2016 SMP/SHIP National Training: CMS CPI Update

Jean Stone
Program Integrity Senior Specialist
Center for Program Integrity
August 4, 2016
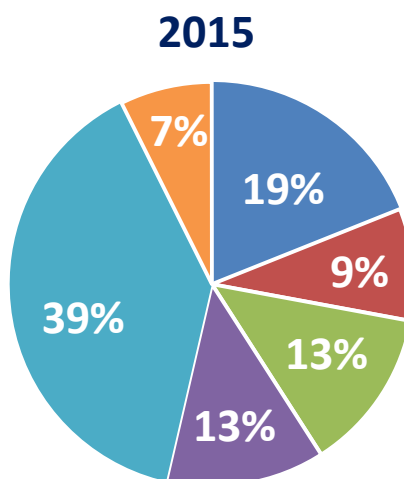
Size and Scope of CMS Responsibilities

- 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

Changing Face of CMS Consumer: Program Enrollment 2010, 2015, 2020

2010

2015

2020
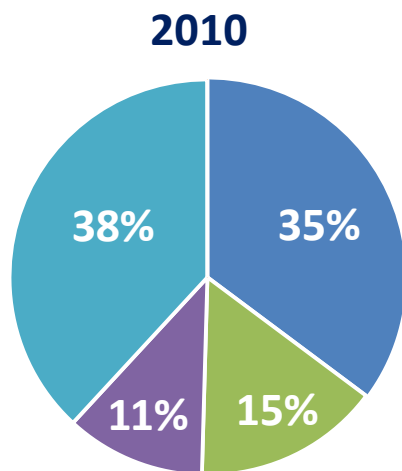
Total:	102 million	138 million	165 million
Fee for Service:	50%	41%	38%
Managed Care:	50%	59%	62%

Legend: Medicare FFS · Medicare APM · Medicaid FFS · MA · Medicaid Managed Care · Marketplace

