Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Fiscal Intermediary Fraud Units

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E X E C U T I V E S U M M A R Y

PURPOSE

The purpose of this report is to provide national information on fiscal intermediary fraud units.

BACKGROUND

Fiscal intermediaries are companies under contract with the Health Care Financing Administration (HCFA) to administer a major part of the Medicare program. Individual fiscal intermediaries vary in many ways including the amount of claims and payments they process. Likewise, their fraud units differ from one another. But, all must meet requirements outlined in the Medicare Intermediary Manual. Fiscal intermediaries were responsible for $130 billion, or 75 percent, of total Medicare payments in 1996. The other 25 percent was handled by companies called carriers.

The HCFA requires that fiscal intermediaries and carriers have distinct units to detect and deter fraud and abuse. These units are part of HCFA's overall Medicare integrity program and are monitored by HCFA regional offices. The HCFA is currently planning to separate future anti-fraud functions from other intermediary and carrier operations. These activities will become the purview of a few contractors to be known as program safeguard contractors.

For this report, we surveyed all 41 fiscal intermediary fraud units that were under contract with HCFA in 1996 and still under contract in 1998. We collected fraud unit data for fiscal year 1996.

FINDINGS

Fraud units differed substantially in the number of complaints and cases handled. Some units produced few, if any, significant results.

While one would expect units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads.

- *Fraud units handled between 3 and 1,892 complaints per unit.*
- *The number of cases handled by each fraud unit ranged from 0 to 625.*
- *Fraud units referred between 0 and 102 cases to the Office of Inspector General.*

Despite HCFA's expectation that fraud units proactively identify fraud, half of the fraud units did not open any cases proactively.

More than one-third of fraud units did not identify program vulnerabilities.

Key words and terms related to fraud unit work vary in meaning. This hinders HCFA's ability to interpret fraud unit data and measure fraud unit performance.

RECOMMENDATIONS

The HCFA and fiscal intermediary fraud units have significant responsibilities in identifying and deterring fraud in a part of the Medicare program where $130 billion is at risk. The variation in fraud detection, especially among units with similar resources, raises concern about possible poor performance by some fraud units.

Although HCFA currently conducts performance evaluations of fraud units, we believe there is a need to strengthen the monitoring and oversight of contractors' efforts to identify fraud and abuse. In recent years, HCFA has focused on continuous improvement as a method of evaluating contractor performance. In light of the disparity in fraud detection among contractors, the agency may need to refocus its evaluation efforts to include some type of return on investment analysis.

In order that HCFA may have a better understanding of fraud unit performance, which in turn will lead to making better decisions about fraud unit funding, selecting future contractors, and working collaboratively with other anti-fraud entities, we recommend that HCFA:

- Improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

- Require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

- Establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

- Establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

- Provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

COMMENTS

The draft of this report was reviewed by HCFA, and they concurred with our recommendations. In concurring with the recommendations, HCFA stated that (1) they plan to develop specific national objectives, (2) they are designing a new program integrity management information

system, (3) they identified and distributed a list of the most significant data metrics for regional office use in the fiscal year 1998 contractor evaluation process, (4) they will review definitions of key words in the Medicare Intermediary Manual and make appropriate revisions, and (5) they convened a national conference in March 1998 to identify best practices in fighting waste, fraud, and abuse.

T A B L E O F C O N T E N T S

I N T R O D U C T I O N

PURPOSE

The purpose of this report is to provide national information on fiscal intermediary fraud units.

BACKGROUND

Fiscal Intermediaries

Fiscal intermediaries are companies under contract with the Health Care Financing Administration (HCFA) to administer a major part of the Medicare program. As a group, fiscal intermediaries have responsibility for processing 75 percent of Medicare payments. Other contractors called carriers process the remaining 25 percent. In 1996, fiscal intermediaries processed $130 billion in Medicare payments.[1] Intermediaries pay for inpatient services under Medicare Part A, and certain types of outpatient claims under Medicare Part B. The types of providers billing intermediaries are: hospitals, skilled nursing facilities, home health agencies, rural health clinics, renal dialysis centers, federally qualified health centers, rehabilitation facilities, community mental health centers, and hospices. Individual fiscal intermediaries vary in the amount of Medicare claims and payments they process.

Fraud Units

Fraud units are part of HCFA's overall Medicare integrity program. As of 1993, HCFA required all fiscal intermediaries and carriers to have distinct units to detect and deter Medicare fraud. In 1996, HCFA budgeted 20 percent of its program integrity dollars to fiscal intermediary fraud units and 80 percent to carrier fraud units. From 1993 through 1997, funding was based mainly on the contractors' claim volume. However, in fiscal year 1998, HCFA changed the funding methodology to take into account the contractors' workload, risk, and performance.[2]

Fraud units differ in human and financial resources as well as workload. However, regardless of differences, they all must meet requirements outlined in the Medicare Intermediary Manual. According to the Manual (Section 3950ff), fraud units are expected to:

- identify program vulnerabilities;
- proactively identify fraud within their service area and take appropriate action;
- determine factual basis of complaints of fraud made by beneficiaries, providers, HCFA, Office of Inspector General (OIG), and other sources;
- explore fraud leads in their jurisdiction;
- initiate action to deny or suspend payments where there is reliable evidence of fraud;
- develop cases and refer them to the OIG for consideration of civil and criminal prosecution and/or application of administrative sanctions; and
- provide outreach to providers and beneficiaries.

