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HHS/DOJ To Use New Predictive Modeling Tools To Prevent Health Care Fraud As Heightened Enforcement Yields Record Recoveries

December 16, 2010

As part of ongoing efforts to prevent and fight health care fraud, US Department of Health and Human Services Secretary Kathleen Sebelius and Attorney General Eric Holder today announced that the Centers for Medicare and Medicaid Services (CMS) plans to acquire and new state-of-the-art predictive modeling fraud fighting analytic tools to prevent wasteful and fraudulent payments in Medicare, Medicaid and the Children's Health Insurance Program before they occur As Sebelius and Holder made the announcement at a Fraud Prevention Summit held at the University of Massachusetts in Boston, CMS issued a solicitation for state-of-the-art fraud fighting analytic tools to help the agency predict and prevent potentially wasteful, abusive or fraudulent payments before they occur.

CMS intends to use these new tools into the National Fraud Prevention Program and to complement and expand fraud detection and enforcement work and practices utilized by the joint HHS and Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) in recent years. In HEAT, CMS and the Department of Justice have used data mining and predictive modeling systems to identify background information on potential fraudulent actors and links to questionable affiliations.

CMS now hopes that expanding its predictive modeling capability will enable it to take anti-fraud actions before a claim is paid. Building on the experiences gained through HEAT and the use of predictive modeling systems to detect and prevent fraud in banking and other industries, CMS and the Justice Department plan to expand the use of these tools to help prevent fraud by identifying bad actors from enrolling as health care providers or suppliers for the sole purpose of defrauding the health care system and tracking billing patterns and other information to identify real-time aberrant trends indicative of fraud.

CMS is already starting to take administrative action to stop payments in various pilot programs or other anti-fraud initiatives. It recently has been using predictive modeling too to identify what it perceives as "false fronts" in Texas. In another pilot program, CMS partnered with the Federal Recovery Accountability and Transparency Board (RATB) to investigate a group of high-risk providers. By linking public data (information found by anyone on the Internet) with other information like fraud alerts from other payers and existing court records, a sophisticated, potentially fraudulent, scheme was uncovered. The scheme involved opening multiple companies at the same location on the same day using provider numbers of physicians in other states. The data confirmed several suspect providers who were already under investigation and, through linkage analysis, identified affiliated providers who are now also under investigation.

The move to acquire and use additional predictive model tools comes as CMS is implementing new and expanded health care fraud detection and enforcement authority provided in the Patient Protection and Affordable Care Act (Affordable Care Act). The Affordable Care Act providing an additional $350 million in funding for health care fraud detection and enforcement over the next ten years. The Affordable Care Act also empowered CMS to suspend payments, toughened sentencing for criminal activity, enhances screenings and enrollment requirements, encouraged increased sharing of data across government, expands overpayment recovery efforts, and provided CMS greater oversight of private insurance abuses.

CMS and the Justice Department are moving aggressively to take advantage of these new powers and resources. In recent months HHS founded the new Center for Program Integrity within CMS would focus on identifying and stopping fraud and acting swiftly to protect beneficiaries. It also proposed new rules implementing enhanced health care fraud investigation and enforcement powers enacted as part of the Affordable Care Act. Among other things, the proposed rules will:

- Define requirements for suspending payments to providers and suppliers based on credible allegations of fraud in Medicare and Medicaid;

- Establish CMS authority for imposing a temporary moratorium on Medicare, Medicaid, and CHIP enrollment on providers and suppliers when necessary to help prevent or fight fraud, waste, and abuse without impeding beneficiaries' access to care.
- Strengthen and build on current provider enrollment and screening procedures to more accurately assure that fraudulent providers are not gaming the system and that only qualified health care providers and suppliers are allowed to enroll in and bill Medicare, Medicaid and CHIP;
- Outline requirements for states to terminate providers from Medicaid and CHIP when they have been terminated by Medicare or by another state Medicaid program or CHIP;
- Solicit input on how to best structure and develop provider compliance programs, now required under the Affordable Care Act, that will ensure providers are aware of and comply with CMS program requirements.

Meanwhile, CMS and the Justice Department have continued to aggressively investigate and prosecute suspected health care fraud. Already, stepped up fraud enforcement efforts have produced significant recoveries. CMS reports that in FY 2009, anti-fraud efforts put $2.51 billion back in the Medicare Trust Fund resulting from civil recoveries, fines in criminal matters, and administrative recoveries. This was a $569 million, or 29 percent, increase over FY 2008. In FY 2009, more than $441 million in federal Medicaid money was returned to the Treasury, a 28 percent increase from FY 2008. Most recently, in FY 2010, the Department of Justice obtained settlements and judgments of more than $2.5 billion in False Claims Act matters alleging health care fraud. This is more than ever before obtained in a single year, up from $1.68 billion in FY2009.

