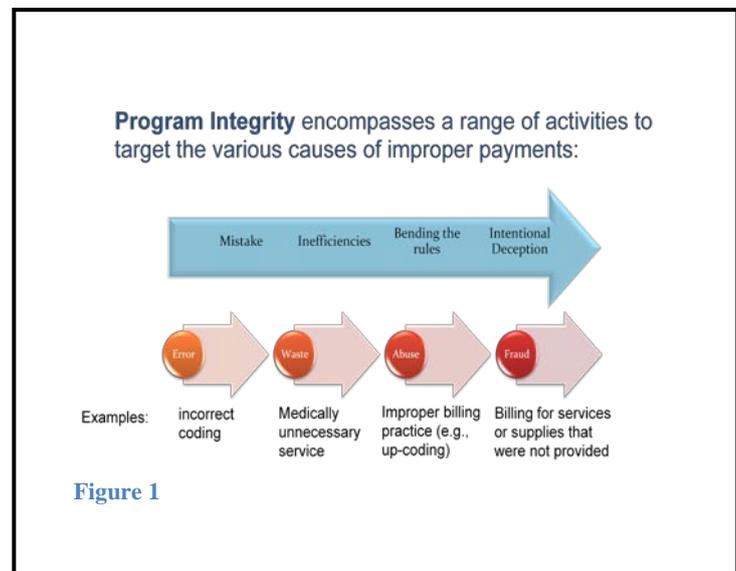


Centers for Medicare & Medicaid Services
Center for Program Integrity
New Strategic Direction and Key Antifraud Activities

Introduction

The Centers for Medicare & Medicaid Services (CMS) is the agency within the Department of Health and Human Services (HHS) responsible for the administration of the Medicare and Medicaid programs as well as the Children's Health Insurance program (CHIP). CMS is organized into six centers and nine offices that provide program management for designated areas. The Center for Program Integrity (CPI) is among these components and serves as the focal point for the prevention and detection of all national and State-wide fraud and abuse issues in the Medicare and Medicaid programs and CHIP. CPI was created in April 2010 to bring together under one management structure the Medicare and Medicaid program integrity groups, which had previously existed separately. This

change was made in order to strengthen and better coordinate existing and future activities to prevent and detect fraud, waste and abuse. In February 2011, CPI reorganized into five groups to further target program integrity policies: Data Analytics, Provider Enrollment, Program Integrity Enforcement as well as the Medicare and Medicaid program integrity groups. This targeted approach has enabled CMS to pursue a more strategic and coordinated set of program integrity policies and activities across Medicare and Medicaid.



As Figure 1 above demonstrates, program integrity (PI) activities target the range of causes of improper payments, from mistakes such as incorrect coding (errors), inefficiencies including medically unnecessary services (waste), bending the rules through improper billing practices (abuse), to intentional deception by billing for services that were never provided (fraud). CPI coordinates with the other CMS components, including the Center for Medicare, the Center for Medicaid and CHIP Services and the Office of Financial Management (OFM), to implement a comprehensive PI strategy. OFM, for example, leads the work on the Improper Payment Rate measurement and oversees the Medicare Fee-For-Service Recovery Audit Contractors. In addition, CPI is working closely with our law enforcement partners, including the Health and Human Services Office of Inspector General (OIG), the Department of Justice (DOJ), and State Medicaid Fraud Control Units, as well as private sector partners, to develop innovative strategies to reduce health care fraud and abuse across the country. An overview of key CPI anti-fraud and abuse activities is provided below.

The Center for Program Integrity

CPI Vision and Mission

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 in the Medicare and Medicaid programs.

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 in the Medicare and Medicaid programs.

Strategic Direction

CPI's new approach has six key strategies. The first is moving beyond the established approach "pay and chase" operations to innovative prevention and detection activities. The second shift is to develop a risk-based approach for program integrity requirements, rather than operating as if "one size fits all." The third strategy is to rethink legacy processes with innovation as a key requirement. CPI is also committed to becoming more transparent and accountable, which complements the fifth strategy of meaningfully engaging our public and private partners. Finally, CPI is dedicated to continuing to coordinate and integrate the Medicare and Medicaid strategies to become more effective while reducing burden on the legitimate provider and supplier community.