The HCFA also has other expectations of the fraud unit. For example, all fraud units must enter their fraud cases in the national Fraud Investigation Database. The database was created by HCFA and implemented in May 1996. It tracks contractors' cases of fraud and abuse. It is meant to be an information sharing tool for Medicare, Medicaid, and law enforcement agencies, including the OIG, Federal Bureau of Investigations, and Department of Justice. Also, HCFA has stressed that fraud units should develop fraud cases through proactive data analysis, and not use complaints as the sole driver of case development.

Oversight of Fraud Units

The HCFA regional offices have oversight authority for the contractor fraud units in their regions. They stay in touch with fraud unit staff, oversee the Fraud Investigation Database, and collect various mandatory reports (e.g., quarterly workload reports) from the fraud units. The regional HCFA staff conduct annual or biennial performance evaluations of each fraud unit. They give the fraud unit a written evaluation report, pointing out areas where the unit has improved from the previous evaluation and where the unit has weaknesses. Emphasis is on continuous improvement. Copies of evaluation reports are sent to HCFA Central Office.

New Program Safeguard Contractors

The HCFA is currently planning to separate future anti-fraud activities from other carrier and fiscal intermediary operations. These activities will become the purview of new contractors to be known as program safeguard contractors.[3]

National Study of Fiscal Intermediary Fraud Units and Related OIG Studies

This study is the first national evaluation of fiscal intermediary fraud units since their creation in fiscal year 1993. Our national study of carrier fraud units was issued in November 1996 *(Carrier Fraud Units, OEI-05-94-00470)*. In August 1995, we issued a study of HCFA's new approach to monitoring contractors' program integrity efforts (*Monitoring Medicare Contractor Performance: A New Approach, OEI-01-93-00160).*

SCOPE AND METHODOLOGY

We surveyed all 41 fiscal intermediaries that were under contract in 1996 and still under contract in 1998. We selected fiscal year 1996 as the period for our study because it was the most recent year for which a complete year of fraud unit workload data were available. In the text and tables of this report, complaint and case workload data represents fiscal year 1996. These workload data include complaints and cases that were open during any part of fiscal year 1996.

Fraud Unit Information

Our primary data collection instrument was a self-administered questionnaire. It was mailed to all fraud unit managers, and all fraud units responded. We also telephoned the fraud units to answer

any questions they might have about the intent of the questionnaire and the definition of terms used. When incomplete questionnaires were returned to us, we contacted the fraud units for clarification. We did not, however, independently verify the responses.

The questionnaire was developed with assistance from HCFA staff in Central Office and Region III as well as a fiscal intermediary fraud unit manager. These individuals provided insight as to the variety of fraud unit operations and the kind of data that should be available from all units. They also provided advice on question wording, layout, and definition of terms. The program integrity staff in HCFA Central Office gave us the definitions for the terms "complaint" and "case," and we used their definitions with minor paraphrasing. A complaint is an allegation of fraud or abuse committed by a provider, beneficiary, or other individual or entity against the Medicare program. A case is expanded data collection and analysis performed on (1) substantiated complaints, or (2) proactively identified fraud or abuse.

While most fraud units handle complaints as well as cases, and while complaints may lead to the collection of overpayments, our questionnaire contained few questions about complaints. Complaints frequently turn out to be misunderstandings or billing errors, not fraud or abuse. Therefore, we limited complaint questions to the issue of complaint volume in the fraud unit workload.

In addition to collecting data from the fraud units, we collected data from HCFA regarding Medicare payment amounts, claim volume, and fraud unit funding. In order to compare fraud units of similar size, we arrayed the 41 intermediaries by the amount of their 1996 Medicare payments. We did not use claim volume as a size indicator because HCFA's database did not contain claim volume for two of the 1996 intermediaries. In any case, Medicare payments and claim volume were generally correlated. We then grouped the intermediaries into large, medium, and small categories, as shown in the table below.

We calculated the totals and medians for key variables within the large, medium, and small categories including: fiscal intermediary Medicare payments, fraud unit budget, full-time-equivalent (FTE) staff, complaint volume, case volume, number of fraud unit cases opened proactively, number of cases referred to the OIG, and number of program vulnerabilities identified. Hereinafter, when we refer to large, medium, and small fraud units, we are referring to the units in the intermediary size categories shown in the table below.

