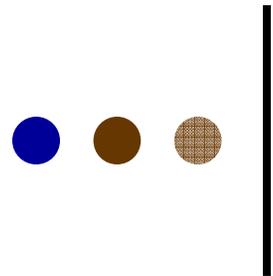




Fraud and Abuse Workgroup

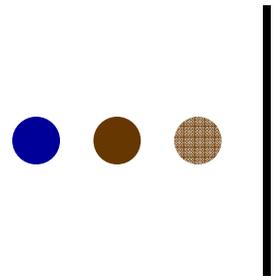
Additional Background Information and Future Work

Presentation by:
Sharon Schiro, PhD
NC Institute of Medicine
16 August 2010



Agenda

- Overview of Fraud and Abuse Workgroup charge
- More detailed description of Affordable Care Act (ACA) provisions
- Next steps



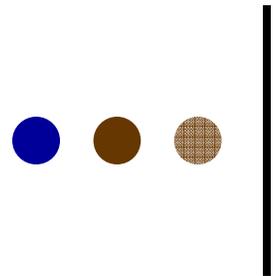
Agenda

- Overview of Fraud and Abuse Workgroup charge
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● ● ● | **Fraud and Abuse Workgroup Charge**

- Charge

- Examine new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance
- Identify implementation steps to meet new Federal requirements
- Understand and educate providers on financial integrity and fraud and abuse reporting requirements



Agenda

- Overview of Fraud and Abuse Workgroup charge
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Fraud and Abuse Overview

- Efforts to reduce fraud and abuse include:
 - Increased funding for investigations of fraud and abuse (by \$350M over the next decade)
 - Enhanced program requirements in Medicare, Medicaid and CHIP, including new provider requirements for participation in these programs
 - Expanded data reporting and matching activities to identify fraud and abuse
 - Increased penalties and federal powers to investigate fraud and abuse





Increased Funding to Reduce Fraud and Abuse

- Increases funding to the Health Care Fraud and Abuse Control Fund by \$350 million over the next decade (Appropriates \$105M in FY 2011, \$65M in FY 2012, \$40M in FY 2013, \$40M in FY 2014, \$30M in FY 2015, \$30M in FY 2016 and \$10M in each FY 2017-FY 2020; Sec. 6402 and 1303 of Reconciliation)
- Funding can be used for covering the costs of fraud and abuse control and for carrying out the Medicare Integrity Program
- Indexes funding for the Medicaid Integrity Program by the consumer price index, \$75 million appropriated in FY 2010 (Sec. 1303 of Reconciliation)



Reducing Fraud and Abuse: Medicare, Medicaid and CHIP

- Requires screenings of all providers and suppliers of services as a part of enrollment and re-enrollment in these programs (Sec 6401, 10603)
 - The level of screening at a minimum will include a licensure check and can include background checks, fingerprinting, unannounced site visits, and cross state checks depending on level of risk for fraud and abuse
- Requires that all new providers and suppliers of services are subject to a period of enhanced oversight after enrollment (Sec. 6401, 10603)
 - May include prepayment review and payment caps



Reducing Fraud and Abuse: Medicare, Medicaid and CHIP (Cont.)

- Requires that providers and suppliers disclose any past affiliation with a provider who has been subject to payment suspension, excluded from participation, or has had their billing privileges denied or revoked (Sec. 6401, 10603)
- Providers and suppliers will be required to establish an anti-fraud and abuse compliance program (Sec. 6401, 10603)
- States are required to apply the new screening, oversight, disclosure and compliance rules in Medicaid and CHIP (Sec. 6401, 10603)



Reducing Fraud and Abuse: Medicare

- Simplifies procedures to initiate prepayment review for fraud and abuse (Sec. 1302 of Reconciliation)
- Community Mental Health Centers must provide at least 40% of partial hospitalization services to individuals not eligible for Medicare (Sec. 1301 of Reconciliation)
- Prohibits Community Mental Health Centers from providing partial hospitalization services in an individual's home or in an inpatient or residential setting (Sec. 1301 of Reconciliation)



Reducing Fraud and Abuse: Medicaid

- States must terminate providers from participation in Medicaid who have been terminated from participation in Medicare or CHIP (Effective: Jan. 1, 2011; Sec. 6501)

- CMS will inform states of providers who have been terminated from participation in Medicare (Sec. 6401, 10603)

- Excludes providers and suppliers if they are owned by, or own, individuals or entities that: (Effective: Jan. 1, 2011; Sec. 6502)

- have not repaid overpayments;

- are suspended or excluded from participation in Medicaid; or

- are affiliated with an individual or entity that has been suspended, excluded or terminated from participation



Reducing Fraud and Abuse: Medicaid (Cont.)

