Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse

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Summary

According to the 2009 Medicare Trustees report, total Medicare expenditures were $468 billion dollars in 2008 for 45 million beneficiaries. The Office of the Actuary projects overall Medicare spending to reach $507.1 billion for 2009. Because of a number of factors, such as advances in health care delivery and technology, an aging population, and overall increases in medical costs, spending on Medicare services is expected to grow more quickly than spending in the U.S. economy. As expenditures continue to rise in the nation's largest health insurance program, efforts to preserve the integrity of the program receive increased attention from policy makers.

In general, initiatives designed to fight fraud, waste, and abuse are considered program integrity activities. This includes processes directed at reducing payment errors as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud. As the agency responsible for administering Medicare, the Centers for Medicare and Medicaid Services (CMS) oversees a network of private contractors that perform various program integrity activities such as auditing providers, reviewing claims for medical necessity, and conducting investigations. Contractors develop and refer suspected cases of fraud to the Department of Health and Human Services Office of the Inspector General (HHS OIG) and the Department of Justice (DOJ) for further investigation and prosecution.

Medicare program integrity activities are funded in statute, largely through the Health Care Fraud and Abuse Control (HCFAC) and Medicare Integrity Programs (MIP), which were both established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). The HIPAA legislation provided CMS and federal law enforcement agencies with dedicated funds to coordinate Federal, state, and local activities to fight health care fraud. Beginning in FY2009, Congress approved additional discretionary funds to enhance these efforts.

This report provides an overview of Medicare's program integrity efforts. A description of key program integrity activities is presented as well as a discussion of the role that private contractors and law enforcement agencies play in maintaining Medicare's integrity. Detailed information on federal funding for program integrity efforts is also presented. The report concludes with a summary and analysis of recent efforts to oversee Medicare's program integrity activities.

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Introduction

According to the 2009 Medicare Trustees report, total Medicare expenditures were $468 billion dollars in 2008 for 45 million beneficiaries.[1] The Office of the Actuary projects overall Medicare spending to reach $507.1 billion in 2009.[2] Because of a number of factors, such as advances in health care delivery and technology, an aging population, and overall increases in medical costs, spending on Medicare services is expected to grow more quickly than spending in the U.S. economy. As expenditures continue to rise in the nation's largest health insurance program, efforts to preserve the integrity of the program receive increased attention from policy makers.

As the agency responsible for administering Medicare, the Centers for Medicare and Medicaid (CMS) oversees a network of private contractors that conduct various program integrity activities. The six main types of activities are (1) conducting provider audits, (2) reviewing claims for medical necessity, (3) identifying and investigating fraud, (4) ensuring that Medicare pays only for services for which it has primary responsibility, (5) educating providers on Medicare billing procedures, and (6) identifying improper billing practices that affect both Medicare and Medicaid. Contractors refer suspected cases of fraud to the Department of Health and Human Services Office of the Inspector General (HHS OIG) and the Department of Justice (DOJ) for further investigation and prosecution.

Medicare program integrity activities are funded in statute, largely through the Health Care Fraud and Abuse Control (HCFAC) and Medicare Integrity Programs (MIP), which were both established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). The HIPAA legislation provided CMS and federal law enforcement agencies with dedicated funds to safeguard federal monies and prevent health care fraud, waste, and abuse.[3] Beginning in FY2009, Congress approved an additional discretionary investment of $198 million for FY2009 and $311 million for FY2010 to further enhance Medicare's program integrity efforts.

This report provides an overview of Medicare's program integrity activities. The report begins with an introduction to the problem of health care fraud in Medicare. The report continues with descriptions of the types of program integrity activities undertaken by CMS to prevent fraud, waste, and abuse, and a discussion of the role that private contractors and federal law enforcement agencies play in maintaining Medicare's integrity. Detailed information on federal funding for anti-fraud efforts is also presented. The report concludes with a summary and analysis of recent efforts to oversee Medicare's program integrity activities.

Although this report addresses program integrity activities undertaken to prevent fraud in Medicare's private Part C and D programs, it is largely focused on Medicare's approaches to

[1] CMS Office of the Actuary, 2009 Medicare Board of Trustees Report, http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2009.pdf.

[2] CMS Office of the Actuary, National Health Expenditures (NHE) Projections for 2009-2019, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2009.pdf.

[3] Section 1128C of the Social Security Act (SSA) governs the Health Care Fraud and Abuse Control (HCFAC) program. Section 1893 of the SSA governs the Medicare Integrity Program (MIP).

ensure integrity in its FFS program (Parts A and B), which constitute the largest share of Medicare spending.[4]

Background on Medicare

Medicare is the nation's health insurance program for persons aged 65 and older and certain disabled persons. Of the program's 45 million enrollees, approximately 85% are aged and the remaining 15% are disabled.[5] The majority of Medicare spending, nearly 75%, is for benefits provided by Parts A and B, the FFS portion of the program otherwise known as "original" or "traditional" Medicare. The remaining 25% is spent on private health care plans that deliver Medicare services to beneficiaries under Part C, the Medicare Advantage (MA) program, and Part D, the new prescription drug benefit.

Medicare consists of four distinct parts: Parts A, B, C, and D. Medicare Part A (Hospital Insurance) covers inpatient hospital, skilled nursing facility, home health, and hospice services. Medicare Part B (Supplementary Medical Insurance) covers a variety of other medical services, such as physician visits, outpatient hospital care, laboratory services, and durable medical equipment (DME)[6]. Beneficiaries also have the option to enroll in a private MA plan to receive all required Part A and B benefits, and a private Prescription Drug Plan (PDP) for prescription drug benefits. Most beneficiaries who opt to enroll in a private plan choose a MA-PD (Medicare Advantage Prescription Drug) plan for combined Part C and D coverage. Approximately 75% of beneficiaries receive services through original Medicare, and 25% receive services through a MA plan.

Medicare is administered by CMS within the Department of Health and Human Services. CMS contracts with private entities to oversee day-to-day operations and conduct program integrity activities for Parts A, B, C, and D. Each year, Medicare contractors process nearly 1.2 billion claims for over 1 million providers enrolled in the Medicare program. In addition to processing and paying claims, contractors conduct program integrity functions. Contractor activities are overseen by two departments within CMS: the Program Integrity Group and the Center for Drug and Health Plan Choice. The Program Integrity Group is responsible for oversight related to Parts A and B and the Center for Drug and Health Plan Choice is responsible for oversight activities related to Part C and D. On February 17, 2010, CMS announced the creation of a new Center for Program Integrity to oversee both Medicare and Medicaid program integrity activities.[7]

[4] For additional information on oversight of the Part D benefit see CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Patricia A. Davis.

[5] The disabled population includes persons under age 65 who receive cash disability benefits from Social Security or the Railroad Retirement systems for at least 24 months and persons under age 65 with end stage renal disease (ESRD).

