
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Demystifying the Center for Program Integrity (CPI)

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About CPI

Created: HHS Secretary created CPI to align Medicare and Medicaid activities in March 2010.

Employees: Approximately 500

Current Organization:

- 7 Groups
- 32 Divisions, including four field offices

Budget: 14 funding sources totaling approximately $1billion

Work: Our mission is to detect and combat fraud, waste and abuse of Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Exchanges

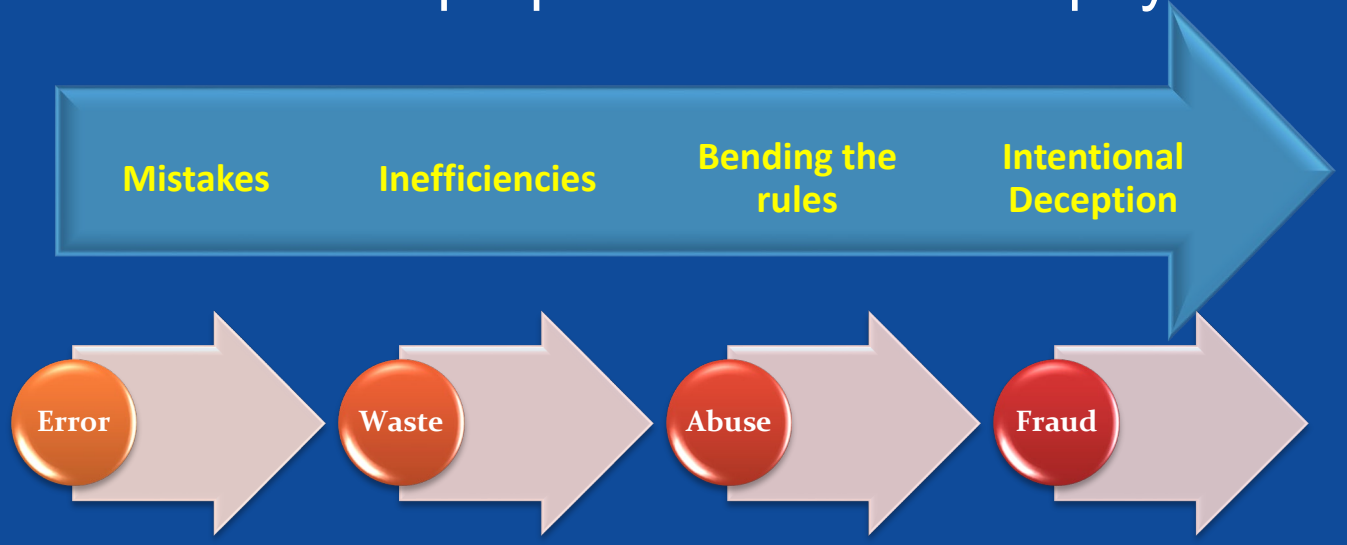
What Are CPI's Major Responsibilities?

Mission: ensure that correct payments are made to legitimate providers and states for covered, appropriate, and reasonable services for eligible beneficiaries and consumers of Medicare, Medicaid, CHIP, and the Exchanges.

Primary Focus: deter, reduce, and eliminate improper payments, fraud, waste and abuse in Medicare, Medicaid, CHIP, and Exchange programs, including taking action against those that commit or participate in fraudulent or other unlawful activities.

What Is Program Integrity?

Program Integrity encompasses a range of activities to target the causes of improper and fraudulent payments.



What is CPI Working to Achieve?

Reduce improper payments across Medicare and Medicaid Programs

Increase savings from prevention and recovery

Improve patient safety by ensuring appropriate health care services

How Are We Getting this Done?

- Addressing the full spectrum of waste, abuse and fraud
- Proactively managing provider screening and enrollment
- Moving swiftly to take administrative action
- Continuing to build states' capacity to protect their Medicaid programs
- Increasing alignment of Medicare and Medicaid program integrity
- Extending work in Medicare Parts C and D and Medicaid Managed Care
- Improving enterprise risk management and recovery
- Enhancing professional development and engagement of our staff

What Is the Value of Our Work?

