2016 SMP/SHIP National Training:
CMS CPI Update

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CMS is the largest purchaser of health care in the world; with approximately $802.9 billion per year in total expenses.

Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) provide health care for one in four Americans or health care coverage to roughly 107 million beneficiaries.

CMS processes more than one billion Medicare claims annually, and answers about 75 million inquiries annually.

CMS ensures the safety and quality of medical facilities, and maintains the largest collection of healthcare data in the United States.

### Total:
- **2010**: 102 million
- **2015**: 138 million
- **2020**: 165 million

### Enrollment Types:
- **Fee for Service**
  - **2010**: 50%
  - **2015**: 41%
  - **2020**: 38%
- **Managed Care**
  - **2010**: 50%
  - **2015**: 59%
  - **2020**: 62%

Sources: CMS, OACT, Congressional Budget Office
Medicare and Medicaid Spending

![Graph showing historical and projected growth rates for Medicaid, Medicare, and US nominal GDP per-capita spending.]

**Growth rate: federal Medicaid spending per enrollee**

**Growth rate: federal Medicare spending per enrollee**

**Growth rate: US nominal GDP per-capita**

### Table: Historical and Projected Growth Rates

<table>
<thead>
<tr>
<th>Year</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>1.1</td>
<td>4.4</td>
<td>-3</td>
</tr>
<tr>
<td>2010</td>
<td>-0.8</td>
<td>1.6</td>
<td>3.1</td>
</tr>
<tr>
<td>2011</td>
<td>-1.7</td>
<td>2.4</td>
<td>3</td>
</tr>
<tr>
<td>2012</td>
<td>2</td>
<td>-0.2</td>
<td>3.5</td>
</tr>
<tr>
<td>2013</td>
<td>3.9</td>
<td>0.1</td>
<td>3.1</td>
</tr>
<tr>
<td>2014</td>
<td>-0.8</td>
<td>2.7</td>
<td>2.9</td>
</tr>
<tr>
<td>2015</td>
<td>2</td>
<td>1.1</td>
<td>2.6</td>
</tr>
<tr>
<td>2016</td>
<td>2.3</td>
<td>3.1</td>
<td>3.7</td>
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<tr>
<td>2017</td>
<td>2.8</td>
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</tr>
<tr>
<td>2018</td>
<td>4.2</td>
<td>3.4</td>
<td>4.3</td>
</tr>
<tr>
<td>2019</td>
<td>5</td>
<td>4.9</td>
<td>4.2</td>
</tr>
<tr>
<td>2020</td>
<td>5</td>
<td>5</td>
<td>4.1</td>
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<tr>
<td>2021</td>
<td>5.2</td>
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<tr>
<td>2023</td>
<td>5.2</td>
<td>4.8</td>
<td>3.9</td>
</tr>
<tr>
<td>2024</td>
<td>5</td>
<td>4.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

**SOURCE:** CMS Office of the Actuary National Health Expenditure Data (2014-2024 projections)
Payment accuracy encompasses a range of activities to target the causes of improper and fraudulent payments:

- **Mistakes**
  - Error
    - Incorrect coding

- **Inefficiencies**
  - Waste
    - Inappropriate use and overutilization

- **Bending the rules**
  - Abuse
    - Medically unnecessary services

- **Intentional Deception**
  - Fraud
    - Billing for services or supplies that were not provided

Examples:

Spectrum of Payment Accuracy Issues
## Program Oversight

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
<th>Federally Funded Marketplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee For Service</td>
<td></td>
<td><strong>Tax Credits and Subsidies</strong></td>
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<tr>
<td>Managed Care</td>
<td></td>
<td><strong>Eligibility and Enrollment</strong></td>
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<tr>
<td>Drug Benefit</td>
<td></td>
<td><strong>States (State Based</strong></td>
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<td><strong>Marketplace/State Partner</strong></td>
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<tr>
<td></td>
<td></td>
<td><strong>Marketplace)</strong></td>
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</table>
Scope of Issues

- Waste alone may account for 30% of overall health care costs
- The Institute of Medicine estimates that the U.S. health care system loses about $765 billion/year.
  - $210B: unnecessary services
  - $130B: inefficiently delivered services
  - $190B: administrative costs
  - $105B: excessive prices
  - $75B: fraud

Scope of Cost Inefficiencies

Figure. Proposed “Wedges” Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste

Industry-wide Efforts to Control Costs

The Cost of Health Care
How much is waste?