- Groups submitting claims on behalf of providers must register with the state and CMS (Effective: Jan. 1, 2011; Sec. 6503)
- Expands the period, from 60 days to one year, that states have to recover overpayments (Effective: Upon enactment; Sec. 6506)
- Prohibits states from providing payment for services under Medicaid to entities outside the U.S. (Effective: Jan. 1, 2011; Sec. 6505)



Expansion of the Recovery Audit Contractor (RAC) Program

- States must establish a RAC program to identify underpayments and overpayments and recoup overpayments under Medicaid (Effective Dec. 31, 2010; Sec. 6411)
- Payments to RAC contractors will come from amounts recovered, a portion of the recovered overpayments will be used to identify underpayments, and states must establish an appeals process
- Expands the RAC program to Medicare Advantage Plans and Medicare Part D (Sec. 6411)



Reducing Fraud and Abuse: Home Health Services and Durable Medical Equipment (DME)

- Requires a face-to-face encounter before certification for home health services under Medicare and Medicaid, and payment for DME under Medicare (Effective: Jan. 1, 2010; Sec 6407, 10605)
 - Encounters can be with: a physician, nurse practitioner, clinical nurse specialist, certified nurse-midwife or physician assistant
- Providers and suppliers in Medicare are required to supply documentation about referrals to, orders for DME, and certification for home health services to entities at a high risk for fraud and abuse (Effective: for orders, certification, or referrals on or after Jan. 1, 2010; Sec 6406)

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Reducing Fraud and Abuse: Home Health Services and DME (Cont.)

- Requires adjusting the size of surety bonds for DME and home health agencies by billing volume (Sec. 6402)
- Withholds payment to DME suppliers for 90 days if there is a significant risk for fraud (Effective Jan. 1, 2011; Sec. 1304 of Reconciliation)
- Prohibits physicians, or eligible professionals, not enrolled in Medicare from ordering home health services or DME for Medicare beneficiaries (Effective: July 1, 2010; Sec. 6405)



New Provider Obligations to Reduce Fraud and Abuse

- Individuals who receive overpayments through Medicare, Medicaid and CHIP are required to report and return the overpayment within 60 days (Sec. 6402)
- Providers and suppliers of services are required to include their National Provider Identifier on all enrollment applications and claims submissions through Medicare, Medicaid and CHIP (Effective Jan. 1, 2011; Sec. 6402)



New Data Reporting Requirements to Reduce Fraud and Abuse

- States and Medicaid managed care organizations must submit an expanded set of Medicaid data elements (Effective: for data submitted on or after January 1, 2010; Sec. 6504)
- State Medicaid information systems must be compatible with the National Coding Initiative (Effective: October 1, 2010; Sec. 6507)
- Requires the Integrated Data Repository (IDR) of CMS to include claims and payment data from Medicare, Medicaid, CHIP, the Dept. of Veterans Affairs, the Dept. of Defense, the Social Security Administration, and the Indian Health Services (Sec. 6402)
- Data in the IDR will be matched to identify fraud and abuse in Medicare and Medicaid





National Health Care Fraud and Abuse Data Collection Program

- Establishes a National Health Care Fraud and Abuse Data Collection Program for the reporting of all final actions against health care providers, suppliers, and practitioners (Effective: whichever is later, one year after enactment or when regulations are published; Sec. 6403)
- States are required to report all final actions, which include:
 - Revocation or suspension of licenses, reprimands, or probation
 - Dismissal or closer of fraud and abuse proceedings
 - Any other lost of license, or the right to apply for or renew a license, or other negative action
- State licensing, law, or fraud enforcement agencies will report any corrections to reported information



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Reducing Fraud and Abuse: Exchanges, Co-Ops, and Multi- State Health Insurance Plans

- To prevent fraud and abuse in the new state insurance exchanges: (Sec 1313)

- The Secretary may investigate the exchanges for fraud and abuse and if there is serious misconduct the Secretary may reduce payments due to states by, at maximum, 1% until changes are made

- Individuals who commit fraud and abuse can be subject to federal prosecution if payments received through the Exchanges involved federal money

- Co-Ops and multi-state health insurance plans are required to comply with all the same federal *and* state laws as private health insurance issuers (Sec. 1324, 10104)



Reducing Fraud and Abuse: Multiple Employer Welfare Arrangement Plans (MEWAs)

