

Overview of CMS Program Integrity Activities

Center for Program Integrity
Centers for Medicare & Medicaid Services

Angela Brice-Smith
Director, Medicaid Integrity Group



May 30, 2012

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.

Four Key Approaches to PI Activities

- **Prevention:** CPI is moving beyond the “pay and chase” model to prevent fraud by screening providers and suppliers effectively and spotting fraudulent practices early before claims are paid.
- **Detection:** CPI is adopting the best strategic use of tools and techniques to detect fraud, waste and abuse and is sharing these best practices with our partners.
- **Transparency and Accountability:** CPI has developed a comprehensive PI strategy to share key information with internal and external stakeholders.
- **Recovery:** CPI has key activities with strong emphasis on the identification and recovery of overpayments.

Prevention

The Medicaid Integrity Institute (MII)

- At the Medicaid Integrity Institute (MII), CPI provides substantive training, technical assistance and support to State Medicaid program integrity staff.
- As of April 2012, the MII has trained over 2,900 State employees, at no cost to the States.
- Courses at MII also provide an opportunity for State staff to engage each other on challenges and best practices for Medicaid programs.
- CPI is exploring establishing a credentialing process through MII to validate professional qualifications for State program integrity employees.

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)

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.

Prevention

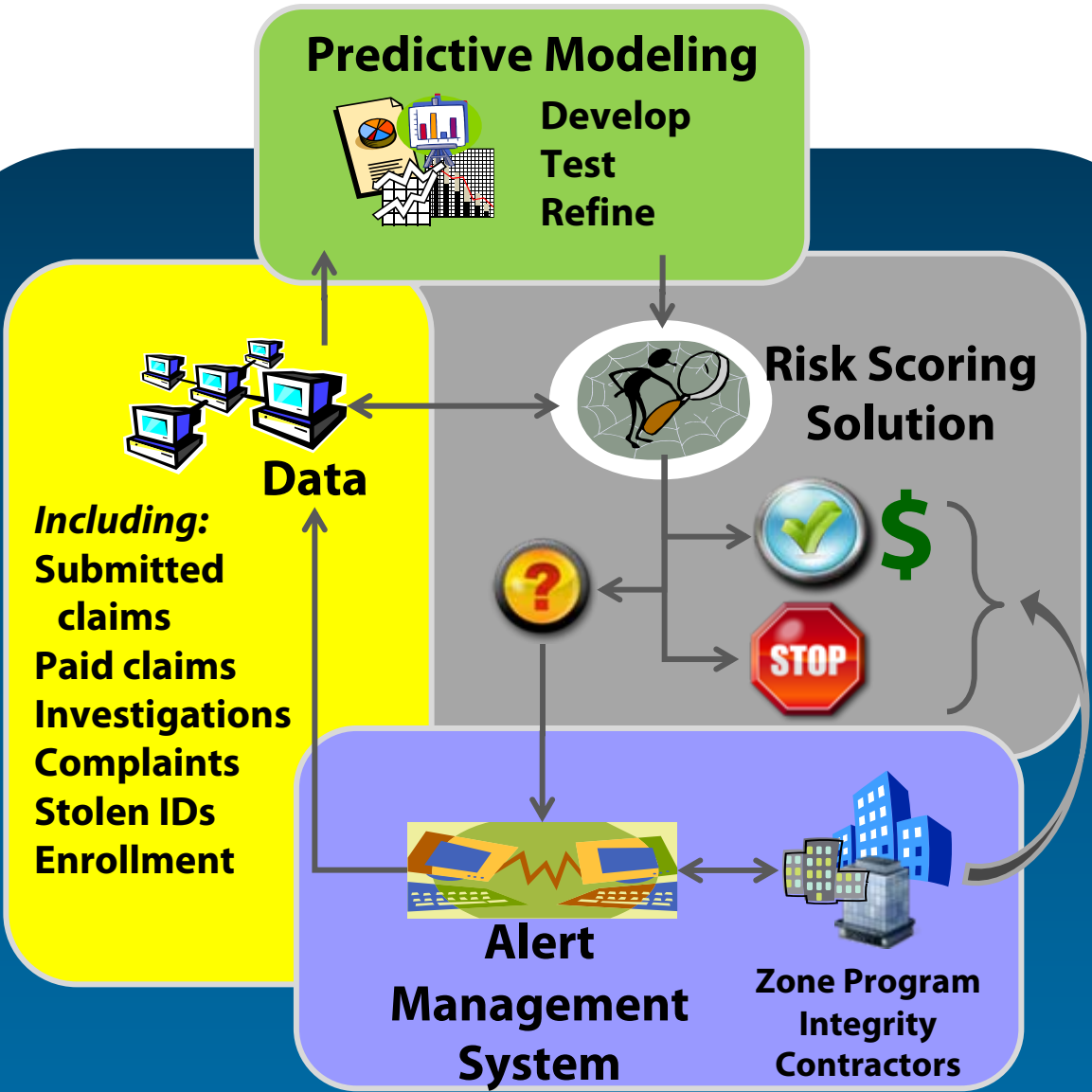
Termination Across Programs

- Section 6501 of the Affordable Care Act and final implementing regulations require State Medicaid programs to terminate providers who have been terminated for cause by another State Medicaid or CHIP program or had their billing privileges revoked by Medicare for cause.
- CMS may revoke the billing privileges of Medicare providers when such providers have been terminated by a State Medicaid program or CHIP.
- CPI established a platform for States to share information on terminated providers and suppliers with each other.

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, and
 - Prevent payment of improper claims with quick administrative action.

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

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 was awarded the system development contract, and they provided a system that was:
 - Immediately transferable to Medicare FFS claims nationwide, and
 - 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 for the development of additional models for future integration into the FPS.
- CPI is exploring options to expand FPS-like technology to Medicaid.

Detection Strategies

Medicaid Integrity Data Analytics

- CPI created and now operates a Medicaid data analysis management information system.
- This system captures and stores a subset of State Medicaid data to detect suspect Medicaid payment, and support CPI's responsibility of overseeing payments to Medicaid providers.
- Over 100 unique algorithm concepts have been developed and used to detect payment anomalies – one algorithm led to the recovery of over \$5 million.
