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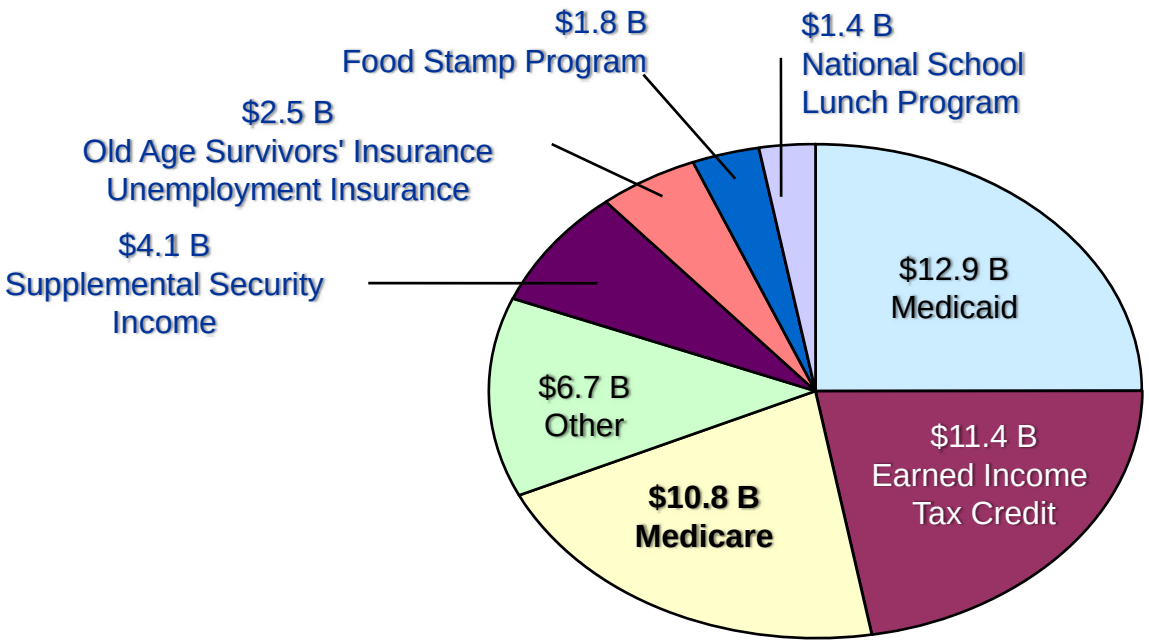
Reducing Improper Payments and Fighting Fraud at CMS: An Ever Changing Landscape

PROGRAM INTEGRITY

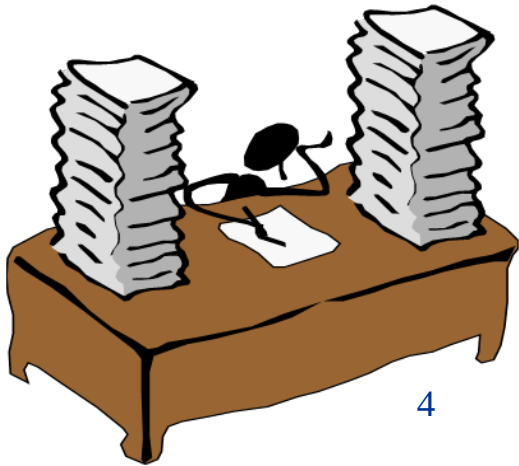
- Background and Challenges
- Elements of Our Efforts
- Current Program Integrity Initiatives
- Future Actions

- A key objective for CMS program integrity is assuring accurate payments
- Improper payments in FFS Medicare equal about $10.5 billion/year



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.

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.

Elements of Our Efforts

- How does CMS Fight Fraud and Improper Payments?
  - Provider and Supplier Enrollment
  - Provider Education
  - Data Analysis
  - Medical Review
  - Benefit Integrity

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 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
- Medical Review 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