[6] DME includes items such as hospital beds, wheelchairs, respirators, walkers, and artificial limbs specifically for home use.

[7] Currently, the Program Integrity Group is overseen by the CMS Office of Financial Management and the Medicaid Program Integrity Group by the Center for Medicare and Medicaid State Operations. For further information on the recent CMS reorganization visit: http://thehill.com/blogs/blog-briefing-room/news/81439-medicare-agency-adds-ex-va-official-plans-reorganization.

The Problem of Health Care Fraud

Renewed interest in health care reform has focused Congressional attention on the problem of health care fraud, waste, and abuse. Although the actual dollar value lost to health care fraud is unknown, fraud analysts and law enforcement officials estimate that anywhere between 3% and 10% of total health care expenditures are lost to fraud on an annual basis.[8] Not only does fraud and abuse contribute to the rising cost of health care, but it can also harm patients, particularly when medically necessary services are not provided or are provided unnecessarily.

Generally, the term "fraud and abuse" refers to misconduct in the delivery and financing of health care. Typically one thinks of financial misconduct when discussing health care fraud, however, delivering poor or substandard quality care has received increased attention from fraud enforcers in recent years.[9] Federal regulations define fraud and abuse separately. Specifically, Medicaid regulations define fraud as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. Similarly, abuse is defined as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care.[10] There is no corresponding definition of fraud and abuse in Medicare regulations.

Although health care fraud encompasses many different types of erroneous behavior, the types of fraud schemes being committed today share certain characteristics. According to law enforcement officials, fraud perpetrators often target public health insurance programs (Medicare and Medicaid) and private health plans simultaneously. Fraud schemes frequently span multiple states and can involve both providers of services, many of whom have little or no experience in health care, and beneficiaries. For example, in several recent cases, fraud perpetrators paid both providers and senior citizens kickbacks to obtain their billing numbers in order to submit fraudulent claims to Medicare. Other examples of recent fraudulent activity include billing for unnecessary services or tests provided to patients, submitting claims for services provided by unlicensed providers, and illegally marketing drugs or products for higher reimbursements.[11] Further, recent fraud investigations have revealed evidence of an increase in organized crime in health care. At a recent hearing before the House Energy and Commerce Health Subcommittee, the Inspector General of the Department of Health and Human Services (HHS) testified that health care fraud has become attractive to perpetrators of organized crime because the penalties are lower than for other organized crime-related offenses, there are low barriers to entry, fraud schemes are easily replicated, and a lack of data hampers detection efforts.[12]

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[8] The National Health Care Anti-Fraud Association (NHCAA) estimates conservatively that 3% of all health care spending—or $68 billion—is lost to health care fraud. See NHCAA consumer alert available at: http://64.211.220.122/eweb/DynamicPage.aspx?webcode=anti_fraud_resource_centr&wpscode=TheProblemOfHCFraud. Also see the Federal Bureau of Investigation (FBI) Annual Financial Crimes Report available at: http://www.fbi.gov/publications/financial/fcs_report2008/financial_crime_2008.htm#health.

[9] Alice G. Gosfield, *Medicare and Medicaid Fraud and Abuse 2008 Edition*, pp. 5-6.

[10] 42 C.F.R. 455.2.

[11] *Department of Health and Human Services (HHS) and Department of Justice (DOJ) Annual Health Care Fraud and Abuse Control (HCFAC) Program Annual Report for FY2008*, September 2009, http://oig.hhs.gov/publications/docs/hcfac/hcfacreport2008.pdf.

[12] U.S. Congress, House Committee on Energy and Commerce, Subcommittee on Health, *Health Care Reform:* (continued...)

Although there is some overlap, the types of fraud committed against Medicare's FFS program can be different than the types of fraud committed against Medicare's Part C and D plans. These differences stem largely from differences in Medicare's payment structure. In FFS, Medicare pays providers directly for a specified unit of service delivered to a beneficiary (i.e. procedure, visit, test, or group of services). This can create an incentive for providers to over-utilize health care services or provide more care to beneficiaries in order to maximize reimbursement. Examples of fraudulent activity in the FFS program include:

- Billing for services not furnished and/or supplies not provided.
- Altering claim forms, electronic claim records, medical documentation, etc., to obtain a higher payment amount (i.e. upcoding).
- Billing for services already provided (i.e. duplicate payments).
- Soliciting, offering, or receiving a kickback, bribe, or rebate, e.g., paying for a referral of patients in exchange for the ordering of diagnostic tests and other services or medical equipment.
- Billing non-covered or non-chargeable services as covered items.
- Billing separately for services or equipment included in global rate (i.e. unbundling).

In contrast, under Parts C and D, Medicare pays private health and PDP plans a fixed monthly payment amount per enrollee, otherwise known as capitation. The payment amount is made in advance for a pre-determined set of benefits, either Part A and B benefits administered by a MA plan or prescription drug benefits administered by a PDP plan. Under capitation, the monthly payment amount is fixed, regardless of the amount of services provided. Therefore, providers have an incentive to limit health services or provide fewer services to beneficiaries in order to maximize reimbursement. In Medicare Parts C and D, types of fraudulent activities may include:

- Engaging in fraudulent marketing practices (i.e. offering beneficiaries a cash payment to enroll, enrolling beneficiaries without their consent, conducting unsolicited door-to-door marketing, or using unlicensed agents).
- Selectively enrolling health enrollees (i.e. "cherry picking").
- Failing to provide medically necessary services.
- Inappropriately overestimating or underestimating bid amounts for payment.
- Imposing excessive beneficiary premiums.

Historically, Medicare's program integrity approaches have focused on combating fraud in the FFS sector. However, with enrollment in private Medicare plans on the rise and the addition of the new Part D drug benefit, program integrity approaches to fight fraud in capitated payment systems has become increasingly important.

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Opportunities to Address Fraud, Waste, and Abuse, Testimony of Daniel R. Levinson, HHS OIG, 111th Cong., June 25, 2009, http://oig.hhs.gov/testimony/docs/2009/06252009_testimony_health_reform.pdf.

Overview of Medicare Program Integrity

In Medicare, program integrity typically encompasses two types of activities: (1) processes directed at reducing payment errors or improper payments and (2) activities designed to prevent, detect, investigate, and ultimately prosecute fraud.

Since 1990, the Government Accountability Office (GAO) has declared Medicare at high risk for improper payments and fraud due to its size, scope, and decentralized administrative structure.[13] To protect the Medicare Trust Fund from improper payments, CMS contracts with private organizations to review claims to determine whether the services provided are medically reasonable and necessary. In Medicare, improper payments include both underpayments and overpayments to providers and largely result from provider billing mistakes or inadvertent claims processing errors. Although Medicare's claims review strategies do identify some instances of fraud, they are not specifically designed to do so. Of the claims that are reviewed, the majority are reviewed on a post-payment basis.

