations.

CMS integrates various processes to identify and mitigate vulnerabilities before exposure to protect proactively people with Medicare. For example, to mitigate risks during the recent efforts to send new Medicare cards to beneficiaries, CMS implemented an enhanced address validation process to verify beneficiaries’ identities and addresses against multiple information sources. This ensured that we mailed new Medicare cards to the right person at the right address. We reviewed over 61 million cards for address accuracy, which we estimate saved billions of dollars in fraudulent claim payments.

An important aspect of fraud prevention is having various sources of information. CMS relies on important partnerships to share data and information that help narrow down on potential areas of concern. One of our most critical relationships is the Healthcare Fraud Prevention Partnership (HFPP). This is a voluntary, public-private partnership between Federal government, state and local agencies, law

enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations that come together to collaboratively identify and reduce fraud, waste, and abuse across the healthcare sector. We use this partnership for stakeholder engagement and to share information and leads across partners. The leads are used to conduct various studies and the results help CMS identify potential issues that may not have otherwise been caught. Currently there are 144 partners and counting. The more members we have, the more data is gathered, and the better insights we have into fraud across the entire healthcare system.

We are also addressing potential healthcare fraud by targeting high-risk areas and implementing policy changes. In September, CMS issued a first-of-its-kind final rule, Program Integrity Enhancements to the Provider Enrollment Process (CMS-6058-FC), which will reduce criminal behavior across our programs. This rule applies proactive methods to keep unscrupulous providers and suppliers out of Medicare and Medicaid from the outset and enhances our ability to promptly identify and act on instances of improper behavior – helping us to stop fraud before it happens. It creates several new revocation and denial authorities to bolster CMS' efforts to stop fraud, waste and abuse. Importantly, a new "affiliations" authority in the rule allows CMS to identify individuals and organizations that pose an undue risk of fraud, waste or abuse based on their relationships with other previously sanctioned entities. This rule marks a critical step forward in CMS' longstanding fight to end "pay and chase" in Federal healthcare fraud efforts and replace it with smart, effective and proactive measures.

Looking forward, we are looking to add private sector technology tools to complement our fraud prevention analytics so our future capabilities will be faster, smarter and more robust.

- **Mitigate Emerging Programmatic Risks.** Too often, tackling fraud, waste and abuse is akin to playing the world's largest game of whack-a-mole. We must be vigilant in monitoring new and emerging areas of risk. To that end, tried and true methods like prior authorization have been effective. Just this year, we proposed a list of high-risk durable medical equipment, prosthetics, orthotics and supply (DMEPOS) items that could be subject to prior authorization. This allows us to capture vulnerable items that were previously excluded from prior authorization, such as orthotics and prosthetics, which have been the target of recent telemarketing fraud schemes. The proposed changes also give us the flexibility to respond to future data and trends and tailor our strategies accordingly. Implementing prior authorization for these items as well as additional items in the future will help ensure that services billed are medically necessary.

We also are using demonstrations to test new approaches for high vulnerability services such as home health. The Review Choice Demonstration for Home Health Services illustrates how CMS is working proactively to identify and prevent fraud in an area with high improper payment rates while minimizing unnecessary provider burden. The demonstration helps ensure that the right payments are made at the right time for home health services but allows providers the flexibility to choose what works best for them. This protects Medicare funding from improper payments, reduces the number of Medicare appeals, and improves provider compliance with Medicare program requirements. In response to stakeholder feedback, this demonstration incorporates more flexibility and choice for providers on how their claims are reviewed, as well as risk-based changes to reduce burden on providers demonstrating compliance with Medicare home health policies.

More recently, Medicare Advantage enrollment continues to grow and we have added many value-based payment programs as part of our strategy to improve how healthcare is delivered and paid for in the Medicare program. New payment models have been very beneficial but also have the potential to cause new challenges in identifying improper payments, beneficiary safety issues, and other program integrity concerns. CMS is continuing to explore ways to identify and reduce program integrity risks related to value-based payment programs by looking to experts in the healthcare community for lessons learned and best practices.

