Updates from OFM Part C & D Improper Payment Activities

Chrissy Fowler, CMS

Carolyn Kapustij, CMS

Kristen Renkes: So our afternoon – our next sessions this afternoon will provide an overview of the improper payments and – sorry – improper payment measure processes, historical Medicare Part C and D improper payment rates, and upcoming initiatives. Please welcome Chrissy Fowler and Carolyn Kapustij.

Chrissy Fowler: Thank you so much, Kristen, for the introduction.

So, good afternoon. I'm sure you guys hopefully will be up for the next at least 15 minutes for our presentation. Or longer. We know it's after lunch and sometimes it gets a little – eyelids get a little heavy. But, most of all we just want to thank CM for inviting us this year to this conference. I think it's actually the first year that we've actually presented on improper payment measurements, specifically for Medicare Parts C and D here at CMS.

So, just to start off, I'm Chrissy Fowler. I am the Group Director for the Payment Accuracy and Reporting Group. I report to the Office of Financial Management. And Carolyn Kapustij, it took me probably two weeks to get her name correct, pronouncing it. So Carolyn just joined our team probably, I'm going to say, three or four months ago. Yeah.

Carolyn Kapustij: Yeah.

Chrissy Fowler: Joined our team from the Center for Program Integrity. And Carolyn has extensive knowledge and experience with the improper payment

measurements for Medicare Parts C and D. So I'm super excited to have her on my team within OFM.

Here, I'll go ahead and give you the clicker.

Okay.

So, today we're kind of going to give you an overview of improper payments for Parts C and D within OFM. So, again, we're the Payment Accuracy and Reporting Group. And so we're going to talk about the process for improper payment measurement for part – Medicare Part C and Part D and then looking ahead and some future modernizations that we plan on doing to the improper payment measurements.

So as I mentioned, we're – Payment Accuracy and Reporting Group is within OFM. And we oversee the Medicaid fee-for-service improper payment measurement. It's called the Comprehensive Error Rate Testing Program, the CERT Program. And then we also oversee the Medicaid and CHIP improper payment measurements. We call it the PERM Program. And then we're currently in the process of developing the Exchange Improper Measurement Program for the federally-facilitated exchanges and the state-based exchanges. And that is currently under development, and we're hoping to have our first improper payment measurements out on – on the exchanges in 2021.

And then, most recently, we have taken on the work for the Medicare Part C and Part D improper payments.

So, like I said, as I mentioned earlier, previously the Medicare Parts C and D improper payment measurements were conducted by the Center for Medicare, the Medicare Plan Payment Group. And it just recently transferred over to our group this year, and we've been transitioning the workload roughly between May of this year to August. And so now we – the Payment Accuracy and Reporting Group, we call ourselves PARG, are responsible for all improper payment measurements, which makes

sense. It creates efficiencies and consistencies across all improper payment measurement programs.

So, the – the question is, why do we measure improper payments? So, there's a law out there, a statutory requirement, it's the Improper Payment Information Act of 2002. It's been amended twice, as you can see here. And then it has implementing guidance that OMB gives for agencies to actually measure. And that's the OMB A-123, Appendix C.

So, the law requires agencies to annually review their programs that they administer to see if, one, they are at risk for significant improper payments, and if they are, report those improper payments – those estimated improper payments – annually to Congress and the public. And the venue that we usually do this is the – the Department of Health and Human Services Agency Financial Report. And in that, we're supposed to not only report the improper payments and the causes, but we're also required to describe or talk about the actions the agency is taking to mitigate such payment vulnerabilities.

So, what is an improper payment? And this is – this comes specifically from statute. They are payments that shouldn't have been made or they were made in the incorrect amount. So they can include both and under payments. So it's the gross amount that we report, not the net amount. So it's payments for ineligible recipients, ineligible services, duplicate payments, payments for services not received, payments for incorrect amounts. And keep in mind, when we're measuring the improper payments, improper payments really represent government payments that do not meet the statutory, regulatory, or administrative, or other legally-binding applicable payment requirements. So, not all improper payments represent, you know, expenses that shouldn't have gone out the door. They could be for technical reasons. So we just want to make sure that's clear.

