

# **Centers for Medicare & Medicaid Services (CMS)**

**Important Issues Affecting Health Care for  
Individuals and Providers in**

**New Mexico**

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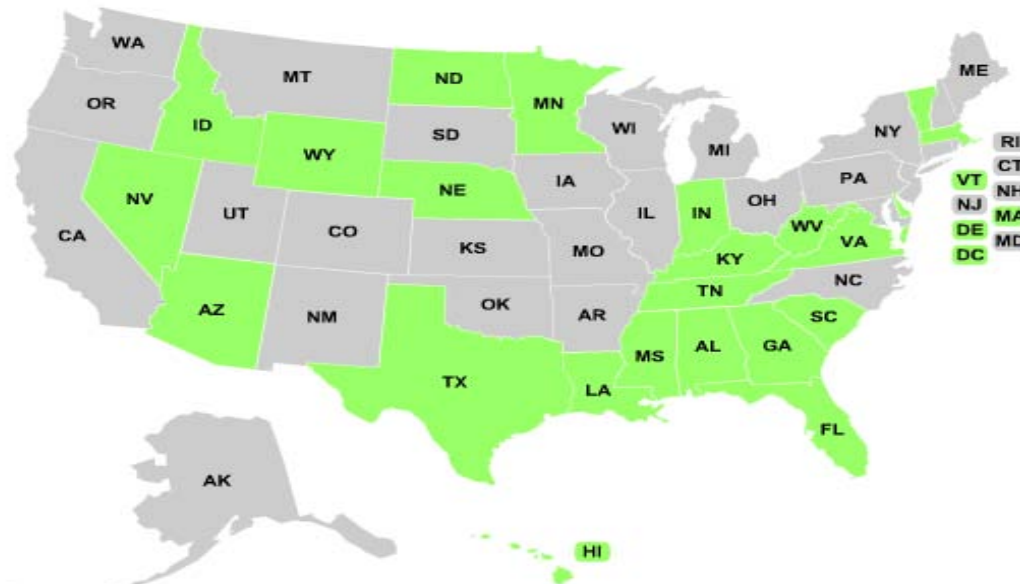
**September 28, 2011**



# Pre-Existing Condition Insurance Plan (PCIP) Program

# Pre-Existing Condition Insurance Plan Program

- Statutory Authority for PCIP
  - Section 1101 of the Affordable Care Act (ACA) requires that DHHS establish a “temporary high risk health insurance pool program”
  - Provides coverage for individuals with pre-existing conditions until the Health Insurance Exchanges are available in 2014
    - ▶ Law required establishment within 90 days of enactment



# Eligibility for PCIP

- A person applying for PCIP must:
  - Reside within the service area of the PCIP;
  - Be a U.S. citizen or reside in the U.S. legally;
  - Have been without health coverage for a minimum of 6 months before applying; and
  - Have a pre-existing condition, as defined by the PCIP and approved by HHS.
- Each PCIP determines how applicants must satisfy its pre-existing condition requirement.
- In federally-run PCIP, applicants must provide:
  - a denial of coverage,
  - offer of coverage with an exclusionary rider,
  - offer of coverage at least twice as much as PCIP rate,\* or
  - provider's documentation of a current or prior condition.\*\*
- In state-run PCIPs, documentation requirements vary.

\*Applicable only for a child under age 19 or for a person who lives in Massachusetts or Vermont.

\*\* Currently applicable only for a child under age 19. Beginning July 1, adults will also be able to provide this kind of documentation.

# Applying for PCIP Coverage

- Each PCIP establishes mechanisms for enrollment, e.g. mailing or faxing a paper application or completing an online form.
- In federally-run PCIP, people can apply for coverage by:
  - Mailing a paper application;
  - Calling the call center to complete an application over the phone; or
  - Filing out an online application at [www.pcip.gov](http://www.pcip.gov).
  - Portable – from federally-run state to another federally-run state
- In New Mexico, to apply for coverage:
  - Consult the New Mexico Medical Insurance Pool (NMMIP)
  - Call 877-5REFORM (877-573-3676), or
  - Visit <http://www.nmmip.org>
  - Not Portable – if moving from New Mexico, must reapply in state of residence

