

Transparency, Reporting & Data Mining

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Size and Scope of Data

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Medicare: Scope and Size of Data

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Each DAY Medicare receives and processes the following data:

- Nearly 3,000,000 eligibility inquiries
- More than 4.4 million claims from over 1.2 million providers
- More than 165,000,000 Part D prescription drug events
- Approximately \$1.2 billion in Medicare payments that go out to providers

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Medicare: Scope and Size of Data

Each MONTH Medicare receives and processes the following data:

- 240,000+ new Medicare beneficiaries; 200,000 deaths
- As many as 25,000,000 transactions from MA and Part D plans
- Calculate and pay more than \$12,000,000,000 monthly for Medicare Advantage and Part D

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Medicare: Scope and Size of Data

For Fiscal Year 2009 this all adds up to:

- 45.9 million Medicare beneficiaries (compare this to 19.1 million when the program started in 1966)
- \$461 billion in total Medicare payments (12.5% of the Federal budget)

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Medicare Business Partners to Process Data

- Medicare FFS
 - 15 Medicare Administrative Contractor Jurisdictions (Parts A & B)
 - 4 Durable Medical Equipment Medicare Administrative Contractors
 - Qualified Independent Contractors (Appeals)
 - Coordination of Benefits Contractor
 - 1.2 million + Health Care Providers
- Medicare Advantage and Part D
 - Over 700 Plan sponsors
 - Retiree Drug Subsidy Contractor
- Medicare Program Integrity
 - 7 Zone Program Integrity Contractors (down from 10 Program Safeguard Contractors)
- 1-800-Medicare
- Medicare and Health Care Quality
 - 53 Quality Improvement Organizations
 - 18 End Stage Renal Disease Networks

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Scope & Size of Regional Health Operations

- 64,000 claims processed per day
- Net revenue \$466.3 million
- Bad debt 5.9% of net revenue
- Charity 4.7% of net revenue
- High Medicaid population
- 5 hospitals
- 20+ clinics
- Durable Medical Equipment
- Home Health
- Skilled Nursing Facilities
- Family Practice Residency


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Major Points: CMS

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- CMS is the nation's largest purchaser of health care, and within that, of managed care.
- CMS' systems environment is large and complex, interacting with the systems of multiple Medicare contractors and participating providers to administer Medicare and ensure care is delivered to beneficiaries.
- The core claims processing environment was designed and built in the 1970s and 80s and remains largely the same. Significant additional capabilities have been added through the years to enable new business capabilities.

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Major Points: Provider

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- Regional Health is not the largest provider
- Our systems environment is large and complex, interacting with systems of thousands of business partners
- 1357 payors
 - Each payor mandates how the CPU format is to be presented.
 - Not all payors are electronic and paper copies are filed.

