Update: CMS Program Integrity
NHCAA ANNUAL TRAINING CONFERENCE

Atlanta, Georgia
November 16, 2011

Center for Program Integrity
Centers for Medicare & Medicaid Services

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Center for Program Integrity Mission and Vision

Mission

The central purpose and role of the Center for Program Integrity is to ensure that correct payments are made to legitimate providers for covered appropriate and reasonable services for eligible beneficiaries of the Medicare and Medicaid programs.

Vision

Over its first three years, the Center for Program Integrity will become an organization within CMS that uses state-of-the-art methods to prevent and detect fraud and to reduce waste, abuse, and other improper payments under the Medicare and Medicaid programs.

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CPI Strategic Direction

	Established Approach	New Approach
1	Pay and Chase	Prevention and Detection
2	‘One Size Fits All’	Risk-Based
3	Legacy Processes	Innovation
4	Inward Focused Communications	Transparent and Accountable
5	Government Centric	Engaged Public & Private Partners
6	Stand Alone PI Programs	Coordinated & Integrated

National Fraud Prevention Program

- The National Fraud Prevention Program integrates two key program integrity activities: Provider Screening and Claims Processing
- The coordinated program will permit CMS to:
  - Prevent bad actors from enrolling in Medicare and to share that information with State Medicaid programs
  - Prevent the payment of fraudulent claims, and remove bad providers and suppliers from Medicare and Medicaid
  - Prevent payment of improper claims with quick administrative action