# PCIP Offers Comprehensive Benefits...

- Care in medical offices for treatment of illness or injury
- Emergency services
- Inpatient and outpatient hospital services
- Inpatient and outpatient mental health and substance abuse services
- Prescription drugs
- Home health care and hospice services
- Outpatient laboratory and diagnostic services
- In- and out-of-network benefits
- First-dollar coverage for preventive care
- No lifetime maximum on the amount the plan pays for enrollee's care
- Benefits are available immediately when coverage begins, even for pre-existing conditions
- The ability to receive benefits at any qualified provider

# 2011 Plan Options and Out-of-Pocket Costs

- As in commercial coverage, PCIP enrollees pay monthly premiums and deductibles for coverage:
  - Third-party payers can pay premiums
  - Coverage of newborns
  - Eligibility for children under age 19\*

\*Currently applicable only for a child under age 19. Beginning July 1, adults will also be able to provide this kind of documentation.

Beneficiary Responsibilities	Federal Plans			State Plans
	Standard Option	Extended Option	HSA-eligible Option	
Monthly premium	\$93 - \$578	\$125 - \$778	\$97 - \$600	\$69 - \$1,806
Medical deductible	\$2,000	\$1,000	\$2,500	\$0 - \$5,000
Drug deductible	\$500	\$250	Incl. in medical	\$100 - \$500 or incl.
Out-of-pocket limit	\$5,950	\$5,950	\$5,950	\$5,950

- NOTE: Above amounts represent in-network costs. More information on costs and benefits is available at <http://www.pcip.gov>.
  - NEW MEXICO Premium = \$112 to \$596 per month

# What Enrollees Pay for Care

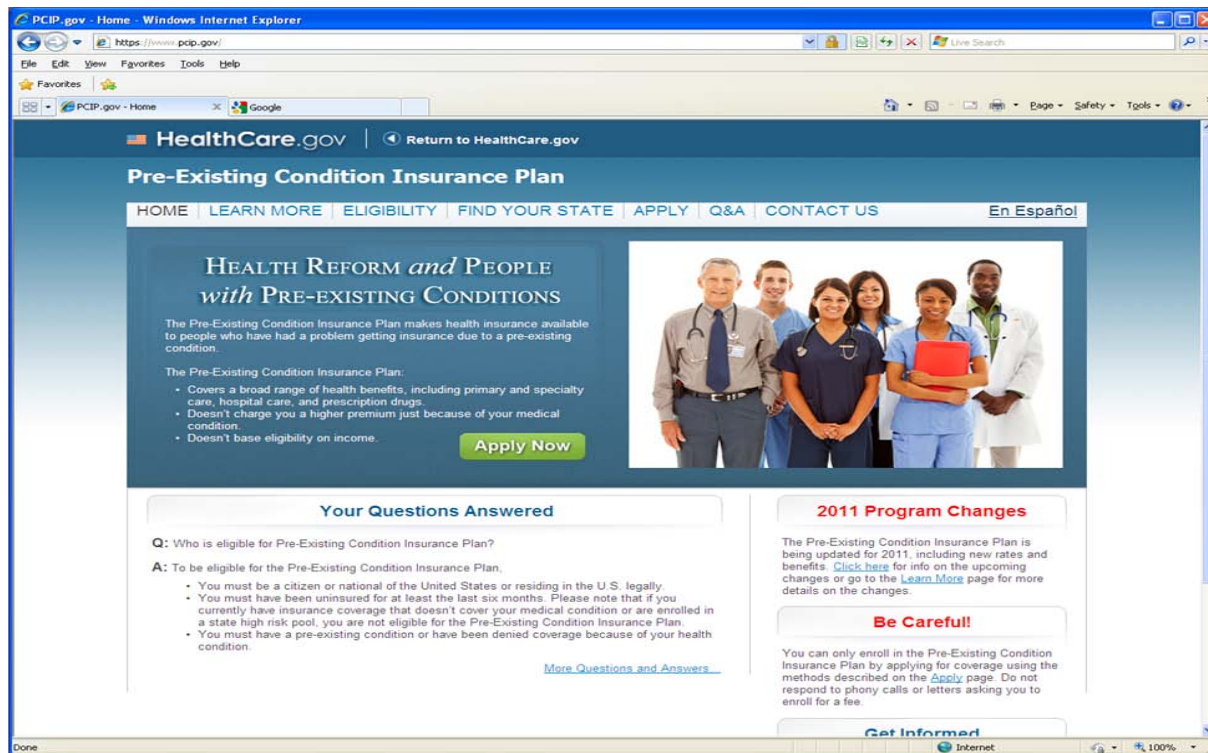
Beneficiary Responsibilities	Standard Option	Extended Option	HSA-eligible Option*	State Plans
Inpatient and Outpatient Hospital Services	20%	20%	20%	Varies
Emergency Services	20%	20%	20%	
Lab and Diagnostic Services	20%	20%	20%	
Medical Coinsurance	20%	20%	20%	
Office Visit Copay	\$25**	\$25**	\$25	
Drug Copay	\$4/\$40/25%	\$4/\$30/25%	\$4/\$30/25%	

