CMS Medicare Program Integrity Update

April 18, 2010

AGENDA

- Current Focus Areas for Medicare Program Integrity
  - Provider Enrollment
  - Data Analysis
  - Benefit Integrity

- Medicare Program Integrity Contractor Activities
  - Medicare Parts A & B Fee-for-Service (FFS)
  - Medicare Parts C & D

- Hot Topics
  - CMS realignment
  - HEAT
  - Fraud and Abuse Provisions in Health Care Reform
BACKGROUND

CONTRACTOR WORKLOAD:
- 240,000+ new Medicare beneficiaries monthly; 200,000 deaths
- Nearly 3,000,000 eligibility inquiries daily
- As many as 25,000,000 monthly transactions from MA and Part D plans
- More than 1.2 Billion Fee-For-Service claims processed annually
- Receive, process and store more than 165,000,000 Part D prescription drug events daily
- Make nearly $1 billion in FFS payments daily
- Calculate and pay more than $12,000,000,000 monthly for Medicare Advantage and Part D

OVERALL SIZE AND SCOPE

- Beneficiaries
  - 45 million Medicare Beneficiaries
  - 50+ million Medicaid Beneficiaries
  - 9 million Beneficiaries are dually eligible
- Enrollment
  - 35 million Medicare FFS
  - 28 million Part D and/or Medicare Advantage
CURRENT FOCUS AREAS FOR MEDICARE PROGRAM INTEGRITY

Challenge: Number of New Enrollees

- Each month CMS receives:
  - 18,000 Part A & B provider enrollment applications, and
  - 900 DME supplier applications

- Onsite pre-enrollment visits are required for DME, but not for A/B.
Provider/Supplier Enrollment

- Ensure that only properly licensed individuals furnish services to Medicare beneficiaries
- Monitor providers and suppliers to ensure they are only paid for items they are properly licensed to provide
- Revocations and deactivations to remove “bad” providers and suppliers from the program
- Oversee DME Accreditation program
- Efforts conducted by FIs, Carriers, NSC, MACs and Accrediting Organizations

Provider Enrollment Update

- Implementation of the Surety Bond and Accreditation requirements on October 1, 2009, has resulted in over 10,000 suppliers being revoked from participation in the DMEPOS program.

- Increased funding for site visits in DMEPOS high risk areas led to 265 revocations from October 1 – December 31, 2009.

- Continued future focus on enhanced screening of enrollment applications, more on site visits before billing numbers are issued and more frequent site visits to verify compliance with Medicare rules after the provider/supplier receives their billing number.
INTERNET-BASED PROVIDER ENROLLMENT, CHAIN and OWNERSHIP SYSTEM (PECOS)

- All providers and suppliers, except durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers, can use Internet-based PECOS to enroll, change, or view their Medicare enrollment data.

- DMEPOS suppliers will be able to use PECOS to enroll, change or view their enrollment data in the summer of 2010.

INTERNET-BASED PECOS

- Educational Materials
  - [www.cms.hhs.gov/MedicareProviderSupEnroll](http://www.cms.hhs.gov/MedicareProviderSupEnroll)

- Outreach
  - Provider Enrollment Open Door Forums held to update providers on emerging enrollment issues. Next one will be in May.
  - Discussions with National Associations
Challenge: Volume of Claims

- Medicare pays over 4.4 million claims valued at $1.1 billion per working day.
- To over 1.5 million providers/suppliers.
- Totaling over $440 billion in annual Medicare payments.

