CMS Program Integrity and the Affordable Care Act

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AGENDA

- Background
- Program Integrity Strategic Principles
- Program Integrity Activities
- ACA and RACs
- Questions?

BACKGROUND

- **Program Integrity** refers to all CMS programs designed to ensure that correct payments are made to legitimate providers and suppliers for appropriate and reasonable services and supplies for eligible beneficiaries.

BACKGROUND

- **Program Integrity** activities in practice focus on:
  - Preventing and reducing improper payments – from errors, mistakes, misunderstandings or aberrant practices; and
  - Eliminating outright fraud

BACKGROUND

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

Program Integrity Strategic Principles

- Target interventions
- Prevent before payment
- Detect improper payments
- Measure recoveries
- Enhance partnerships

Program Integrity Strategic Principles

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

Program Integrity Strategic Principles

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

Program Integrity Strategic Principles

- **Increase the detection of improper payments with the use of innovative technologies and highly skilled staff**
  - **Continue to implement the Integrated Data Repository**
  - **Implement new analytic strategies**

Program Integrity Strategic Principles

- **Improve the recovery of improper payments and sharing the results with key stakeholders, including public and government partners**
  - **Streamline processes to reduce the time between identification and recovery of improper payment**
  - **Develop baseline measures that will illustrate Program Integrity's progress**

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 such as the Regional Fraud Summits**
  - **Reach out to beneficiaries and healthcare providers to promote engagement in the fight against fraud**

Program Integrity Activities

- In March, the Affordable Care Act ("ACA") provided additional resources and authorities to fight fraud and prevent improper payments
- In June, the President announced the commitment to reducing improper payments in Medicare FFS by 50% by 2012

Program Integrity Activities

Provisions that are aimed at eliminating outright fraud:

- Physician who order or refer to high risk services must be Medicare enrolled (CMS-6010-IFC)
- Face-to-Face Encounters before receipt of high-risk services (ACA § 6407)
- Enhanced Medicare enrollment screening requirements based on risk (ACA § 6401)

Program Integrity Activities

Provisions that are aimed at preventing and reducing improper payments:

- Expansion of Recovery Audit Contractors (RACs) to Medicare C/D and Medicaid (ACA § 6411)
- Overpayments must be reported and returned within 60 days of identification (ACA § 6402(a))
- Mandatory State use of the National Correct Coding Initiative (ACA § 6507)

Expansion of RACs to Medicare Part C/D

- CMS must establish Medicare C/D RAC programs by December 31, 2010.
- Medicare C/D RACS must ensure that each MA and drug plan has an anti-fraud plan in effective, and to 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

Expansion of RACs to Medicaid

- States and territories must establish Medicaid RAC programs by December 31, 2010. This will be accomplished through amending existing Medicaid State Plans.
- 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.
- Payments to Medicaid RACs must be made only from amounts recovered.

Expansion of RACs to Medicaid

- States must have an adequate appeals process. States may use their current appeals process or develop a new process, as long as providers are ensured due process.
- 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.

Expansion of RACs to Medicaid

Next steps:

- CMS will issue a proposed regulation, State Medicaid Director Letter and a State Plan preprint.
- CMS will coordinate with States that already have "RAC-like" programs in place.
- CMS will release an educational video on the Medicaid RAC program.
- CMS will also provide topic-specific training related to procurement tips and lessons learned from the Medicare RAC program.

QUESTIONS?