Medicare and Medicaid Spending

Historical ⟷ Projected

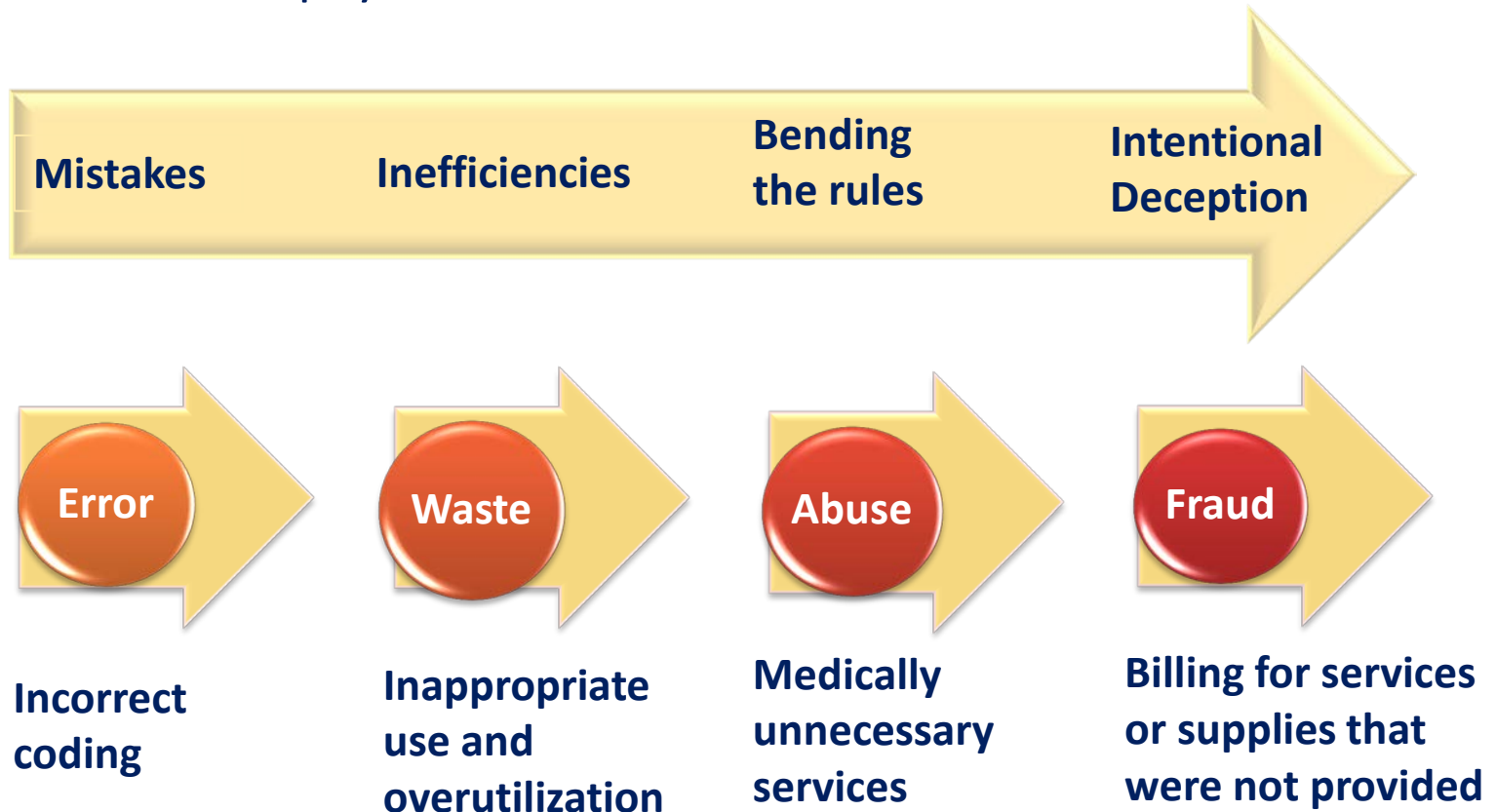|	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Medicaid	1.1	-0.8	-1.7	2	3.9	-0.8	2	2.3	2.8	4.2	5	5	5.2	5.1	5.2	5
Medicare	4.4	1.6	2.4	-0.2	0.1	2.7	1.1	3.1	3.3	3.4	4.9	5	4.8	4.8	4.9	4.8
GDP	-3	3.1	3	3.5	3.1	2.9	2.6	3.7	4.3	4.3	4.2	4.1	4	3.5	3.9	3.6

Legend:
- Growth rate: federal Medicaid spending per enrollee
- Growth rate: federal Medicare spending per enrollee
- Growth rate: US nominal GDP per-capita

SOURCE: CMS Office of the Actuary National Health Expenditure Data (2014-2024 projections)

4

Spectrum of Payment Accuracy Issues

Payment accuracy encompasses a range of activities to target the causes of improper and fraudulent payments:

Mistakes	Inefficiencies	Bending the rules	Intentional Deception
Error	**Waste**	**Abuse**	**Fraud**

Examples:

Incorrect coding	Inappropriate use and overutilization	Medically unnecessary services	Billing for services or supplies that were not provided

Program Oversight

| Medicare	Medicaid	Federally Funded Marketplace
Fee For Service		Tax Credits and Subsidies
Managed Care		Eligibility and Enrollment
Drug Benefit		States (State Based Marketplace/State Partner Marketplace)

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

Fisher, Bynum, Skinner (2009). NEJM, 360(9): 849-852; Institute of Medicine. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. The National Academies Press, 2012.