SIZE CATEGORY	# OF INTERMEDIARIES	RANGE OF 1996 MEDICARE PAYMENTS
LARGE	11	Over $4 billion
MEDIUM	18	Between $1 and $4 billion
SMALL	12	Less than $1 billion

Review of Contractor Performance Evaluations

In addition to the fraud unit questionnaire, we collected contractor performance evaluations for 1995, 1996, and 1997. Between 1995 and 1997, HCFA conducted at least one evaluation for 40 of the 41 fraud units in our study. Most of the evaluation reports were sent to us by the fraud units. The remainder came from HCFA.

We reviewed one evaluation report for each fraud unit evaluated between fiscal years 1995 and 1997. Since all fraud units are not evaluated annually, we reviewed as many as possible (22) for our study year. We then sought evaluations from 1997 (5) and then from 1995 (13) for a total of 40 evaluations. We examined the following variables in each evaluation report: cases, complaints, proactive data analysis, and identification of program vulnerabilities.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

F I N D I N G S

FRAUD UNITS DIFFERED SUBSTANTIALLY IN THE NUMBER OF COMPLAINTS AND CASES HANDLED. SOME FRAUD UNITS PRODUCED FEW, IF ANY, SIGNIFICANT RESULTS.

While one would expect fraud units of different size and resources to handle different size workloads, we found units of similar size and resources handling substantially different workloads. We also found some small fraud units that had greater workloads than larger units with more resources. In addition, some fraud units did not develop any cases or send any case referrals to the OIG.

Fraud units handled between 3 and 1,892 complaints per unit.

A total of 17,796 complaints were handled by 39 fraud units. Two of the 41 fraud units reported that they did not handle complaints. In those two instances, the fiscal intermediary had other staff screening complaints, and the fraud unit handled only cases.

As shown in the table below, the range of complaints handled by fraud units of similar size is quite broad. Among large fraud units, the unit with the highest complaint workload handled eight times more complaints than the unit with the smallest workload. Among medium and small units, the largest workload of complaints was 20 and 100 times greater than the smallest workload.

Range of Complaints Handled by Fraud Units of Similar Size

Size Category	Number of Fraud Units	Highest # of Complaints Handled	Lowest # of Complaints Handled	Median # of Complaints Handled
Large	11	1,892	223	795
Medium	18	1,508	74*	311*
Small	12	357	3	63

*Does not include the two fraud units that did not handle complaints.

Not only were there significant differences among fraud units within the same size category but unexpected differences were also found between categories. In the aggregate, as evidenced by the median number of complaints (see table above), larger units tended to handle more complaints than smaller units. However, one small fraud unit had more complaints than three of the large fraud units and twelve of the medium-sized units. The table on the next page lists each unit by size, and provides data regarding intermediary Medicare payments and fraud unit resources, complaint workload, and case workload.

Variability in Large, Medium, and Small Fraud Units

	ID#	Medicare Payments	Fraud Unit Budget	Fraud Unit FTEs	Fraud Unit Complaints	Fraud Unit Cases
Large	1	$10,013,524,077	$428,100	6.25	1696	168
	2	$9,574,962,625	$612,300	6	1892	12
	3	$8,156,383,788	$359,000	2.5	802*	45*
	4	$6,125,735,620	$353,452	3.75	795	564*
	5	$5,860,334,858	$374,128	7.25	1750	259
	6	$5,698,345,959	$486,534	5	371	365*
	7	$5,138,463,636	$360,200	3	223	128
	8	$4,695,746,722	$363,000	7	1277	18
	9	$4,266,043,734	$518,300	6	307	236
	10	$4,205,559,254	$402,000	3.5	250	78
	11	$4,164,323,154	$512,680	8.25	385	192
Medium	12	$3,946,244,913	$45,760	1.75	88	0
	13	$3,528,029,526	$231,800	3.5	699	50
	14	$3,046,336,774	$217,600	3	240	3
	15	$3,033,310,183	$249,400	2.75	559	15
	16	$2,825,729,802	$125,640	2	74	6
	17	$2,714,180,846	$155,809	3	646	31*
	18	$2,687,677,846	$145,800	3	250	25
	19	$2,413,141,222	$111,508	3	935	625
	20	$2,409,518,487	$142,100	1.5	158	11
	21	$2,049,178,456	$100,000	2.5	402	79
	22	$1,619,800,963	$87,993	1.75	0	285
	23	$1,600,681,825	$156,470	1.75	320	22
	24	$1,544,764,282	$107,900	1.25	0	65
	25	$1,246,209,143	$74,248	1.5	307*	190*
	26	$1,132,721,108	$109,600	2	157	2
	27	$1,093,918,076	$81,600	1	1508	83
	28	$1,066,891,562	$50,953	1.5	314	246*
	29	$1,063,221,043	$103,700	1	193	0
Small	30	$993,720,360	$74,100	2.25	357	46
	31	$986,682,696	$55,000	1.5	116	40
	32	$940,136,850	$97,035	2.5	242	35
	33	$573,157,206	$62,600	2	158	1
	34	$501,923,887	$45,800	2	123	7
	35	$461,651,557	$58,200	1	9	51
	36	$418,758,568	$79,300	1.5	24	13
	37	$318,344,371	$34,218	1.25	97	1
	38	$300,584,905	$7,841	1.25	3	9
	39	$287,546,633	$4,400	0.5	28	1
	40	$258,659,723	$40,400	0.5	27	1
	41	$109,546,573	$15,400	0.25	14	0
	TOTAL	**$113,071,692,814**	**$7,641,869**	**112.75**	**17,796**	**4,008**

