5th National Health Care Fraud and Abuse Control Program Conference

Program Safeguard Contractors: The Future of Benefit Integrity

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September 2002

Medicare Program Overview

- CMS largest purchaser of health care services in the United States.
- By FY 2003 our programs are projected to serve approximately 79 million beneficiaries.
- Our programs account for more than one of every three dollars spent on health care in the US.
- Second to only Social Security in the level of Federal Spending.

A Historical View: Program Safeguard Activities

Program Safeguards in the 1990s

- A time of awakening.
- Providers draining the Medicare Trust Funds without:
  - providing services;
  - accurately coding for provided services;
  - operating a legitimate place of business; or
  - complying with program rules.

Program Safeguards in the 1990s

- CMS cracked down on fraud and abuse.
- Operation Restore Trust Initiative:
  - More intense review of providers.
  - More on-site presence.
  - More collaboration with law enforcement.
  - More diligence.

Program Safeguards in the 1990s

Our effectiveness was evident.

- Slowed growth in a variety of provider groups: home health and CMHCs.
- Increased fines, penalties and convictions of unscrupulous providers.
- More information sharing and more effort on preventing, as well as detecting fraud and abuse.

Program Safeguards in the 1990s

CMS strengthened many administrative tools:

- Statistical sampling;
- Consent settlement;
- Building the Medicare Exclusion Database and the Fraud Investigation Database; and
- Linking medical review and provider enrollment to fraud activities.

Program Safeguards on the 2000s

- Pay It Right.
- Ensure proper payments for medically necessary services, to legitimate providers, for covered services, provided to eligible beneficiaries.

Program Safeguards in the 2000s

- Recognize that the vast majority of the over 1 million providers participating in the Medicare program are honest.
- Focus on prevention and committed some program integrity resources to provider education.
- Focus efforts on the relatively small number of fraudulent or abusive providers.

Program Safeguards in the 2000s

- CMS is not soft on fraud.

- Benefit Integrity funding increased by:
  - 10.16% in FY 2000,
  - 5.80% in FY 2001, and
  - 10.30% in 2002

Program Safeguards in 2002

- We have the attention of providers across the country.
- A community in a state of fear.
- The era of compliance.

Program Safeguards in 2002

- Work with the provider community to promote compliance.
- Model Compliance Plans
- Customer Service
- Differentiating between fraudulent providers and honest billing errors – establish balance.

Program Safeguard Contractors

Program Safeguard Contractors

Background:

- In 1996, Congress enacted HIPAA and the Medicare Integrity Program.
- Created authority for CMS to contract with other than Medicare Carriers and Fiscal Intermediaries (FIs) to perform certain payment safeguard activities.

Program Safeguard Contractors

May1999: CMS created a Multiple Award Contract schedule and awarded Indefinite Delivery, Indefinite Quantity contracts to 12 PSCs to perform some or all of the following program integrity functions:

- Medical review
- Benefit integrity
- Cost report audit
- Data analysis
- Provider education

The 12 PSCs

AdvancedMed (formerly DynCorp.)

Aspen Systems Corporation

Cahaba Safeguard Administrators

Computer Sciences Corporation (CSC)

Electronic Data Systems Corp (EDS)

IntegriGuard a Division of CMRI

The 12 PSCs

LifeCare Management Partners, Inc.

Mutual of Omaha

Reliance Safeguard Solutions, Inc.

Science Applications Intl. Corp (SAIC)

TriCenturion, LLC

Trust Solutions, LLC

PSC Implementation Strategy

Be Opportunistic.

Test different PSC workload configurations.

- Benefit Integrity Support Center - EDS
- Western Integrity Center - CSC
- Region A DMERC PSC - TriCenturion
- North Carolina PSC – Cahaba
- Ohio/West Virginia PSC – Advanced Med

PSC Implementation Strategy

- Begin proactively transitioning the fraud and abuse detection and prevention work to PSCs.

- Adopt outcomes-based contracting strategy.
  - Establish outcomes not processes.
  - All contractors permitted to innovate when developing program safeguard tools in order to achieve intended outcomes.
  - Contracts provide incentives for good work through profit and rewards.

Outcomes-Based Approach

Medicare Carriers and FIs:

- Minimize the fee-for-service claims payment error rate.
- Measured according to the Comprehensive Error Rate Testing Program.

PSCs:

- Minimize fraud and abuse in the Medicare program.