Scope of Cost Inefficiencies

Figure. Proposed "Wedges" Model for US Health Care, With Theoretical Spending Reduction Targets for 6 Categories of Waste
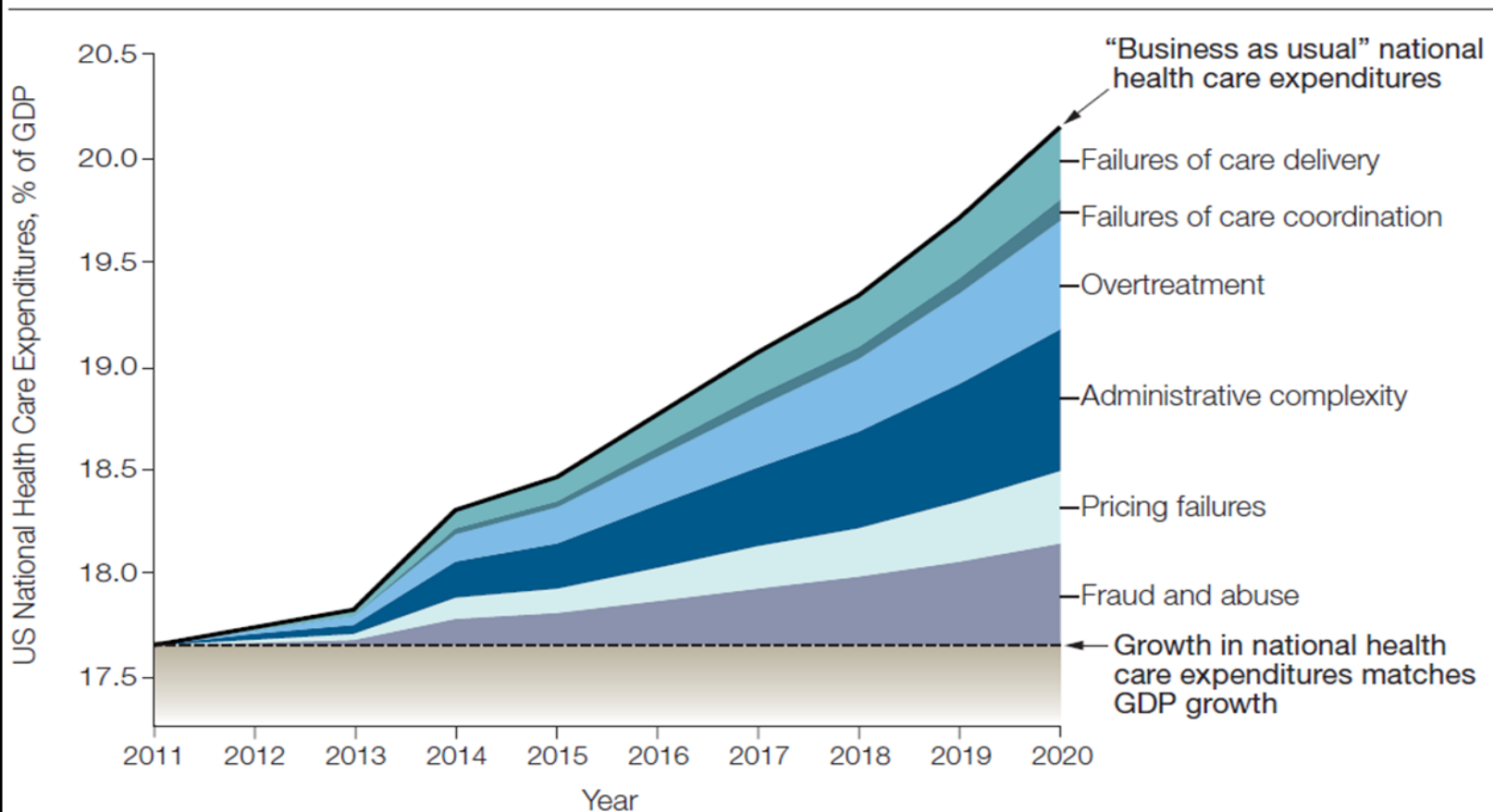
Industry-wide Efforts to Control Costs

The Cost of Health Care
How much is waste?