* Workloads estimated by fraud units.

The number of cases handled by each fraud unit ranged from 0 to 625.

Nationally, fraud units handled a total of 4,008 cases. Of the 41 fraud units, 3 did not have any cases. As shown in the table below, the difference between the fraud units with the highest and lowest cases handled in each category is extreme.

Range of Cases Handled by Fraud Units of Similar Size

Size Category	Number of Fraud Units	Highest # of Cases Handled	Lowest # of Cases Handled	Median # of Cases Handled
Large	11	564	12	168
Medium	18	625	0	28
Small	12	51	0	8

Variation among individual fraud units could not always be explained by size or resources (see table on page 6). For example, of the three fraud units with zero cases, two were medium fraud units and one was small. In addition, the fraud unit with the largest caseload (625) was a medium unit. This unit had one-third the fraud budget of any large fraud unit and less staff than most large units. Another example is that 60 percent of the medium units and 25 percent of the large units handled fewer cases than one of the small fraud units. Moreover, the large fraud unit with the least number of cases (12) had the highest budget and 6 FTEs. In contrast to this, the large fraud unit with the highest caseload (564) had the smallest budget and fewer staff.

Fraud units referred between 0 and 102 cases to the OIG.

Fraud units are required to develop cases and refer them to the OIG for consideration of civil and criminal prosecution and/or the application of administrative sanctions. The fraud units referred a total of 346 cases to the OIG in 1996 (9 percent of the national case workload).

Ten fraud units (5 medium and 5 small units) made no referrals to the OIG. Out of 41 fraud units, 27 (or 66 percent) referred three or fewer cases. Nearly half of fraud units referred less than 5 percent of their cases to the OIG. Table 1 in Appendix A provides a list of all fraud units in large, medium, and small categories, and shows the number and percent of each unit's case workload that was referred to the OIG.

As with complaint and case workloads, the number of case referrals to the OIG differed among fraud units of similar size. For example, although 79 percent of cases referred to the OIG (273 of 346) were from large fraud units, there was a wide disparity among individual units in this category. One large unit was responsible for nearly 30 percent of all cases referred to the OIG (102 of 346). This was twice as many as the unit with second highest number of referrals (51 of 346). In contrast, four large units referred seven or fewer cases each.

Between size categories, several smaller fraud units referred more cases than larger units. For instance, one medium unit referred more cases than over half (7 of 11) of the large units. Another

example is that one small unit referred more cases than three-quarters of the medium units and one-quarter of the large units.

Overall, 56 percent of the 346 referred cases were accepted by the OIG. Another 16 percent were referred by the OIG to other law enforcement agencies. Nine percent of the cases were returned to the fraud units for administrative closure, and 1 percent were returned for further development. The fraud units could not provide the status of the remaining 18 percent of referred cases. Individual fraud units had OIG acceptance rates ranging from 0 to 100 percent of cases. Table 2 in Appendix A provides the number and status of cases fraud units referred to the OIG.

DESPITE HCFA'S EXPECTATION THAT FRAUD UNITS PROACTIVELY IDENTIFY FRAUD, HALF OF THE UNITS DID NOT OPEN ANY CASES PROACTIVELY.

Overall, fraud units developed few cases proactively. Even though HCFA emphasizes the importance of doing proactive work, most cases were developed in reaction to complaints. Of the 4,008 fraud unit cases, only 5 percent (184) were opened as a result of proactive case development. Fifty-one percent of fraud units (21 of 41) did not open any cases proactively. Furthermore, the fraud unit opening the largest number of proactive cases (97) was responsible for more than half the national total. The unit with the second highest number of proactive cases had 24, and the unit with the third highest number had 10. These three units alone opened 71 percent of the proactive cases. Rarely did the size of the fiscal intermediary, or the resources of the fraud unit correlate to the number of cases opened proactively. For example, half the large, medium, and small fraud units had no such cases, and one small fraud unit had seven (see Appendix A, Table 3).