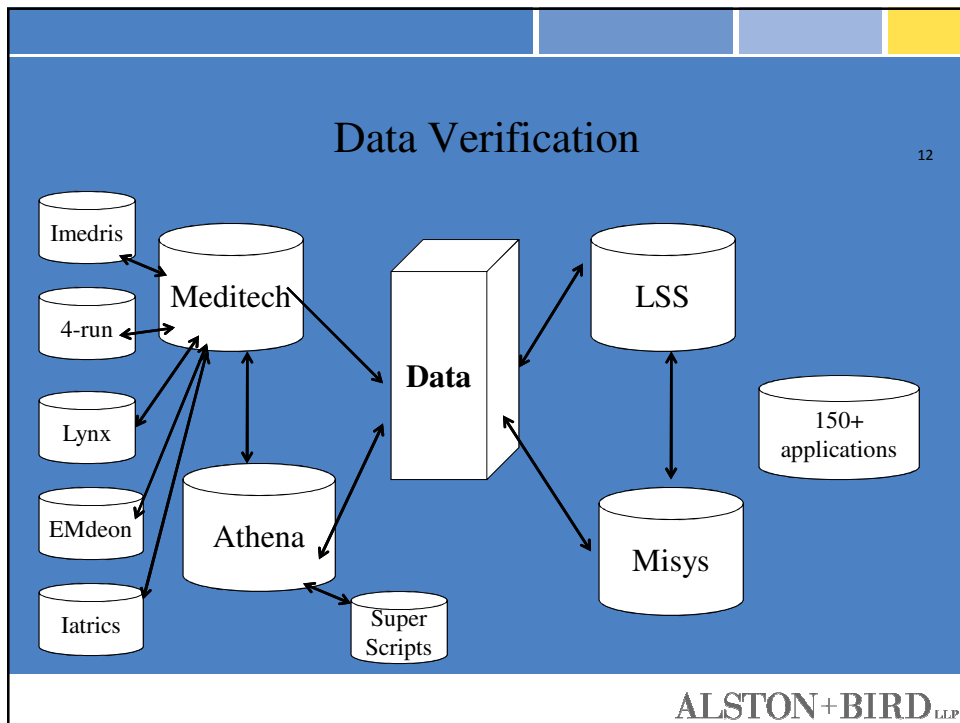
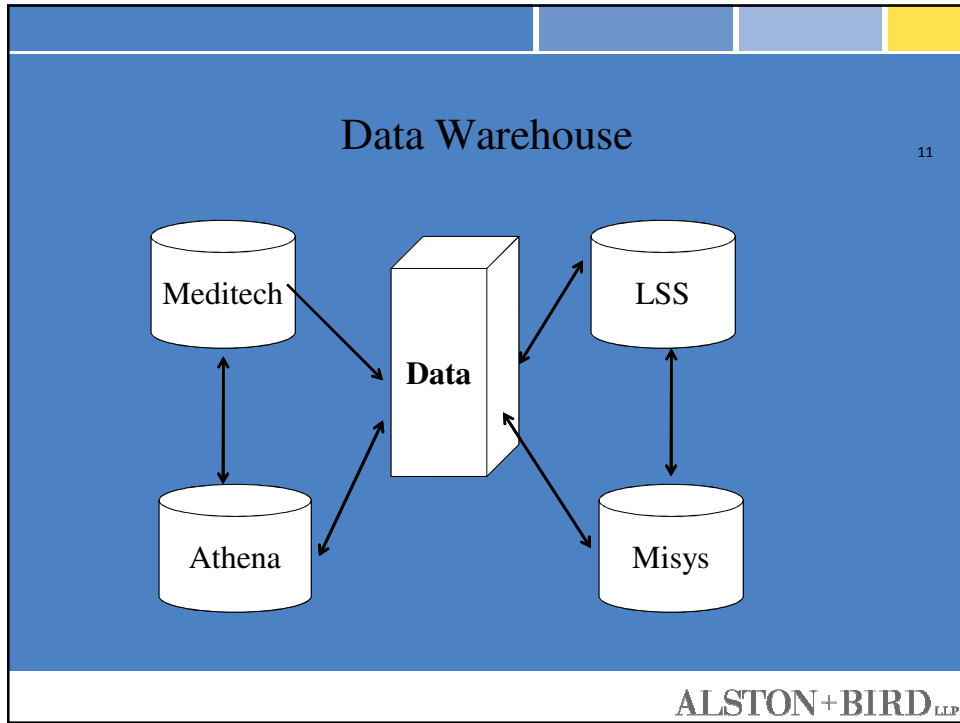
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Provider Operations

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Variations in eligibility verification

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- Medicare: DOB, Policy number NPI number
- Medicaid: Policy number and provider ID (NPI)
- IHS:
 - No referral card
 - Do not allow phone calls
 - Arrangement with each tribal unit
 - Fax sent to verify whether item is covered
 - Must provide a list of services, charges and a copy of the records before payment is made.
 - Just because it is approved doesn't mean the claim is paid.