= $1 Billion

Unnecessary Services
$210 Billion

Fraud
$75 Billion

Excessive Administrative Costs
$190 Billlion

Inefficiently Delivered Services
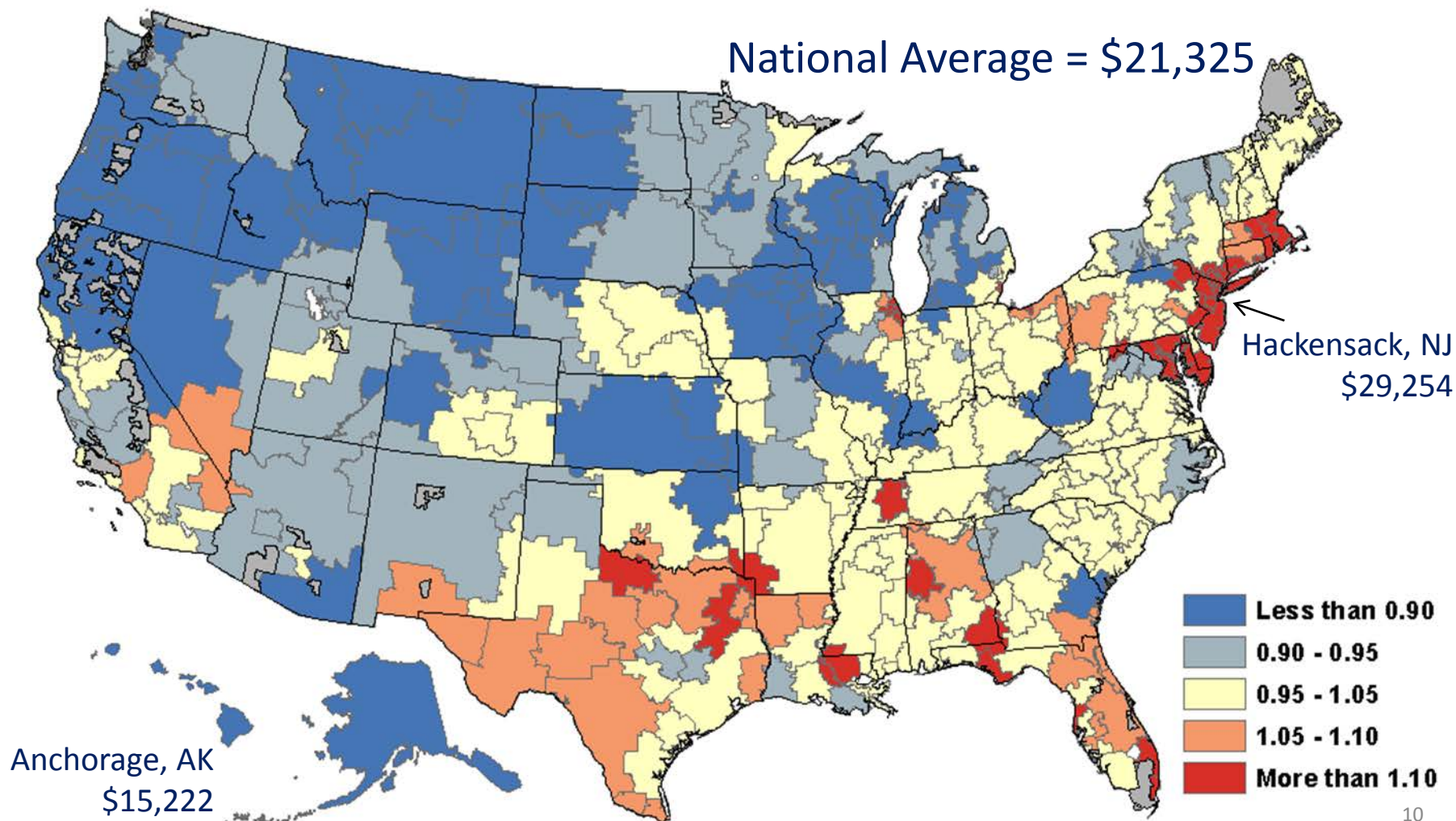$130 Billion