Challenge: Prompt Pay Limitations

- By law, CMS must pay submitted claims within 14-30 days of receipt.
- Due to time and resource limitations, Medicare reviews fewer than 3% of all submitted claims before they are paid.
Data Analysis

- Error Rate Measurement
- Data Analysis to identify potentially fraudulent misconduct
- Vulnerability Forecasting
- Primarily conducted by CMS Staff, PSCs, MACs and the RACs

Provider Education

- Ensure that only properly licensed individuals furnish services to Medicare beneficiaries and that those individuals understand the Medicare laws and regulations
- Includes 1:1 education, Open Door Forums, Online education, Listserv messages, etc.
- Efforts conducted by CMS Staff, MACs, NSC and Accrediting Organizations
Medical Review

MR is designed to identify and correct existing and eliminate future errors

- Conduct pre- and post pay medical review of claims
- Develop policies to address root cause of billing errors and prevent errors resulting from lack of understanding
- Contractor Oversight to ensure consistent adherence to Medicare claims review guidelines
- Identify patterns suggesting fraud and abuse and refer to Benefit Integrity
- Primarily conducted by A/B and DME MACs and the RACs

Benefit Integrity

- Ensure that fraudulent or abusive behavior against the Medicare program is identified and corrective action is taken
- Serve as law enforcement liaison to ensure coordination on cross cutting issues
- Impose Administrative Actions such as suspensions, overpayment collections or sanctions
- Primarily conducted by CMS Staff and PSC/ZPICs
Challenges In Preventing Fraud

- Staying a step ahead of the fraudsters
- Distinguishing between bona fide and fraudulent business deals
- Preventing fraud through effective program safeguards
- Funding for anti-fraud efforts

Efforts Must Be Balanced

- The majority of providers and suppliers are honest and want to do the right thing.
- Tension exists between:
  - paying claims on time vs. conducting medical review of claims; and
  - preventing and detecting fraud and being a “good business partner” for honest providers through timely enrollment and payment
Benefit Integrity Contracting

The Health Insurance Portability and Accountability Act (HIPAA) created the Medicare Integrity Program (MIP) funding mechanism with specific statutory language stating the money must be used by the Secretary to “to contract with entities who promote the integrity of Medicare.” These entities were the Program Safeguard Contractors (PSCs).

- Their goal was to perform data analysis, develop fraud cases, support law enforcement and assist CMS in imposing administrative actions. Their focus was on particular payment types (Part A, B, etc.) in a specific geographic area. 18 PSCs eventually were created.

- Over time it became apparent that limiting the PSCs to one type of claims data was not the most effective use of CMS resources.
ZONE PROGRAM INTEGRITY CONTRACTORS (ZPICs)

- Formerly Program Safeguard Contractors (PSCs)
- Seven zones aligned with Medicare Administrative Contractor (MAC) jurisdictions

- Five “hot spot” zones
  - California, Florida, Illinois, New York and Texas
  - “Hot spots” align with existing Program Integrity field offices
  - Focus on quick response to fraud and administrative actions

- Two other zones
  - 24 states with limited incidence of fraud
  - Continue using proven Program Safeguard Contractor (PSC) processes

Zone Program Integrity Contractors (ZPICs)

- 7 ZPICs with the following areas of focus:
  - Identify fraud, waste, and abuse through data analysis.
  - Impose Administrative Actions such as suspensions, overpayment collections, referrals or sanctions.
  - Provide data to law enforcement to ensure coordination on investigations.

- Data available to ZPICs:
  - Part A/B claims, Home Health/Hospice claims, DME claims, and Part D PDE data
  - Beneficiary and provider information
More targeted projects in “hot spot” areas like the home health project in Florida which has resulted in $2.2 million in savings from edits placed on 270 beneficiaries who did not qualify for home health services and the imposition of over 30 suspensions of home health agencies with a 20% reduction in the amount billed to Medicare by those HHAs in less than one year.