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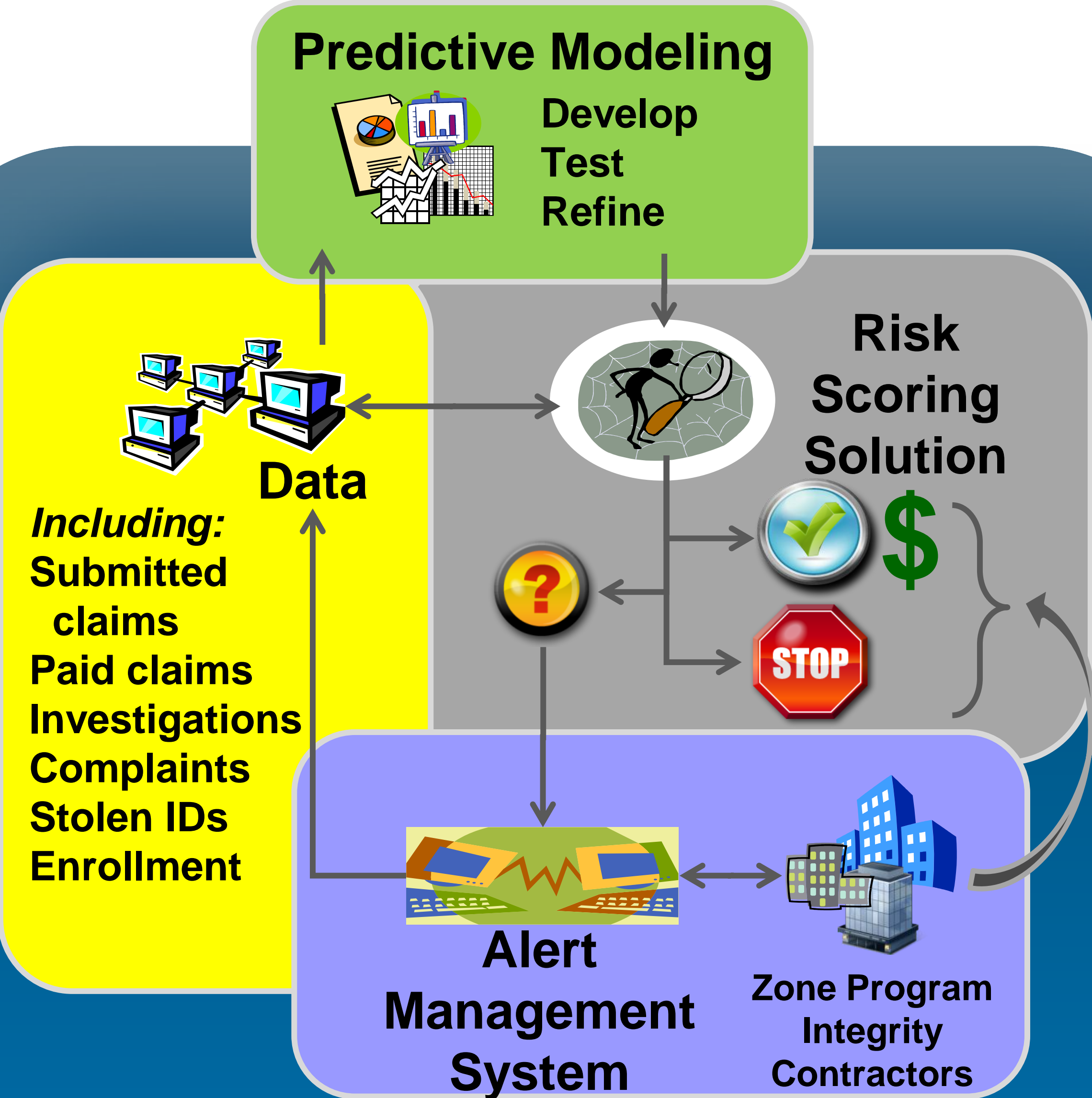
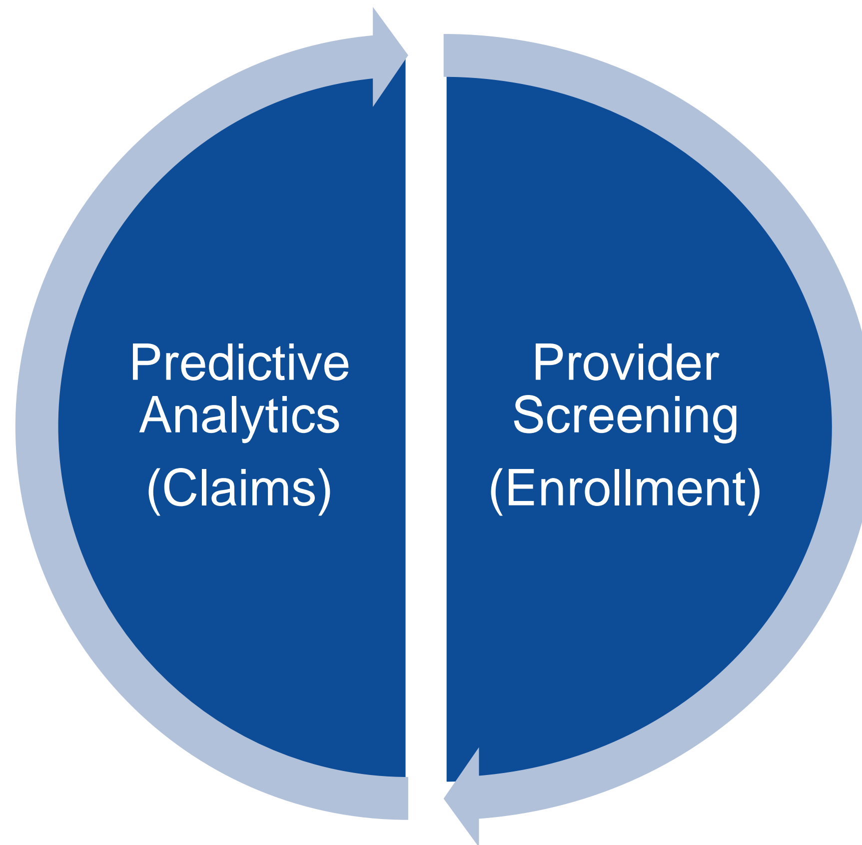
National Fraud Prevention Program



- Predictive modeling part of end-to-end solution that triggers effective, timely administrative actions by CMS.
- Assures that analytics are effective (minimize false positives), efficient (return on investment), and risk-based.
- Meets the requirements of Section 4241 of the Small Business Jobs Act of 2010