- MEWAs are subject to state anti-fraud and abuse laws and regulations (Sec. 6604)
- Employees of MEWAs who make false statements concerning the financial condition or solvency, benefits, or regulatory status of the plan are subject to civil penalties (Sec. 6601)
- Enables the Sec. of Labor to issue cease and desist orders, if there is evidence of fraud and abuse, to temporarily shut down MEWAs (Sec. 6605)
 - Allows the Sec. of Labor to seize the MEWAs' assets if it is in a financially hazardous condition
- Requires MEWAs to register with the Sec. of Labor before beginning operations in a state (Sec. 6606)



Preventing Fraud and Abuse in CLASS

○ In order to prevent and fraud and abuse in CLASS (The Community Living Assistance Services and Supports Program): (Sec. 8002)

- Establishes procedures to allow authorized representatives access to a beneficiaries' benefits that prevent fraud and abuse
- CLASS regulations will include provisions to prevent fraud and abuse



New and Enhanced Penalties for Fraud and Abuse

- Payments, under Medicare and Medicaid, to providers can be suspended during investigations of fraud and abuse (Sec. 6402)
 - Allows the Secretary to suspend the federal portion of payments, for services under Medicaid, to providers who are under investigation for fraud and abuse if the state does not suspend payments
- Medicare, Medicaid and CHIP beneficiaries who participate in fraud and abuse can be subject to administrative penalties (Sec. 6402)



New and Enhanced Penalties (Cont.)

- Providers can be excluded from participation in Medicare, Medicaid, and CHIP if they make false statements when applying for, or making, claims and bids and can be subject to civil penalties up to \$50,000 per false claim (Sec. 6402, 6408)
- Also subject to civil penalties are Medicare Advantage or Part D plans that involuntarily enroll beneficiaries, transfer individuals between plans to earn commissions, do not comply with marketing regulations, or contract with individuals that engage in these activities (Sec. 6408)
- Changes the federal sentencing guidelines to raise the penalties for convictions of federal health care offenses (with a net loss over \$1M) (Sec. 10606)



New and Enhanced Penalties (Cont.)

- Persons who do not provide timely access to information for audits, investigations, evaluations, or other statutory functions can be subject to monetary penalties of \$15,000 per day (Sec. 6408)



Enforcement and Investigation into Fraud and Abuse

- Changes the intent requirement for health care fraud so that individuals do not need to know that their actions are fraudulent in order to be prosecuted for fraud and abuse (Sec. 10606)
- Permits, in exclusion-only cases, Inspector General of DHHS to issue subpoenas and require the production of evidence and testimonials related to the investigation (Sec. 6402)
- Grants the Inspector General of DHHS access to data from any individual (including beneficiaries) in order to investigate fraud and abuse (Sec. 6402)



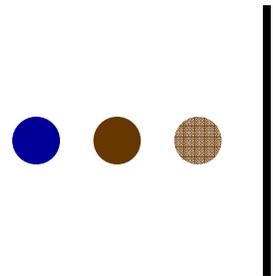
Enforcement and Investigation into Fraud and Abuse (Cont.)

- Organizations that investigate fraud and abuse, under the Medicare and Medicaid Integrity Programs, are required to provide performance statistics (Sec. 6402)
 - Such as: the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such activities
- Provides for confidential communication between state and federal agencies that is related to investigations into fraud and abuse (Sec. 6607)
 - Included state and federal agencies: state insurance departments, state attorney generals, the National Association of Insurance Commissioners, the Dept. of Labor, the Dept. of the Treasury, the Dept. of Justice, and the Dept. of Health and Human Services



Reporting Suspected Fraud and Abuse

- Directs the National Association of Insurance Commissioners to develop a uniform reporting form that private health insurance issuers will submit to state insurance departments in to report suspected fraud or abuse for investigation (Sec. 6603)



Agenda

- Overview of Fraud and Abuse Workgroup charge
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- **Next steps**

● ● ● | **Next steps for consideration**

- Identify gaps in surveillance, enforcement, and oversight, and develop implementation steps to meet new requirements (State and providers).
- Identify mechanisms to educate providers on new program integrity provisions under Medicaid, Medicare (as it affects the state), and insurance.

● ● ● | **Next steps, continued**

- Develop mechanisms to meet new reporting requirements, e.g., licensure, fraud, or abuse actions
- Develop mechanisms to integrate information on providers, and to bring data information systems in compliance with new regulations.
- Identify steps required to implement a Recovery Audit Contractor (RAC) program.



Next steps, continued

- Develop methods to educate providers on financial integrity and fraud and abuse reporting requirements.
- Identify what information is needed for next meeting.