- NOTE: Above amounts represent costs for selected in-network services. More information on costs and benefits is available at <http://www.pcip.gov>.
- \*With the exception of preventive care, the full deductible must be met prior to receipt of benefits, including prescription drugs.
- \*\*Services in a physician's office are available at fixed copay, even if deductible is not met.

# PCIP Moving Forward

- ◆ Focus on Outreach
  - Pursuing a targeted outreach and enrollment strategy
  - Forging relationships with other federal agencies to identify potentially eligible consumers
  - Partnering with external groups to educate consumers
  - Using CMS toolkits: newsletter drop-in articles, poster, website links, fact sheets, poster prints are downloadable from website.

- For more information on the Pre-existing Condition Insurance Plan, please visit <http://www.pcip.gov>



# Medicare's Perspective for Protecting the Trust Fund



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*Unauthorized disclosure may result in prosecution to the full extent of the law.*



# CPI's Vision & Mission Statement

*VISION: Use state-of-the-art methods to prevent and detect fraud and to reduce waste, abuse and other improper payments under the Medicare and Medicaid programs.*

*MISSION STATEMENT: To ensure correct payments are made to legitimate providers for covered, appropriate and reasonable services for eligible beneficiaries of the Medicare and Medicaid programs.*

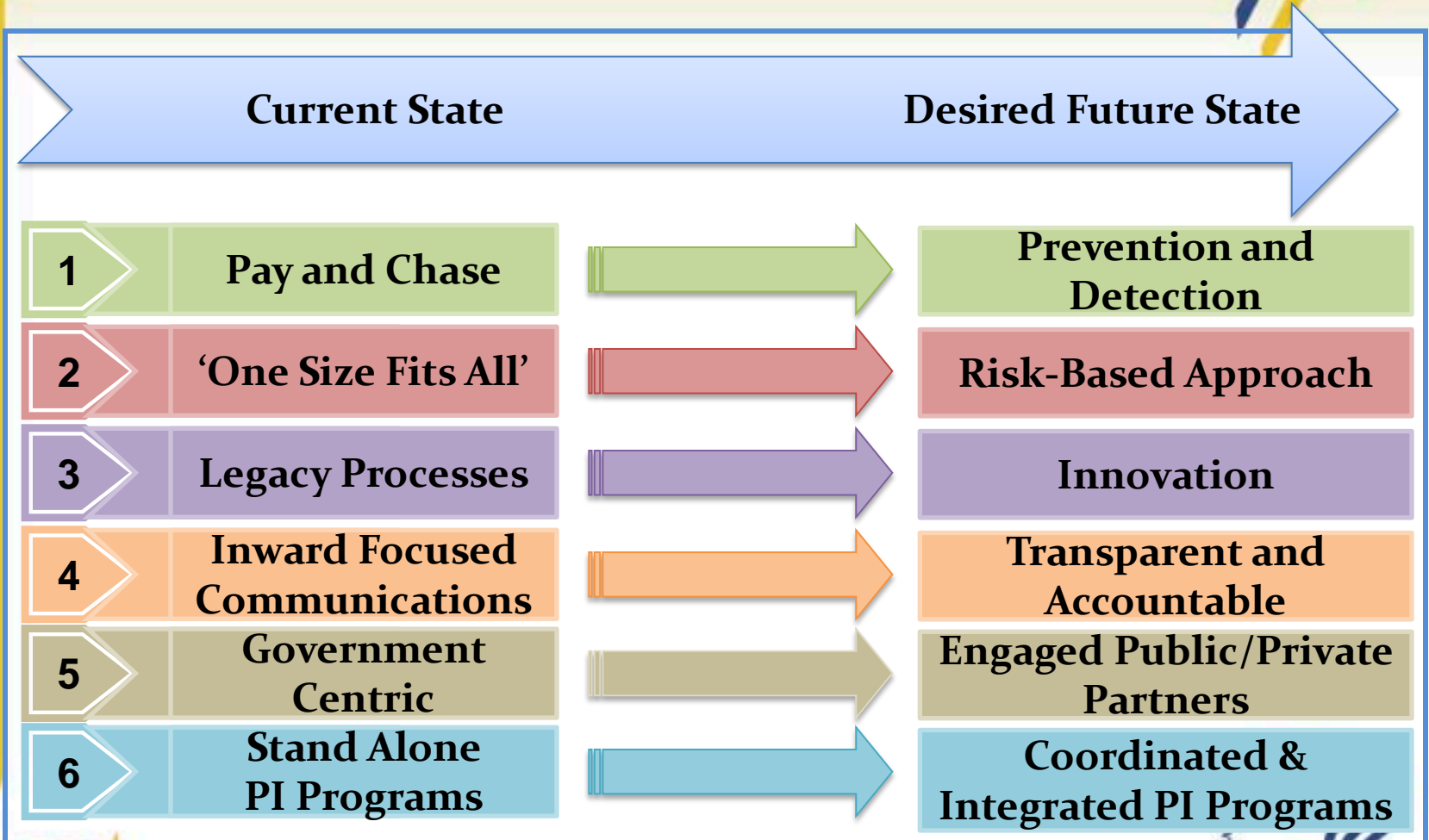
# The Medicare Challenge

- Each working day, Medicare:
  - ▶ Pays over 4.4 million claims