For more details about HEAT and other joint CMS and Justice Department health care fraud activities, see **here**.

For More Information or Assistance

If you need assistance dealing with health care fraud or other compliance, risk management, transactional, operational, enforcement or public policy concerns, please contact the author of this update, Cynthia Marcotte Stamer, at (469) 767-8872, **cstamer@Solutionslawyer.net**.

Vice President of the North Texas Health Care Compliance Professionals Association, Past Chair of the ABA Health Law Section Managed Care & Insurance Section and the former Board Compliance Chair of the National Kidney Foundation of North Texas, Ms. Stamer has more than 23 years experience advising physicians, hospitals and other health industry clients about regulatory compliance and enforcement, quality assurance, peer review, licensing and discipline, and other medical staff performance matters. She continuously advises health industry clients about the use of technology, process and other mechanisms to promote compliance and internal controls, workforce and medical staff performance, quality, governance, reimbursement, and other risk management and operational needs. As part of this experience, she has worked extensively with health care providers, payers, health care technology and consulting and other health industry clients, as well as other businesses, on privacy, data security, trade secret and related matters. A popular lecturer and widely published author on health industry concerns, Ms. Stamer also publishes and speaks extensively on health care compliance, staffing and human resources, compensation and benefits, technology, medical staff, public policy, reimbursement, privacy, technology, and other health and managed care industry regulatory, and other operations and risk management concerns for medical societies and staffs, hospitals, the HCCA, American Bar Association, American Health Lawyers Association and many other health industry groups and symposia. Her highly popular and information packed programs include many highly regarded publications on HIPAA, FACTA, medical confidentiality, state identity theft and privacy and other many other related matters. Her insights on these and other related matters appear in the Health Care Compliance Association, Atlantic Information Service, Bureau of National Affairs, World At Work, The Wall Street Journal, Business Insurance, the Dallas Morning News, Modern Health Care, Managed Healthcare, Health Leaders, and a many other national and local publications. To review some of her many publications and presentations, or for additional information about Ms. Stamer, her experience, involvements, programs or publications, see **here**.

Other Recent Developments

If you found this information of interest, you also may be interested in reviewing some of the following recent Updates available online by clicking on the article title:

- **President Signs Long-Sought Red Flag Rule Exemption Into Law**
- **Red Flag Rule Relief For Health Care Providers, Lawyers & Other Service Providers Awaits President's Signature**
- **Quality, Recordkeeping & Unprofessional Conduct Lead Reasons For Medical Board Discipline of Physicians**
- **12/15 Deadline For Input on New Joint Commission Heart Failure Certification**
- **CMS Finalizes Calendar Year 2011 Physician Fee Schedule & Other Medicare Part B Payment Policies**

- **DEA Cautions Practitioners Must Restrict Delegation of Controlled Substance Prescribing Functions, Urges Adoption of Written Policies & Agreements**
- **OIG Shares Key Insights On When Owners, Officers & Managers Face OIG Program Exclusion Based On Health Care Entity Misconduct**
- **CMS Delegated Lead Responsibility For Development of New Affordable Care Act-Required Medicare Self-Referral Disclosure Protocol**
- **HHS announces Rules Implementing Tools Added By Affordable Care Act to Prevent Federal Health Program Fraud**
- **DMEPOS Suppliers Face 9/27 Deadline To Meet Tightened Medicare StandardsInitial EHR Certification Bodies Named**
- **HHS Announces Adjustments to Federal Medical Assistance Percentage (FMAP) Rates**
- **CMS Publishes Corrections To Proposed 2011 Physician Fee Schedule Rules**
- **Medicare Changing How It Pays For Outpatient Dialysis**
- **Rite Aid Agrees to Pay $1 Million to Settle HIPAA Privacy Case As OCR Moves To Tighten Privacy Rules**
- **HHS Invites Input On Medicaid Changes To Promote Children's Health Quality**
- **CMS Adopts ESRD Facility Prospective Payment System & Proposes New Quality Incentive Program**
- **CMS Rule Clarifies When Outpatient Services Subject to 3-Day Rule & Finalizes FY 2011 Inpatient Payment Rates**
- **New Affordable Care Act Mandated High Risk Pre-Existing Condition Insurance Pool Program Regulations Set Program Rules, Prohibit Plan Dumping of High Risk Members**
- **CMS Proposes Changes To Civil Monetary Penalty Rules For Nursing Homes**

For More Information

We hope that this information is useful to you. You can review other recent health care and internal controls resources and additional information about the health industry and other experience of Ms. Stamer **here**. If you or someone else you know would like to receive future updates about developments on these and other concerns, please be sure that we have your current contact information – including your preferred e-mail – by creating or updating your profile at **here** or e-mailing this information **here**. To unsubscribe, e-mail **here**.