Prices That Are Too High
$105 Billion

Missed Prevention Opportunities
$55 Billion

Choosing Wisely®

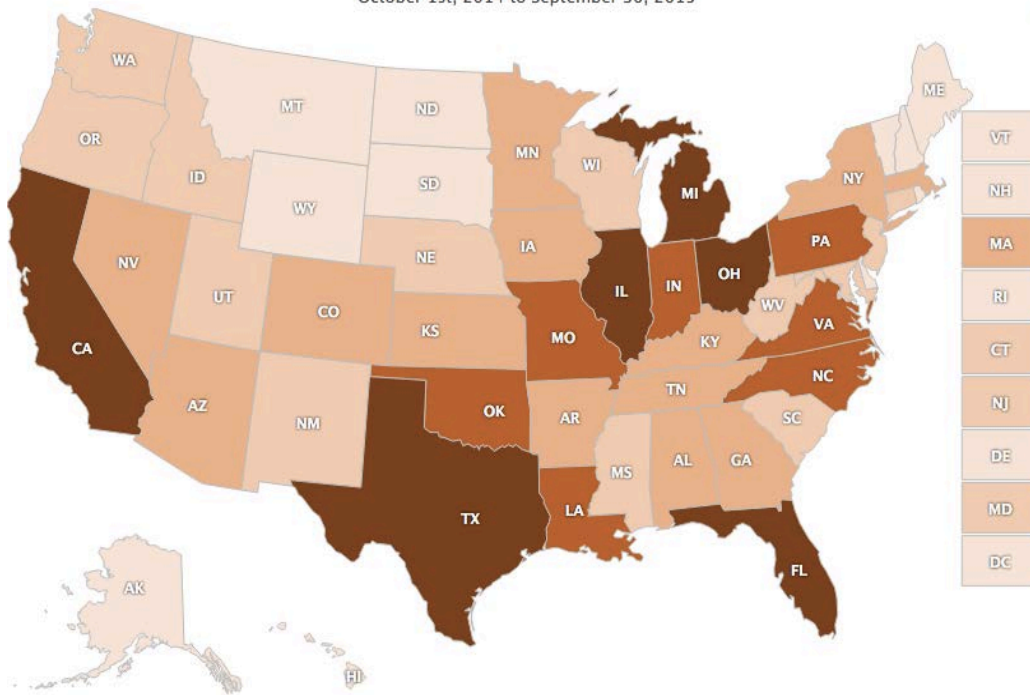*An initiative of the ABIM Foundation*

Geographic Variation in Cost
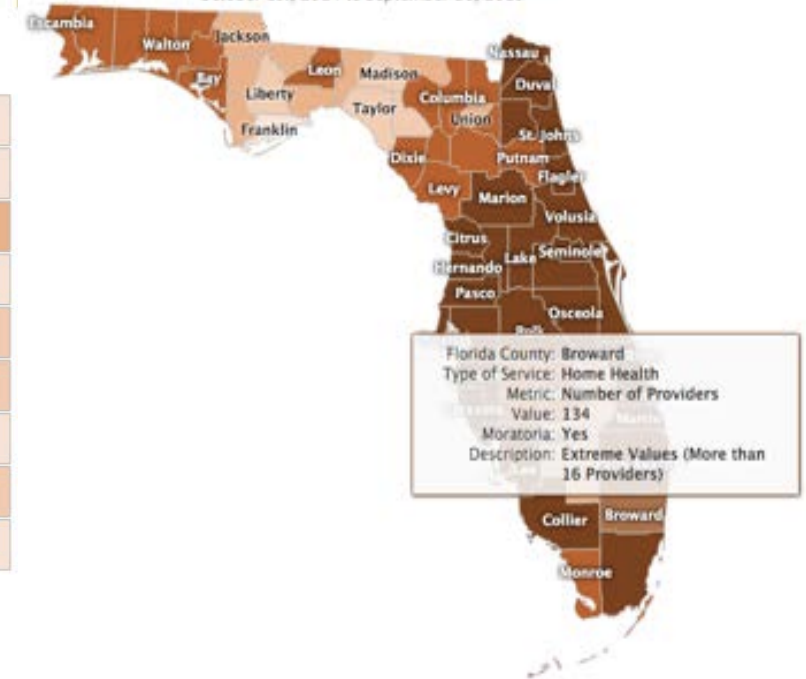
MS-DRG 470: Hip/Knee Replacement Episode Cost