Ninety percent of fraud units (37 of 41) said they used proactive methods in their attempt to uncover fraud and abuse. Yet, only half of these units (20 of 37) opened any cases proactively. Seventeen units that said they used proactive methods did not open cases as a result of their proactive work.

The most commonly used proactive method was data analysis. Used by 80 percent of fraud units, proactive data analysis was used to open 72 percent of proactive cases (133 of 184). Proactive data analysis is defined as using data to identify fraud leads by looking for patterns, trends, or aberrancies versus using data solely to expand the scope of an investigation. The second most common method of proactively identifying fraud was networking with other intermediary units and with external entities. Used by 56 percent of fraud units, networking was used to open 21 percent of proactive cases (38 of 184). Table 4 in Appendix A lists the proactive methods used by fraud units, the number and percent of units that used each method, and the number of times the method was used to open cases.

In our review of the units' contractor performance evaluations, we found that 80 percent of the evaluation reports (32 of 40) addressed the subject of using proactive methods to identify fraud. In addition, 65 percent (26 of 40) specifically noted whether or not the unit had conducted any proactive data analysis. However, only 50 percent (20 of 40) reminded the fraud units that they are expected to conduct proactive data analysis to identify potential fraud cases.

MORE THAN ONE-THIRD OF FRAUD UNITS DID NOT IDENTIFY PROGRAM VULNERABILITIES.

The identification of program vulnerabilities heads the list of fraud unit responsibilities in the Medicare Intermediary Manual. Yet 39 percent of fraud units (16 of 41) did not identify any. In addition, fraud units are not required to keep track of identified program vulnerabilities.[4] At least one fraud unit that identified vulnerabilities had to rely on memory to describe them.

In our review of the contractor performance evaluations, we found that few HCFA reviewers addressed the importance of identifying program vulnerabilities. Only 10 percent of evaluation reports (4 of 40) stated whether or not the fraud unit identified any program vulnerabilities, and only 18 percent (7 of 40) reminded the fraud unit they are expected to identify them.

Sixty-one percent of fraud units (25 of 41) identified a total of 61 program vulnerabilities. The number of vulnerabilities identified by these units ranged from 1 to 5 (see Appendix A, Table 3). Based on fraud unit descriptions of the vulnerabilities, 52 percent (32 of 61) seemed to be systematic problems that make the Medicare program vulnerable to abuse, such as, loose guidelines that promote inappropriate billing for a service. Another 41 percent (25 of 61) were described as instances of wrongdoing, such as, billing a non-covered service as a covered service. The remaining 7 percent (4 of 61) were simply described as types of providers, such as, an assisted living facility or a community mental health center.

KEY WORDS AND TERMS RELATED TO FRAUD UNIT WORK VARY IN MEANING. THIS HINDERS HCFA'S ABILITY TO INTERPRET FRAUD UNIT DATA AND MEASURE FRAUD UNIT PERFORMANCE.

The HCFA and fraud unit staffs have work-related terms which help them communicate about program integrity operations and performance outcomes. This specialized language is necessary in order to quickly convey meaning about complex subjects. Many of the words and terms do not sound like specialized terms because they are also used in common speech, e.g., "complaint," "case," "program vulnerability" and "overpayment." However, for Medicare fraud control, these words have special meanings. For example, a "complaint" is not simply an expression of discontent, it is an allegation of fraud or abuse. In addition, among fraud unit and HCFA staff, meanings of key words can vary depending on who is using them and the context in which they are used.

The variety of meanings for key terms is a problem in the Medicare integrity program because it hinders HCFA's ability to interpret the data it receives from fraud units and its regional oversight staff. In addition, there are potential problems when HCFA and fraud units share data with one another or collaborate with other fraud control entities. Furthermore, differences in the use of key terms in contractor performance evaluations make performance measurement with this tool difficult if not impossible. These shortcomings are likely to hamper HCFA's effectiveness in making funding decisions or selecting future program safeguard contractors.

Below we discuss a few key terms that vary in meaning and, consequently, can hinder HCFA in its ability to interpret data and measure performance.

Complaints and cases

Complaints and cases represent two very different types of workload, yet the terms are often used interchangeably and sometimes are tracked as one type of workload. In our fraud unit questionnaire, we required fraud units to (1) distinguish complaints from cases when they quantified their workload, and (2) use the definitions for case and complaint given in the questionnaire. The purpose of these requirements was to ensure data integrity. However, this posed a problem for several fraud units. For example, it was necessary for some fraud units to estimate their workload numbers because they had one computer tracking system that did not distinguish cases from complaints.

In addition, the terms case and complaint were also confused in contractor performance evaluations. In 43 percent of the evaluation reports (17 of 40), the words case and complaint were used interchangeably. Moreover, we found inconsistencies in the way the words case and complaint were used in the Medicare Intermediary Manual (section 3966), and in certain HCFA guidelines for reporting fraud unit activities.