To protect the Medicare Trust Fund from fraud and abuse, CMS contracts with private organizations to conduct activities directed at identifying and detecting actual fraud. CMS typically classifies these functions as benefit integrity activities. Examples of benefit integrity methods include performing ongoing data analysis of claims to identify aberrant billing patterns, conducting fraud investigations, auditing providers, contacting Medicare beneficiaries and providers to verify that medical services were actually provided, and referring suspected cases of fraud to law enforcement personnel for prosecution. When these activities reveal suspected fraudulent activity, contractors develop and refer cases to the HHS OIG for further investigation and administrative sanctions. Fraud cases may then be referred to the DOJ for prosecution.

Types of Program Integrity Activities

To protect Medicare from improper payments, as well as fraud, waste, and abuse, Medicare contractors have historically conducted six main types of program integrity activities: cost report auditing, medical review, benefit integrity, Medicare secondary payer, provider education, and operating a Medicare-Medicaid Data Match Program. These six functions are stipulated in law and are largely performed as part of CMS's MIP program.[14]

Cost Report Auditing

Part A Medicare providers such as hospitals, nursing homes, home health agencies, and other institutional providers are required to submit cost reports to CMS annually.[15] Cost reports contain

[13] U.S. Government Accountability Office, *High Risk Series: An Update*, GAO-09-271, January 2009, http://www.gao.gov/new.items/d09271.pdf.

[14] Section 1893 of the SSA governs the MIP program. Other program integrity methods employed by CMS not discussed in this report include scrutinizing provider applications upon enrollment, conducting in-person site visits to provider locations to verify that they meet certain standards, and conducting inspections of provider facilities.

[15] Generally, Part A Medicare providers are paid under a prospective payment system (PPS). Under PPS, providers are paid pre-determined payment amounts based on specified units of service, such as hospital stays. When performing cost report audits, CMS reviews the few items that could affect a provider's payment under PPS, such as bad debt, organ (continued...)

information on the provider's allocation of costs across services. CMS contractors analyze these cost reports by conducting desk reviews. The objective of the desk review is to assess whether the reported costs are adequate and accurate, and to determine whether a more comprehensive, on-site audit is necessary. If the desk review reveals problems with the cost report, contractors may conduct field audits at the provider's place of business. Field audits are designed to ensure compliance with Medicare regulations and reimbursement policies and to obtain reasonable assurance that the cost report was prepared in accordance with Medicare laws, regulations, and instructions. The cost report auditing activity also includes audits of MA plan cost reports.[16] Part B providers (physicians, outpatient hospital, durable medical equipment providers, and others) are not required to submit cost reports to CMS.

Medical Review

Medical review activities are designed to identify and prevent payment errors and mistakes in billing. More specifically, medical review activities are conducted to ensure that a payment is appropriate for the service that is provided and meets professionally recognized standards of care. As part of this process, Medicare contractors review claims, largely through the use of automated computer edits, to verify that the services are (1) covered by Medicare, (2) provided by legitimate providers, (3) delivered to eligible beneficiaries, and (4) reasonable and medically necessary.[17] When an edit reveals a billing error or problem with a claim, contractors may conduct a manual pre-payment or post-payment claims review, request additional medical documentation from the provider, or contact beneficiaries to verify that the services were actually provided.[18]

Benefit Integrity

Benefit integrity involves the identification and investigation of potential fraud cases and referrals to law enforcement. CMS contractors hired to perform benefit integrity work may conduct national and regional data analysis to identify aberrant patterns of billing, request medical documentation from providers to verify services delivered, investigate beneficiary complaints related to fraud, and educate providers about fraud detection and prevention. When fraud is suspected, contractors refer cases to the OIG or law enforcement for further investigation,

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procurement costs, payments for indirect and direct medical education, and the numbers of low-income patients hospitals serve. Recent studies conducted by GAO and MEDPAC have questioned the degree to which CMS's current audit process assesses the accuracy of Medicare costs for providers paid under PPS. See GAO-06-813, *Medicare Integrity Program: Agency Approach for Allocating Funds Should be Revised*, September 2006, http://www.gao.gov/new.items/d06813.pdf, and MEDPAC, *Report to the Congress: Sources of Financial Data on Medicare Providers*, June 2004, http://www.medpac.gov/publications/congressional_reports/june04_990_DataNeeds.pdf.

[16] Although the law requires that CMS annually audit the financial records of at least one-third of Part C MA plans, a GAO report released in July 2007 found that CMS did not document its process for ensuring that it met this requirement for years 2001-2005. See GAO-07-945, *Medicare Advantage: Required Audits of Limited Value*, July 2007, http://www.gao.gov/new.items/d07945.pdf.

[17] Computerized edits also check for errors such as incomplete or duplicate claims, claims where diagnosis codes do not match procedure codes, and unallowable code combinations.

[18] Manual pre-payment and post-payment claims reviews are initiated only after billing problems have been identified with a provider. Under pre-payment review, contractors will conduct a manual medical review on a percentage of claims before payment is made. When conducting post payment review, contractors examine a statistically valid sample of paid claims from a provider. The majority of the claims that are reviewed are reviewed on a post-payment basis.

prosecution, or both. Benefit integrity activities may also include recoupment[19] of overpayments and suspension of future payments when fraud is suspected.

Medicare Secondary Payer (MSP)[20]

MSP activities ensure that Medicare pays only for those services where it has primary responsibility for payment. Under MSP rules, Medicare is prohibited from making payments for any item or service when payment has been made or can reasonably expect to be made by certain third-party payers. Statutorily, Medicare is the secondary payer to employer-based insurance plans, auto liability insurance, and workers compensation insurance. CMS maintains a comprehensive database of all Medicare beneficiaries' health insurance information and uses the database to conduct investigations related to MSP.

Provider Education

To help prevent errors and keep providers abreast of any changes in Medicare billing and coding procedures, contractors are required to conduct regular outreach and educational activities. Examples of educational activities include seminars, workshops, articles and fact sheets, and other website publications. Provider education activities also include developing resources for providers to help them avoid and detect fraud, waste, and abuse. When billing problems or improper payments are identified, CMS contractors are required to work with Medicare providers directly to correct mistakes.

Medicare-Medicaid Data Match Program

Referred to as the Medi-Medi program, this activity is designed to identify fraudulent or improper billing practices that affect both Medicare and Medicaid programs. By matching data across both programs, CMS investigates atypical billing patterns that may not be evident when analyzing the data from each program separately. When problems are identified, CMS works with the states to initiate payment recovery actions. CMS currently has Medi-Medi projects operating in 10 states.[21]According to HHS, in FY2008, 30 Medi-Medi cases were referred to law enforcement and over $27 million in overpayments were identified for collection.[22]

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[19] Recoupment is recovering a Medicare overpayment by reducing present or future Medicare payments and applying the amount withheld against the debt.