PSC Implementation Schedule

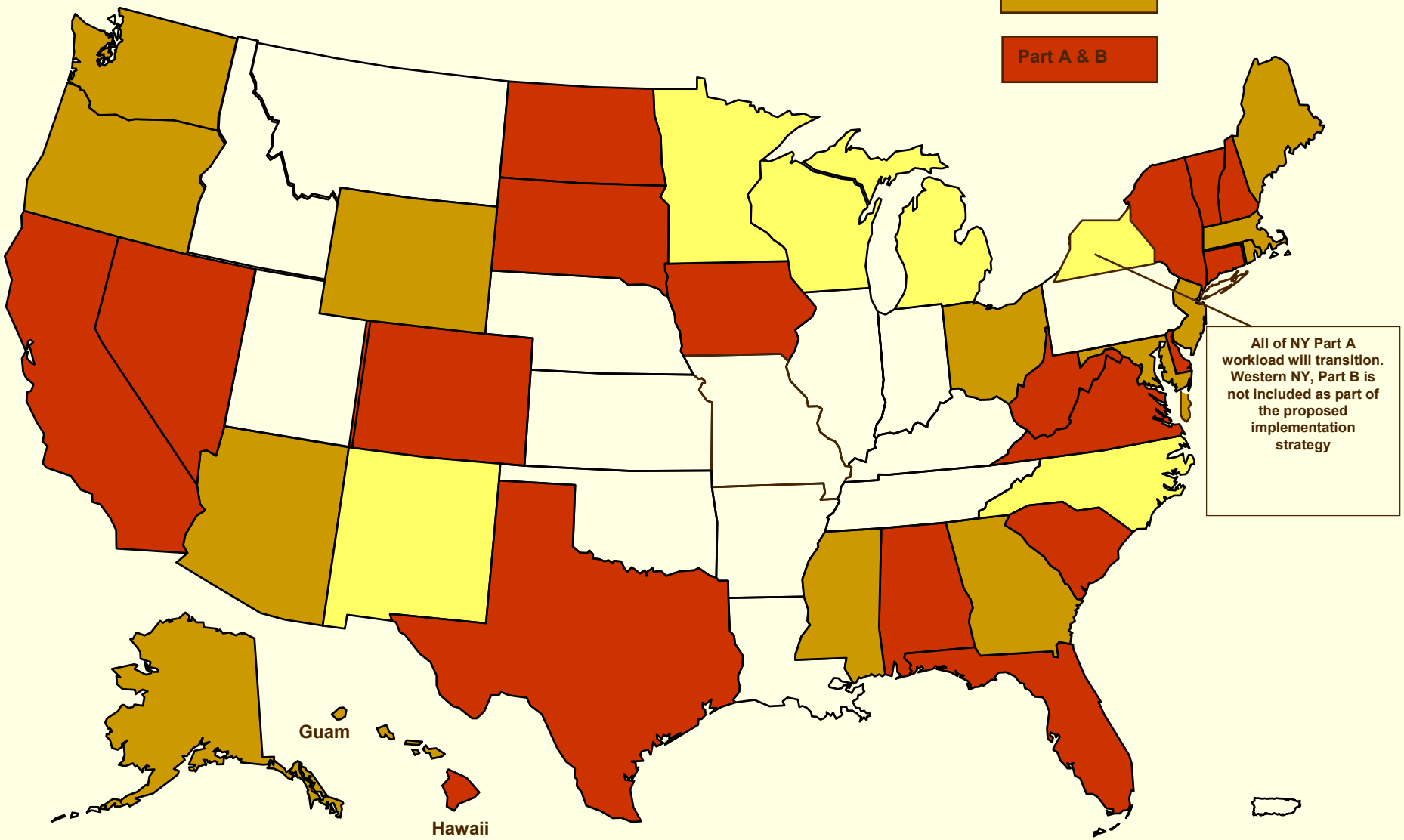
- August 1, 2002 Transition
  - CIGNA
- October 1, 2002 Transition
  - National Heritage Insurance Company (NHIC)
  - TrailBlazer
  - United Government Services (UGS)
- January 1, 2003 Transition
  - Blue Cross Blue Shield of Alabama
  - First Coast Service Options
  - Palmetto GBA
  - Empire Blue Cross Blue Shield

PSC Implementation Strategy

Next Steps:

- Expand PSC task orders to include additional states or complimentary A or B workloads.
- Compete work in remaining FIs and Carriers.
- Evaluate expanding the model to DME Regional Carriers.
- Consider re-alignment of PSC work to create more geographically-based contractors.