- **Reduce provider burden**. While we strengthen program integrity we must ensure our efforts don't create unnecessary time and cost burden on providers. To that end, we have increased efforts to educate providers in CMS program rules and regulations and remedy onerous processes to assist rather than punish providers who make good faith claim errors. That's the purpose of our Targeted Probe and Educate (TPE) program and our efforts to streamline our recovery audit processes. It's vital to separate providers who make clerical errors from truly nefarious actors. Our current program transparency and oversight efforts have reduced provider burden and appeals to an all-time low, but there is more to be done. That includes providing sufficient educational opportunities, including one-on-one education for providers who simply made mistakes. Between October 2017 and February 2019, we contacted 20,000 providers and suppliers through the TPE program to provide one-on-one education. As a result, approximately 80% of those providers and suppliers were released from further review. In FY 2018, the recovery audit program identified approximately $89 million in overpayments and recovered $73 million. Since its inception in 2009, the program has played a major role in reducing improper

payments, recouping more than $10 billion for the Medicare program. These programs are one of several factors that led to more than a 10% decrease in the number of claims appeals. Fewer appeals mean providers are being paid what they expected, lowering Medicare's administrative costs from resolving appeals. CMS will continue to streamline processes and grow the Targeted Probe and Educate program to allow more providers to have the benefit of one-on-one mentoring about proper medical record documentation.

The TPE program has also highlighted provider burden and confusing policies. The Medicare documentation requirements appear in various locations and on separate websites, causing burden to providers who must navigate the various websites to find coverage rules, including documentation and prior authorization requirements. That's why CMS is collaborating with ongoing industry efforts to streamline workflow access to coverage requirements, starting with developing a prototype Medicare FFS Documentation Requirement Lookup Service. This initiative will allow providers to discover Medicare FFS prior authorization and documentation requirements at the time of service and within their EHR.

The initiatives above are a few of many projects we have to reduce provider burden. For example, we're proposing to eliminate "certification statements" for some hospital transfers. These statements add time and burden and are often duplicative with other required documents. In addition, we're changing our practices to focus more on problematic billing, not all billing. For example, we're proposing to reduce DMEPOS prior authorization for some providers who demonstrate good billing practices. If they do a good job, we don't need to make them jump through more hoops because others may not.

CMS also has vigorous provider screening and enrollment tools at our disposal to prevent fraud schemes. However, we believe that there is a tremendous opportunity for the Federal government and private plans to improve the provider enrollment experience. CMS is currently exploring ways to centralize screening and continuous monitoring for all payers. Cumulatively, these efforts are defining a new approach to program integrity that reduces burden and increases education to achieve a better shared understanding of how the programs operate.

- **Leverage New Technology**. We plan to leverage healthcare sector innovation to modernize and automate our program integrity tools. Today, the Medicare FFS program relies on clinician reviewers — human beings — to review the medical records associated with items and services billed to Medicare. Providers also have to send us copies of medical records which is time-intensive and burdensome. That is why we only review less than one percent of medical records.

> Looking forward, CMS is seeking new, innovative strategies and technologies, perhaps involving artificial intelligence and/or machine learning, which are more cost effective and less burdensome to both providers, suppliers and the Medicare program. This new technology could allow the Medicare program to review compliance on more claims with less burden on providers and less cost to taxpayers. Advanced analytics and artificial intelligence (AI) can perform rapid analysis and comparison of large scale claims data and medical records that could allow for more expeditious, seamless and accurate medical review, and ultimately, improved payment accuracy.

We currently use sophisticated systems such as the Fraud Prevention System, and case management systems that use predictive analytics to identify abnormal trends and billing patterns, investigate abnormalities to find the root cause, act quickly to address any potential fraud, and capture fraudulent behavior. While these systems have helped us to obtain a positive return on investment, we believe that by adopting cutting edge technology – such as AI and machine learning tools -- we can achieve greater savings for taxpayers and allow us to review more claims. These innovations could be used in both our current payment models, as well as in new payment models.

RFI: Using Advanced Technology in Program Integrity: https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Advanced-Technology-RFI.pdf

The Future of Medicare Program Integrity

As part of CMS's program integrity strategy to leverage new technology, CMS seeks to hear from providers, innovators, and private insurers on ways CMS can advance and modernize efforts to combat Medicare fraud, waste, and abuse (FWA) through innovation. Today CMS is issuing two Requests for Information (RFIs) asking for input from the healthcare community on the program integrity challenges involved in the transition from a fee-for-service system to value based care. We are also requesting input on new techniques and approaches involving advanced data analytics and artificial intelligence. During the RFI comment period, CMS will be holding a series of listening sessions across the country soliciting ideas and feedback on how to tackle the enduring issues plaguing our efforts to "pay it right."

Simply stated, CMS must elevate program integrity, unleash the power of modern private sector innovation, prevent rather than chase fraud waste and abuse through smart, proactive measures, and unburden our provider partners so they can do what they do best – put patients first. For these very important reasons, we seek and welcome input

and expertise from all stakeholders on how to best improve our program integrity strategy and tools as we strive to protect both taxpayer dollars and the health and well-being of beneficiaries.

RFI: The Future of Program Integrity: https://www.cms.gov/About-CMS/Components/CPI/Downloads/Center-for-Program-Integrity-Future-of-PI-RFI.pdf

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