- Application of these algorithms has also resulted in the identification of audit targets and the development of data models.

Detection Strategies

Medicaid Audits

- Fiscal Year (FY) 2011 marked the third full year of the national Medicaid provider audit program.
- Through the end of FY 2011, 1663 audits were assigned in 44 States and CPI efforts identified an estimated \$15.2 million in overpayments, through both direct provider audits and other reviews of state claims.
- Very positive returns regarding collaborative audits.
- Expanding our efforts on collaborative audits, currently in discussions with 12 additional States to develop collaborative audit approaches.

Detection Strategies

Special Field Projects

- Provide resources to support State special projects to target suspect providers in high-fraud areas.
- MIG has provided resource support to highly successful special projects in California, Florida, and New York, mostly targeting home health and DME.
 - 654 providers and 43 home health agencies and DME suppliers interviewed;
 - 1,150 beneficiaries interviewed; and
 - Approx. 400 actions taken against providers including fines, suspensions, licensing referrals, fraud referrals, and education letters.

Transparency and Accountability

Medicaid Integrity Manual

- Goal: to promote continuity and consistency in the Medicaid Integrity Program (MIP) by providing a comprehensive guide to its overall operations.
- Reference tool to assist State Medicaid officials, providers, health care organizations, CMS components, and other Federal agencies in:
 - understanding the goals and objectives of the MIP;
 - improving the communication and transparency of the MIP; and
 - educating outside entities of the evolving functions of the MIP.

Transparency and Accountability

MEDICAID.GOV, CMS.GOV

- CMS Medicaid Integrity Program site:
<http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Program-Integrity/Program-Integrity.html>
 - Comprehensive Plan for Medicaid Program Integrity (CMIP)
 - Annual Report to Congress
 - State PI Review Annual Summary Reports
 - Medicaid Guidance Fraud Prevention –(Best Practices and Performance Standards for States to use)
- Medicaid RACs-at-a-Glance
 - <http://www.cms.gov/medicaidracs/>

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, and
 - 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.

National Correct Coding Initiative: *Medicaid*

- Section 6507 of the Affordable Care Act amends section 1903(r) of the Social Security Act and requires the Secretary to:
 - Identify NCCI methodologies that are compatible with Medicaid claims;
 - Identify Medicare NCCI methodologies compatible with Medicaid, but not utilized by Medicare;
 - Notify States of methodologies identified; and
 - Submit a report to Congress by 3/1/2011 on the implementation of NCCI in Medicaid.
- States were required to implement Medicaid NCCI methodologies by October 1, 2010.

National Correct Coding Initiative: *Medicaid (cont.)*

- Guidance to States on implementation of NCCI
 - State Medicaid Directors Letter (SMDL) issued September 1, 2010
 - SMDL on NCCI appeals issued on April 22, 2011
- Report to Congress on NCCI implementation was released on March 1, 2011
- All are available at: www.medicaid.gov

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