PSC Coverage
Post Implementation 2003



Mutual of Omaha's FI work and the RHHI work of UGS, Cahaba, and Palmetto are not shown, but they will be covered by a PSC.

NOTE: In the red colored states, more than one PSC may be operating- one for Part A and one for Part B.

Program Safeguard Contractors

- A Time of Change
- How will the PSCs work with the Carriers and Fiscal Intermediaries?
  - Continuum of Cases
  - Joint Operating Agreement
- Harkin Grantee Tracking System

The Future of Benefit Integrity

Future Benefit Integrity Efforts

- Integrate providers' compliance efforts.
- Implement PSCs.
- Continue and improve core work.
- Strengthen administrative tools.

Our Core Work: Benefit Integrity

The most prevalent allegations of fraud reported have been as follows:

- Accepting/Soliciting Bribes/Gratuities/Rebates/Discounts
- Medicare/Medicaid Kickbacks
- Billing for Services Not Rendered
- Duplicate Billing
- Overutilization
- Services Not Provided

Strengthening Administrative Tools: MED and FID

Medicare Exclusion Database

- Builds off of the OIG exclusion database.
- Standardizes formatting and data fields.
- Enables linkages to other CMS databases like OSCAR and PECOS.
- Enables Medicare contractors to integrate information into their claims processing systems so no Medicare payments to excluded providers.

Medicare Exclusion Database

- Federal Register notice of a new system of records published on February 26, 2002.
- The MED was distributed for the first time in mid-April to all Medicare contractors.
- We are also working to make the files available to the Medicaid State Agencies.