Improper Payments and Fraud

Like other large and complex Federal programs, Medicare, Medicaid, and CHIP are susceptible to payment, billing and coding errors—called "improper payments." Improper payments can result from a variety of assorted circumstances, including: 1) services with no documentation, 2) services with insufficient documentation, 3) incorrectly coded claims, 4) services provided that were not determined "reasonable and necessary," or 5) services that were billed for but never provided. Improper payments are not always the result of fraud or necessarily payments for inappropriate claims; rather, they tend to be an indication of errors made by the provider or supplier in filing a claim or inappropriately billing for a service. Most improper payments by providers and suppliers are classified as such because they relate to claims where the information in the medical record did not support the services billed. Other payment errors result when providers or suppliers fail to submit documentation when requested, fail to submit adequate documentation to support the claim, or submit a claim, which Medicare pays, that should have been paid for by a group health plan or other liable party. Fraud, on the other hand, involves intentional deception and diversion of Medicare and Medicaid resources away from health care to an illicit purpose.

The Center for Program Integrity's Groups

CPI is divided into five separate groups which are responsible for and perform tasks based on their functional areas. As mentioned previously, although each group has its own responsibilities, coordination among these groups occurs frequently so that the best results can be obtained. An overview of these groups is provided below.

Medicare Program Integrity Group (MPIG)

Medicare Program Integrity functions include the prevention, detection and deterrence of fraudulent, abusive or wasteful billing in Parts A, B, C and D of the Medicare Program. This is accomplished through the development of policies, regulations and program guidance and collaboration with our private sector fraud investigators, the Zone Program Integrity Contractors and Medicare Drug Integrity Contractor. In addition, MPIG uses enhanced provider enrollment activities, proactive data analysis and investigative techniques such as on-site visits and

beneficiary and provider interviews to combat fraud, waste and abuse.

Medicaid Integrity Group (MIG)

In February 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law and created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act (the Act). The Medicaid Integrity Group (MIG) is responsible for implementing the MIP.

The MIP is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste, and abuse in the Medicaid program. It also supports the program integrity efforts of State Medicaid agencies through a combination of oversight and technical assistance. Although individual States work to ensure the integrity of their respective Medicaid programs, the MIP provides CMS with the ability to more directly ensure the accuracy of Medicaid payments and to deter those who would exploit the program.

MIG has two broad responsibilities under the MIP. The first responsibility is to provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse. MIG fulfills these responsibilities by completing work in four areas; audits, State support, data, and education. The second responsibility is to oversee contractors that review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.

Data Analytics and Control Group (DACG)

The Data Analytics and Control Group is the focal point for proactive data analytics. The group identifies emerging fraud, waste or abuse trends through the use and development of advanced analytical techniques and serves as the focal point for all activities related to data analytics. DACG implemented and oversees the Fraud Prevention System and established the Analytic Lab to develop and test new models for use in the FPS.

Provider Enrollment Operations Group (PEOG)

The Provider Enrollment Operations Group oversees the Medicare Administrative Contractors provider and supplier enrollment activities. PEOG works closely with the provider community to resolve any provider or supplier enrollment concerns and is in the process of developing a streamlined Medicare provider and supplier enrollment approach.