And then also one of the big things that we always fight – not fight but are trying to persuade or – or the messaging is that the improper payments,

it's not a fraud measure. I mean, we're taking statistically valid random samples and – and therefore we are not targeting to identify fraud.

Any questions before I move on?

So, I'm going to turn it over to Carolyn Kaputstij to go through the details on the operations for the Medicare Parts C and D improper payment measurements.

Carolyn Kapustij: Oh, thank you, Chrissy. So, the basis of the Part C improper payment measure is the error and risk-adjustment data that's been submitted to CMS for payment. The measure is based on sample of Medicare Advantage enrollees from across all plans so that we can derive a national improper payment rate. The sample totals 930 beneficiaries. That's what we're using at the moment. And it is split into three strata based on the disease component of the risk score for the beneficiaries, so you effectively have people at high risk scores, medium risk scores, and low risk scores.

Chrissy Fowler: Oops, sorry.

Carolyn Kapustij: That's okay.

So, especially where we need your cooperation is once CMS determines the sample, Medicare Advantage organizations receive notification and notice of training. You'll get a list of the enrollees selected for your – for your plan. And you'll be asked to provide medical records to support the payments they receive from CMS. And, we want to emphasize it's very important that you respond to the request, that the policy officials and our counterpart CM are really looking at response rates and non-response as a measure to possibly change policies.

Chrissy Fowler: And – and keep in mind, for some of the other measurements, we have insufficient doc errors in them as well. And a lot of them, for example for Medicaid and CHIP, are related to eligibility verifications. And so, the Agency has been looking at their policies regarding documentation

requirements, and so, that's the kind of stuff that we're, you know, the Agency looks at from our data standpoint it's like, do we need to strengthen those requirements? And so, that's something that – it's very important to make sure that, you know, the organizations actually submit the documentation in.

Carolyn Kapustij: So, the medical records that you submit should support the CMS HCCs that the plan received payment for. And the validation is aggregated to the CMS HCC not the diagnosis level. So, you receive payment for a diabetes HCC the corresponded – any corresponding diagnosis that maps to that will be accepted as validation.

Once CMS completes review of the medical records, we recalculate the risk score. So you'd have your – a score that you were paid on. Then you'd have a revised risk score based on medical record review. And the difference is an enrollee-level improper payment amount. Many times that amount will be zero showing that the diagnosis could be validated. After we get that amount for the sample, we then extrapolate it up to the population level.

This diagram just expands on the steps in the sample. And you can see the measurement process. The first step is sampling. As I said before, we identify the enrollees. We have certain operational criteria around that. We want the beneficiary to be enrolled in Medicare Advantage for the entire data collection year through the payment year.

After we validate the sample and make sure everything is okay with that, we go out with the medical record request where we notify Medicare Advantage organizations that they have an enrollee sample. We ask them to set up users in the HPMS system if the user is not set up already. And then we give you notification of a training teleconference.

As I said before, all of this will continue to occur in the Health Plan Management System.

So, we have the submission window open. The organizations are going to have about 16 weeks to submit the medical records that have been requested. And then we begin the review process. CMS has contractors who do the reviews. At first we do an intake process. The intake process is simply looking at, is this medical record an acceptable medical record for risk adjustment validation? Is it from an acceptable provider type? Is it from the correct date of service for which you were paid? Is it a credentialed provider?

After it makes it through the intake check, then it will go through ICD-10 coders who will look at the medical records and see what diagnoses there are on there and extract the diagnoses.

I should note that for – during the intake process, feedback is provided on a rolling basis in HPMS so you can see if there's a problem with the record. Is there no signature which will allow you to look for a different record to submit to possibly support the HCC? Any record from within the year is acceptable.