  - ▶ To 1.5 million providers
  - ▶ Worth \$1.1 billion
- Each month, Medicare
  - ▶ Receives almost 19,000 provider enrollment applications
- Each year, Medicare:
  - ▶ Pays over \$430 billion
  - ▶ For more than 45 million beneficiaries

# The Medicaid Challenge

- Each year, Medicaid:
  - ▶ For more than 54 million beneficiaries
  - ▶ 56 State and territory-administered programs
- By 2014, Americans who earn less than 133 percent of the poverty level (approximately \$29,000 for a family of four) will be eligible to enroll in Medicaid.
- 9.4 million (17%) of Medicaid beneficiaries are “dual eligibles” who also qualify for Medicare coverage.

# CPI Strategic Direction



# Antifraud Activity in 4 Major Areas

## • Fraud Prevention

- Engaging Medicare Beneficiaries & Stakeholders
- Antifraud Marketing
- Keeping Out Fraudulent Providers and Suppliers
- Avoiding Paying Fraudulent Claims
- Predictive Analytics
- Improving Payment Accuracy

## • Fraud Detection

- Coordination with Law Enforcement
- Data Analytics

## • Transparency and Accountability

## • Recovery

# Improved Beneficiary Communication

- ◆ CMS is implementing 1-800-Medicare changes to make it easier for beneficiaries to identify and report fraud:
  - ▶ Enhanced collection and analysis of fraud calls
  - ▶ Interactive Voice Response allows beneficiaries to go on [MyMedicare.gov](http://MyMedicare.gov) to listen to most recent claims

# Marketing Strategy

- Goal

- To increase public awareness by educating and engaging beneficiaries and other stakeholders in helping Medicare fight fraud.