Program vulnerabilities

The Medicare Manual (section 3953) directs fraud units to "identify Medicare and intermediary policies and procedures that may make Medicare vulnerable to fraud and abuse." A shorter way of saying this is that fraud units should identify program vulnerabilities. However, the term "program vulnerability" is another key term that has more than one interpretation. As we mentioned previously, fraud units identified 61 program vulnerabilities. Yet, all the vulnerabilities fraud units described were not systematic problems which make Medicare vulnerable to fraud and abuse. Forty-one percent of them (25 of 61) were described as instances of wrongdoing by a provider, and 7 percent (4 of 61) were described as types of providers.

Overpayments

Responses to our fraud unit questionnaire suggest that the word overpayment may have various meanings in the context of contractor operations and fraud unit cases. In general, overpayments are Medicare funds that providers receive in excess of amounts owed to them, but we did not provide this definition in our questionnaire. We asked the fraud units to list their cases where overpayments were identified (not recovered) in fiscal year 1996. Our analysis found that fraud units identified overpayments in only 15 percent of the national case workload (610 of 4,008) and in 36 percent of cases referred to the OIG (124 of 346) even though the Manual (section 3968) states that identifying overpayments is part of the case development process.

It is conceivable that fraud units were defining the term overpayment in one of two ways when answering our question: (1) as the actual amount of money they requested back from providers, or (2) the amount of money at risk associated with a fraud case. If some fraud units used the first definition, it is possible that they would not have listed an overpayment amount for this question. However, it is also possible that the fraud units were unable to determine or track the risk associated with fraud cases.

RECOMMENDATIONS

The Health Care Financing Administration (HCFA) and fiscal intermediary fraud units have significant responsibilities in identifying and deterring fraud in a part of the Medicare program where $130 billion is at risk. The variation in fraud detection, especially among units with similar resources, raises concern about possible poor performance by some fraud units.

Although HCFA currently conducts performance evaluations of fraud units, we believe there is a need to strengthen the monitoring and oversight of contractors' efforts to identify fraud and abuse. In recent years, HCFA has focused on continuous improvement as a method of evaluating contractor performance. In light of the disparity in fraud detection among contractors, the agency may need to refocus its evaluation efforts to include some type of return on investment analysis.

In order that HCFA may have a better understanding of fraud unit performance, which in turn will lead to making better decisions about fraud unit funding, selecting future contractors, and working collaboratively with other anti-fraud entities, we recommend that HCFA:

- Improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

- Require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

- Establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

- Establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

- Provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

COMMENTS

The draft of this report was reviewed by HCFA, and they concurred with our recommendations. In concurring with the recommendations, HCFA stated that (1) they plan to develop specific national objectives, (2) they are designing a new program integrity management information system, (3) they identified and distributed a list of the most significant data metrics for regional office use in the fiscal year 1998 contractor evaluation process, (4) they will review definitions of key words in the Medicare Intermediary Manual and make appropriate revisions, and (5) they

convened a national conference in March 1998 to identify best practices in fighting waste, fraud, and abuse. The full text of HCFA's comments is in Appendix B.

E N D N O T E S

1. The 41 fiscal intermediaries in our study processed $113 billion in Medicare payments in 1996.

2. The Health Care Financing Administration's funding of all Medicare fraud control activities since the passage of the Health Insurance Portability and Accountability Act of 1996, is discussed in the U.S. General Accounting Office's report, *Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS-98-160),* issued June 1998.

3. In September 1998, the Health Care Financing Administration made available a Scope of Work regarding Program Safeguard Contractors.

4. Nowhere in section 3950ff of the Medicare Intermediary Manual is there a requirement to track the number or kind of program vulnerabilities that fraud units identify.

A P P E N D I X A

Table 1: Fraud Unit Cases Referred to the OIG in FY 1996

	ID#	Total Cases FY 1996	Number of Cases Referred to the OIG	Cases Referred as a Percent of Total Cases
Large	1	168	3	2%
	2	12	3	25%
	3	45*	21	47%
	4	564*	17	3%
	5	259	51	20%
	6	365*	16	4%
	7	128	102	80%
	8	18	7	39%
	9	236	15	6%
	10	78	3	4%
	11	192	35	18%
Medium	12	0	0	-
	13	50	0	0%
	14	3	3	100%
	15	15	0	0%
	16	6	3	50%
	17	31*	4	13%
	18	25	3	12%
	19	625	5	1%
	20	11	3	27%
	21	79	3	4%
	22	285	0	0%
	23	22	3	14%
	24	65	2	3%
	25	190*	20	11%
	26	2	2	100%
	27	83	1	1%
	28	246*	5	2%
	29	0	0	-
Small	30	46	4	9%
	31	40	1	3%
	32	35	5	14%
	33	1	1	100%
	34	7	0	0%
	35	51	3	6%
	36	13	1	8%
	37	1	1	100%
	38	9	0	0%
	39	1	0	0%
	40	1	0	0%
	41	0	0	-
	TOTAL	**4,008**	**346**	**9%**

* Workloads estimated by fraud units.