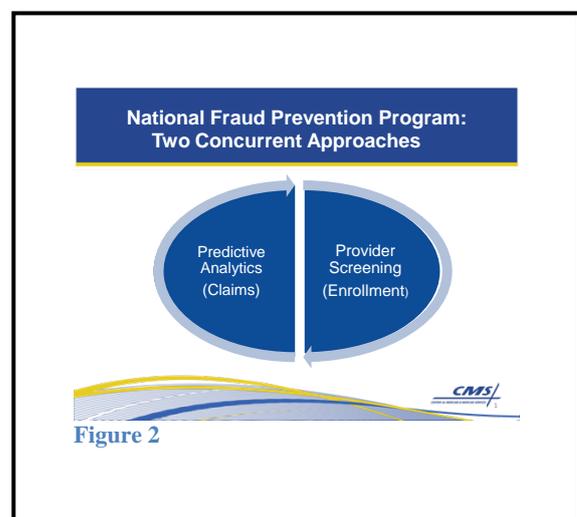
Program Integrity Enforcement Group (PIEG)

The Provider Integrity Enforcement Group works closely with the HHS Office of Inspector General to levy civil monetary penalties against individuals or organizations that commit or participate in fraudulent or abusive activities. PIEG houses the Field Offices (FOs) located in Los Angeles, New York and Miami. The FOs provide a “boots on the ground” presence in key geographic zones across the country.

CPI's Approaches to Minimizing, Preventing and Detecting Fraud, Waste and Abuse

The 4 major approaches to key anti-fraud, waste and abuse activities CPI has taken across the groups on are:

- Prevention
- Detection



- Increasing Transparency and Accountability
- Recovery

Prevention

National Fraud Prevention Program

CMS has integrated many of its high-tech program integrity solutions into the National Fraud Prevention Program. Figure 2 illustrates CMS' concurrent approaches to fraud prevention: predictive analytics for claims and provider screening for enrollment, that make up CMS' holistic approach in the National Fraud Prevention Program. By leveraging sophisticated analytic tools in claims processing and provider and supplier enrollment, CMS is now better able to identify fraudulent claims and ensure that the providers and suppliers who submit false claims are quickly and permanently removed from Medicare, Medicaid, and CHIP. CMS anticipates that its continued use of sophisticated analytical technologies will enable it to better combat fraud, waste, and abuse. The National Fraud Prevention Program streamlines the Agency's strategic projects into one coordinated program that is stronger and more efficient than any stand-alone effort.

The Fraud Prevention System

The Fraud Prevention System (FPS), CMS' new predictive modeling technology, is screening all Medicare fee-for-service claims before payment is made. Much like the predictive technologies used in the credit card industry, the FPS uses sophisticated algorithms and models to identify suspicious behavior. The FPS uses historical data and external databases to build robust profiles for beneficiaries, providers and suppliers; these profiles are key to identifying unusual billing patterns and determining the likelihood of fraudulent activity. Using all available information, the FPS calculates risk scores that are used to automatically set priorities for our program integrity contractors' workload. This focuses our CPI investigative resources on the highest risk scores that demand immediate attention and response, while lower risk scores are added to the workload as appropriate. By streaming claims on a prepayment basis, CMS and its investigative partners are able to stop payment of fraudulent claims and respond to emerging trends. CMS is exploring an expansion of its predictive modeling technology to the Medicaid program by 2015, as required by the Small Business Jobs Act of 2010.

Strengthening Provider Enrollment

CMS is in the process of implementing an automated provider and supplier enrollment screening tool that will automatically compare information received from a provider and supplier on a Medicare enrollment application to various public and private databases. The data sources used for this effort include the National Plan and Provider Enumeration Systems for the National Provider Identifier (NPI), the General Services Administration (GSA) Excluded Parties List, for parties excluded from receiving Federal contracts, and the Office of Inspector General (OIG) exclusion database, for providers and suppliers who are excluded from any Federally-funded healthcare program. The screening solution will also monitor all providers and suppliers to ensure they continue to meet Medicare enrollment requirements, such as State licensure, on an ongoing basis for the duration of their enrollment. The automated screening tool is anticipated to "go live" by January 2012, and will replace the time- and resource-intensive manual review process. The new process will decrease the application processing time, enable CMS to continuously monitor the accuracy of its enrollment data, and assess applicants' risk to the program using standard analyses of provider and supplier data.

