CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

29th Annual Conference
National Association for Medicaid Program Integrity

CMS Center for Program Integrity Update

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Centers for Medicare and Medicaid Services

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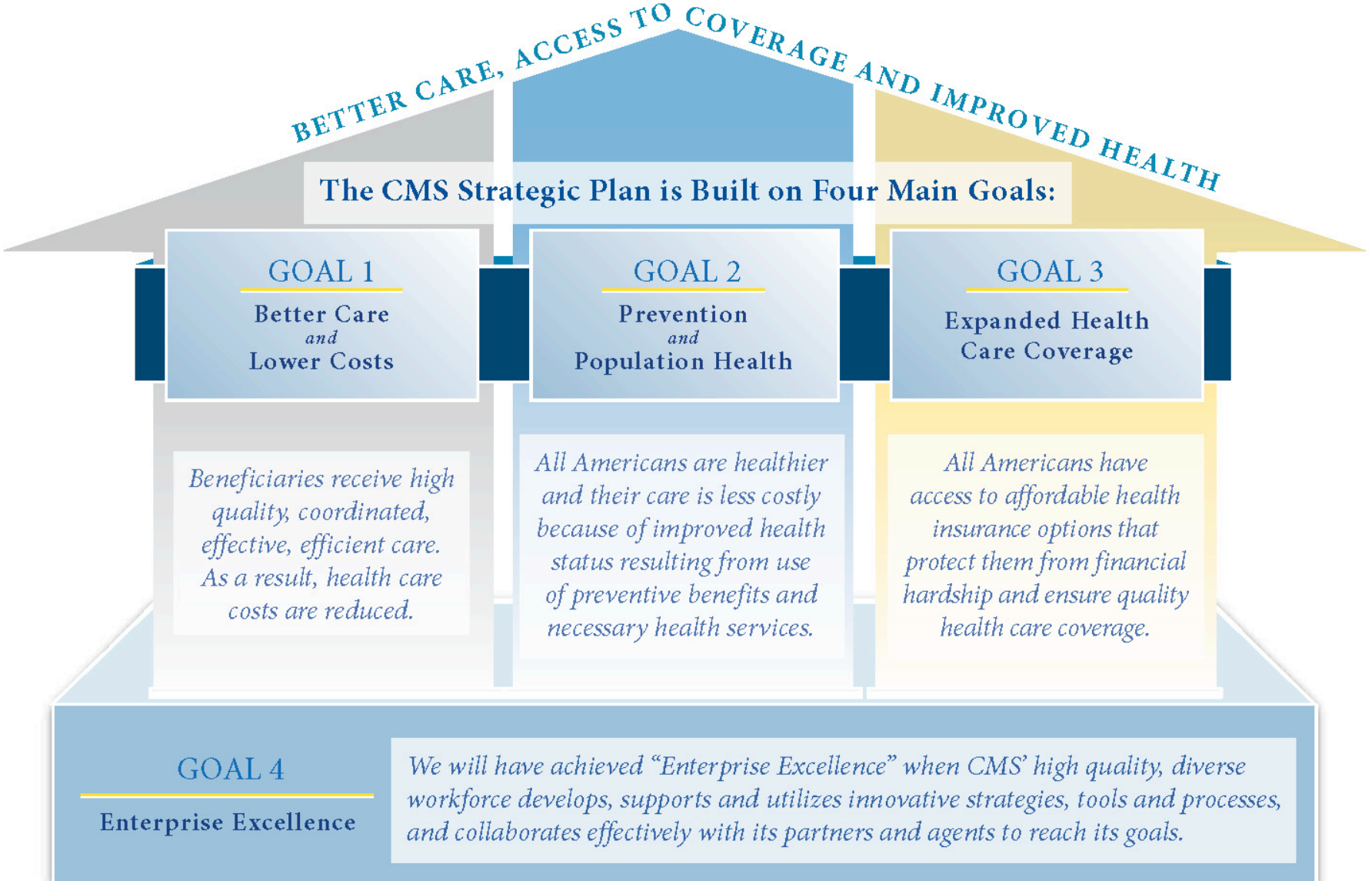
The CMS Strategy: Mapping the Road Forward