= $1 Billion

Unnecessary Services
$210 Billion

Fraud
$75 Billion

Excessive Administrative Costs
$190 Billion

Inefficiently Delivered Services
$130 Billion

Prices That Are Too High
$105 Billion

Missed Prevention Opportunities
$55 Billion

Choosing Wisely
An initiative of the ABIM Foundation
Geographic Variation in Cost

MS-DRG 470: Hip/Knee Replacement Episode Cost

National Average = $21,325

Anchorage, AK
$15,222

Hackensack, NJ
$29,254
Provider Market Saturation: Home Health
• Documentation and billing are key determinants of health care cost but are not performed well by many physicians

• Numerous studies have found discordance between medical record documentation and billing such that documentation frequently fails to support the magnitude of billing

• Billing level does not precisely correlate with diagnoses in the clinical record

• Even the severity of patient presentation has been found to only moderately correlate with billing

Improper payments were an estimated $43.3 billion in 2015.
Incentive-Driven Behavior

- Incentives embedded in the fee-for-service payment structure can be motivating factors for waste/abuse as well.

- There is increasing evidence that economic thinking impacts health care utilization.
  - Studies have evaluated the use of various discretionary diagnostics and found a statistical association between physician ownership of imaging equipment and use of testing.
  - Correlation holds even for physicians within the same specialty and after risk-adjusting patients.

Physician-Driven Fraud (Medicaid)

Examples

• Impossible utilization (e.g., provision of services for > 24 hours/day)
• Billing for services not provided (e.g., abortions in non-pregnant women)
• Unnecessary procedures (e.g., unneeded cataract operations)
• Unlikely diagnoses
• Up-coding

“Explanation”

• Patient welfare
• Autonomy of medical decision-making
• Inconsistency in requirements between public and private payers
• Overcharging to “get what they deserved”
• Government bureaucracy

Source: Jesilow et al (1991), Fraud by Physicians Against Medicaid, JAMA, 266: 3318-3322
Strategies to Lower Cost

**Decision-making**
- Network Control and Enrollment Requirements
- Payment and Coverage Policy
- Utilization Management
- Prior Authorization
- Education
- Data Transparency and Sharing
- Clinical Standards and Evidence-Based-Medicine (EBM)
- Case Management

**Payment**
- Pricing
- Payment Policy (e.g., bundling)
- Payment Processing
- Pre- and Post-Payment Review or Audit
- Investigation
- Administrative Authorities (e.g., payment suspension)
- Law Enforcement Collaboration

Delivery System and Payment Reform (correct delivery failures, align incentives)
Medicare FFS: Comparative billing reports

Part D Prescriber Data:

<table>
<thead>
<tr>
<th>Categories</th>
<th>Total Treatments</th>
<th>30-Day Equivalent</th>
<th>Unique Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Values in 2015 (to date*)</td>
<td>95</td>
<td>102</td>
<td>24</td>
</tr>
<tr>
<td>Average of Your Peers in 2015 (to date*)</td>
<td>10.7</td>
<td>14.2</td>
<td>3.6</td>
</tr>
</tbody>
</table>

Your Prescribing in 2015 Relative to Your Peers

95
General Medicare Data Releases

May 2013
- Hospital Inpatient & Outpatient
  - 3,000+ Hospitals
  - 150,000+ records
  - $62 billion in Medicare payments

April 2014
- Physician & Other Supplier*
  - 880,000+ NPIs
  - 9+ million records
  - $90 billion in Medicare payments

April 2015
- Part D Prescriber
  - 1+ million NPIs
  - 23+ million records
  - $103 billion in prescription drugs and supplies paid under the Part D program

Oct 2015
- DME and POS
  - 385,000+ NPIs
  - 1.9 million records
  - $11 billion in Medicare payments

Dec 2015
- Home Health Agency
  - 11,000+ HHAs
  - 100,000+ records
  - $18 billion in Medicare payments
Open Payments: A National Transparency Program

Mandated Implementation of the Affordable Care Act’s Physician Payments Sunshine Act

- Makes financial relationships between providers and industry transparent on a national scale to reduce conflicts of interest
- Gives consumers information needed to ask questions and make more informed decisions about their healthcare professionals
Open Payments Summary Data

- Simple search tool to review data
- Data Explorer to search for, filter and export full data sets
- Download the entire database for analysis in external tools
- Application Program Interface (API) to pull data directly

Total US Dollar Value: $9.92 Billion
Total Records Published: 15.71 Million

- Total Companies Making Payments: 1,617
- Total Physicians with Payment Records: 683,000
- Total Teaching Hospitals with Payment Records: 1,143
Summary Impact of Current Programs

Program Integrity Savings

CMS deactivated 543,163 providers and suppliers and revoked 34,888 providers and suppliers since March 2011.

About $2.4 billion was or will be prevented in payment to the revoked providers since 2011.

CMS saved >$25 billion through recoveries and prepayment denials since 2011.
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Data Sharing and Partnership Group
CMS Center for Program Integrity

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