And then foll – following the medical record review, we calculate the payment error estimate and then go forward with the reporting in the Agency Financial Report which is around in November.

This slide just gives you a sense of what the improper payment estimate has been over the last few years. As you can see, it's a general downward trend, although we're still – the payments for Medicare Advantage are still high, you know, last year were still at over $15 billion in improper payments.

So now, we also do the Part D improper payment measure which is based on errors in PDE data. It's also referred to as (inaudible) which stands for Payment Errors Related to PDE Validation. And that's going to look at errors in the prescription drug events.

You might ask, how can we have errors in prescription drugs when not – all of it is not CMS liability? That's because improper payments can occur in the cost sharing part of it or the reinsurance part of it.

Also if there's errors in a – if you're looking at an enrollee's stream of PDEs, if you have one error, it can have a ripple effect and move people in and out of the catastrophic phase more quickly which would change the government liability.

Our sample for Part D right now is approximately 4,500 PDEs, again sampled from across all organizations. And if a PDE is sampled, to support the payment you'll be asked to submit a copy of the prescription and a claim detail file which was how this claim was processed in your system.

For the PDE review, CMS is going to compare the PDE which shows what CMS paid with the supporting documentation, which is the prescription – the actually prescription – and the claim detail file.

There are pharmacists who participate in the review process.

And any discrepancies between the PDE and the supporting documentation can result in an improper payment.

The payment error is based on a – the gross drug cost calculating gross drug cost error and comparing that, again, was on the PDE with what's supported in the claim detail file and the prescription.

To get to the improper payment estimate for the program, the results from the PDE review are imputed. We do a simulation thousands of times and run it through enrollee files to get a revised PDE stream to when you get an enrollee-level error, then extrapolate it up to the population.

The review steps are similar to those in Part C. First we have a sampling process. We select 4,500 PDEs. And this is also a stratified sample. It's based on certain characteristics of the PDE. Is it for a low-income beneficiary? Is it from a long-term care facility?

Sponsors are notified of selection. We hold a training. And the submission window begins in HPMS.

Similar to Part C, there's a preliminary review that happens. It's called an element check. Just basically checking are the data elements that we requested there in the claim detail file.

Next it moves on to the clinician review where the prescription – where we have pharmacists who actually review the prescriptions and compare that to the information in the PDE.

Based on the comparison of these documents, there's a recalculation of the gross drug costs, any components – the components that make that up. Ingredient costs, dispensing fee, I've seen administration fee. And if there's a difference, that is what the error is. Again, that's extrapolated up to the population. And on November 15 – around November 15 – that amount is reported in the Agency Financial Report.

On this slide, it gives you a sense of the – what the Part D improper payment measure has been for the last few years. Just want to note that at one time there were several components in the D measure. Now the – measuring the main source of error and the main component which is related to PDE submission.

I want to give you all a sense of what to expect. Just looking ahead, we've created preliminary timelines for both measures, and we expect notification to occur very early next year. There will be the training teleconferences. And then the submission window will open. You'll get – we expect this to occur in the first quarter of next year. And, again, we'll continue to use the HPMS system.

Chrissy Fowler: So, on – as I mentioned earlier, we have some modernizations and some changes that we're going to be incorporating in the Medicare Part C and D since it's coming over to the OFM team here. And a lot of the – the modernizations we're doing is we're trying to streamline the measurement to be similar where applicable to other measurements that we have here

at CMS. So, changes for this year. So we – we have modified the contracts to have the review contractors to actually provide the training for 2020 instead of having a separate review – or contractor to actually go out there and train. They are the ones that know what they need and know how best to train the – the organizations and plans on what to submit. So RELI will be the Part C training and review contractor and Booz Allen Hamilton for Part D.

Another change that we're making this year is instead of having two separate medical review contractors for the Part C program, we are having one contractor. And it will reduce the coding reviews from four down to two. But we still will have the level of integrity and accuracy checks all within that one con – medical contractor review.

