

CMS Program Integrity and the Affordable Care Act

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AGENDA

- Background
- Program Integrity Strategic Principles
- Program Integrity Activities
- Questions?



BACKGROUND

- History of the Center for Program Integrity
 - March 23, 2010 – The Affordable Care Act (“ACA”) was enacted
 - April 11, 2010 – Secretary Sebelius realigns CMS into four Centers, creating the Center for Program Integrity
 - June 8, 2010 – The President announces CMS will reduce the improper payment rate in Medicare FFS by 50% by FY2012



BACKGROUND

- The Center for Program Integrity has:
 - Realigned Medicare and Medicaid program integrity groups into an integrated operation
 - Coordinated traditional PI efforts and is implementing the Affordable Care Act
 - Committed to reducing the Improper Payment Rate as directed by the President



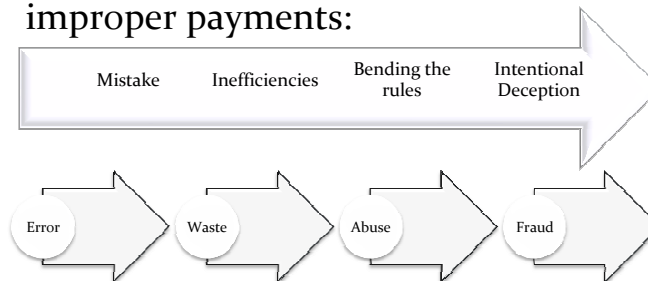
BACKGROUND

- **The Medicare Challenge**
 - **Each working day, Medicare:**
 - ▶ Pays over 4.4 million claims
 - ▶ To 1.5 million providers
 - ▶ Worth \$1.1 billion
 - **Each month, Medicare**
 - ▶ Receives almost 19,000 provider enrollment applications
 - **Each year, Medicare:**
 - ▶ Pays over \$430 billion
 - ▶ For more than 45 million beneficiaries



BACKGROUND

- **Program Integrity** encompasses a range of activities to target the various causes of improper payments:



Program Integrity Strategic Principles

- Prevent Fraud
- Target interventions to focus on risk
- Innovate to identify improper claims before payment
- Accountability by measuring success
- Foster public and private partnerships



Program Integrity Strategic Principles

- ◆ Strengthen prevention of improper payments at the front end of the claims payment systems
 - Keep the 'bad actors' out
 - Educate providers on common billing mistakes



Preventing payments: Enhanced screening of providers

- CMS-6010-IFC: Changes in Provider and Supplier Enrollment - May 2010
 - Providers or suppliers who is eligible for an NPI must report NPI on enrollment application and claims (ACA § 6402(a))
 - Providers who order or refer for certain Part A and Part B services must be enrolled in Medicare (ACA § 6405(a))



Preventing payments: Enhanced screening of providers

- CMS-6010-IFC: Document retention requirements on referrals to high risk programs
 - Providers will maintain and provide access to documentation relating to written orders for DME, HH for 7 years from the date of service
 - The Secretary may revoke enrollment for a period of not more than one year for each act if a provider fails to provide documentation (ACA § 6406)



Preventing payments: Additional provisions from ACA

- Reporting and Returning Overpayments (ACA § 6402 (a))
- Enhanced Oversight(ACA § 6401(a))
 - The Secretary shall withhold payment to DMEPOS suppliers for a period of 90 days after initial enrollment if there is a significant risk of fraudulent activity



Preventing payments: Additional provisions from ACA

- Provider Screening (ACA § 6401(a)) – September 2010
 - The Secretary shall determine the appropriate level of screening according to the risk of fraud, waste and abuse per provider or service type
 - Screening may include:
 - ▶ Licensure check
 - ▶ Identification verification
 - ▶ Unannounced site visits
 - ▶ Cross-State database checks
- Temporary Moratorium (ACA § 6401(a))
 - The Secretary may impose an enrollment moratorium of new providers if necessary to combat fraud, waste or abuse in Medicare, Medicaid or CHIP



Preventing payments: Predictive Modeling

- CMS is seeking Predictive Modeling Solutions for Medicare FFS to:
 - Manage real time systems that will identify high risk claims pre-payment and deny improper claims
 - Provide real time transaction risk scoring and have referral strategy capabilities
- CMS is conducting market research to identify qualified businesses



Program Integrity Strategic Principles

- Target interventions towards the areas where fraud and abuse are the greatest
 - Geographic areas
 - Health care services
 - Provider and supplier types



Targeted Intervention: South Florida

- Reasons for Developing South Florida Pilots
 - Miami is considered “Ground Zero” for Fraud
 - Focus on Vulnerabilities (e.g. Enrollment, Home Health, Referring Physician Practices, Appeals)
 - Disseminate Lessons Learned and Best Practices
 - Develop National Models for Preventing Fraud
 - ▶ Expanding fraud hotline to engage beneficiaries
 - ▶ Increase & improve provider enrollment site visits
 - ▶ Enhance Home Health approach to stop saturation



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Targeted Intervention: South Florida Fraud Hotline

- Enables beneficiaries to call 24/7 to report that their ID number has been stolen or to report any other suspected instances of fraud.
- Hotline number is placed on Medicare Summary Notices (MSNs) for Miami-Dade, Broward, and Palm Beach counties.
- MSNs issued monthly in South Florida so beneficiaries have the opportunity to review their statements frequently
- Investigations into referrals from the hotline have resulted in:
 - 51 providers placed on pre-pay review
 - 22 provider numbers revoked
 - \$2.8 million seized by law enforcement
 - \$2 million denied based on pre-payment review
 - \$11 million referred for overpayment collections



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Targeted Intervention: South Florida High Risk Enrollment

- Collaborative effort between two Medicare contractors in South Florida that enables CMS to identify program changes to stop fraud in the high risk areas of **Miami-Dade, Broward, and Palm Beach** counties.
- Focuses on the provider and supplier categories of laboratories, physicians and non-physician practitioners deemed high risk, community mental health centers, comprehensive outpatient rehabilitation facilities, and independent diagnostics testing facilities.