National Fraud Prevention Program
Two Concurrent Approaches



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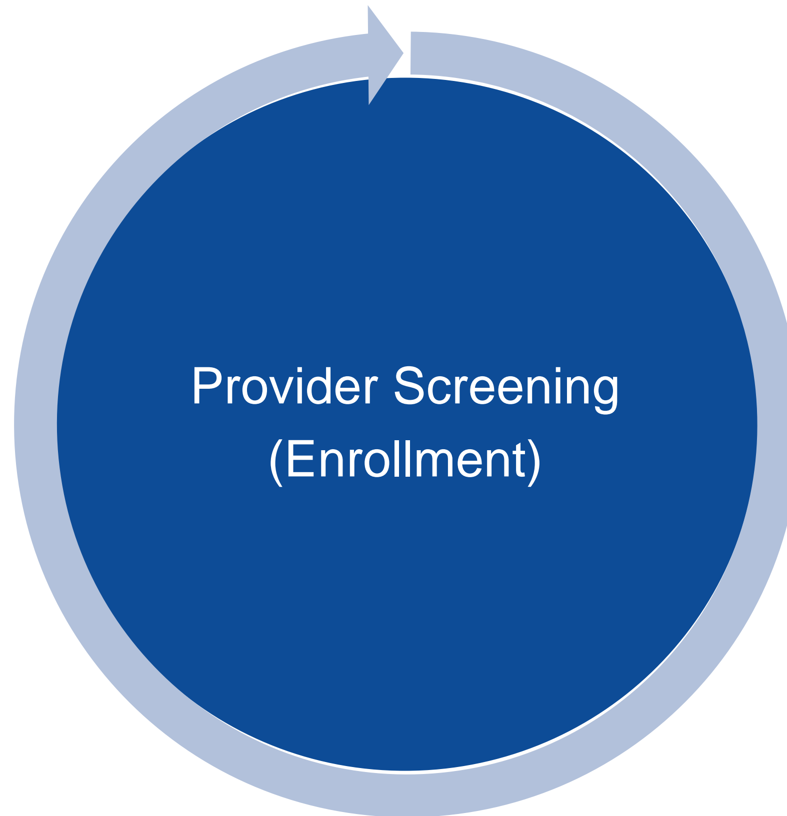
National Fraud Prevention Program: *Provider Screening*



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Prevention
Strengthening Provider Enrollment

- CMS awarded an Automated Provider Enrollment Screening contract on September 30, 2011 and will implement the system in January 2012 or earlier
- The automated screening tool will continuously compare information received on an enrollment application to various public and private databases, such as:
  - National Plan and Provider Enumeration Systems for National Provider Identifiers
  - GSA Excluded Parties List
  - OIG Exclusion database
  - Other useful data bases as they become available

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Prevention
Strengthening Provider Enrollment

- Goals of Automated Enrollment Screening
  - Reduce enrollment application processing time
  - Assess providers' risk of fraud before the receipt of billing privileges
  - Enable CMS to monitor accuracy of enrollment data on an on-going basis
  - Provide a shared view of screening results where CMS, MACs and PI Contractors can verify, update, and act on relevant information found during the enrollment process

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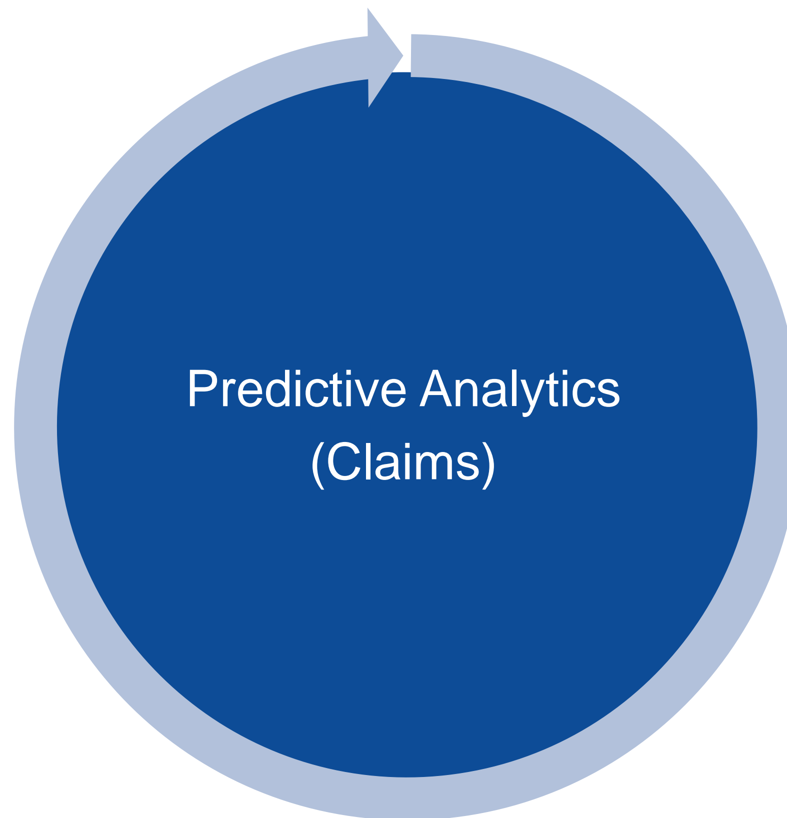
National Fraud Prevention Program
Predictive Analytics - Claims