Education for Medicaid State PI

In terms of education of State program integrity employees, the Medicaid Integrity Institute (MII) stands out as one of MIG's most significant achievements. The MII provides a unique opportunity for CMS to offer substantive training, technical assistance, and support to States in a structured learning environment. In its three years of existence, the MII has offered numerous courses and trained over 2,265 State employees at no cost to the States. Over time, the MII intends to create a credentialing process to elevate the professional qualifications of State Medicaid program integrity employees. As a result of the MII courses, State staff from across the country have the opportunity to engage in productive dialogue about the challenges they face combating fraud, waste, and abuse issues unique to their State Medicaid programs. This interaction permits participants to share their success stories, to learn from other's successes, to give their Medicaid programs a wider range of perspectives on available policy options, and to help identify problem providers who attempt to migrate from one State Medicaid program to another.

The Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act, collectively known as the Affordable Care Act (ACA), was signed into law on March 23, 2010. The ACA provides CMS with powerful new tools that are helping to move the PI strategy beyond "pay and chase" to a proactive approach, as well as aligning Medicare and Medicaid program integrity requirements. CPI has implemented many of these important program integrity provisions to date. For example, CMS published a final rule with comment titled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" on February 2, 2011. This final rule established risk-based provider and supplier enrollment screening requirements that are parallel between Medicare and Medicaid, and permits States to rely on the results of Medicare screening for providers who participate in both programs. The final rule also established CMS' authority to suspend payments pending an investigation of a credible allegation of fraud, and the authority to impose temporary provider enrollment moratoria when the Secretary determines there is a risk of fraud. This regulation also requires the termination of Medicaid providers or suppliers if they have been terminated "for cause" from Medicare or any other Medicaid program, and enables CMS to terminate from Medicare if the provider has been terminated from any Medicaid program.

Detection

Integrated Data Repository and the One Program Integrity (OnePI) tool

Since 2006, CMS has been building the Integrated Data Repository (IDR), a data warehouse to integrate Medicare and Medicaid data so that CMS and our partners can access data from a single source. It is currently populated with seven years of historical Part A, Part B, and Part D paid claims, and pre-payment stage claims data will be integrated in the spring of 2012. CMS also plans to incorporate Medicaid data for all 50 states by the end of FY2014. CPI maintains the OnePI tool used to access and analyze the data contained within the IDR, and provides training to program integrity contractors and law enforcement. The IDR provides an encompassing view of the data beyond just claims data that includes beneficiary, plan and clinical perspectives (e.g. quality data). It also complements the work done in the FPS, by providing a space for the testing and development of new predictive models that will be integrated into the Fraud Prevention System.

Improving Fraud Reporting

CMS has expanded the scope and character of data analysis to enhance ongoing detection efforts. It has implemented a geospatial toolset to create a national “heat map” of beneficiary calls to 1-800-MEDICARE that raise a question about possible fraud. The technology has the ability to track such calls to identify changing trends and new hot spots just as they are emerging. Using existing data in this innovative way also enables CMS to target providers and suppliers with multiple beneficiary complaints for further investigation.

CMS has also undertaken a provider identify theft victims project, to assist providers who have had their medical identities stolen or compromised. CPI has developed a new process to determine and validate whether a provider has been a victim of identity theft and to absolve related debts, such as Medicare overpayments or tax obligations. This approach established a consistent process for CMS’ contractors to work through potential fraud cases, while being responsive to the needs of legitimate providers. It augments processes already in place to assist providers victimized by identity theft and will continue to be enhanced.

Medicare Part C and D Compliance Activities

The Medicare Modernization Act of 2003 (MMA) made significant changes to the Medicare program. The most significant change was the addition of a voluntary prescription drug benefit (Part D). Multiple components within CMS are responsible for the development, implementation, and oversight of this benefit. CPI’s Division of Plan Oversight and Accountability (DPOA) is the focal point for fraud, waste and abuse oversight of Medicare Advantage and Part D. CPI oversight includes managing a national benefit integrity contractor that conducts investigations based on complaints received from Medicare Advantage and Part D plan sponsors, beneficiaries and other individuals that believe fraud, waste or abuse may have occurred. The benefit integrity contractor also conducts proactive investigations based on the results of data analysis, and refers fraud cases to the HHS Office of Inspector General as appropriate. CPI also collaborates with the Center for Medicare in the development of fraud, waste and abuse compliance audit elements and the selection of plan sponsors for compliance audits.

