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The Program Integrity Provisions of Health Reform- -
What Health Care Providers Need To Know

by Brenda Laigaie, Esq.

The Health Reform Law * contains over 32 sections related to fraud and abuse prevention and enforcement. In some instances, the Health Reform Law amends existing fraud statutes. In other instances, the Health Reform Law creates new and complicated anti-fraud measures. This article will focus on the program integrity provisions ("Program Integrity" or "PI") of the Health Reform Law.

The Centers for Medicare and Medicaid Services ("CMS"), through its Center for Program Integrity, has an improved and updated approach to Program Integrity. Under the National Fraud Prevention Program, CMS is using sophisticated data analysis and predictive modeling to transform its fraud prevention efforts. CMS has two concurrent approaches to its fraud prevention and detection initiatives. One approach focuses on the prevention of improper payment of claims. The other approach focuses on provider screening through the enrollment process. The goal is three fold: 1) prevent improper payment of Medicare and Medicaid claims; 2) identify bad actors and prevent them from enrolling in the Medicare/Medicaid system; and 3) remove the bad actors from the Medicare/Medicaid system and keep them out.
CMS is not alone in its efforts. CMS has identified strategic partners, such as the OIG, DOJ and FBI with respect to law enforcement, as well as state and private insurers for purposes of information exchange and sharing of data. In addition, on the heels of the successful Recovery Audit Contractor (RAC) pilot program and roll-out of the full program, CMS will use Zone Program Integrity Contractors or ZPICs to assist it in finding and preventing fraud.

<u>Part One: Prevention of Improper Payment of Claims</u>
Implemented on or about June 30, 2011, CMS's fraud prevention system looks at provider claims' submissions on a pre-payment basis. Using predictive modeling, results are prioritized based on risk and forwarded to the ZPICs to analyze and investigate. At the conclusion of the investigation, results are made available to the Center for Program Integrity and to the law enforcement partners identified by CMS. What this means is that CMS is moving away from the "pay and chase" model and concentrating on prevention and risk assessments and, it doesn't stop there. Beyond monitoring of submitted claims, the fraud prevention system's purview extends to complaints, stolen identifications, paid investigations, and enrollment.

Part Two: Provider Screening in the Enrollment Process

CMS has set three goals toward improvements in the Medicare/Medicaid enrollment process: 1) faster enrollment time; 2) user-friendly on-line enrollment; and 3) having all enrollees in the same data base with up to date information. In the past, CMS has reported that fraudulent providers and suppliers were able to register with stolen medical identities, provide phony addresses, re-enter the system after being revoked, and were able to stay in the local system even if revoked in the national system. The new Automated Provider Screening ("APS") system, implemented on or about December 31, 2011, allows CMS to check applicants more thoroughly. All enrollments will be housed in the national system. In addition, CMS now has the ability to check medical identities, validate locations, and check for revocations, exclusions, and felony convictions.

Using predictive modeling, the APS system will indentify applications of providers that may be at high risk based on specific indicators. The APS system leverages thousands of government, public, and private resources to verify and supplement data by providers. Monitoring alerts are put into place that immediately notifies CMS when there are changes to critical eligibility requirements. The APS system also regularly re-screens all information for continued accuracy.

Part Three: More on ZPICs

Unlike RACs, which are charged with identifying and correcting overpayments and underpayments in the Medicare system, ZPICs are charged with finding and preventing fraud and abuse. While RACs are paid on a contingency basis, ZPICs are paid on a fixed contracted rate with bonuses tied to quality of service and administrative action. ZPICs have the authority to conduct investigations into whether overpayments to providers were made due to fraudulent or abusive billing practices. Moreover, the ZPIC authority extends to denial of payments, recoupment of overpayments, as well as referral to the OIG, DOH or FBI. At its core, ZPICs have comprehensive technological capabilities that enable them to analyze complex data, evaluate billing trends and patterns, and detect abnormal patterns among providers when compared to other "similarly situated" providers. Given the success of the Medicare RACs and ZPICs, providers should be advised that Medicaid RACs and Medicaid Integrity Contractors (MICs) exist, have authority, and are effective.

Part Four: What Should Providers Do?

Compliance! Compliance! Compliance! Having an active compliance program is mandatory as well as practical. If a compliance plan is used effectively, it will assist in identifying and preventing mistakes that could lead to refunding money to payors, interruptions of payments – or worse. In addition, providers need to stay on top of fraud alerts, advisory opinions, and bulletins. Although not law, these publications give guidance and are instructive. Providers should also know the issues identified by the OIG in its work plan as well as the areas identified by CMS as high risk. Through professional organizations and societies, providers should be aware of changes to existing laws as well as the passage of new laws and regulations that impact on their area of practice.

* The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

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Ms. Laigaie has a wide range of experience in health law focusing on physician contracting and transactional matters. Ms. Laigaie's practice concentrates on assisting physicians and their practices in all matters pertaining to payor contracting and negotiations, including responding to audits, overpayment demands, and related payment matters. In addition, Ms. Laigaie has considerable expertise in areas involving general corporate and business matters, fraud and abuse and other regulatory matters, general employment matters, practice acquisitions and mergers, practice sales, and physician/hospital arrangements, including medical staff matters.

Prior to joining Wade, Goldstein, Landau & Abruzzo, P.C., Ms. Laigaie served as in-house counsel to the University of Pennsylvania Health System, primarily assisting in all areas of managed care contracting, payor negotiations, physician networks, and disease management initiatives.

Ms. Laigaie has led lectures and seminars on health care law related issues for nationally-recognized organizations, including the Pennsylvania Bar Institute, the Hospital and Health System Association of Pennsylvania, the University of Pennsylvania Health System and the American Academy of Ophthalmology (2010; Preparing for a RAC Audit, Employment Law Boot Camp) (2011; Compliance After Health Reform; MACs, RACs, MICs, and ZPICs and How To Prepare; and Employment Law (specifically discussed social media) and the Employment Policy).

Ms. Laigaie graduated from Temple University's Beasley School of Law with awards for participation on Temple Law School's trial team.

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