Table 2: Disposition of Fraud Unit Cases Referred to the OIG in FY 1996

	ID #	Cases Referred to the OIG	Cases Accepted by the OIG	Cases Referred by OIG to Other Law Enforcement	Cases Returned to Fraud Unit for Further Development	Cases Returned to Fraud Unit for Administrative Handling	Cases Where Status was Unknown
Large	1	3	2	0	0	1	0
	2	3	0	1	0	2	0
	3	21	15	0	0	0	6
	4	17	16	0	0	1	0
	5	51	11	2	0	1	37
	6	16	6	3	0	3	4
	7	102	98	0	0	2	2
	8	7	0	5	0	0	2
	9	15	5	0	1	6	3
	10	3	0	2	0	0	1
	11	35	13	18	0	3	1
Medium	12	0	-	-	-	-	-
	13	0	-	-	-	-	-
	14	3	0	3	0	0	0
	15	0	-	-	-	-	-
	16	3	1	2	0	0	0
	17	4	0	3	1	0	0
	18	3	1	0	0	0	2
	19	5	1	1	0	3	0
	20	3	2	1	0	0	0
	21	3	2	1	0	0	0
	22	0	-	-	-	-	-
	23	3	0	1	1	1	0
	24	2	2	0	0	0	0
	25	20	9	2	0	6	3
	26	2	2	0	0	0	0
	27	1	1	0	0	0	0
	28	5	0	4	0	1	0
Small	29	0	-	-	-	-	-
	30	4	4	0	0	0	0
	31	1	1	0	0	0	0
	32	5	1	3	0	0	1
	33	1	0	0	1	0	0
	34	0	-	-	-	-	-
	35	3	1	1	0	1	0
	36	1	1	0	0	0	0
	37	1	0	1	0	0	0
	38	0	-	-	-	-	-
	39	0	-	-	-	-	-
	40	0	-	-	-	-	-
	41	0	-	-	-	-	-
	TOTAL	**346**	**195**	**54**	**4**	**31**	**62**
	% OF CASES REFERRED	**100%**	**56%**	**16%**	**1%**	**9%**	**18%**

Table 3: Proactive Cases Opened and Program Vulnerabilities Identified

	ID#	Medicare Payments	Fraud Unit Budget	Fraud Unit FTEs	Total Fraud Unit Cases	Proactive Cases**	Program Vulnerabilities
Large	1	$10,013,524,077	$428,100	6.25	168	4	3
	2	$9,574,962,625	$612,300	6	12	1	0
	3	$8,156,383,788	$359,000	2.5	45*	0	3
	4	$6,125,735,620	$353,452	3.75	564*	0	5
	5	$5,860,334,858	$374,128	7.25	259	4	0
	6	$5,698,345,959	$486,534	5	365*	10	4
	7	$5,138,463,636	$360,200	3	128	97	3
	8	$4,695,746,722	$363,000	7	18	0	1
	9	$4,266,043,734	$518,300	6	236	0	2
	10	$4,205,559,254	$402,000	3.5	78	6	2
	11	$4,164,323,154	$512,680	8.25	192	0	2
	12	$3,946,244,913	$45,760	1.75	0	0	0
	13	$3,528,029,526	$231,800	3.5	50	6	1
	14	$3,046,336,774	$217,600	3	3	0	0
	15	$3,033,310,183	$249,400	2.75	15	0	2
	16	$2,825,729,802	$125,640	2	6	3	0
	17	$2,714,180,846	$155,809	3	31*	3	3
	18	$2,687,677,846	$145,800	3	25	0	1
	19	$2,413,141,222	$111,508	3	625	0	0
Medium	20	$2,409,518,487	$142,100	1.5	11	3	1
	21	$2,049,178,456	$100,000	2.5	79	0	0
	22	$1,619,800,963	$87,993	1.75	285	24	1
	23	$1,600,681,825	$156,470	1.75	22	0	2
	24	$1,544,764,282	$107,900	1.25	65	0	0
	25	$1,246,209,143	$74,248	1.5	190*	2	5
	26	$1,132,721,108	$109,600	2	2	0	0
	27	$1,093,918,076	$81,600	1	83	2	0
	28	$1,066,891,562	$50,953	1.5	246*	5	4
	29	$1,063,221,043	$103,700	1	0	0	0
	30	$993,720,360	$74,100	2.25	46	2	0
	31	$986,682,696	$55,000	1.5	40	7	1
	32	$940,136,850	$97,035	2.5	35	0	2
	33	$573,157,206	$62,600	2	1	0	0
	34	$501,923,887	$45,800	2	7	0	0
Small	35	$461,651,557	$58,200	1	51	1	3
	36	$418,758,568	$79,300	1.5	13	1	2
	37	$318,344,371	$34,218	1.25	1	0	0
	38	$300,584,905	$7,841	1.25	9	2	2
	39	$287,546,633	$4,400	0.5	1	1	4
	40	$258,659,723	$40,400	0.5	1	0	0
	41	$109,546,573	$15,400	0.25	0	0	2
	TOTAL	**$113,071,692,814**	**$7,641,869**	**112.75**	**4,008**	**184**	**61**

* Workloads estimated by fraud units.