National Average = $21,325

Hackensack, NJ
$29,254

Anchorage, AK
$15,222

Legend:
- Less than 0.90
- 0.90 - 0.95
- 0.95 - 1.05
- 1.05 - 1.10
- More than 1.10

Provider Market Saturation: Home Health

Moratoria Map: Home Health – Number of Providers
October 1st, 2014 to September 30, 2015

Moratoria Map: Home Health – Number of Providers
October 1st, 2014 to September 30, 2015

Florida County: Broward
Type of Service: Home Health
Metric: Number of Providers
Value: 134
Moratoria: Yes
Description: Extreme Values (More than 16 Providers)

Lowest 25%
Second Lowest 25%
Third Lowest 25%
Top 25% Excl. Extreme Values
Extreme Values
10 or fewer users – excluded from analysis
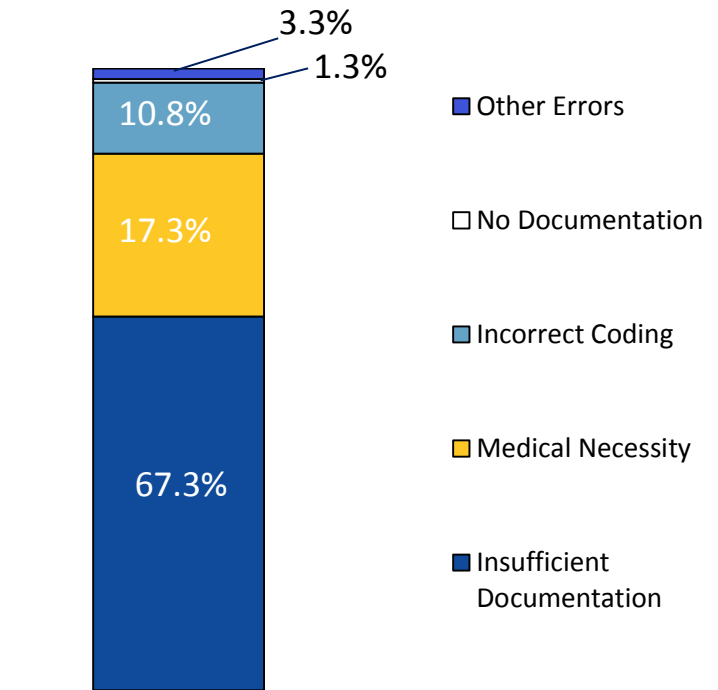
Billing and Documentation

- 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

Source: Cadieux, Tamblyn(2008). Accuracy of Physician Billing Claims for Identifying Acute Respiratory Infections in Primary Care, Health Services Research, 43(6): 2223-2238; Wiler et al (2011). Emergency Severity Index Triage System Correlation with Emergency Department Evaluation and Management Billing Codes and Total Professional Charges, Academic Emergency Medicine, 18(11): 1161-1166.

Medicare Improper Payment Rate

Medicare FFS improper payment rate (%)

Fiscal Year	Improper Payment Amount (billions)	Actual Rate	Target Rate
2010	$29.7	9.1%	9.5%
2011	$28.8	8.6%	8.5%
2012	$29.6	8.5%	5.4%
2013	$36.0	10.1%	8.3%
2014	$45.8	12.7%	9.9%
2015	$43.3	12.1%	11.5%

Cause of improper payment

- 3.3%
- 1.3%
- 10.8%
- 17.3%
- 67.3%

Legend:
- Other Errors
- No Documentation
- Incorrect Coding
- Medical Necessity
- Insufficient Documentation