Our Vision:

A high quality health care system that ensures better care, access to coverage and improved health



Our Vision: *A high quality health care system that ensures better care, access to coverage, and improved health.*

Our Goals: *Better Care and Lower Costs – Prevention and Population Health – Expanded Health Care Coverage – Enterprise Excellence*

Customers & Stakeholders

1.0 Improve Quality Care

2.0 Improve Preventive Health Benefits

3.0 Strengthen Consumer Protections

4.0 Expand Coverage

Financial Stewards

5.0 Improve Payment Models

6.0 Strengthen Program Integrity

Internal Processes

7.0 TRANSFORM BUSINESS OPERATIONS

Develop Flexible Portfolio-based Processes for Prioritizing Projects

Enhance Agency-wide Performance Management Capabilities

Enhance Acquisition Management

Enhance Customer Service Operations

Enhance Communications and Engagement

Organizational Capacity

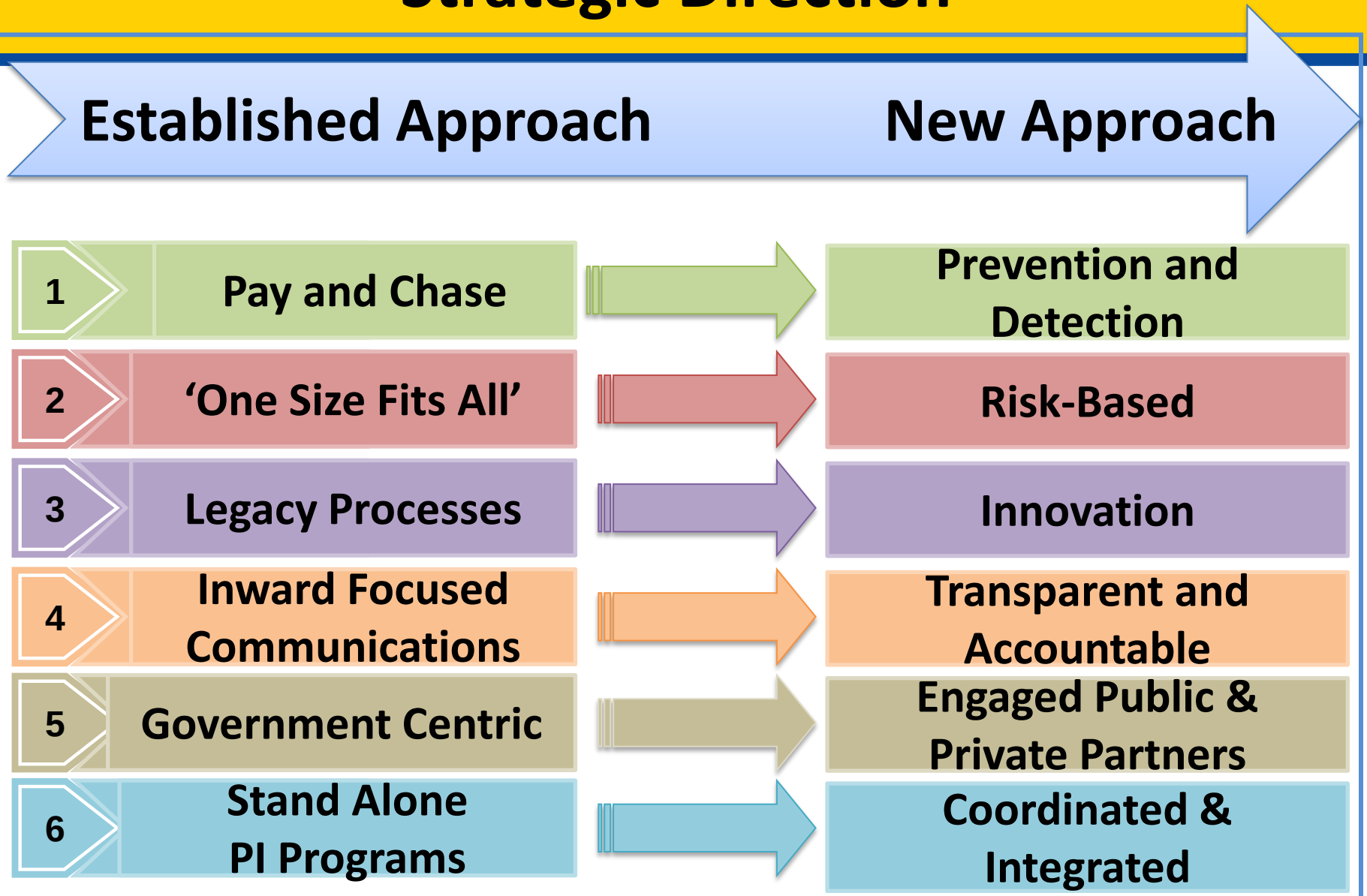
Enhance Human Capital Development and Management