[20] For more information on Medicare Secondary Payer, see CRS Report RL33587, *Medicare Secondary Payer - Coordination of Benefits*, by Hinda Chaikind.

[21] The Medi-Medi program is currently operating in the following 10 states: California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois. The Deficit Reduction Act of 2005 mandated the expansion of the Medi-Medi program nationwide. However, states receive no funding to participate in the program. In FY2010, the OIG plans to release a report on CMS's oversight and monitoring of the Medi-Medi program. See the OIG's FY2010 Workplan available at: http://www.oig.hhs.gov/publications/docs/workplan/2010/Work_Plan_FY_2010.pdf.

[22] U.S. Congress, Senate Committee on the Judiciary, *Effective Strategies for Preventing Health Care Fraud*, Testimony of HHS Secretary William Corr, 111th Cong., October 28, 2009, http://www.hhs.gov/asl/testify/2009/10/t20091028a.html.

Types of Program Integrity Contractors

To conduct program integrity activities, Medicare contracts with an array of different contractors. The types of activities undertaken by these contractors vary depending on their Statement of Work (SOW). Some process and pay Medicare claims in addition to performing program integrity functions (i.e. Medicare Administrative Contractors or MACs). Others specialize solely in program integrity and fraud prevention activities such as Zone Program Integrity Contractors (ZPICs), Medicare Drug Integrity Contractors (MEDICs), Recovery Audit Contractors (RACs), the Comprehensive Error Rate Testing (CERT) contractor, and the Coordination of Benefits (COB) contractor. A brief description of each of these contractors and their scope of work are described below. This list is not exhaustive.

Medicare Administrative Contractors (MACs)

Congress, with the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), mandated that the Secretary contract with MACs to process and pay Medicare claims.[23] Historically, fiscal intermediaries (FIs) performed claims administration functions for Part A providers (i.e. hospitals and facilities) and carriers performed claims administration functions for Part B providers (i.e. physicians). The MMA required that CMS replace the 40+ FIs and carriers with competitively selected MACs. In addition to processing and paying claims, these contractors perform select program integrity functions, including medical review of claims, identifying and recovering improper payments, conducting provider audits, educating providers on appropriate billing practices, and screening beneficiary complaints related to alleged fraud. The MMA required that CMS replace all FIs and carriers with MACs by October 2011. Currently, CMS has awarded all 19 MAC contracts – 15 to process claims for Part A and B providers (A/B MACs) and 4 to process claims for DME providers (DME MACs). As of January 2010, all 4 DME MACs and 9 A/B MACs were fully operational. The remaining six A/B MAC contracts are under procurement corrective action.

Program Safeguard Contractors (PSCs) and Zone Program Integrity Contractors (ZPICs)

Since 1997, Medicare has contracted with PSCs to detect and investigate potential fraud and abuse in Medicare's FFS program. CMS is in the process of transitioning these benefit integrity

[23] Requiring the Secretary to contract with MACs was part of an overall legislative strategy to reform Medicare's administrative structure. Prior to the MMA, CMS was not authorized to select administrative contractors using a competitive selection process. Due to concerns that the enactment of Medicare would result in a large Federal intervention in the provision of health care, Section 1816 of the SSA authorized providers such as hospitals and nursing facilities to nominate their own FIs. Although the statute did afford the Secretary the authority to choose carriers to process Part B claims, Medicare regulations still limited the Secretary's flexibility in contracting. For example, the Secretary was prohibited from terminating an agreement with an administrative contractor without cause or the opportunity for a public hearing. Additionally, contracts were renewed automatically from year to year and were required to be cost-based and not performance-based. One goal of implementing the MAC initiative was to make Medicare contracting more consistent with the standard federal government contracting procedures governed by the Federal Acquisition Regulation (FAR). Today Section 1874A of the SSA requires that the Secretary use competitive procedures, which take into account quality as well as price, when selecting its claims processing contractors. The Secretary is also required to competitively select the MACs at a minimum once every 5 years and is authorized to include performance incentives in its contracts.

activities from PSCs to ZPICs. Once fully operational, ZPICs are expected to perform benefit integrity activities for Medicare Parts A, B, C, and D. Unlike CMS's contracting strategy for PSCs, there will not be separate ZPICs responsible for reviewing DME, home health, and hospice claims. Program integrity activities for all claim types will be conducted under a single ZPIC contract. ZPICs and PSCs conduct data analysis to identify improper billing patterns, perform provider audits, investigate fraud leads, refer cases to the OIG or DOJ for prosecution, and implement administrative actions to recover improper payments (i.e. pre-and post-payment claims review, payment suspension, payment denial, or recoupment of overpayments).

To facilitate coordination and communication among contractors, CMS established 7 ZPIC zones to align with the new MAC jurisdictions. The agency plans to have one ZPIC serving each zone. Five of these zones will encompass states identified by CMS as having high levels of fraudulent activity (California, Florida, Illinois, New York, and Texas). As of January 2010, CMS had awarded contracts for 4 ZPIC zones. The ZPICs operating in two of these zones are fully operational. The remaining two ZPIC awards were protested by other bidders.[24] Currently, the two ZPICs that are operational are performing anti-fraud activities in two of the five high-risk states – Florida and Texas.

Medicare Drug Integrity Contractors (MEDICs)

Medicare contracts with MEDICs to conduct program integrity activities in the Medicare prescription drug benefit program.[25] At the beginning of FY2009, CMS added fighting fraud, waste and abuse in Medicare Part C to the scope of work for the MEDICs. The MEDICs perform many similar functions as the ZPICs, including data analysis to identify patterns of erroneous billing, conducting investigations, referring cases to the OIG or DOJ for prosecution, and implementing administrative actions to recover improper payments. MEDICs are also responsible for auditing the fraud, waste, and abuse compliance programs that are a requirement for participation as a Part D plan in the Medicare program.[26] There are currently two regional MEDICs under contract to investigate fraud in the prescription drug program nationwide.[27]

[24] CMS issued an RFP for ZPICs on May 1, 2008. On October 8th, 2008 CMS announced that it had awarded the first two ZPIC contracts to Health Integrity, LLC for Zone 4 (Texas, Oklahoma, Colorado, and New Mexico) and Safeguard Services, LLC for Zone 7 (Florida, Puerto Rico, and U.S. Virgin Islands). These two ZPICs are fully operational. In 2009, the agency awarded ZPIC contracts for Zone 5 (West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, and Louisiana) and Zone 2 (Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, and Missouri) to AdvanceMed Corporation. Both of these awards to AdvanceMed were subsequently protested by other program integrity contractors. On January 25, 2010, the GAO upheld the protests for the Zone 2 and Zone 5 ZPIC contracts.

[25] For additional information on oversight of the Part D benefit see CRS Report R40611, *Medicare Part D Prescription Drug Benefit*, by Patricia A. Davis.