Medicaid Integrity Data Analytics

MIG created and now operates a data analysis management information system. This system is able to capture and store a subset of State Medicaid data translated into a format that can be used to detect and report suspect Medicaid payments or answer general research questions. The system is used in support of the MIG’s responsibility for reviewing payments made to Medicaid providers to identify overpayments. Analyses are underway in almost all States. Over 328 algorithms have been developed and used to detect payment anomalies – one algorithm alone led to the recovery of over \$5 million from a State. The application of these algorithms has resulted in the identification of audit targets and the development of data models. MIG continues to work with many States to conduct projects on cross-border, regional, and national issues related to Medicaid fraud, waste or abuse.

Medicaid Audits and State Support

Fiscal Year (FY) 2010 marked the second full year of the national Medicaid provider audit program. CMS awarded task orders in all regions for contractors to review provider claims, conduct provider audits, and initiate the provider education activities required by Section 1936 of the Act. Through the end of FY 2010, 947 audits were underway in 45 States and MIG efforts identified an estimated \$10.7 million in overpayments, through both direct provider audits and automated reviews of state claims. To fulfill the requirement to provide support and assistance to State Medicaid program integrity efforts, MIG performs 17 comprehensive State program

integrity reviews every year, putting States on a three year rotation. The reviews identify problems that warrant improvement or correction in State operations, and also highlight commendable practices. Moreover, MIG responds to numerous State requests for technical support outside of the review cycle.

Increasing Transparency and Accountability

Provider Outreach and Education

CPI has initiated a number of outreach efforts to providers in order to educate them about PI activities and programs – as well as to garner input in order to improve these activities. One of the most significant programs in terms of education and impact is the Correct Coding Initiative, which is designed to encourage correct claims coding, minimize errors, and stop issues well before formal investigation is required. The Initiative works closely with other CMS Components as well as national specialty societies to develop and disseminate coding edits. CPI is also a major participant in the Regional Health Care Fraud Summits, which is jointly hosted by the Department of Health and Human Services and the Department of Justice, and brings together providers with other stakeholder in program integrity. As a result of these Summits, CPI has worked with the California Medical Association and California Department of Healthcare Services to develop a program integrity and fraud curriculum for physicians and other providers. This curriculum was delivered in a series of CME-granting seminars entitled “California Fraud Prevention and Awareness Month” and will be made available nationally. Augmenting such outreach, CPI is working to leverage provider input through working groups to improve internal operations, such as the Medicare enrollment system and processes implemented to prevent, investigate and resolve provider identity theft.

Voluntary Correction Project

CMS is implementing a pilot project to encourage provider self-auditing and compliance activities to avoid the time, cost, and burden of external audits or fraud investigations. This program is aimed at the majority of providers who are legitimate and may make billing errors. CMS will send letters to select providers who use select procedure codes based on data analysis of billing aberrancies. The letter will educate providers on the proper use of the identified procedure codes, request providers to review identified claims and request providers to voluntarily return any over-payments received as a result of improper use of the procedure codes.

Partnering with Law Enforcement

CMS has partnered with the Department of Justice to host Health Care Fraud Prevention Summits in six cities since 2010: Miami, Los Angeles, Brooklyn, Boston, Detroit, and Philadelphia. These summits bring together a wide array of Federal, State and local partners, beneficiaries, and providers to discuss innovative ways to eliminate fraud, waste and abuse across the U.S. health care system. The summits are part of the larger joint effort of the DOJ and HHS through the Health Care Fraud Prevention and Enforcement Action Team (HEAT).

CMS is also heavily involved with the development of law enforcement cases. As Secretary Sebelius announced in a recent, joint HHS-DOJ press conference, CPI had a key role in a multi-state takedown of fraudulent providers, resulting in the arrest of 91 individuals responsible for \$295 million in false Medicare billings on September 7, 2011.

