Medicare: Issue of the Day

September 8, 2004

BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

CMS STRENGTHENS EFFORTS TO REDUCE FRAUD AND ABUSE IN MEDICARE, MEDICAID

Centers for Medicare & Medicaid Services Administrator Mark B. McClellan, M.D., Ph.D. recently announced a new CMS initiative and a proposed regulation to **protect the nation's largest federal health programs from fraud and abuse and further reduce improper payments through the use of enhanced electronic tools now available.**

"America's taxpayers – and all of our beneficiaries – put their trust in us to **protect both Medicare and Medicaid from unscrupulous persons looking to steal from the taxpayer**," said Health and Human Services Secretary Tommy G. Thompson. "By using all of the means we have available, along with more targeted education efforts to health care providers, we can do even more **to protect these programs against both fraud and abuse**."

- CMS is **building on its current program integrity efforts** by implementing new steps to analyze program data to detect improper payments and potential areas of fraud and abuse in the Medicare and Medicaid programs **more quickly and accurately**.
  - CMS is using these analyses to **more effectively educate providers and beneficiaries** about ways to prevent and minimize waste, fraud, and abuse.
  - CMS' program integrity efforts are being expanded beyond fee-for-service Medicare to **encompass oversight of the discount drug card program, Part D prescription drug benefit and the new Medicare Advantage plans.**
  - CMS is also planning to focus more efforts on its oversight of Medicaid program integrity.
- CMS issued a proposed regulation **calling on states to report improper payments in Medicaid and State Children's Health Insurance Programs to HHS**.
  - Under the proposed rule, which is open for public comment until September 27, CMS will require states to estimate these improper payments by reviewing a monthly sample of Medicaid and SCHIP claims.
  - This information will be used to determine the accuracy of the payments based on whether the individual was eligible for the program, medical review and data processing. Once CMS receives this information from all 50 states and the District of Columbia the national error rate will be calculated.
  - The proposed rule can be found at: http://a257.g.akamaitech.net/7/257/2422/06jun20041800/edocket.access.gpo.gov/2004/04-19603.htm
- CMS has contracted with a Program Safeguard Contractor (PSC), IntegriGuard, to monitor the activities associated with drug cards.
  - A critical task of this PSC is a **weekly assessment of the sponsor's drug pricing information to identify any "bait and switch" activities**.

- Additionally IntegriGuard will be working with CMS to identify and prevent potential fraudulent activities involving the discount drug card program, such as counterfeit cards and identity theft schemes.
- The PSC will also conduct a survey of weaknesses in Medicaid drug programs and **how states deal with those** to help CMS prepare for potential issues and the possible resolution of those issues that may arise in the new Medicare Prescription drug benefit.

❖ Several areas of the country have been identified as **fraud "hot spots"** where unscrupulous individuals systematically defraud the programs.

- In one of these areas, Southern California, **CMS has opened a satellite office in the Los Angeles area to focus Agency efforts on the large number of reported fraud activities that have been occurring in that area**.
- Current CMS oversight efforts have **identified many illegal storefront operations set up to defraud the Medicare and Medicaid programs by billing for services never provided**, including an aggressive effort to curb fraudulent billing activities at a number of home health agencies in the Southern California area.
- CMS' efforts in this area have resulted in the successful suspension of payments to many fraudulent entities, **stopping payments of more than $260 million in savings to the Medicare trust fund between January 2003 and June 2004.**

"These **illegal operations and other activities conducted by unscrupulous individuals force both federal and state governments to pay out millions of taxpayer dollars in improper Medicare and Medicaid payments**," Dr. McClellan said. "We have been successful in looking closely at our data to find patterns of fraud, abuse and improper payments and will continue to do just that, while **we use even more of our resources to help reduce simple errors through the use of education efforts**."

❖ To augment the Agency's new data oriented approach to program integrity, it is **expanding the Medicare-Medicaid (Medi-Medi) match program where claims data from both programs are analyzed together to detect patterns that may not be evident when billings for either program are viewed in isolation**. As a result of combining the data, CMS can identify previously undetected patterns, such as "time bandits," providers who bill for a total of more than 24 hours in a day in both programs. CMS' goal is to ultimately review this data in "real time."

- Given its success in the first seven states (California, Florida, Illinois, New Jersey, North Carolina, Pennsylvania and Texas), **CMS is expanding the Medi-Medi project to the states of Ohio and Washington. Federal expenditures in these states exceed $28 billion**.

❖ CMS recently announced a pilot project to assess the effectiveness of hospital compliance programs by **tying the elements of a compliance program to data outcomes**.

- The CMS pilot will endeavor to show whether particular actions by a healthcare provider, such as aggressive auditing and monitoring, have a direct impact on their billings (resulting, for example, in lower claim denial rates).
- At the end of the pilot, CMS will issue best practices guidance detailing the findings of the pilot and educating the provider community on effective compliance practices identified through the pilot.
- CMS intends to **expand this effort to other provider types if it proves successful**.

❖ CMS has seen success through its **Comprehensive Error Rate Testing (CERT) program**, resulting in an adjusted **error rate of 5.8 percent in 2003, down from 14 percent in 1996**.

- The CERT program **combines data analysis with extensive education efforts to health care providers and the private companies that pay Medicare claims**.
- To build upon the CERT program, CMS is implementing an initiative to determine the payment error rate for the Medicaid program and the State Children's Health Insurance Program.