** Proactive cases are a subset of total fraud unit cases.

Table 4: Fraud Unit Use of Proactive Methods to Identify Fraud and Abuse

PROACTIVE METHOD [1]	Number of Fraud Units Using Method N=41	Percent of Fraud Units Using Method	Number of Times Proactive Method was Used to Open Cases [2]
Data Analysis	33	80%	133
Internal and External Networking	23	56%	38
Look for Patterns and Trends (Not Data Analysis)	10	24%	11
Conduct Research and Analysis on Fraud Alerts	8	20%	1
Conduct Medical Review	7	17%	10
Conduct and Receive Training	5	12%	0
Expand Case	5	12%	5
Monitor (e.g.,Edits and Audits)	5	12%	1
Conduct Education or Outreach	4	10%	0
Review News Media	4	10%	1
Survey Providers	4	10%	2

1. Except for “Data Analysis,” all other proactive methods were identified by the fraud units themselves.

2. The total for this column (202) differs from the total number of cases opened proactively (184) because more than one proactive method could have been used to open each case.

A P P E N D I X B

COMMENTS FROM THE HEALTH CARE FINANCING ADMINISTRATION

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D C 20201

DATE: OCT 27 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Fiscal Intermediary Fraud Units," (OEI-03-97-00350)

We welcome the suggestions in the above-referenced report that provides national information on the performance of fiscal intermediary fraud units. We appreciate OIG's efforts to help us strengthen the monitoring and oversight of fraud unit efforts.

The data collected for the report covered fiscal year (FY) 1996. Beginning in 1997, the Health Care Financing Administration (HCFA) mandated that fiscal intermediaries (FIs) use the HCFA Customer Information System as a fraud detection tool. The tool will enable the FIs to proactively identify fraud. In addition, during FY 1999, HCFA contractors will attend OIG regional training sessions that will further educate them about the proper development of cases to be referred to law enforcement agencies.

We concur with the report's recommendations. Our specific comments follow:

OIG Recommendation #1

HCFA should improve the contractor performance evaluation system so that it not only encourages continuous improvement, but also holds contractors accountable for meeting specific objectives.

HCFA Response

We concur and plan to develop specific national objectives to be evaluated during FY 1999. In September 1998, we visited 13 contractor fraud units to gather information that will help us develop ambitious, but practical, objectives. In addition, HCFA through its contractor has just completed gathering the requirements to be used in the design of a new program integrity management information system. The process required that the data metrics needed to evaluate Medicare contractor medical review and benefit integrity effectiveness be identified before building the new system. A contract has been let to build the new system.

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OIG Recommendation #2
HCFA should require that all contractor performance evaluations list HCFA's national and regional objectives and address whether or not the fraud unit is meeting those objectives.

HCFA Response
We concur with the intent. The fraud unit contractor performance evaluation standards are being re-examined and will reference national objectives. Our regional offices have the authority to negotiate individual performance objectives with each contractor, so the creation of regional standards may not be necessary.

OIG Recommendation #3
HCFA should establish a standard set of data that can be used to measure fraud units' performance in meeting established objectives. Require that all contractor performance evaluation reports contain this data.

HCFA Response
We concur. In March 1998, HCFA identified and distributed a list of the most significant data metrics for regional office use in the FY 1998 contractor evaluation process. The development of national objectives will include the data metrics to be used in determining if objectives have been met.

OIG Recommendation #4
HCFA should establish clear definitions of key words and terms (e.g., complaint, case, program vulnerability, and overpayment). Disseminate definitions and require that HCFA program integrity staff and fraud unit staff use the same definitions. In a future update of the Medicare Intermediary Manual, revise sections so that these words are consistently used to mean the same thing.

HCFA Response
We concur. We will review the definitions of key words in our current Medicare Intermediary Manual. To the extent that we find inconsistencies, we will make appropriate revisions.

OIG Recommendation #5
HCFA should provide opportunities for fraud units to exchange ideas, compare methods, and highlight best practices relating to fraud and abuse detection.

HCFA Response

We concur. In March 1998, HCFA convened a national conference to identify best practices in fighting waste, fraud, and abuse. The conference brought together representatives from Medicare contractors, private industry, law enforcement, health care providers, and beneficiaries, in order to discuss ways to combat fraud. HCFA listened to these experts, and we are working to incorporate their effective methods into our own program integrity strategy.