[26] According to a recent report released by the OIG, none of these audits were conducted by the MEDICs in FY2008. See OEI-03-08-00420, *Medicare Drug Integrity Contractors' Identification of Potential Part D Fraud and Abuse*, HHS OIG, October 2009, http://oig.hhs.gov/oei/reports/oei-03-08-00420.pdf. As a condition of participation in Medicare, both MA and PDP plans are required to have in place a compliance plan which should include, among other elements, measures for detecting, correcting, and preventing fraud, waste, and abuse. Required elements of the plan include designation of a compliance officer; training, education, and effective lines of communication between the compliance officer and the organization's employees; procedures for ensuring prompt response to detected offenses; and procedures to voluntarily self-report potential fraud or misconduct to CMS (42 C.F.R 423.503 & 42 C.F.R 423.504).

[27] CMS awarded contracts to three regional MEDICs in FY2007. The three MEDIC contracts were consolidated into two in the Fall of 2008 when CMS did not renew the contract for one of the original three MEDICs.

Recovery Audit Contractors (RACs)

In 2003, Congress authorized a three year demonstration program in the MMA to test the use of a new type of administrative contractor in Medicare called a RAC. RACs are charged with identifying improper payments made in Part A and B Medicare and recouping overpayments. In 2006, Congress made the RAC program permanent and mandated its expansion nationwide by the year 2010.[28] On October 6, 2008, CMS announced the names of the four national RACs: Diversified Collection Services (DCS), CGI Technologies and Solutions (CGI), Connolly Consulting Associates, and Health Data Insights (HDI). Each RAC is responsible for reviewing claims for approximately one-fourth of the country. All providers who receive payment under Parts A and B could be subject to a RAC audit.[29] The statute does not authorize RACs to look for improper payments in the MA or PDP programs.

Although identifying potential fraud is not a RAC responsibility, the RACs are required to refer claims they believe may be fraudulent to CMS for further investigation. In February 2010, the OIG released a report indicating that during the three year demonstration program (2005 – 2008) RACs referred only two cases of potential fraud to CMS.[30]

Comprehensive Error Rate Testing (CERT) Contractor

CMS contracts with a CERT contractor to calculate improper payment rates for its FFS program.[31] In 2002, Congress enacted the Improper Payments Information Act (IPIA, P.L. 107-300), which requires federal agencies to estimate and report an annual amount of improper payments for all programs and activities. The CERT contractor calculates three types of improper payment rates: 1) a national improper payment rate, 2) contractor-specific improper payment rates, and 3) improper payment rates by provider type. According to the agency, the contractor-specific improper payment rates are used to assess MACs, FIs, and carriers performance in paying claims accurately. The provider-specific rates are to see how well providers' are complying with Medicare's billing and coding requirements. On November 18, 2009, CMS reported a FY2009 national improper payment rate of 7.8%, or $24.1 billion in paid claims for original FFS Medicare. CMS produces midyear and annual improper payment reports, which can be accessed publicly on the agency website.[32]

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[28] The legislation also provided CMS with the authority to pay RACs differently than other Medicare contractors, raising concerns among opponents of the RAC program. Historically, Medicare has paid its administrative contractors using cost-based contracts. Under a cost-based contract, Medicare reimburses contracting organizations for all necessary and proper costs incurred during the year. In contrast, the MMA legislation required Medicare pay RACs on a contingency basis. Under a contingency-based contract, contractors are reimbursed a portion, usually a percentage, from amounts recovered in improper payments. For additional information on Medicare's RAC program see CRS Report R40592, *Medicare's Recovery Audit Contractor (RAC) Program: Background and Issues*, by Holly Stockdale.

[29] This includes inpatient hospitals, physicians, skilled nursing facilities, inpatient rehabilitation facilities, DME suppliers, home health agencies, and other Part A or B providers.

[30] HHS OIG, *Recovery Audit Contractors' Fraud Referrals* , OEI-03-09-00130, February 2010, http://oig.hhs.gov/oei/reports/oei-03-09-00130.pdf.

[31] An improper payment is any payment that should not have been made or that was made in an incorrect amount. This includes duplicate payments, payments to ineligible recipients, payments for ineligible services, or payments for services not received. In Medicare, improper payments include both underpayments and overpayments to providers and largely result from provider billing mistakes and inadvertent claims processing errors.

[32] To access CMS annual improper payment rate reports see: https://www.cms.hhs.gov/apps/er_report/index.asp.

National Supplier Clearinghouse (NSC) Contractor

The NSC is responsible for reviewing enrollment applications from DME suppliers and conducting site visits to confirm their compliance with Medicare enrollment standards (i.e. maintaining a physical facility and primary business telephone number). DME suppliers are required to re-enroll in Medicare once every three years in order to continue billing the program. The NSC conducts mandatory site visits upon initial enrollment and re-enrollment. The NSC may conduct random, unannounced site visits at other times if there is evidence that a supplier may be out of compliance. In the most recent (May 2009) Compendium of Unimplemented Recommendations, the OIG included a recommendation that CMS strengthen the DME supplier enrollment process by conducting more unannounced site visits.[33]

Coordination of Benefits (COB) Contractor

The main purpose of the COB contractor is to identify payments that are the responsibility of another or secondary payer. Statutorily, Medicare is the secondary payer to employer-based insurance plans, auto liability insurance, and workers compensation insurance. By using data match programs, the Medicare COB is responsible for the collection, management, and reporting of other health insurance coverage for Medicare beneficiaries. In January of 2001, the COB contractor assumed responsibility for researching and conducting all MSP claim investigations. There is one COB contractor that handles all program integrity functions related to MSP.

Program Integrity Partners

CMS shares responsibility for ensuring Medicare program integrity with the HHS OIG, the DOJ, and the Federal Bureau of Investigation (FBI). The OIG is an independent unit within HHS that has the primary responsibility for detecting health care fraud and abuse in all federal health care programs.[34] Most of its work, however, relates to the Medicare and Medicaid programs. The agency conducts audits of health care programs, providers, and agencies, and it performs criminal and civil investigations related to specific instances of health care fraud or abuse. CMS contractors, upon detecting potential fraud, will develop and refer cases to the OIG for further investigation and possible administrative sanctions.

The OIG has the authority to impose civil monetary penalties[35] and program exclusions[36] on Medicare providers that have been convicted of certain fraudulent activities. The OIG does not

[33] HHS OIG, *Compendium of Unimplemented Recommendations*, May 2009, http://www.oig.hhs.gov/publications/docs/compendium/compendium2009.pdf.

[34] For additional information on the authority, duties, and responsibilities of Inspectors General throughout the federal government see CRS Report 98-379, *Statutory Offices of Inspector General: Past and Present*, by Frederick M. Kaiser.