Establish Flexible and Scalable Shared Services

Enhance Data Management and Analytics

Build Agile and Flexible IT Platform

Center for Program Integrity Strategic Direction



CMS Fraud Prevention System (FPS)

- Implemented on June 30, 2011.
- Monitors 4.5 million Medicare claims (all Part A, B, DME) each day using a variety of analytic models.
- Alerts generated and consolidated around providers and subsequently prioritized based on risk.
- Results are provided to the anti-fraud contractors with views by regions.
- Results are available to CPI and law enforcement partners in a prioritized national view.

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Examples of "Models" in Credit Card Fraud

Rule	**Charge for TV in FL – Cardholder lives in CA** (Unlikely charge) ***Healthcare:*** **Geodispersion of providers and beneficiaries beyond acceptable bounds**
Anomaly	**Charges for 3 TVs in one day** (99% of people buy less than 3 in a single day) ***Healthcare:*** **# procedures / provider or length of stay or # units per day exceeds the relevant norm**
Predictive Model	**Charges for multiple TVs out of state, after a $1.00 charge, on Wednesdays after midnight** (Experience shows high probability of being bad) ***Healthcare:*** **Pattern of billing behavior similar to known fraudulent providers**
Social Network	**Charges at address known to be used by bad actor** (relationship suggests a problem) ***Healthcare:*** **Connections among multiple providers with elevated risk**

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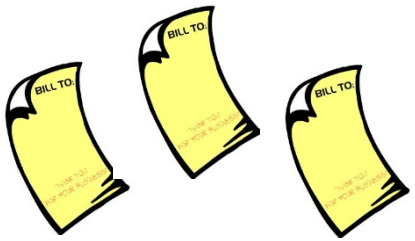
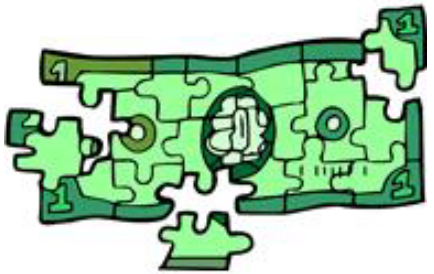
Models Run Simultaneously → Risk Score

Rule	Anomaly	Predictive Model	Social Network



Health Care Claims Trigger FPS

Investigations
Complaints
Stolen IDs
Information from Enrollment



Risk Score by a Provider's Book of Business, Not Individual Claim

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Fraud Prevention System (FPS) Background

- The Fraud Prevention System Report to Congress for the first implementation year was released in December 2012.
  - Prevented or identified $115.4 million in payments
  - Generated leads for 536 new investigations and augmented information for 511 pre-existing investigations
  - Achieved a positive return on investment (ROI), saving an estimated $3 for every $1 spent in the first year
- CMS will seek to expand the use of predictive analytics technologies to Medicaid and CHIP by providing technical assistance. This may include:
  - Providing detailed information to states regarding the algorithms currently used to identify fraudulent providers
  - Providing training in predictive analytics technologies at the Medicaid Integrity Institute.