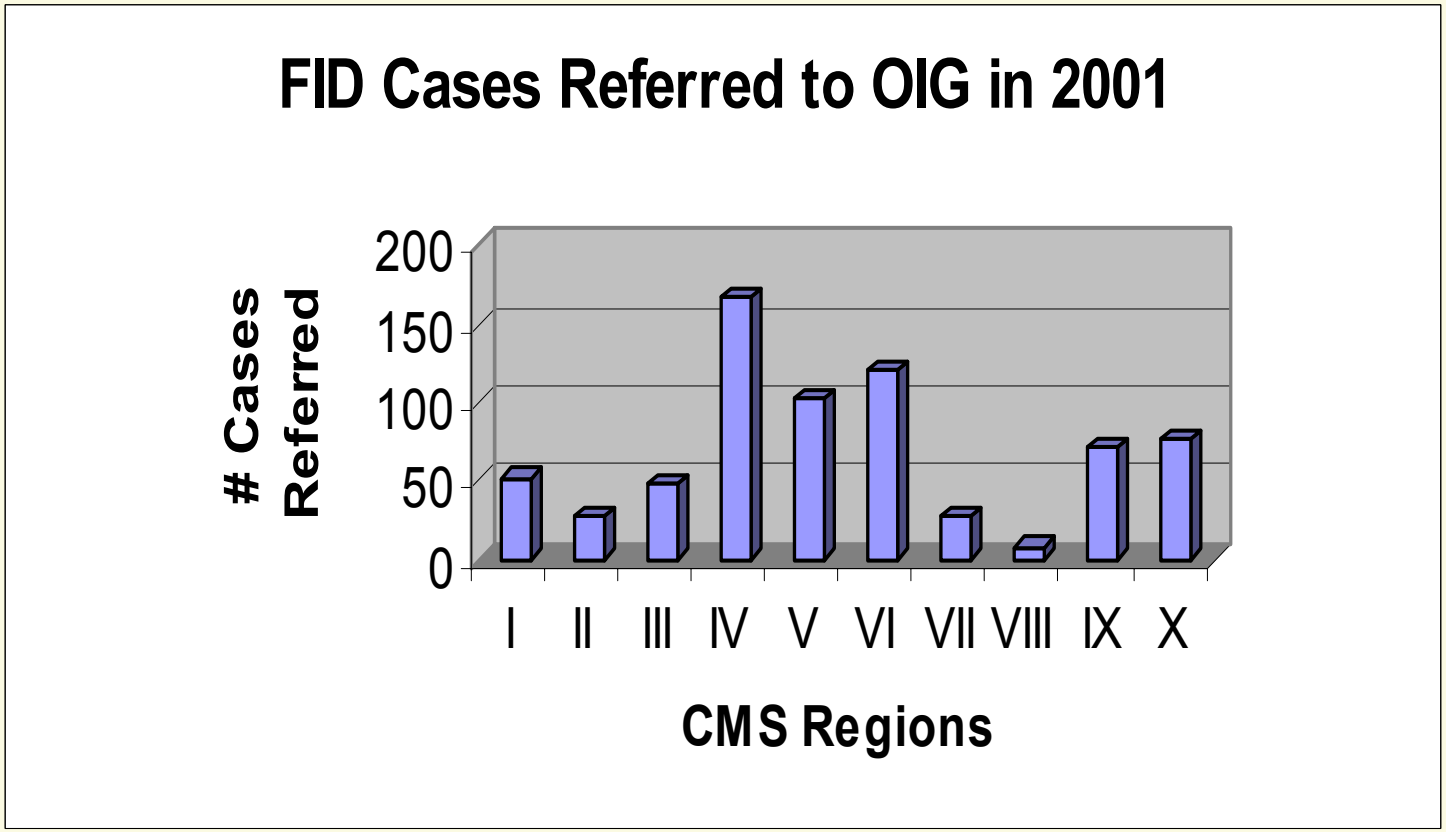
Fraud Investigation Database

- First created in 1996, first nation-wide system devoted to Medicare and Medicaid fraud and abuse data accumulation.

- Improvements:

  - Create a Windows based environment.
  - CMS has a new contractor – AMS.
  - Expect FID updates to be within the next month.

Fraud Investigation Database



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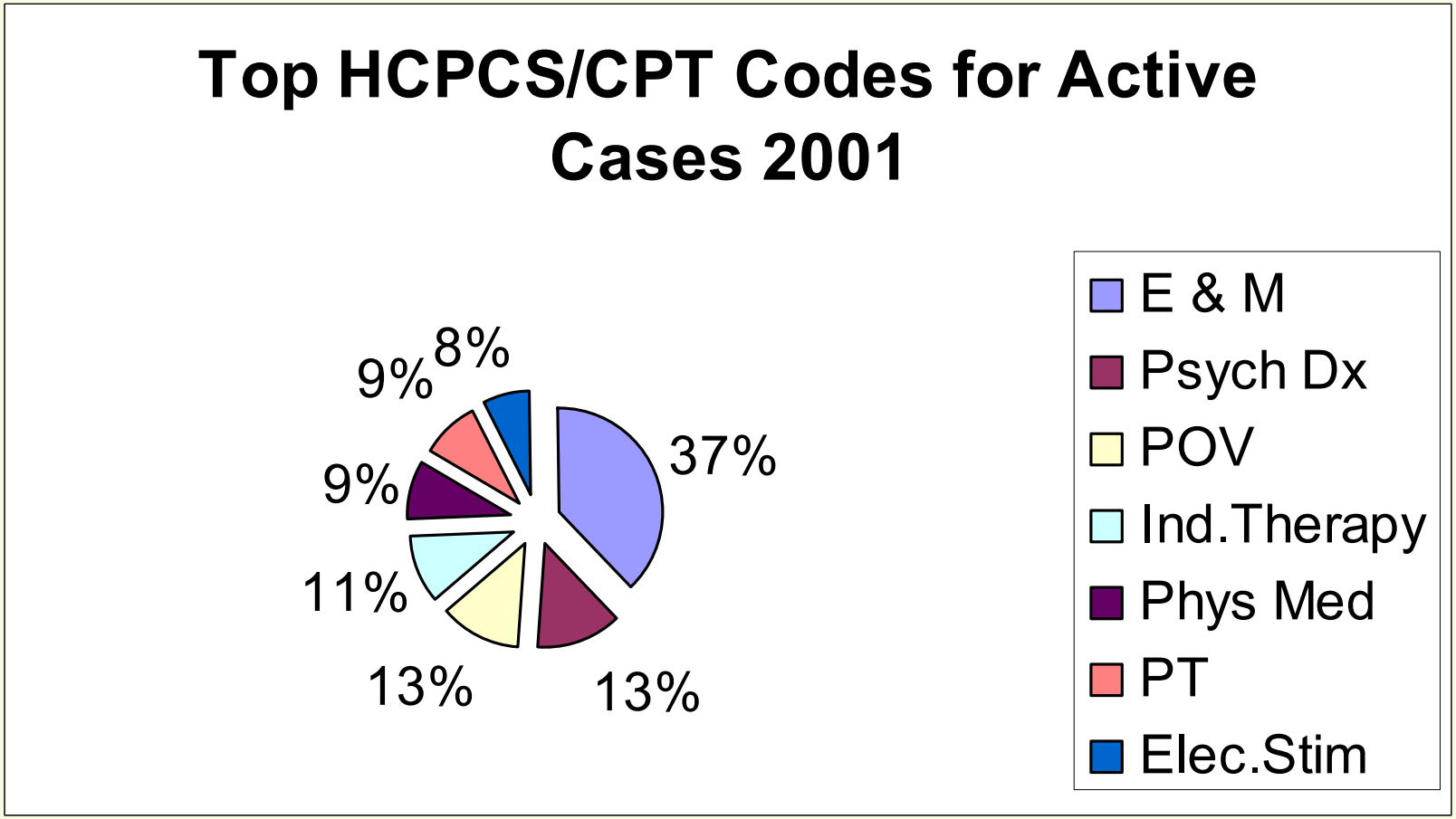