- Enhanced data analysis capabilities now that ZPIC can access all claims data allowing more predictive modeling and proactive data analysis.
- Better support for law enforcement efforts by allowing access to a combined data repository and better leads through more targeted data analysis.
ZPICs - Benefits of the Strategy

- Strategy achieves best value for CMS by leveraging economies of scale and concentrating in high fraud areas
- Increased efficiency to look at providers across all benefit categories
- Economies of scale through the consolidation of contractor management, data/IT requirements, facility costs, etc.
- Streamline CMS costs in acquisition, management and oversight
- Better coordination and less resources required for the States
- Increased security of PHI due to fewer contractors handling the data

Recovery Audit Contractors

**RAC PROJECT**

- to detect and correct past improper payments
- to implement actions that will prevent future improper payments.
  - **Providers** can avoid submitting claims that don't comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** & future Medicare beneficiaries are protected
**Recovery Audit Contractors**

**RAC TASKS**
- Detecting Medicare Improper Payments
- Correcting Improper Payments
  - Collect overpayments from providers
  - Pay back underpayments to providers to detect and correct past improper payments

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**Recovery Audit Contractors (RACs)**

- The Tax Relief and Health Care Act of 2006 established a permanent RAC program to replace the pilot RAC project initiated as a result of the Medicare Modernization Act.

- RAC program was required to be nationwide by January 2010 and CMS completed implementation of the nationwide RAC program in October 2009.

- As part of the RAC national roll out, CMS completed outreach in all 50 states to providers and provider associations.
Recovery Audit Contractors (RACs)

- 4 RACs with the following areas of focus:
  - Identify past improper payments made on claims for items or services provided to Medicare beneficiaries.
  - Recoup improper payment errors.
  - Make recommendations to recoup improper payments.
- Data available to RACs:
  - Part A/B claims, Home Health/Hospice claims, and DME claims.
  - All applicable data files for all claims paid during the specific timeframes of the contract for the appropriate geographic area.
- Timeliness of Data:
  - Adjudicated claims data updates are provided by CMS as they become available (monthly or quarterly).

Recovery Audit Contractor Regions

Thursday, April 22, 2010
Future State of RACs

- Prior to beginning widespread review of an issue the RAC must receive CMS approval. As of December 9, 2009, CMS has approved 98 new issues.

- Coordinating with other CMS audit contractors to share information on overpayment recoupments to identify potential trends.

Medicare Part D Integrity Contractors

- Background: The creation of the Part D Prescription Drug Program as a result of the Medicare Modernization Act (MMA) presented an opportunity for CMS to develop an oversight structure for the new benefit. The Medicare Part D Integrity Contractors (MEDICs) were part of that oversight strategy with an initial focus on ensuring appropriate enrollment and eligibility for those entering the new program.

- As the program evolved, the MEDICs were split geographically first into three, then into two, areas with the contractors for each area conducting audit and fraud, waste and abuse activities.

- In November 2009, CMS finalized a realignment of the MEDIC functions so that one MEDIC is responsible for audit and policy while the other MEDIC is responsible for fraud, waste and abuse activities.
Medicare Part D Integrity Contractors

- 2 MEDICs with the following areas of focus:
  - Ensure that fraudulent or abusive behavior against the Medicare program is identified and corrective action is taken.
  - Serve as a law enforcement liaison to ensure coordination on cross-cutting issues.
  - Identify, monitor and track fraud, waste, and abuse in Medicare through data analysis.
  - Conduct compliance and financial audits.

- Data available to MEDICs:
  - Prescription Drug Event (PDE) data and Part B claims data
  - Complaints Tracking Module (CTM) data

Future State of MACs

- FY 2011 President’s Budget Proposal contains 2 administrative proposals which impact the MACs:
  - Consolidation of Medicare Provider Enrollment Activities: reducing from 15 to 2 or 3 the number of contractors responsible for the provider enrollment function will help ensure only legitimate providers are enrolled in Medicare by increasing program oversight and ensuring more consistent application of CMS enrollment policy.
  - Consolidation of Medical Review Activities: consolidate the number of MACs performing medical review from 19 into a fewer number of specialized contractors to ensure consistency of claims review and adjudication.
HOT Topics in Program Integrity

- CMS Realignment
- Healthcare Enforcement and Prevention Action Team (HEAT)
- Fraud and Abuse Provisions in Healthcare Reform

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