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Prevention: Provider Enrollment Moratoria

- CMS exercised new Affordable Care Act authority for the first time in July 2013 to combat fraud, waste, and abuse in high risk areas.
- CMS worked with Medicaid and Program Integrity officials in 3 States to implement the moratoria for Medicaid and CHIP.
- Existing providers and suppliers of these services may continue to render and bill for services, but no new provider and supplier applications for these supplier/provider types will be approved in these geographic areas for Medicare, Medicaid, or CHIP for the duration of the moratoria.
- Effective Tuesday, July 30, 2013, moratoria in place for 6 months (with the ability to extend).
- The affected metropolitan areas and provider /supplier types are:
  - Miami: Home Health Agencies in Miami-Dade and Monroe counties
  - Chicago: Home Health Agencies in Cook, DuPage, Kane, Lake, McHenry and Will counties
  - Houston: Ambulance suppliers in Harris, Brazoria, Chambers, Fort Bend, Galveston, Liberty, Montgomery and Waller counties

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CMS's Medicaid Program Integrity Work

Support and Assistance to States

- Medicaid Integrity Institute (MII);
- Best practices;
- Boots on the Ground assistance;
- Provider education;
- Medicare-Medicaid coordination.

Review and audit services furnished under the Medicaid Integrity Program

- State Program Integrity Reviews;
- Collaborative audits.

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States' Medicaid Program Integrity Work

State Program Integrity – Recoveries

FY 2006	FY 2012	Increase
$265,178,662	$1,428,915,682	$1,163,737,020

Source: CMS -64

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CMS's Medicaid Program Integrity Partnership Activities

- Since 1998, the Medicaid Fraud & Abuse Technical Advisory Group (TAG) and its State subject matter experts have provided guidance to CMS on program integrity issues.
- The TAG is comprised of a chair and 10 regional representatives, all of whom are senior State program integrity officials.
- CMS meets with the TAG as well as other State program integrity officials in a monthly national teleconference and in annual face-to-face meetings.
- The Medicaid Fraud & Abuse TAG State partners provide a critical voice in CMS' program integrity efforts.

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CMS's Partnership Activities (*cont.*) Medicaid Integrity Institute (MII)

- GAO: "Widely acclaimed by state officials"
- Established in September 2007 in partnership with the Department of Justice as the first national Medicaid program integrity training center.
- From its first course in February 2008 through June 2013, MII has trained over 4,000 State staff through 91 courses at no expense to the States.
- All 50 States, D.C., and Puerto Rico have participated in MII courses.
- MII Provides a secure, web-based forum for states to exchange information and best practices about Medicaid program integrity.
- As of June 2013 20 state employees in 17 states have received the credential of Certified Program Integrity Professional (CPIP) designation
- 2013 began regular distance learning through monthly webinars in partnership with the University of South Carolina.
- 21 on-site courses on FY 2014 schedule

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Healthcare Fraud Prevention Partnership

- The Secretary of the Department of Health and Human Services and the Attorney General of the United States announced the Partnership on July 26, 2012.
- The new Partnership is designed to enable partners to individually share information and best practices to improve detection and prevent payment of fraudulent health care billings across a number of ***public and private*** payers.
- The Healthcare Fraud Prevention Partnership is intended to enable the exchange of data and information among the partners.
- Establishes operational and technical capabilities to allow for data sharing and collaboration.

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Healthcare Fraud Prevention Partnership Overview

Purpose:

- To enable members **to individually share** successful anti-fraud practices and effective methodologies and strategies for detecting and preventing health care fraud
- To focus on information sharing **in two primary areas:**
  1. **Data sharing and analytics**
  2. **Outreach, education and information sharing**

Membership:

- Approximately 30 partners from federal, state, private plans and associations

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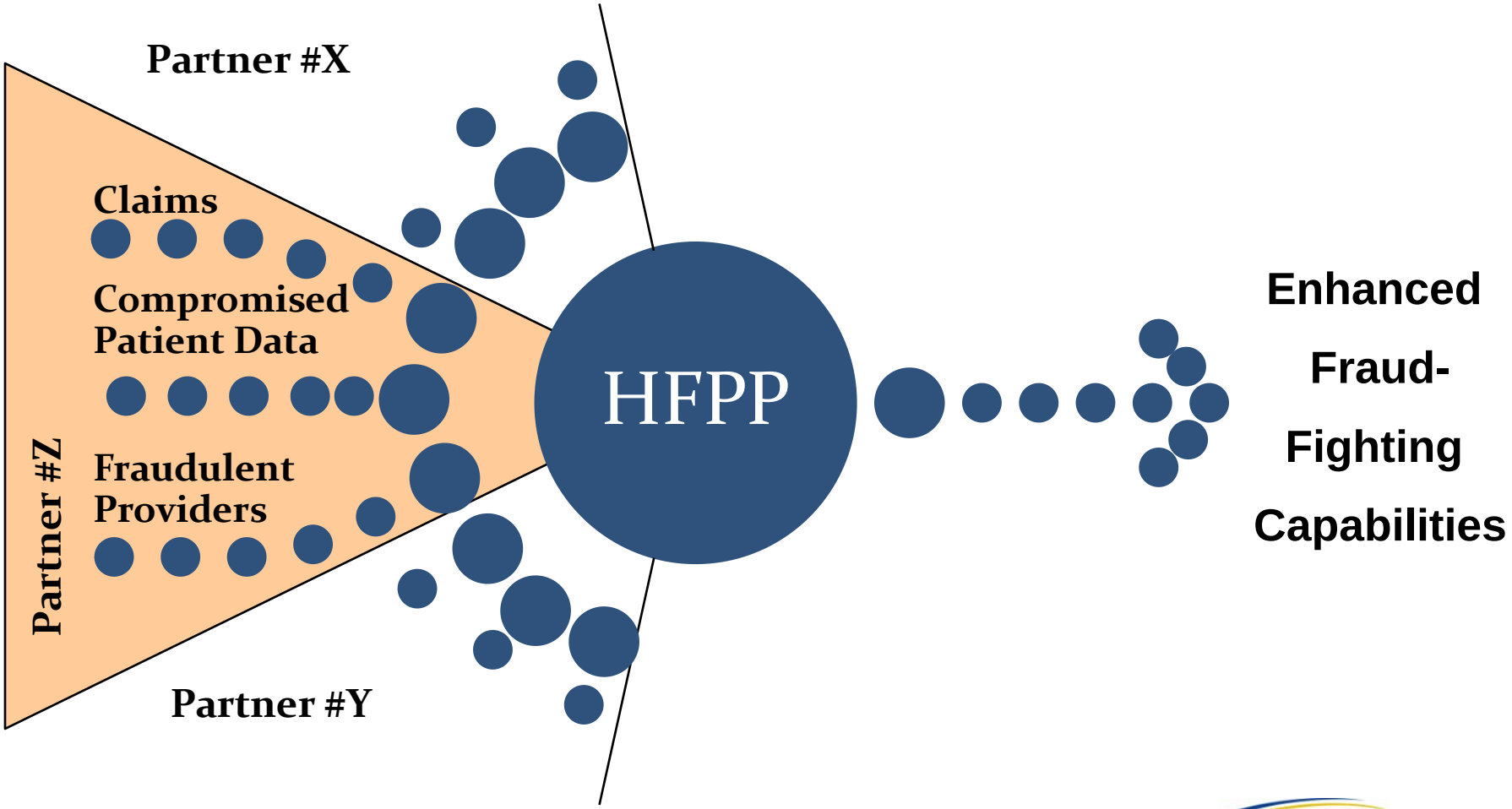
Value Proposition



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Current Healthcare Fraud Prevention Partnership

Federal Partners

- ✓ Department of Health and Human Services, Associate Deputy Secretary's Office
- ✓ Department of Health and Human Services, Centers for Medicare and Medicaid Services
- ✓ Department of Health and Human Services, Office of the Inspector General
- ✓ Department of Justice, Criminal Division
- ✓ Department of Justice, Federal Bureau of Investigations

State Partners

- ✓ Arizona Medicaid Office of the Inspector General, Arizona Health Care Cost Containment System
- ✓ New York Office of Medicaid Inspector General
- ✓ Iowa Insurance Fraud Bureau (NAIC's representative on the Information Sharing Committee)
- ✓ Ohio Attorney General's Office (NAMFCU's representative on the Information Sharing Committee)
- ✓ Kansas Attorney General's Office (NAMFCU's representative on the Executive Board)