Sharing Data with Private Plans

CMS is committed to continuing to work with our private sector partners to detect and prevent fraud, waste and abuse, and is actively pursuing a formal framework for a public-private

partnership in fighting fraud. CMS has developed a process to share payment suspension data on Medicare providers and suppliers with private insurers that provide supplemental coverage to Medicare beneficiaries.

Collaborating with States

CPI has implemented a new system that provides a platform for States to share information on terminated providers and suppliers. The Affordable Care Act requires States to terminate providers who have been terminated from another State Medicaid or CHIP program. CMS will be sharing information on providers who have been terminated from Medicare for cause with the State programs as well. This tool is the beginning of a smarter, more efficient Federal-State partnership, integrating technology solutions to routinely share relevant program information in a collaborative effort.

Recovery

Medicare Fee-For-Service Recovery Audit Contractor Program

The Recovery Audit Contractor (RAC) program is an important tool in CMS' efforts to detect improper payments and thereby reduce waste in Federal health care programs. The RAC program began as a limited State demonstration project required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Congress expanded the RAC program in the Tax Relief and Health Care Act of 2006, directing CMS to implement a permanent national RAC program in Medicare fee-for-service (FFS) by January 1, 2010.

RACs work to identify overpayments and underpayments in previously submitted and paid claims; per the statute, these contractors are paid on a contingency fee basis. RACs have proven successful at identifying and correcting improper payments made by CMS. In the demonstration project, RACs identified and corrected \$1.03 billion in improper payments, including approximately \$990 million in collected overpayments. As of June 30, 2011, the permanent Medicare FFS RAC program, has corrected a total of \$684.8 million in improper payments, including \$109.6 million in underpayments and \$572.2 million in collected overpayments.

Expansion of Recovery Audit Contractors to Medicare Part C and D

The Affordable Care Act expanded the RAC program to Medicare Parts C and D. CPI solicited comments on innovative strategies to implement the requirement that Part C and D RACs review the effectiveness of plan's antifraud plans on December 27, 2010, and awarded a contract for a Medicare Part D RAC in January 2011. CMS has drawn on lessons learned from the Medicare FFS RAC program in the development of the Part C and D RACs.

Expansion of Recovery Audit Contractors to Medicaid

The Affordable Care Act also requires States to establish Medicaid RAC programs. CPI required States to submit State plan amendments by December 31, 2010, to detail how they will establish their RAC program. CMS published a final rule titled, "Medicaid Program: Recovery Audit Contractors" in the Federal Register on September 14, 2011 that requires States initiate Recovery Audit Contractors to identify and recoup improper payments made in the Medicaid programs by January 1, 2012. The final rule aligned the Medicaid RAC requirements to existing Medicare requirements where feasible, and provided State flexibility to tailor the programs where appropriate. Medicaid RACs will be paid by the States on a contingency basis. They will review Medicaid provider claims to identify and recover overpayments and identify underpayments made for services provided under Medicaid State plans and Medicaid waivers.

Conclusion

CPI has many activities that are targeted at improving compliance with Medicare and Medicaid program and CHIP requirements, as well as rooting out fraud, waste and abuse against the programs. The innovative solutions that have been implemented in the short time CPI has been operating are helping move the strategy beyond “pay and chase” to a new focus on prevention. Medicare and Medicaid fraud, waste and abuse affect every American by draining critical resources from our health care system, and contribute to the rising cost of health care for all. Taxpayer dollars lost to fraud, waste, and abuse harm multiple parties, particularly some of our most vulnerable citizens. However, the Affordable Care Act has provided CMS with more tools than ever before to implement important strategic changes in pursuing fraud, waste, and abuse. Through partnerships with public and private stakeholders, CMS is working to better protect our health care system. CMS believes every effort we make to fight fraud, waste and abuse and to keep the bad actors out of the Medicare and Medicaid programs, as well as CHIP improves the quality of care practitioners are able to provide to patients.