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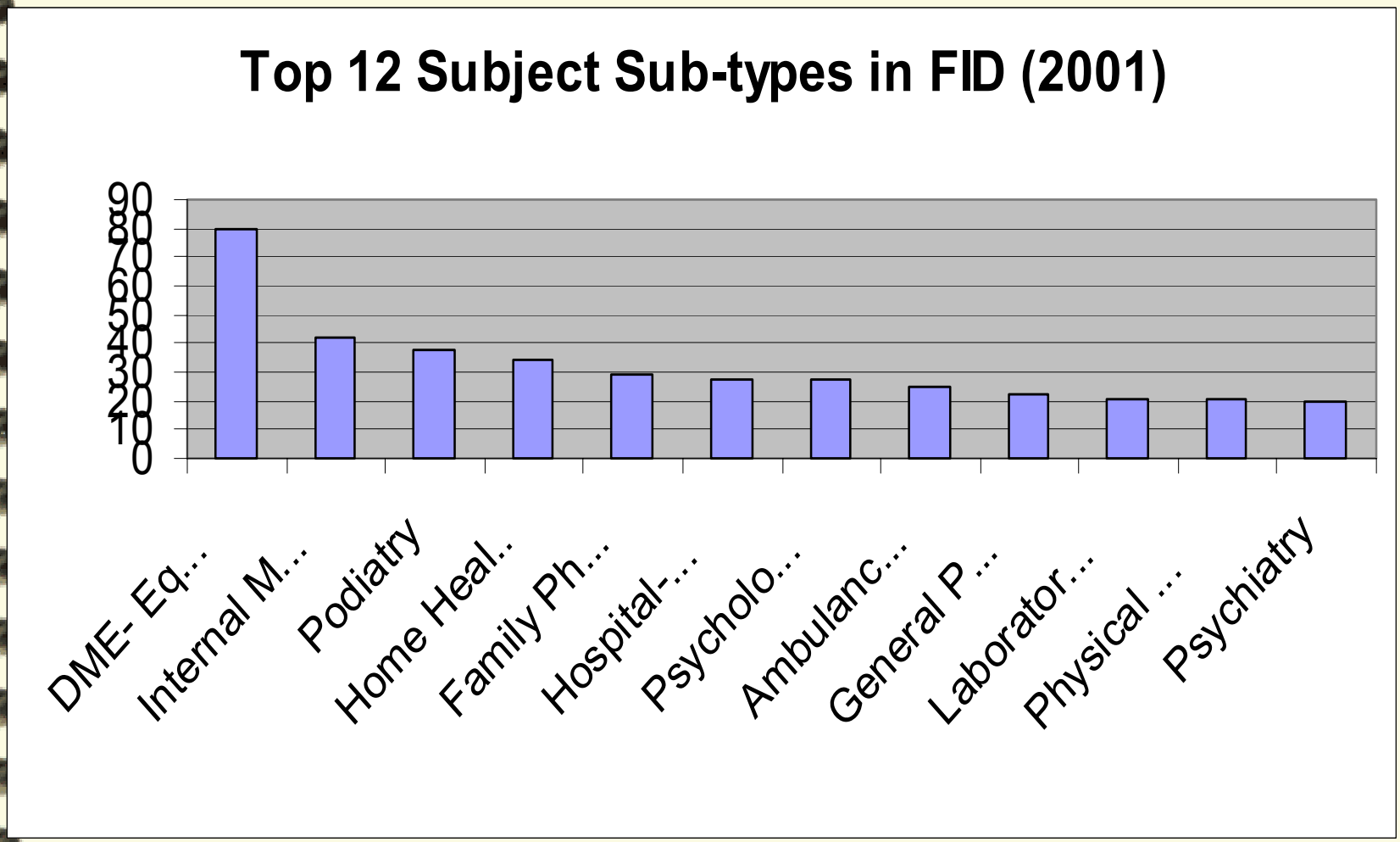