- Focus on prevention, early detection, and data sharing to prevent and reduce improper payments and promote program integrity.
- Foster a proactive approach to detect and prevent health care fraud through the voluntary sharing of data and information between the public and private sectors.
- Program integrity activities saved Medicare an estimated total of $12 billion in FY 2018, for an annual return on investment of $8.3 to 1.
  - Automated Actions
  - Prepayment Review Actions
  - Provider Enrollment Actions
  - Other Actions

Approximately 80% of savings due to prevention

- CMS supports state Medicaid Integrity Programs by providing education and training opportunities and engaging in collaborative audits, among other efforts. In FY 2018, federal and state collaborative program integrity efforts for Medicaid and CHIP resulted in estimated federal share savings of $1.3 billion.

What Are We Doing that No One Else Does?

- Managing the enrollment of every Medicare provider in the country and sharing that information with all Medicaid programs
- Using advanced analytics on a scale no other government or private entity has done before – over 4.5 million claims and $1 billion every day
- Utilizing principles from the GAO Fraud Risk Framework to identify, score, prioritize and assess vulnerabilities
- Exchanging data with private payers to identify emerging fraud trends
- Integrating investigations and audits across Medicare and Medicaid to maximize our results while reducing burden on providers
- Publishing data on payments made by drug and medical device makers to physicians so consumers can make informed choices
- Working with states to improve and strengthen the integrity of Medicaid and CHIP

CPI Workstreams

- Provider Enrollment
- Program Integrity Partnerships
- Data Analysis
- Medical Review
- Investigations
- Provider Education
- State Program Integrity
- Parts C/D Program Integrity
- Exchanges Program Integrity
- Policy and Vulnerability Analysis

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Data Analysis

Modeling and Analytics

- Provide statistical and data analysis for CPI
- Identify emerging fraud trends through data mining, social media monitoring, and other analytic techniques
- Develop Fraud Prevention System (FPS) models and edits
- Deliver data-driven insights that help guide and shape CPI’s approaches to preventing and detecting FWA.
- Provide analytic findings to support CPI's strategic direction.

Fraud Prevention System (FPS)

FPS performs the following functions:

- Examines Medicare FFS claims nationwide for schemes/patterns of FWA
- Alerts investigators to aberrant activity to see if action is necessary
- Rejects or denies claims exhibiting noncompliance with policy

FPS Models

DMA develops anomaly, rule-based, social network, machine learning, and predictive models that identify and/or predict FWA in claims data.

FPS Edits

FPS edits prevent payment for claims that are suspect for FWA.

Modeling and Analytics

- **1-800-Medicare Complaints Team** - Analyzes 1-800-Medicare data to detect newly-emerging fraud schemes and analyze schemes for leads development.
- **COVID-19 fraud prevention and mitigation** - Monitor data in key service areas impacted by the PHE 1135 waivers to detect FWA.
- **MAC eligibility lookup systems log monitoring** – Analyze MAC eligibility lookup systems logs to detect potentially fraudulent activity.
- **Open Payments Team** - Explores application of the Open Payments data for PI purposes.