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Variations in eligibility verification

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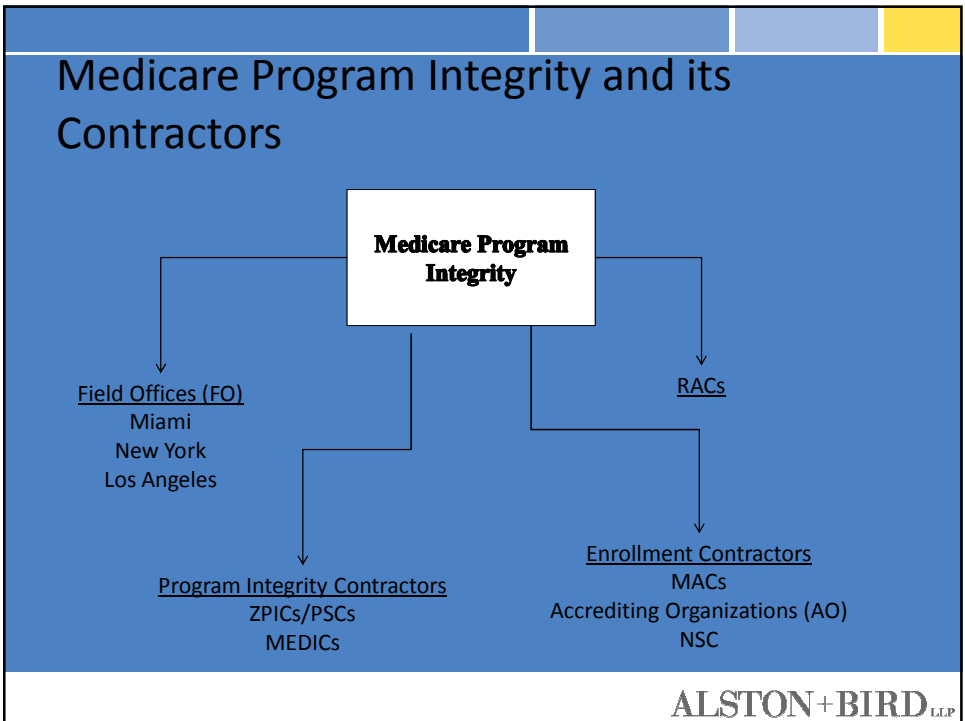
- VA/Champus: All referred with an order and authorization
- Commercial: DOB, SSN. Not all payers are electronic (manual entering on website)
- Additional information
 - Advanced Directives
 - Power of attorney
 - Living will
 - Charity Care application
 - HIPAA

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Medicare Business Operations

Medicare Program Integrity

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3 Key Types of Contractors For CMS Program Integrity Data Analysis:

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- *Zone Program Integrity Contractors (ZPICs)* audit claims data across all providers to determine if, for example, Medicare and Medicaid claims filed for dual-eligible beneficiaries are not being billed for the same services twice.
- *Recovery Audit Contractors (RACs)* review claims from any provider who was paid by Medicare, identifies net overpayments and recoups them on an automated or complex review basis.
- *Comprehensive Error Rate Testing (CERT)* contractors analyze paid claims and calculate an error rate. They then can assess medical records and recoup overpayments.

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ZPIC Geographic Map

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Data Analysis for Program Integrity - ZPIC Data Mining

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Data mining activities performed by the ZPICs apply all major types of data analysis, including:

- statistical modeling
- network analysis
- other artificial intelligence processes

Each type of analysis can and has been used to investigate fraud and abuse specific to:

- services and procedures
- geographic location
- place of service
- benefit type
- facility type
- provider specialty

ZPICs integrate clinical guidelines, national coverage determinations, local coverage determinations, and state policies into their analyses.