Private Payers

- ✓ Aetna
- ✓ Amerigroup
- ✓ Blue Cross and Blue Shield of Alabama
- ✓ Blue Cross and Blue Shield of Louisiana
- ✓ Humana
- ✓ Independence Blue Cross
- ✓ Travelers
- ✓ Tufts Health Plan
- ✓ United HealthCare
- ✓ WellPoint

Associations

- ✓ America's Health Insurance Plans (AHIP)
- ✓ Blue Cross and Blue Shield Association (BCBSA)
- ✓ Coalition Against Insurance Fraud (CAIF)
- ✓ National Association of Insurance Commissioners (NAIC)
- ✓ National Association of Medicaid Directors (NAMD)
- ✓ National Association of Medicaid Fraud Control Units (NAMFCU)
- ✓ National Health Care Anti-Fraud Association (NHCAA)
- ✓ National Insurance Crime Bureau (NICB)

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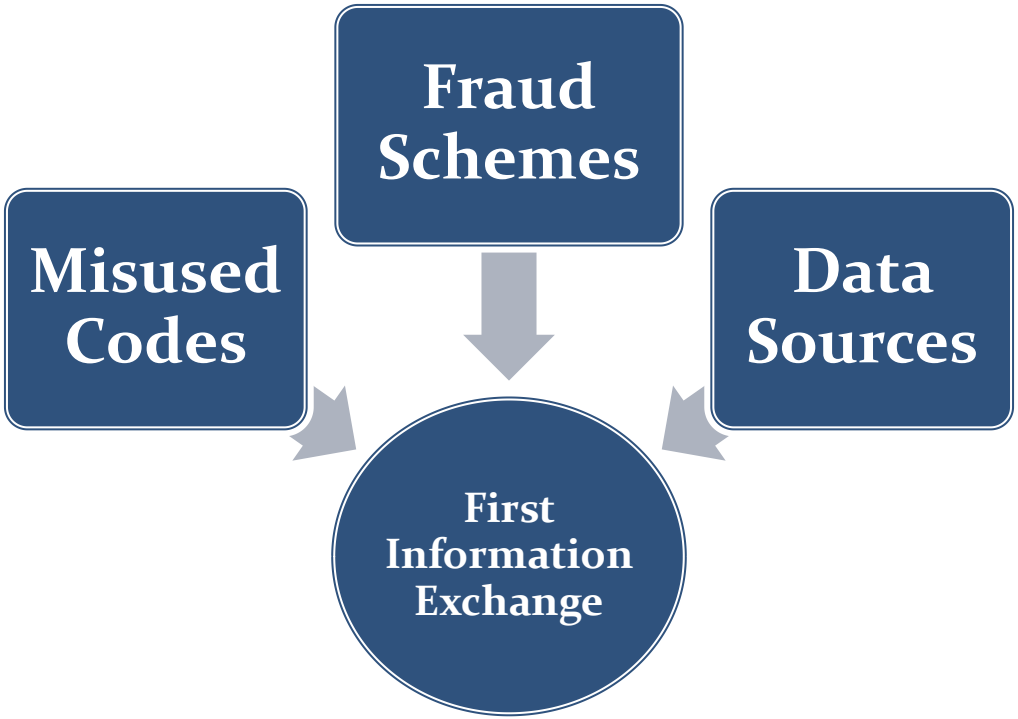
First Information Exchange

- 11 Partners Contributed
  - 2 federal
  - 4 national health insurance companies
  - 1 national property and casualty company
  - 2 regional insurance companies
  - 1 state Medicaid agency
  - 1 association

- 3 Information Types
  - >1400 Misused Codes
  - >100 Fraud Schemes
  - >44 Data Sources



Partner analysis yielded various findings

CMS' Unified Program Integrity Contractor: Goals for Contractor Consolidation

- To date, CMS' Center for Program Integrity has been procuring contracts via four separate statutory authorities.

- Moving forward, we will look at our authorities holistically, leveraging them to implement an innovative approach that rationalizes our relationships with providers, leverages available resources and enhances relationships with states.

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Comprehensive Strategy

Detect suspicious claims prior to payment

Revoke bad actors from Medicare and Medicaid

Focus on risk and reduce burden on legitimate providers

Engage Partners

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

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