Modeling and Analytics

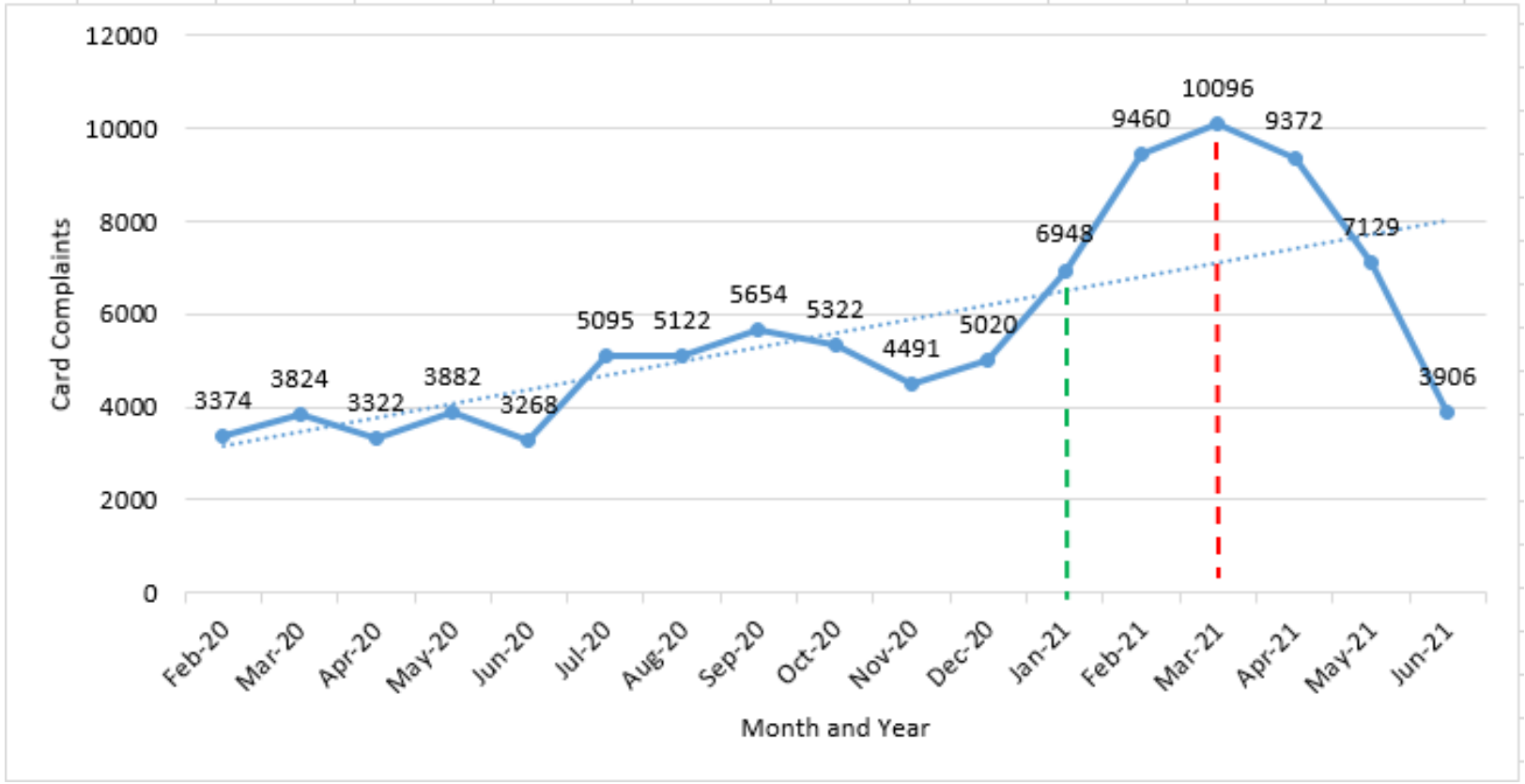
- **Part C Team –** Performs analyses of Part C data in conjunction with FPS or other components of CPI.
- **Part D Team -** Monitor FPS Part D models and perform proactive analysis on Part D data in collaboration with contractors and other Data Analytics and Systems Group Analysts.
- **Transformed Medicaid Statistical Information System (T-MSIS) Team –** The T-MSIS team evaluates T-MSIS (Medicaid) data for use in analytic PI projects and conducts analyses in support of FWA prevention and mitigation projects.