So looking forward, as I talked about, Carolyn came up with this great word of modernizing the Medicare Parts C and D, and it just stuck. And so this is going to be a multi-year project that we're looking at, you know, embarking to change the current measures. Improve them. Enhance them. Make sure that we're accurately reviewing according to the payment policies.

So some of the areas that we're going to be looking at is how we sample. Is there a way to – that we can be more efficient at sampling or sampling in a way that we can get better data to identify the root causes? And actually provide organizations better data on what kind of vulnerabilities are within their organization or plans.

And then we're also looking at the review process. One of the big things that OFM Payment Accuracy Reporting Group do is we pride ourselves on integrity and making sure that we are accurate in accordance with the payment policies that are out there. And so that's something that we're going to be looking at, those payment policies and making sure that we're appropriate capturing them in our medical – or our reviews.

And then, lastly, is the actual calculations, the fiscal methodology. As Carolyn mentioned, the Part D calculation, the simulation many, many

times over and over again, it's very convoluted. And having to explain that clearly and like trying to simplify that and coming up with a better way to be able to identify root causes or specific areas of vulnerability is what we're going to be looking at.

And then, again, just like looking at the, you know, making sure that we're reviewing against – accurately against the true payment policies that are out there. And, as I mentioned earlier, we've already started the process for creating efficiencies and then looking at synergies that we can have with other measures that we are measuring for Medicare, Fee-for-Service, Medicaid, CHIP, and eventually the Exchange and proper payment measurement.

So if you have any questions, feel free to step up to the mic. Or you can always email me. I would recommend emailing Carolyn. She's the expert on this. We just took it on and I'm doing my best to like get up to speed on understanding it. I got a good concept of what – what's going on, but there's a lot of things that I – I know from the other measurement programs that I want to see if we can like translate those operations into the Medi – Medicare Parts C and D.

One other thing we did want to note and – is there are two separate reviews that are going on right now. There is the National Improper Payment Measurement, and a lot of people call it – in the past have called that the National RAD-V, and then you have the Center for Program Integrity, the RAD-V audit. They are two separate programs and have two separate purposes. And so we're trying to make sure that we clearly delineate the difference between the two. One of the things that we're going to do over the – the next coming years is making sure that we coordinate better with CPI on – on the audits, where possible, so there's not as much burden on the plans. And I can't guarantee that it's going to happen overnight, but it is one of the initiatives that I have asked Carolyn and team to embark on.

So I will stop there. Does anyone have any questions? I think people are still awake.

Kristen Renkes: I do have a few that have been submitted.

Chrissy Fowler: Oh, yes, we can go through this.

Kristen Renkes: Okay. How does the Part C improper payment measure relate to contract-level risk adjustment data validation, RAD-V, for audits?

Chrissy Fowler: So I – I think I initially kind of preempted that question. Oops. But I'll let – I'll let Carolyn give you guys a little bit more detail on that.

Carolyn Kapustij: Uh, no, Chrissy – Chrissy covered that earlier, so it's separate activities conducted in separate areas of the Agency. The National – the improper payment measure is to comply with IPERIA and get a measurement for across the program whereas the other audits are done for payment recovery purposes.

Kristen Renkes: Okay. And encounter data is used in the Part C measure?

Carolyn Kapustij: It's used as data that you submit to the Risk Adjustment Processing System would be used because it's a source of diagnoses for which a plan received payment. Those medical records will be audited. The entire payment is audited.

Kristen Renkes: And then, how can plans partner with CMS in the measurement process?

Carolyn Kapustij: That's a really great question. Just encourage you to respond to the audit, as we talked about earlier. Attend the training. Attend the teleconference. And, please, if you have any questions, shout out, ask questions.

Kristen Renkes: Okay. With no questions from our audience, thank you so much Chrissy and Carolyn. We really appreciate it.

Chrissy Fowler: Right. Thank you all for having us.

Have a wonderful afternoon.

Kristen Renkes: It's time for our next session evaluation. Please text A to 22333, or go to pollev.com/cms2019fall.