[35] Section 1128A of the SSA authorizes the Secretary to impose penalties and assessments on persons for engaging in certain activities. For example, a person who knowingly submits a false claim to a federal health care program is subject to a penalty of up to $11,000 for each item or service fraudulently claimed, an assessment of up to three times the amount fraudulently claimed, and possible exclusion.

[36] Section 1128 of the SSA authorizes the Secretary to exclude individuals and entities from participation in federal health care programs. Exclusions are authorized for convictions of criminal offenses related to the delivery of health care, including (1) Medicare or Medicaid fraud, (2) patient abuse or neglect, (3) felonies for other health care fraud, and (4) felonies for the illegal manufacture, distribution, prescription, or dispensing of controlled substances. The Secretary (continued...)

have the authority to prosecute offenders for violations of federal criminal law. In these instances, the OIG refers the case to the DOJ for prosecution. During FY2008, the OIG excluded a total of 3,129 individuals and entities from participating in Medicare, Medicaid, and other federal and state health care programs.[37]

The FBI is the lead investigative agency in the fight against health care fraud. Unlike the OIG, which has the authority to investigate fraud only in federal programs, the FBI has jurisdiction over both federal and private sector insurance programs. Typically, the agency investigates complex fraud schemes involving large-scale medical providers, such as hospitals and corporations. The FBI does not have the authority to impose sanctions. In FY2008, 2,434 FBI-led investigations resulted in 696 criminal health care fraud convictions.[38]

CMS contractors, the OIG, and the FBI all refer potential health care fraud cases to the DOJ for prosecution. Within the DOJ, the Civil and Criminal Divisions handle health care fraud. One of the enforcement tools for prosecuting health care fraud is the False Claims Act (FCA), which prohibits knowingly submitting false or fraudulent claims to the U.S. government. Lawsuits may be brought by private plaintiffs, known as relators or whistleblowers, under the FCA.[39] There are also 93 U.S. Attorneys Offices nationwide, which prosecute civil and criminal health care fraud. During FY2008, prosecutors for the DOJ and U.S. Attorneys Offices opened 957 new criminal and 843 new civil health care fraud investigations. This is compared to 878 new criminal and 776 new civil health care fraud investigations in FY2007.[40]

Finally, Medicare beneficiaries are a source for detecting fraud. Beneficiaries who suspect fraud can call the OIG's National Fraud Hotline at 1-800-HHS-TIPS. To educate beneficiaries on how to detect and report fraud and abuse, the Administration on Aging oversees Senior Medicare Patrol Projects, which recruit retired professionals in all 50 states to conduct one-on-one and group training sessions for Medicare beneficiaries.[41] Contractors investigating anomalies in billing patterns may also contact beneficiaries to verify that the services claimed were actually received by the beneficiary.

Funding for Program Integrity Activities

Medicare program integrity and anti-fraud activities are funded through the HCFAC and MIP programs. HCFAC and MIP were both established by HIPAA, which sought to increase and

(...continued)

has discretionary authority to exclude individuals on other grounds, such as health care fraud offenses involving misdemeanors, license suspension or revocation, provision of unnecessary or substandard services, submission of false or fraudulent claims, and engaging in unlawful kickback arrangements.

[37] HCFAC Annual Report for 2008.

[38] HCFAC Annual Report for 2008.

[39] Under the Federal False Claims Act, 31 U.S.C. §§ 3729-3733, private citizens and relators may file suit on behalf of the U.S. government. Relators are private persons with direct knowledge of health care fraud who file complaints on behalf of the federal government. They are entitled to a percentage of any fraud recoveries.

[40] HCFAC Annual Report for 2008.

[41] The OIG collects annual performance data on these projects and its most recent report can be accessed at: http://www.smpresource.org/Content/NavigationMenu/ResourcesforSMPs/OIGReports/May09OIGPerformanceReport.pdf .

stabilize federal funding for health care anti-fraud activities. Specifically, HCFAC funds are directed to the enforcement and prosecution of health care fraud, whereas MIP funding supports the program integrity activities undertaken by CMS contractors. Prior to HIPAA, funding for Medicare's program integrity activities was taken from CMS's annual program management budget, which was subject to the appropriations process. This sometimes led to fluctuations in funding, as monies originally intended to support program integrity functions were redirected to fund ongoing Medicare operations, such as day-to-day claims processing functions. With the passage of HIPAA, HHS was ensured a stable funding source that it could commit to Medicare anti-fraud activities.[42]

HCFAC

Section 1128C of the SSA authorizes the establishment of the HCFAC program. The purpose of the program, which is jointly administered by the Secretary of HHS and the Attorney General, is to (1) coordinate federal, state, and local law enforcement efforts directed at controlling health care fraud and abuse; (2) conduct investigations, audits, evaluations, and inspections related to health care delivery and payment; (3) facilitate the enforcement of criminal and civil monetary penalties applicable to health care fraud; (4) provide for the establishment of safe harbors, advisory opinions, and fraud alerts; and (5) support the reporting and disclosure of adverse actions against health care providers. To fund the program, HIPAA established within the Hospital Insurance (HI) Trust Fund (Part A) an expenditure account called the HCFAC account. The HCFAC account funds the anti-fraud activities undertaken by HHS, DOJ, and the FBI. All amounts equal to monies collected from health care investigations and enforcement efforts are to be deposited into the HI Trust fund.[43]

MIP

Section 1893 of the SSA authorizes the establishment of the MIP program. Specifically, the authorizing language requires the Secretary to enter into contracts with eligible entities to conduct the following six activities: (1) medical review, (2) audits of cost reports, (3) determinations as to whether payment should not be, or should not have been, made by Medicare (otherwise known as Medicare Secondary Payer determinations), (4) education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues, (5) developing and updating a list of items of DME, which are subject to prior authorization, and (6) the Medicare-Medicaid Data Match Program, or Medi-Medi program. **Table 1** shows HCFAC and MIP mandatory appropriations for selected fiscal years.

[42] In addition, historically, Medicare relied heavily on "pay and chase" methods, which entailed paying claims and then chasing after providers to recover inappropriate payments. Long-term financial support was intended to assist CMS in developing more innovative and preventive strategies to combat fraud and abuse, such as reviewing claims prior to payment as opposed to after payment.

[43] As specified in Section 1817(k)(C) of the SSA, amounts equal to the following are to be deposited into the Federal Hospital Insurance Trust Fund from the U.S. Treasury: (1) amounts equaling unconditional gifts and bequests; (2) criminal fines recovered in cases involving a federal health care offense as defined in Title 18 U.S.C. § 982(a)(6)(B); (3) civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, of the SSA and Chapter 38 of Title 31 of the U.S.C.; (4) amounts resulting from the forfeiture of property by reason of a federal health care offense; and (5) penalties and damages obtained under the False Claims Act, 31 U.S.C. §§ 3729-3933.