Additional Analytics – Outcomes Measurement

Outcomes Measurement for Program Integrity Activities

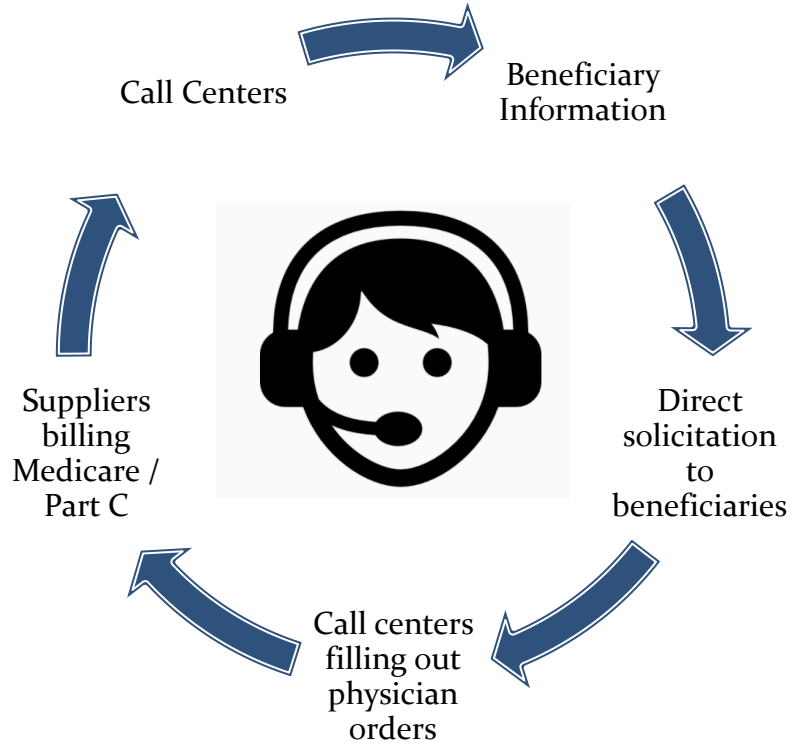
- Develop sound methodologies for calculating outcome measures
- Calculate return on investment and other metrics for FWA activities.

1-800-MEDICARE Complaints –New Card Scheme



1-800-MEDICARE Complaints - DME

DME telemarketing is “ground zero” for emerging DME fraud schemes. CPI is identifying telemarketing rings and the individuals orchestrating them. Identification of call centers working with Medicare-approved suppliers will have a larger impact than focusing on one-by-one supplier leads.



1-800-MEDICARE Complaints – DME + Telemedicine Example

Telemarketer cold calls beneficiary.

The caller encourages the beneficiary to talk about their ailments and records the call.

Recorded information is sent to the physician, who orders orthotics.

The beneficiary receives back and knee braces as well as a $25 bill for a telemedicine consultation.

1-800-MEDICARE Complaints – Genetic Testing

"…they were offering a DNA test for heart disease in return for verification of their Medicare number. Claimed that they were calling on behalf of Medicare to ***make sure her heart was well enough for a COVID vaccine***".

"Explaining that if they did not take this ***mandatory cancer testing,*** that they would discontinue their Medicare insurance ".

Type of Test	Count
Cancer genetic test	2,189
Cardio genetic test	2,394
Both cardio genetic test and cancer genetic test	216
Unclassified	2,523
Total	7,322

6/14/2021 data pull

Text mining terms/combos of terms: heart, cardiac, cardio, cancer, dna, genetic, swab, genome, saliva, salvia, spit, gene

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Handling SMP Referrals

Field Office Handling of SMP Referrals

- High quality SMP referrals received at FO
  - Referrals are screened for:
    - Related cases/scams
    - Related providers/provider type
    - Risk/Intensity of behavior
    - Degree of fraud (# of benes/claims, dollar amt)

