Health Care Alert

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From "Pay and Chase" to "Catch and Keep:" CMS to Introduce Anti-Fraud Predictive Modeling July 1

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On June 17, Secretary of Health and Human Services Kathleen Sebelius announced in a speech in Philadelphia, Pennsylvania that the Centers for Medicare and Medicaid Services ("CMS") will begin using an electronic predictive modeling program in the fight against health care fraud and abuse. While CMS uses various measures to combat fraud after the fact, this program is designed to identify fraudulent claims *prior* to payment. The program is set to kick off on July 1.

Electronic Modeling

CMS has entered into contracts with Northrop Grumman, National Government Services and Federal Network Systems to provide the anti-fraud software, which uses algorithms to spot unusual claims that could be indicative of fraud. The software will track and analyze data related to Medicare and Medicaid claims in order to identify potential fraud before payment is made on the claim. For example, the program will analyze the distance between the beneficiary and provider to assess the likelihood that the claim is legitimate. The analysis then produces an overall risk score for the claim. If the red flags are such that the score reaches a certain threshold, CMS and the Inspector General will review the claim prior to payment. As Secretary Sebelius noted, the system is quite similar to the type used by financial institutions and credit card companies to identify potential fraud, such as a "dozen flat-screen televisions charged to your card in one day."

Impact on Providers

Despite the requirement that Medicare pay claims within 30 days, providers can expect that the anti-fraud predictive modeling system will slow payment in certain instances where claims are flagged and then found to be valid. The 2010 Small Business Jobs Act permits the Department of Health and Human Services to waive the 30-day payment provision if the claim is identified through the modeling system as potentially fraudulent. Further, some providers will have a higher "base" risk score than others. Certain types of providers that have been identified as particularly susceptible to fraud and abuse will have their claims start with higher risk scores than those of other providers. As CMS moves from "pay and chase" to prevention, providers should be prepared to deal with more questions on the front end, before their claims are paid.

If you have any questions about the predictive modeling program, please contact Jay Hardcastle, Heather Iverson or one of the other attorneys in the Health Care group at Bradley Arant Boult Cummings LLP.

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