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

Source: Shah B et al (2011). Association Between Physician Billing and Cardiac Stress Testing Patterns Following Coronary Revascularization, JAMA, 306(18): 1993-2000; Brunt (2011). CPT Fee Differentials and Visit Upcoding Under Medicare Part B, Health Economics, 20: 831-841

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

Strategies to Lower Cost

Decision-making	Payment

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)

Provider Focused Data

Medicare FFS: Comparative billing reports

Comparative Billing Report   April 29, 2014

Organization Name
Full Name
123 Street Lane
Suite 4000
Anytown, XX 555554444

Dear Medicare Provider:

The Centers for Medicare & Medicaid manage Medicare resources. In an effort services firm in Arlington, VA, to dev providers on their billing or referral pr their state and the nation. As CBRs ar for your information.

Attached is a CBR that is designed to referring the same services in your stat tool which may assist you in identifyin CBR, or if you want to change the way via:

— Calling the Toll Free Number, 1-
— Sending an email to cbrsupport@
— Visiting the website at http://w

Table 2: Statistical Comparison of Percentage of Beneficiaries by Modifier Type For You, Your State, and the Nation
July 1, 2013 - December 31, 2013

Modifier Type	Your Percentage of Beneficiaries	Your State's Percentage of Beneficiaries	Comparison with Your State's Average	National Percentage of Beneficiaries	Comparison with the National Average
KS and KX	5%	7%	Does Not Exceed	4%	Higher
KX	51%	34%	Significantly Higher	37%	Significantly Higher

A chi-square test was used in this analysis, alpha=0.05.

Table 3: Statistical Comparison of Average Allowed Services per Beneficiary Rendered by You, Your State, and the Nation
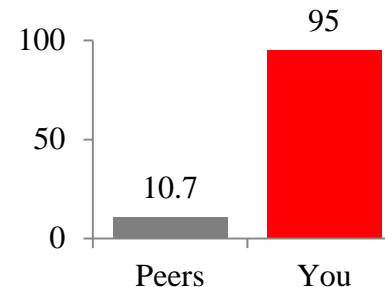July 1, 2013 - December 31, 2013

HCPCS Code and Modifier	Your Average Services per Beneficiary	Your State's Average Services per Beneficiary	Comparison with Your State's Average	National Average Services per Beneficiary	Comparison with the National Average
A4253 KS	1.85	3.02	Does Not Exceed	3.69	Does Not Exceed
A4253 KX	6.28	5.14	Significantly Higher	7.34	Does Not Exceed
A4259 KS	1.23	1.49	Does Not Exceed	1.87	Does Not Exceed
A4259 KX	3.12	2.17	Significantly Higher	3.58	Does Not Exceed