Table 1. HCFAC and MIP Mandatory Appropriations for Selected Fiscal Years (1999-2011)

(dollars in thousands)

	1999	2001	2003	2005	2007	2009	2010	2011 (est)
HCFAC								
HHS	$8,273	$8,428	$31,143	$31,143	$31,746	$33,892	$33,892	$33,892
DOJ	$30,740	$43,469	$49,415	$49,415	$51,793	$55,328	$55,328	$55,328
OIG	$98,220	$130,000	$160,000	$160,000	$165,920	$177,205	$177,205	$177,205
FBI	$66,000	$88,000	$114,000	$114,000	$118,218	$126,258	$126,258	$126,258
MIP	$560,000	$680,000	$720,000	$720,000	$720,000	$720,000	$720,000	$720,000
Medi-Medi	-	-	-	-	$24,000	$48,000	$60,000	$60,000
TOTAL	**$763,233**	**$949,897**	**$1,074,558**	**$1,074,558**	**$1,111,677**	**$1,160,683**	**$1,172,683**	**$1,172,683**

Source: HCFAC Annual Reports for FY1999-FY2008, CMS Justification of Estimates for Appropriations Committees FY2003-FY2011, and GAO Reviews of HCFAC Reports.

Discretionary Funding for Program Integrity Activities

Although CMS has requested additional discretionary funds to supplement the mandatory HCFAC appropriation since 2006, Congress didn't actually approve the adjustment until 2009. The FY2009 discretionary appropriation included $147 million for MIP, $19 million for the DOJ, $19 million for the OIG, and $13 million for CMS for a total of $198 million. For FY2010 Congress approved an additional $311 million in discretionary funding for the HCFAC program, an increase of $113 million over the FY2009 level. The President's budget request for FY2011 includes $561 million for Medicare and Medicaid program integrity activities, an increase of $250 million over the FY2010 level. If approved, total funding for HCFAC in FY2011 would amount to $1.7 billion. **Table 2** shows HCFAC and MIP discretionary appropriations for FY2009-FY2011.

Table 2. HCFAC and MIP Discretionary Appropriations for FY2009 - FY2011

(dollars in thousands)

	2009	2010	2011 (est)
HCFAC			
DOJ	$18,967	$29,790	$90,003
OIG	$18,967	$29,790	$94,830
CMS	$13,028	$31,100	$47,744
MIP	$147,038	$220,320	$328,423
TOTAL	**$198,000**	**$311,000**	**$561,000**

Source: CMS Justification of Estimates for Appropriations Committees FY2009-FY2011.

The President expects this additional discretionary investment for FY2011 to save approximately $9.9 billion over ten years (FY2011 – FY2021).[44] The budget request indicates that the agency plans to allocate $328.4 million of the $561 million to fighting fraud in Medicare, $47.7 million for program integrity activities in Medicaid, $90 million to the DOJ, and $94.8 million to the OIG. Approximately 50% of the $328.4 million for Medicare would be used to fund oversight activities in the MA and Part D programs. The remaining 50% would be directed towards expanding enforcement activities ($16.3M), increasing program oversight ($20.8M), implementing specific administrative and legislative proposals targeted towards fraudulent providers ($71.0M), funding regional fraud hotlines ($19.3M), conducting site visits to DME suppliers ($17.4M), expanding data analysis activities ($14.5M), and enhanced provider oversight efforts ($10.5M).[45]

Other Funding Sources for Program Integrity Activities

In addition to HCFAC and MIP mandatory funds, each year Congress appropriates discretionary funds to support overseeing and administering Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These monies are appropriated into CMS's program management account. For FY2010, Congress approved $3.5 billion for these activities, which include processing provider claims, paying the salaries of CMS staff, inspecting participating health care facilities, and conducting research and demonstrations. A portion of these funds are directed to program integrity functions.

Oversight of Medicare's Program Integrity Efforts

There are a limited number of performance statistics and reports available to help policy makers evaluate the success of Medicare's program integrity efforts. Studies to date have generally examined the performance of the HCFAC and MIP programs separately. When the HIPAA legislation was passed in 1996, Congress mandated that DOJ and HHS report annually the results and accomplishments of its HCFAC efforts to the public. The legislation also requires that the GAO biennially assess the appropriateness and adequacy of HCFAC expenditures for fraud control efforts. However, Congress did not require that HHS, DOJ, or GAO evaluate the MIP program as part of these assessments. As a result, there is less empirical data available on MIP performance than on the results of the HCFAC program. To date, the most comprehensive evaluation on MIP program integrity efforts was a study released by GAO in September of 2006, which identified weaknesses in the methods CMS uses to allocate funds across five MIP program integrity activities (cost report auditing, medical review, benefit integrity, Medicare secondary payer, and provider education). This section summarizes findings from reviews and studies conducted on the HCFAC and MIP programs during the past decade.

[44] Department of Health and Human Services Budget in Brief for 2011, p.2, http://www.hhs.gov/asrt/ob/docbudget/2011budgetinbrief.pdf.

[45] *CMS Justification of Estimates for Appropriations Committees Fiscal Year 2011*, pp. 161-178, http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSFY11CJ.pdf.

Improper Payment Rates

When assessing the performance of the MIP program, CMS relies on statistics measuring the percentage of improper payments Medicare makes to providers each year. On November 18, 2009, CMS reported a FY2009 improper payment rate of 7.8%, or $24.1 billion in paid claims for original FFS Medicare. This is compared to a rate of 3.6% or $10.4 billion for FY2008. The agency attributes the increase between FY2008 and FY2009 to the application of stricter standards for reviewing claims.[46] At the same time CMS announced a calendar year 2007 improper payment rate of 15.4% or $12.0 billion for its MA program. This is compared to an improper payment rate of 10.6% or $6.8 billion for MA in 2006. An improper payment rate for Medicare Part D is under development.

Despite its value as a tool for estimating payment accuracy and administrative efficiency in claims processing, the improper payment rate does not measure fraud and abuse in the Medicare program. It is mainly a measure of administrative errors. The main types of payment errors in the FFS program are incorrect coding by providers, claims for medically unnecessary services, and claims submitted with insufficient or no documentation. According to the agency, the Part C payment error rate primarily reflects health plan errors in documenting members' diagnoses. **Table 3** lists the national paid claims error rates and the total in gross improper payments for selected years between 1996 and 2009.

Table 3. Medicare National Paid Claim Error Rates and Gross Improper Payments for Selected Years Between 1996 and 2009

(dollars in billions)

Year	National Paid Claims Error Rate (as a % of FFS expenditures)	Gross Improper Payments[a]
1996	14.2%	$23.2
1998	8.4%	$14.9
2000	9.4%	$16.4
2002	8.0%	$17.1
2004[b]	10.1%	$21.7
2006	4.4%	$10.8
2008	3.6%	$10.4
2009	7.8%	$24.1

Source: CMS and OIG Improper Payment Rate Reports for years 1996-2009.

a. CMS arrives at a gross improper payment amount by adding underpayments to overpayments.