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Fraud Prevention System

- CPI implemented the Fraud Prevention System (FPS) in Medicare Fee-For-Service on June 30, 2011, under the Small Business Jobs Act of 2010
  – An integrated team led by Northrop Grumman was awarded the system development contract, and they provided a system that was:
    - Immediately transferable to Medicare FFS claims nationwide
    - Based on effective technology that has demonstrated a reduction of fraud losses by orders of magnitude in the contractor's own business, while reducing necessary operational resources in half
  – The Modeling Contract was awarded to IBM for the development of additional models for future integration into the FPS
- CPI is exploring options to expand FPS-like technology to Medicaid

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Prevention
The Affordable Care Act

- The Affordable Care Act enacted the most important and comprehensive anti-fraud provisions in well over a decade
- These provided CMS with powerful new tools to move the PI strategy beyond "pay and chase" to a proactive approach
- CPI has implemented many of these important prevention-oriented PI provisions to date in two key regulations:
  - The "Ordering and Referring" interim final rule, published May 5, 2010 (75 Fed Reg 24437)
  - The "Enrollment Screening" final rule, published February 2, 2011 (76 Fed Reg 5862)

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Prevention
The "Ordering and Referring" Interim Final Rule

- Interim Final Rule was effective July 6, 2010, and required
  - Physicians and other practitioners who order and refer certain services to enroll in Medicare
  - Medicare and Medicaid providers or suppliers who are eligible for an NPI to report NPI on an enrollment application and all claims
- CMS delayed implementation of automatic rejection of claims to give providers ample time to enroll and allow the Medicare Administrative Contractors (MACs) sufficient time to process enrollment applications
- CMS will provide ample notice before automatic edits are in place for claims that fail to meet the ordering and referring enrollment requirement

Prevention
The "Enrollment Screening" Final Rule

- Final rule was effective on March 25, 2011 and contained the following key provisions:
  - Risk-based screening of new providers
    - Requirements are parallel for Medicare, Medicaid, and CHIP and States may rely on the results of Medicare screening
    - Fingerprint-based criminal background checks for Medicare will be implemented through coordination with the FBI
  - Moratorium on enrollment of new providers when there is a risk of fraud to the Medicare, Medicaid and CHIP programs
  - Termination of providers across Medicare, Medicaid and CHIP programs
  - Providers who order or refer certain services must enroll in Medicaid
  - Suspension of payment during the investigation of a credible allegation of fraud

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Prevention
Final Rule: Risk-Based Screening

- Levels of screening by risk-based categories of providers, such as:
  - Limited: physicians, medical groups, clinics, hospitals
  - Moderate: physical therapists, CMHCs, outpatient rehabilitation facilities, ambulance providers, currently enrolled DMEPOS and home health agencies
  - High: prospective (newly enrolling) home health agencies and suppliers of DMEPOS; providers and suppliers who have experienced a triggering event, such as:
    - » Excluded by the OIG
    - » Subject to a payment suspension
    - » Terminated by Medicaid
    - » Subject to other final adverse actions

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Prevention

Final Rule: Required Screening By Risk Level

TYPE OF SCREENING REQUIRED	LIMITED	MODERATE	HIGH
Verification of any provider/supplier-specific requirements established by Medicare	√	√	√
Conduct license verifications, including licensure checks across States	√	√	√
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), licensure, an OIG exclusion, taxpayer identification number, death of individual practitioner, owner, authorized official, delegated official, or supervising physician)	√	√	√
Announced or Unannounced Site Visits		√	√
Criminal Background Check			√
Fingerprinting			√

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Prevention
Final Rule: Temporary Enrollment Moratorium

- CMS may impose a temporary enrollment moratorium in Medicare, Medicaid and CHIP if there is significant potential for fraud, waste and abuse
- Illustrative conditions for a temporary moratorium
  - CMS data suggest trends associated with high risk of fraud, such as highly disproportionate number of providers per beneficiary
  - A State has imposed a moratorium in a particular geographic area or on a particular provider/supplier type
- Determinations in consultation with OIG or DOJ or both
- The moratoria will be limited to:
  - Newly enrolling providers
  - The establishment of new practice locations, but not the change of practice location

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Prevention
Final Rule: Termination Across Programs