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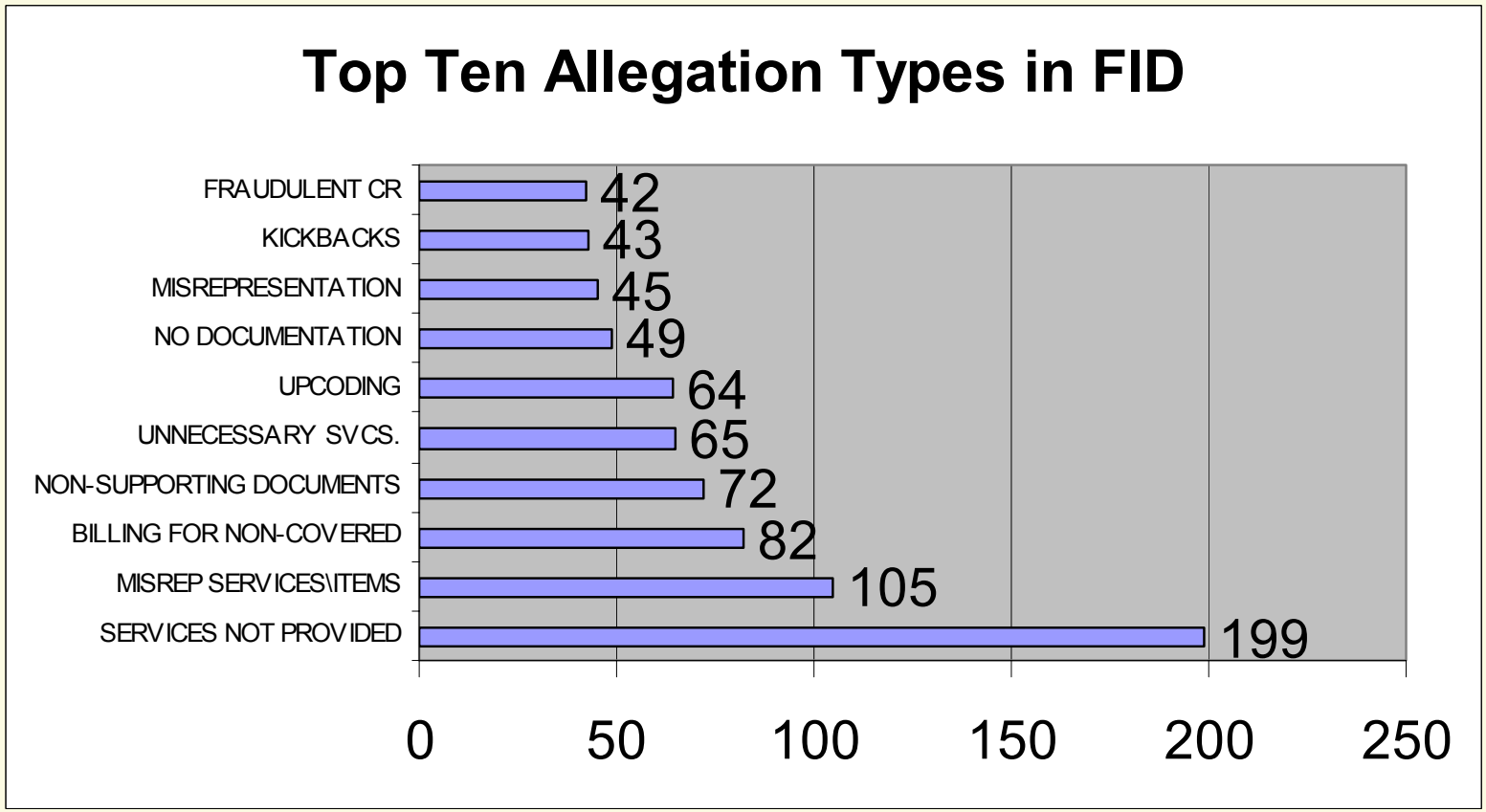

Thank You

Questions ?