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Targeted Intervention: South Florida High Risk Enrollment

- Since April 30, 2010, as part of this project, contractors have completed over 1600 onsite visits in South Florida.
 - 36% of these visits have resulted in revocations or deactivations
 - The remaining 64% were referred to pre-payment review or other actions
- Also since the end of April 2010, contractors have reported a total of \$7.6 million in pre-pay claim edit savings. This represents the amount that would have been paid if the providers were not subjected to a pre-pay edit.



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Targeted Intervention: South Florida Home Health Agencies

- Addresses the saturation problem of Medicare home health agencies (HHAs) in South Florida.
 - In Miami-Dade County, 136 new HHAs were certified during 2009 alone.
 - Now there is a constant investigator presence in the field and increased beneficiary interviews.
- Another problem with HHAs is that insulin injections are frequently administered by skilled nurses for patients who typically are capable of learning how to self-manage.
 - In this project, physicians who order home health care for diabetic patients are interviewed.
 - Solution: gather signed statements reflecting the physicians' determination that their diabetic patients can be taught to self-check blood glucose and self-inject insulin rather than having the HHA nurse do this indefinitely.



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Program Integrity Strategic Principles

- **Innovate to increase the detection of improper payments with the use of innovative technologies and highly skilled staff**
 - **Continue to implement the Integrated Data Repository**
 - **Solicit new strategies from those experienced in analytics**



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Innovate to Increase recovery: Recovery Audit Contractors

- States and territories must establish Medicaid RAC programs by December 31, 2010.
 - Medicaid RACs must identify and recover overpayments and identify underpayments.
 - 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.
 - Medicaid RACs must coordinate their efforts with other auditing entities, including State and Federal law enforcement agencies. CMS and States will work to minimize the likelihood of overlapping audits.



Innovate to Increase recovery: Recovery Audit Contractors

- CMS must establish Medicare C/D RAC programs by December 31, 2010. (ACA § 6411(b))
 - Medicare C/D RACs must ensure that each MA and drug plan has an anti-fraud plan in effect and review the effectiveness of each plan
 - Part D RACs will examine claims for reinsurance to determine if drug plan sponsors submitted claims exceeding allowable costs
 - Part D RACs will review estimates submitted by drug plans for high cost beneficiaries and compare to numbers of beneficiaries actually enrolled in such plans



Program Integrity Strategic Principles

- **Be accountable by measuring success and transparent to key stakeholders regarding policies**
 - **Develop and implement key performance metrics**
 - **Provide consistent messages on new policies and procedures**



Accountability through communication: Distribution of program guidance

- **State Medicaid Director Letter regarding the Mandatory State use of the National Correct Coding Initiative (SMDL 9/1/2010) defined:**
 - **Statutory requirements in ACA § 6507**
 - **Methodologies in Medicare and Medicaid**
 - **Funding for state implementation**
 - **Availability of off-the-shelf software**
 - **Contact information for states**



Accountability through communication: Distribution of program guidance

- The Medicare self-referral disclosure protocol will enable providers and suppliers to disclose an actual or potential violation and will clarify (ACA § 6409) – September 2010:
 - The person, official or office to whom the disclosure shall be made
 - Instructions on the implication of the protocol on corporate integrity and compliance agreements
 - The protocol is distinct from the advisory opinion process at SSA § 1877(g)



Accountability through communication: Distribution of program guidance

- The Medicare self-referral disclosure protocol cont.:
 - The Secretary may reduce the amount owed after consideration of the following factors:
 - ▶ Nature and extent of improper practice
 - ▶ Timeliness of self-disclosure
 - ▶ Cooperation in providing additional information related to disclosure
 - ▶ Other factors the Secretary considers appropriate



Program Integrity Strategic Principles

- **Enhance partnerships with the private sector to share information and methods to detect and prevent fraud**
 - **Continue to coordinate with law enforcement on initiatives**
 - **Reach out to beneficiaries to promote engagement in the fight against fraud**



Enhancing Partnerships: Connecting community efforts

- **The Regional Fraud Summits are coordinated among the Office of Inspector General, the Department of Justice, the Secretary of HHS, the Administration on Aging and CMS:**
 - **Three (Miami, Los Angeles and New York) of seven summits have been held (Detroit, Boston, Los Vegas and Philadelphia remain)**
 - **Provide a space for beneficiaries, providers, hospitals and law enforcement to discuss shared concerns and strategies for collaboration**



Enhancing Partnerships: Engaging beneficiaries

- CMS has a multi-pronged approach to empowering the beneficiaries:
 - Educating beneficiaries and their families about the capability of MyMedicare.gov and 1-800-Medicare to access their health care claims
 - Engaging with the Senior Medicare Patrol to develop an effective strategy for identifying fraud and protecting beneficiaries from medical identity theft



Preventing Fraud, Waste and Abuse While Improving Quality of Care