- The ACA requires all Medicaid programs to terminate providers who have been terminated for cause by another State Medicaid or CHIP program or revoked by Medicare for cause
- CMS may revoke providers from Medicare when they have been terminated under a State Medicaid program
- CPI established a platform for States to share information on terminated providers and suppliers with each other

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Prevention
Final Rule: Payment Suspension Based On a Credible Allegation of Fraud

- Credibility is determined in consultation with the OIG
- Examples of a “credible allegation of fraud” include, but are not limited to:
  - Fraud hotline complaints
  - Patterns identified through provider audits or law enforcement investigations
  - Claims data mining
- Duration of suspension
  - For each suspension, certifications would be required every 180 days from the HHS OIG that the payment suspension should remain in place
  - The suspension will end after 18 months unless certain exceptions are met

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Detection Strategies
Improved Fraud Reporting

- CMS has implemented a geospatial toolset to create a national "heat map" of beneficiary calls with a fraud reference. The technology has the ability to track such calls to identify changing trends and new hot spots just as they are emerging.
- CMS has also undertaken a provider identify theft victims project, to assist providers who have had their medical identities stolen or compromised.
  - CPI has developed a new process to determine and validate whether a provider has been a victim of identity theft and to absolve related debts, such as Medicare overpayments or tax obligations.
  - The project augments processes already in place to assist providers victimized by identity theft and will continue to be enhanced.

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Transparency and Accountability
Partnering with Law enforcement

- CMS partnered with the Department of Justice to host Health Care Fraud Prevention Summits in six cities since 2010: Miami, Los Angeles, Brooklyn, Boston, Detroit, and Philadelphia, as part of the larger joint effort of DOJ and HHS through the Health Care Fraud Prevention and Enforcement Action Team (HEAT).
- The summits brought together Federal, State and local partners, beneficiaries, and providers to discuss innovative anti-fraud strategies
- CMS is also heavily involved with the development of many law enforcement cases. For example, Secretary Sebelius announced in a recent, joint HHS-DOJ press conference, CPI had a key role in a multi-state takedown of fraudulent providers, resulting in the arrest of 91 individuals responsible for $295 million in false Medicare billings.

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Transparency and accountability
Self-referral disclosure protocol

- CMS published the Medicare self-referral disclosure protocol in September 2010
- The process enables providers and suppliers to disclose any actual or potential self-referral violation (ACA § 6409):
- The Secretary may reduce the amount owed after considering:
  - Nature and extent of improper practice
  - Timeliness of self-disclosure
  - Cooperation in providing additional related information
  - Other appropriate factors
  - The protocol is distinct from the advisory opinion process at SSA § 1877(g)

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Recovery
Recovery Audit Contractors: *Medicaid*

- States and territories must establish Medicaid RAC programs (ACA § 6411(a)). CMS-6034-F published September 16, 2011, with an effective date of January 1, 2012.
  - Medicaid RACs must identify overpayments and underpayments, and the RAC or the state must recover overpayments
  - States must pay Medicaid RACs on a contingency fee basis for identification and recovery of overpayments and will determine the fee paid to Medicaid RACs to identify underpayments
  - States and their Medicaid RACs must coordinate their audit efforts with those of other auditing entities, including State and Federal law enforcement agencies. CMS and States are concerned about provider burden. States and their RACs must work to minimize the likelihood of overlapping audits of providers.

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Recovery
Recovery Audit Contractors: *Medicare Parts C/D*

- The ACA required the expansion of RACs to Parts C and D
  - CPI solicited commented on innovative strategies to implement the requirement that RACs review the effectiveness of Part C and D sponsors anti-fraud plans last December
  - CPI awarded a contract for the Part D RAC in January 2011 and is currently implementing RAC procedures
  - CPI is developing a procurement strategy for a Part C RAC

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The New Approach to Combating Fraud, Waste and Abuse

Yesterday	Today & Future State
• Providers suspected of fraudulent activity are put on prepay review, sometimes indefinitely • CMS initiates overpayment recovery • Law enforcement determines if an arrest is appropriate	• CMS will deny individual claims • CMS and its contractors will use prepay review as an investigative technique • CMS will revoke providers for improper practices • CMS and Law Enforcement collaborate before, during and after case development • CMS will address the root cause of identified vulnerabilities

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Comprehensive Strategy

Detect suspicious claims prior to payment

Revoke bad actors from Medicare and Medicaid

Focus on risk and reduce burden on legitimate providers

Program Integrity

Prevent fraudulent providers from enrolling

Keep bad actors from re-enrolling

Share information with States, law enforcement and private plans to target and track fraudsters

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