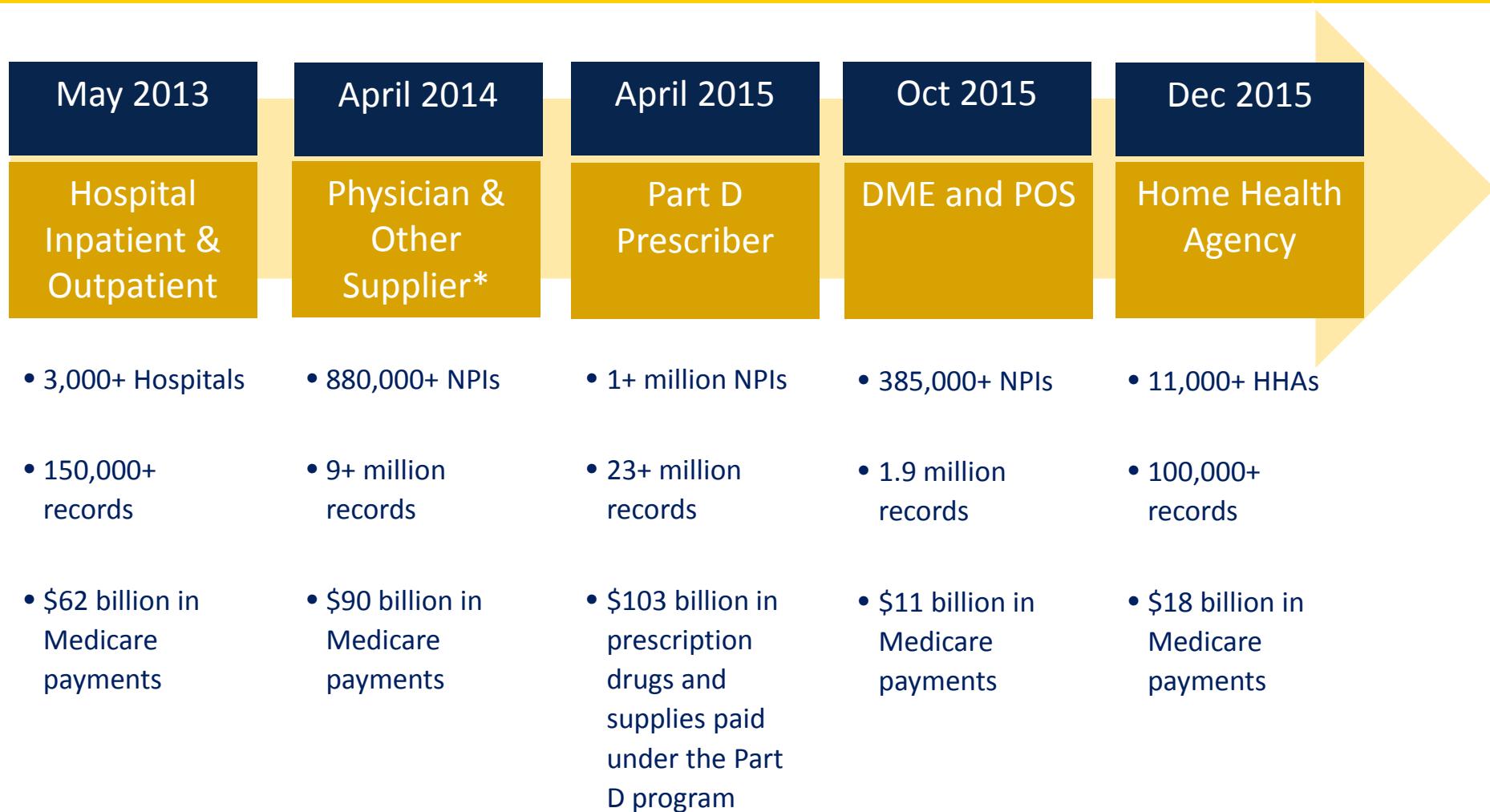A t-test was used in this analysis, alpha=0.05.

Part D Prescriber Data:

Categories	Total Treatments	30-Day Equivalent	Unique Beneficiary Count
Your Values in 2015 (to date*)	95	102	24
Average of Your Peers in 2015 (to date*)	10.7	14.2	3.6

Your Prescribing in 2015 Relative to Your Peers

General Medicare Data Releases

May 2013	April 2014	April 2015	Oct 2015	Dec 2015
Hospital Inpatient & Outpatient	Physician & Other Supplier*	Part D Prescriber	DME and POS	Home Health Agency

- 3,000+ Hospitals
- 150,000+ records
- $62 billion in Medicare payments

- 880,000+ NPIs
- 9+ million records
- $90 billion in Medicare payments

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

- 385,000+ NPIs
- 1.9 million records
- $11 billion in Medicare payments

- 11,000+ HHAs
- 100,000+ records
- $18 billion in Medicare payments

Open Payments:
A National Transparency Program

OpenPaymentsData.CMS.gov

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

ACA

Open Payments Summary Data

Total US Dollar Value

$9.92 Billion

Total Records Published

15.71 Million

- 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 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

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

Jean Stone

Division of Stakeholder Engagement and Outreach

Data Sharing and Partnership Group

CMS Center for Program Integrity

Jean.Stone@cms.hhs.gov