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Data Analysis for Program Integrity - ZPIC Reports

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ZPICs generate a variety of data intelligence

- Top Reports
 - Identify top areas of spending (CPT, DRG, etc.)
 - Identify top paid providers
 - Identify most expensive services
- Trending Reports
 - Specific code across time
 - Specialty across time
 - DRG across time
- Spike Reports
 - Trend Reports that identify significant change

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Data Analysis: RACs

- Information about RAC program, including issues approved for RAC review, can be found at www.cms.gov/RAC
- RAC reports are issued yearly which identify the key RAC findings and can provide a valuable roadmap for providers to use to tailor compliance efforts, particularly auditing, monitoring and training.
- Medicare Quarterly Compliance Newsletter includes information about what issues have been identified by the RACs, ZPICs and other CMS payment and anti-fraud contractors. First issue came out in October 2010, expect more to come. Access current issue at: http://www4.cms.gov/MLNProducts/downloads/MedQtrlyComp_Newsletter_ICN904943.pdf

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Preparing for a ZPIC/RAC Data Analysis Review

- When the ZPICs and RACs and other auditors submit their demands for supporting documentation as part of a “complex” review, and ultimately demanding repayments, it's a good idea to begin and continue conducting reviews on the completeness of responses for those claims and also for claims that have similar characteristics.
- Data mining also can be used for anticipating and ultimately defending the “automated” reviews of ZPICs, RACs and other auditors. For example, claims with an inordinate number of time-based procedure codes in a 24-hour period can be flagged for internal review. And, the implementation of claim “scrubbers” can prevent the submission of National Correct Coding Initiative coding pairs or the duplicate billing of codes for the same patient on the same date-of-service.

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CERT Data Analysis

- Annually, CMS monitors the accuracy of Medicare Fee-For-Service (FFS) payments. CMS contractors use the Comprehensive Error Rate Testing (CERT) program information to determine which services are experiencing high error rates.
- They perform comprehensive data analysis to identify specific providers for Medical Review probe review. In a probe review, a contractor samples a small number of claims from a given provider for a given service and reviews them to determine if the provider is billing in error. When the probe review indicates that corrective action needs to be taken, the contractor may take the corrective action they deem most appropriate, including collecting an overpayment.
- CERT reports are issued each November and can be found at: <http://www.cms.gov/cert>

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Why Providers Need to Focus on Data

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- Quality Data
 - Substandard care, potential false claim
- FERA (Fraud Enforcement Recovery Act) expanded the FCA
- PPACA (Patient Protection & Affordable Care Act)
 - Expansion of FCA to cover anti-kickback violations
 - Expansion of FCA liability for non-repayment of overpayments
 - Un-refunded OP is an obligation under the FCA; therefore retention of an OP may be considered improperly avoiding an obligation.
- CIA's
- IRS 990
- Executive Compensation

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- PPACA increased CMP
 - Failing to grant timely access to the OIG for an audit, investigation or evaluation (\$15,000 per day)
 - Knowing or causing to make a false statement on an application to participate in a federal health care program.
 - Ordering or prescribing an item or service while an MD is excluded.
 - Knowingly participating in health care fraud.

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- New compliance obligations on nursing facilities
 - Data reporting requirements, data mining
 - Quality assurance and performance improvement program mandated
- CMP's to be held in escrow pending appeals
- CMS MAY reduce penalties up to 50% IF deficiency is self-disclosed
 - Disclosure within 10 days of discovery of deficiency
- Nursing facility compliance program 3-23-13 (regulations due 3-23-12)

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Transparency: “Dollars for Doc’s”

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- ProPublica: <http://projects.propublica.org/doc-dollars/states>
- Consolidated payment information in a searchable database
- Listed by provider, amount, payor, time frame and service provided.
- Pharmaceutical companies:
 - Eli Lilly
 - GSK
 - AstraZeneca
 - Pfizer
 - J&J
 - Merck

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Focus on Data Continues

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- Affordable Care Act (ACA) requires CMS to have an integrated data repository for ALL Medicare/Medicaid claims data as well as Veterans Administration, TriCare, Indian Health Service, Federal Employees Health Benefits Program and other federal health care data.
- Small Business Act signed into law on September 27, 2010, requires CMS to:
 - start using predictive analytics technologies starting July 1, 2011, for the 10 states with the the highest instances of fraud/waste/abuse
 - Expand to the next 10 high risk states beginning October 1, 2012
 - Finish using for all other states beginning January 1, 2014.

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Questions?

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