

Partnership Fund Pilot Award Summary

Concept Name: Automating the Provider Enrollment Process for Risk Assessment and Comparative Analysis

Lead Agency: Centers for Medicare & Medicaid Services (CMS)

Funding Level: \$2.9 million

Number of States/Pilot Sites: Four, including at least one “Medi-Medi”¹ state

Summary of Funded Concept: The pilot will test an automated tool to screen Medicaid providers for potential fraud by cross-checking their credentials, background, and history among states and with Federal Medicare data. Currently, CMS and states lack standardized Medicaid provider data, which hampers effective analysis to assess providers for risk of fraud. The National Health Care Anti-Fraud Association estimates that three percent of all health care spending is lost to health care fraud.² In Medicaid, where fraud is difficult both to measure and to prevent, that would equate to approximately \$12 billion in Federal and State funds in FY 2011.

The pilot will leverage and advance existing CMS fraud detection efforts through the following steps:

1. Capture Medicaid Statistical Information System (MSIS) data from pilot States to help form a complete, cross-program data set for a specific provider type (to be determined with state input).
2. Validate Medicaid provider data using CMS Center for Program Integrity Analytics Lab Tools (now used in Medicare), drawing on cross-program information available from a Medi-Medi state.
3. Use this validated data to test an automated cross-check that identifies providers enrolled in both Medicare and Medicaid and to determine an effective provider risk-assessment model.
4. Apply the model to non-Medi-Medi pilot States to identify high-risk providers for follow-up.

The pilot evaluation will address potential savings from fraud reduction for States and CMS, the feasibility of integrating Medicare and Medicaid provider files for joint risk assessment, and potential administrative efficiencies from better targeting follow-up actions. CMS will complete the pilot and evaluation within one year.

Addressing the Partnership Fund’s Goals:

Program Integrity: Faster, systematic detection of likely fraud with clear communication between CMS and States could significantly reduce improper payments.

Administrative Efficiency: The risk assessment tool could help states to focus investigations more quickly on potential fraudulent activity and to prevent fraudulent providers from enrolling in the first place.

Changes from the Original Pilot Concept Submission: None.

Original Concept Proposal Submitted by: CMS, in consultation with the Collaborative Forum. This submission was informed by “Collaborative, Intergovernmental Approach to Reducing Improper Payments,” submitted by the Forum’s Data Sharing, Matching, and Aggregation Work Group.

¹ “Medi-Medi” state refers to states that participate in the Medicare-Medicaid Data Match Program, an existing initiative currently being implemented in select states to use data analytics to detect improper payments.

² National Health Care Anti-Fraud Association. “The Problem of Health Care Fraud.” Located at <http://www.nhcaa.org/>. Accessed September 2, 2011.