- Action Plan

- Use traditional media avenues, emerging technologies, and existing tools to promote message on “how you can help to protect Medicare from fraud and how the Affordable Care Act has strengthened Medicare and its tools to fight fraud.”
- Examples include:

National Fraud Prevention Campaign

- Fraud prevention campaign including TV, radio, and print media: 72% funds TV, 9% print, 11% radio, 7% Ethnic radio/print
- Began Fall 2010

Regional Fraud Summits

- HHS, CMS, DOJ, OIG hosted regional summits in Miami, FL and Los Angeles, CA, Brooklyn, Boston & New York
- Upcoming summits include: Philadelphia, Detroit, Las Vegas



# 2011 “Help Prevent Fraud” Campaign

- **Objective:**
  - To implement an integrated outreach campaign designed to educate Medicare beneficiaries on how to identify, prevent and report Medicare fraud
  - Direct grassroots outreach to beneficiaries with greater focus in high-fraud areas
- **Multi-pronged campaign from August – September 2011**
  - The “message” will run on multiple platforms (radio, TV, print) and in multiple languages
  - Leveraging relationships with information intermediaries (internal/external partners/stakeholders) at the national and local levels
- **Look for: press releases, media toolkits, PSAs, Tweets, MyMedicare.gov, listservs, etc.**

# New Screening and Enrollment Rule CMS-6028-FC

- **Application Fees**

- With the exception of physicians and non-physician practitioners as well as physician and non-physician group practices, providers and suppliers that are:
  - ▶ Initially enrolling in Medicare
  - ▶ Adding a practice location, or
  - ▶ Revalidating their enrollment information **MUST** submit with their application:
    - An application fee in an amount prescribed by CMS and/or
    - A request for a hardship exception to the application fee
- This requirement was implemented for all applications received by a Medicare contractor on or after March 25, 2011

- **The provider or supplier **MUST** pay the application fee electronically through <http://www.pay.gov>**

# New Screening and Enrollment Rule CMS-6028-FC

- **Application Fee**

- Must be in the amount prescribed by CMS for the calendar year in which the application is submitted.
  - ▶ The fee for March 25, 2011 – December 31, 2011 is **\$505.00**
  - ▶ Fee amounts for future years will be adjusted by the percentage change in the consumer price index
  - ▶ CMS will give Medicare contractors and the public advance notice of any changes in the fee amount for the coming calendar year

- **Application Fee**

- Is non-refundable EXCEPT if it was submitted with one of the following:
  - ▶ A hardship exception request that is subsequently approved
  - ▶ An application that was rejected prior to the Medicare contractor's initiation of the screening process; or
  - ▶ An application that is subsequently denied as a result of the imposition of a temporary moratorium.

# New Screening and Enrollment Rule CMS-6028-FC

- **Provider Screening (ACA § 6401(a))**
  - Levels of Screening by Categories of Providers:
    - ▶ Limited – physicians, medical groups, clinics, hospitals
    - ▶ Moderate – Physical therapists, CMHCs, outpatients rehabs, ambulance providers, currently enrolled DMEPOS and home health agencies
    - ▶ High – Prospective (newly enrolling) home health agencies and suppliers of DMEPOS; providers and suppliers who have been reassigned due to a triggering event, such as:
      - Excluded by the OIG
      - Subject to a payment suspension
      - Terminated by Medicaid
      - Subject to other final adverse actions

# New Screening and Enrollment Rule CMS-6028-FC

## Final Required Screening and Levels of Risk

TYPE OF SCREENING REQUIRED	LIMITED	MODERATE	HIGH
Verification of any provider/supplier-specific requirements established by Medicare	√	√	√
Conduct license verifications, including licensure checks across States	√	√	√
Database Checks (to verify Social Security Number (SSN), the National Provider Identifier (NPI), licensure, an OIG exclusion, taxpayer identification number, death of individual practitioner, owner, authorized official, delegated official, or supervising physician )	√	√	√
Announced or Unannounced Site Visits		√	√
Criminal Background Check			√
Fingerprinting			√