Data Analysis

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

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

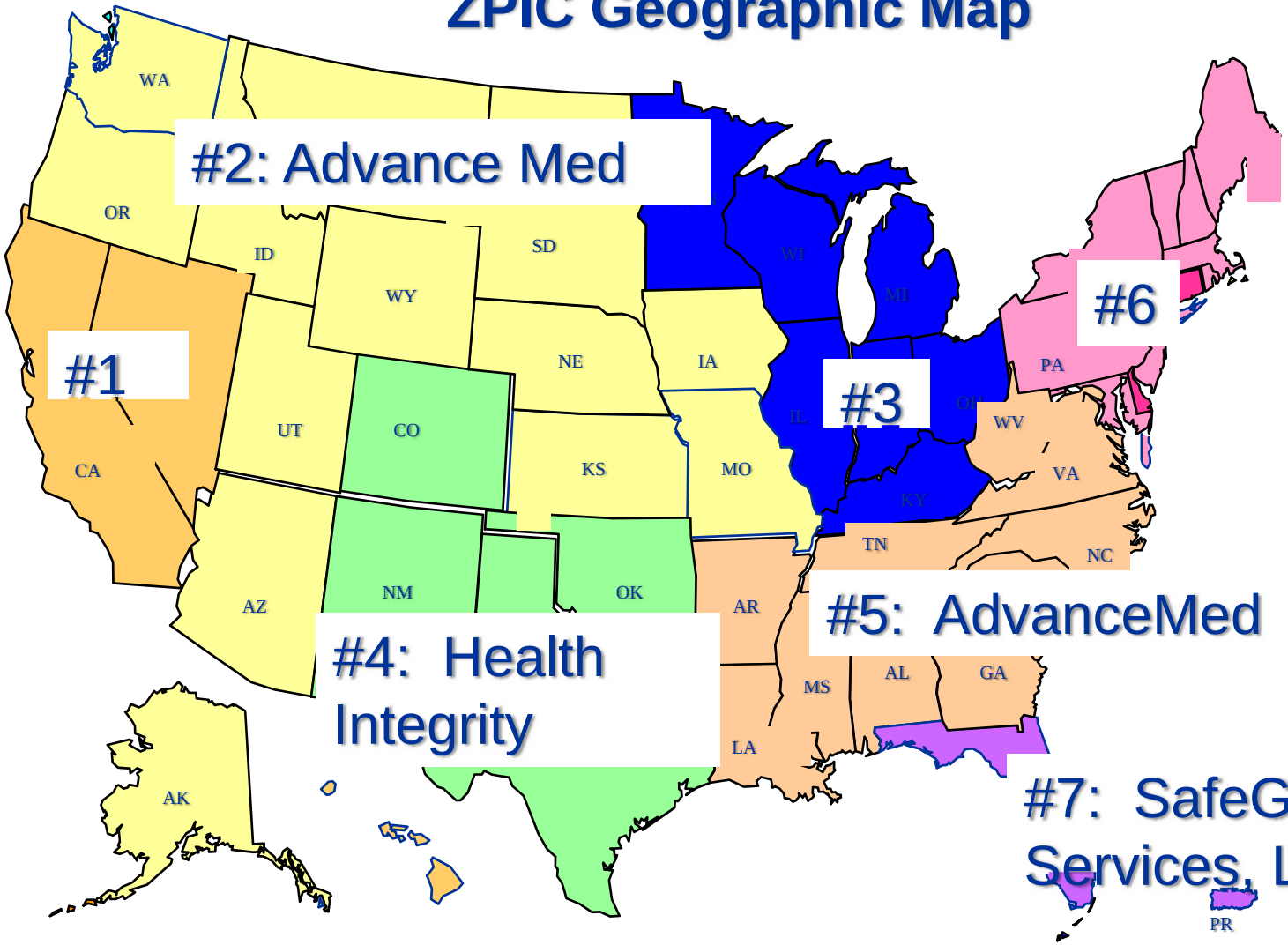
ZONE PROGRAM INTEGRITY CONTRACTORS (ZPICs)

- 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

ZPIC Geographic Map



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

CMS Field Offices

- Beginning in September 2004, CMS began establishing program integrity field offices in high vulnerability areas of the country.
- Three field offices currently exist in New York City, Miami and Los Angeles.
- Role of field offices is to be CMS' "feet on the street" to help combat fraud at the local level and work with law enforcement.

Field Office Success Stories

- Home Health
- Infusion Therapy
- Independent Diagnostic Testing Facilities

Consolidation of Data

- The launch in late 2009 of Phase One of CMS' integrated data repository will be a significant step forward in CMS' ability to prevent and deter fraud.
- Database which eventually will contain all Parts A and B, DME, HHA and key Part D data in addition to Medicaid data and Part C encounter data.

Key Focus Areas for the Future

- Focus on Provider Enrollment
  - Ensuring accurate information on enrollees
  - Site visits to verify presence
- Focus on High Fraud Areas
  - High vulnerability projects (HHA, DME)
  - Data analysis to identify emerging trends
- New data infrastructure
  - Creating integrated database to contain all Medicare payment data (Parts A, B, D and DME)

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