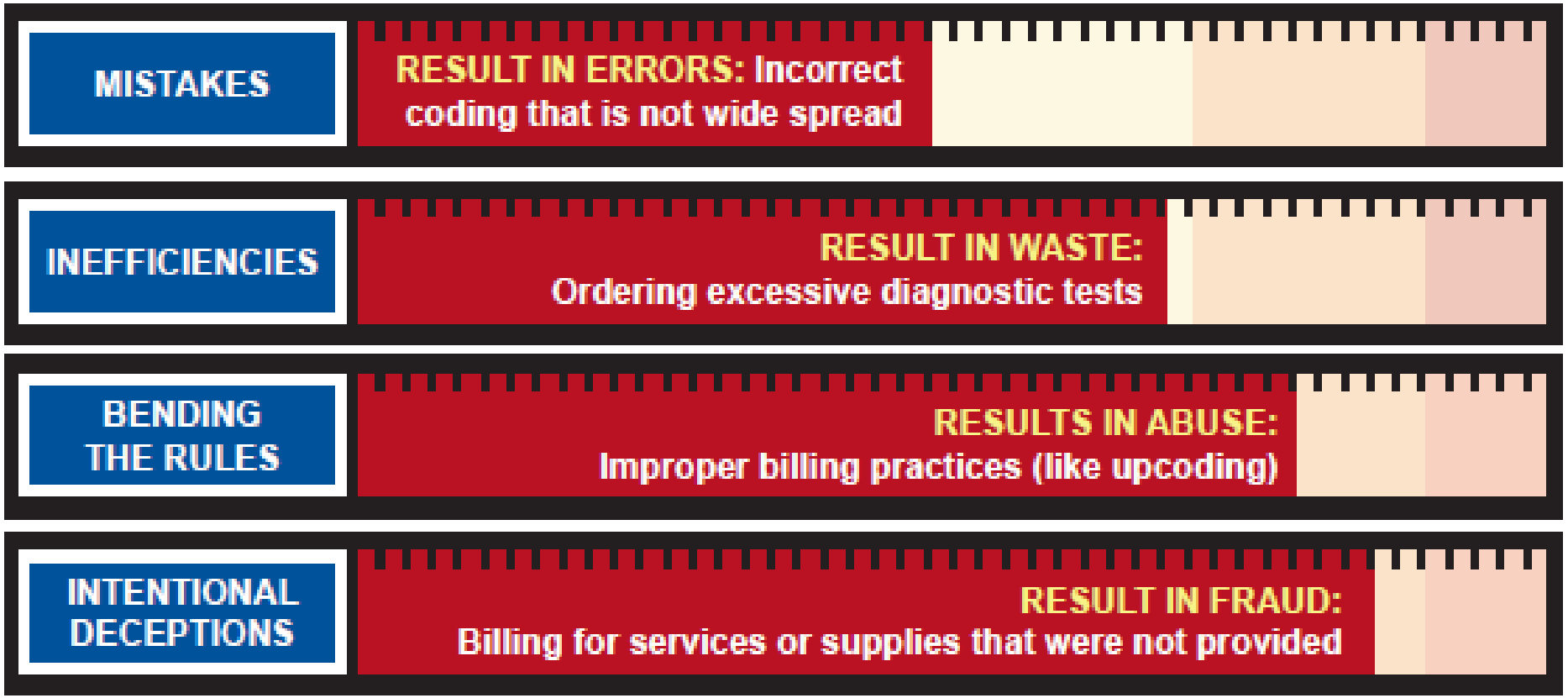
Field Office Handling of SMP Referrals

Screening considerations:

Fraud -- Knowingly submitting false claims or making misrepresentations of fact to obtain a Federal health care payment for which no entitlement would otherwise exist.

Abuse -- Practices that may result in unnecessary costs to the Medicare Program. Abuse includes any practice that does not provide patients with medically necessary services or meet professionally recognized standards of care.

Field Office Handling of SMP Referrals



Field Office Handling of SMP Referrals

- Options
  - Develop Case
  - Refer
  - Hold and Monitor

Field Office Handling of SMP Referrals

- Current Trends
  - Orthotics and wheelchair repair
  - Home Health
  - Hospice
  - Labs – CoViD and genetic testing

Questions?