# New Screening and Enrollment Rule

## CMS-6028-FC

- Temporary Enrollment Moratorium may be imposed for 6 month increments (ACA § 6401(a))
  - Conditions for a temporary moratorium
    - ▶ CMS data suggests trends associated with high risk of fraud, such as highly disproportionate number of providers per beneficiary
    - ▶ A State has imposed a moratorium in a particular geographic area or on a particular provider/supplier type
    - ▶ In consultation with the OIG or DOJ, or both
  - The moratoria will be limited to:
    - ▶ Newly enrolling providers
    - ▶ The establishment of new practice locations, but not the change of practice location

# New Screening and Enrollment Rule CMS-6028-FC

- Suspension of payment based on a credible allegation of fraud (ACA § 6402(h))
  - Examples of a “credible allegation of fraud” include, but are not limited to:
    - ▶ Fraud hotline complaints
    - ▶ Claims data mining
    - ▶ Patterns identified through provider audits
    - ▶ Civil false claims cases
    - ▶ Law enforcement investigations
  - Credibility determined in consultation with the OIG
  - Duration of suspension
    - ▶ For each suspension, attestations would be required every 180 days from the HHS OIG that the payment suspension should remain in place
    - ▶ The suspension will end after 18 months unless OIG or DOJ indicated an action was imminent

# New Screening and Enrollment Rule

## CMS-6028-FC

- Section 6401(a) of the ACA established a requirement for all enrolled providers/suppliers to **revalidate** their enrollment information under new enrollment screening criteria
  - Applies to providers/suppliers enrolled in Medicare prior to March 25, 2011
- Between now and March 23, 2013, Medicare Administrative Contractors (MACs) will send out notices on a regular basis to begin the revalidation process
  - Providers & suppliers must **WAIT** to submit the revalidation **ONLY** after being asked by their MAC to do so
    - ▶ Will effect nearly 1.5 million providers/suppliers
- Most efficient way to submit revalidation is using the Internet-based PECOS
  - Upon receipt of the revalidation request, providers/suppliers have 60 days from the date of the letter to submit complete enrollment forms.
  - All institutional providers/suppliers responding to revalidation request must submit an enrollment fee via <http://www.pay.gov>
  - Failure to submit enrollment forms may result in the deactivation of Medicare billing privileges.

# New Screening and Enrollment Rule CMS-6028-FC

- Termination of a Provider under Medicaid and CHIP if terminated under Medicare (ACA § 6501)
  - Providers who have been terminated under Medicare or another State Medicaid program, or have had billing privileges revoked after January 1, 2011 must be denied enrollment or terminated under other State's Medicaid program or CHIP
  - Providers who have been terminated under a State Medicaid program may be revoked by Medicare

# The National Fraud Prevention Program

- CMS is currently integrating predictive modeling as part of an end-to-end solution for detecting and preventing fraud
- Innovative risk scoring technology will apply a combination of:
  - Behavioral analyses
  - Network analyses
  - Predictive analyses
- CMS is committed to partnering in the private sector to develop new innovative technologies

# Detecting Medicare Fraud

- Coordination with law enforcement
- Improving communications with key stakeholders

# Innovation

- CMS is also using available data in new ways; beneficiary complaints have led to over 30,000 investigations of fraud, and are a valuable tool in identifying fraud
- CMS is now using **1-800-Medicare** beneficiary complaints to:
  - ▶ Target providers or suppliers with multiple beneficiary complaints for further review
  - ▶ Create 'heat maps' of fraud complaints that will show when new fraud scams are heating up in new areas

# Transparency and Accountability

- Provide consistent messages to states on new policies and procedures
- Develop guidance for legitimate providers to clarify responsibilities

# Recovery

## □ HHS and DOJ recently released the Health Care Fraud and Abuse Control Program (HCFAC) FY2010 Report:

- \$4 billion total recoveries
- 3 year average Return on Investment (ROI) (2008-2010) of \$6.8 returned for every \$1.0 spent;

## □ Additional stats...

- FY 2010 – 731 prosecutions
- FY 2011 (1/1/11 – 8/30/11) – 903 prosecutions (24% increase)
- Prosecutions up 71% from 5 years ago
- 91 Defendants Charged Nationally with Submitting \$295 Million in Fraudulent Claims – September 7, 2011

# Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program

- ◆ Part B covered equipment and supplies
  - include items such as walkers, power wheelchairs, hospital beds, and various other medical supplies and accessories.
- ◆ New competitive bidding program
  - Effective 1/1/11 in 9 areas
- ◆ Must use contract supplier
  - In certain areas
  - For certain products
  - Or, it won't be covered by Medicare

# Who the Competitive Bidding Affects

- Beneficiaries who have Original Medicare
  - Reside in Competitive Bidding Area (CBA)
  - Obtain competitive bid items while visiting a CBA
- ◆ To see if ZIP Code is in a Competitive Bidding Area
  - Call 1-800-MEDICARE
  - Visit [www.medicare.gov](http://www.medicare.gov)
- ◆ Medicare Advantage enrollees use plan suppliers

# Round 1 Rebid CBAs

<b>California</b>	<b>Riverside, San Bernardino, Ontario</b>
<b>Florida</b>	<b>Miami, Fort Lauderdale, Pompano Beach</b>
<b>Florida</b>	<b>Orlando, Kissimmee</b>
<b>Missouri and Kansas</b>	<b>Kansas City</b>
<b>North and South Carolina</b>	<b>Charlotte, Gastonia, Concord</b>
<b>Ohio</b>	<b>Cleveland, Elyria, Mentor</b>
<b>Ohio, Kentucky and Indiana</b>	<b>Cincinnati, Middletown</b>
<b>Pennsylvania</b>	<b>Pittsburgh</b>
<b>Texas</b>	<b>Dallas-Fort Worth-Arlington</b>

# Products Included in the Program

1. Oxygen, oxygen equipment, and supplies
2. Standard power wheelchairs, scooters
3. Complex rehabilitative power wheelchairs – Group 2 only
4. Mail-order diabetic supplies
5. Enteral nutrients, equipment, and supplies
6. Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs)
7. Hospital beds and related accessories
8. Walkers and related accessories
9. Support surfaces (Group 2 mattresses/overlays) Miami only

# Using Contract Suppliers

## ◆ Must use contract supplier

- Item and services included in Competitive Bidding Program living in a CBA
- Traveling to or visiting a CBA

## ◆ Exceptions

- Providers can supply certain items (ex: walkers)
- Nursing facility can supply directly if a contract supplier

## ◆ Identifying Contract Suppliers

- Call 1-800-MEDICARE (1-800-633-4227)
- TTY users call 1-877-486-2048
- Visit [www.medicare.gov/supplier](http://www.medicare.gov/supplier)
  - ▶ DMEPOS Supplier Locator Tool

# Round One Rebid, to date...

- \$28 Billion projected savings to Medicare Trust Fund
  - \$17 Billion in savings regarding Medicare expenditures
  - \$11 Billion in savings to Medicare beneficiaries
- 35% Savings to the current fee schedule for competitive bid products
- 51% Contracts were awarded to small businesses
- .9% (point 9) of all calls to 1-800-MEDICARE
- 0% Changes in health status of Medicare beneficiaries

# Round 2

- Program expands
  - 91 Metropolitan Statistical Areas
    - ▶ New Mexico
      - Albuquerque
  - National Mail Order Diabetic Supplies Contract
  - Round 2 product categories:
    1. Oxygen, oxygen equipment, and supplies
    2. Standard (power and manual) wheelchairs, scooters, and related accessories
    3. Enteral nutrients, equipment, and supplies
    4. Continuous Positive Airway Pressure (CPAP) devices and Respiratory Assist Devices (RADs) and related supplies and accessories
    5. Hospital beds and related accessories
    6. Walkers and related accessories
    7. Negative Pressure Wound Therapy pumps and related supplies and accessories
    8. Support Surfaces (Group 2 mattresses and overlays)
- Request for bids begins in 2011
- Visit [www.cms.gov/DMEPOSCompetitiveBid/](http://www.cms.gov/DMEPOSCompetitiveBid/)

# CMS Program Integrity Update on Fraud Initiatives

Questions?