[46] See CMS Press Release dated November 18, 2009, available at: [H:\CMS Administration\Improper Payments\HOW NEW STANDARDS FOR TOUGHER ERROR RATE WERE APPLIED IN THIS YEARS 2009 IMPROPER PAYMENTS REPORT.mht. Prior to 2008, Medicare's Quality Improvement Organizations (QIO) were responsible for calculating the error rate for inpatient hospitals. The improper payment rate for all other FFS claims was calculated by the agency's CERT contractor. Beginning in 2009, the agency transferred the responsibility for calculating the improper payment rate for inpatient hospitals from the QIOs to the CERT contractor. According to the agency, at least one reason for the increase in the FFS error rates between 2008 and 2009 was that the QIOs were using different claims review processes and a different measurement methodology to calculate the amount of improper payments. Now that the CERT contractor is responsible for reviewing all FFS claims, the review procedures for inpatient hospital claims are consistent with the review procedures applied to all other FFS claims.

b. From 1996-2002, the OIG calculated an error rate based on approximately 6,000 claims. Beginning in 2003, CMS took over the calculation of the error rate from OIG and expanded the sample of claims reviewed from 6,000 to approximately 128,000.

Over the years the adequacy and accuracy of CMS's calculation of the Medicare FFS improper payment rate has been questioned by the GAO and the OIG. In April 2006, the GAO reported that the significant reduction in Medicare's national paid claims error rate after 2004 was largely due to CMS's efforts to educate providers about the importance of submitting documentation to justify payments. When providers do not respond to requests for additional documentation, CMS automatically counts the payments as erroneous. According to GAO, despite the success and importance of these educational efforts, they do not reflect an improvement in payment safeguards or internal controls implemented by CMS.[47]

HCFAC Annual Reports

HIPAA requires that every year HHS and the DOJ release a joint annual report to Congress on HCFAC results and accomplishments. Typically, these reports are released late summer or early fall and include numbers and examples of enforcement actions, program accomplishments, and amounts deposited into the HI Trust Fund resulting from health care fraud enforcement activities. Congress did not require that HHS and DOJ include expenditures or results for the MIP program in these reports. Therefore, they are only an indication of HCFAC's successes and challenges in the area of health care fraud enforcement and prosecution and not fraud prevention, which is a key objective of the MIP program. In addition, the authors do not separate out funding and expenditures for specific enforcement actions related to Medicare, Medicaid, or other federal health care programs.[48] The most recent annual HCFAC report released in November 2009 indicates that the federal government won or negotiated approximately $1.0 billion in judgments and settlements (fraud recoveries) during FY2008 and returned $1.94 billion to the HI Trust Fund (transfers).[49]

Figure 1 summarizes HCFAC fraud recoveries and transfers to the HI Trust Fund for fiscal years 1998 through 2008. The difference between the amount collected in fraud recoveries and the amount transferred to the HI Trust Fund in any given year can be attributed to the fact that fraud litigation is a lengthy process that can sometimes take several years. As a result, some of the judgments, settlements, and administrative actions won in one year may not result in monies being transferred to the trust fund until one or more years later.

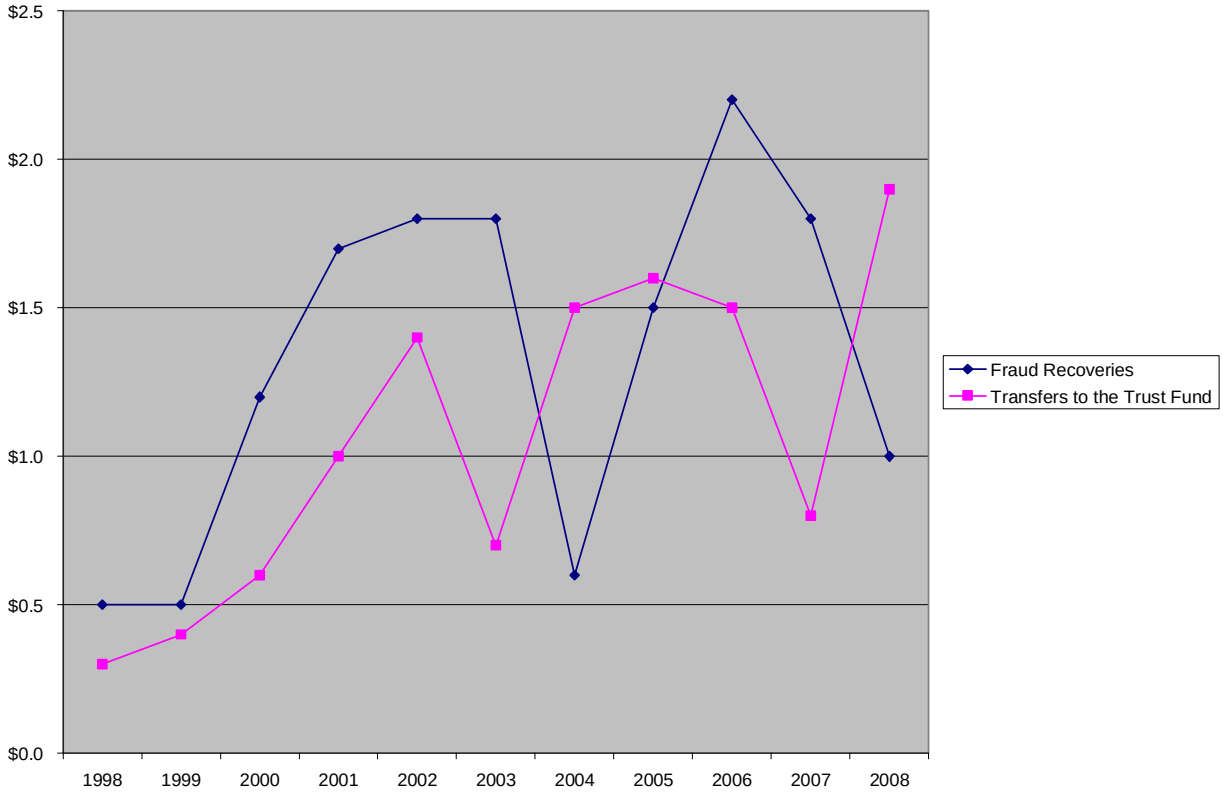
[47] GAO-06-581T, *Challenges Continue in Meeting Requirements of the Improper Payments Information Act*, April 2006, http://www.gao.gov/new.items/d06581t.pdf.

[48] The HIPAA legislation does not require that HHS or DOJ separately track Medicare and non-Medicare expenditures. DOJ officials commented in a 2002 GAO Report on the HCFAC program that it is not practical to separate non-Medicare and Medicare expenditures because of the nature of health care fraud (GAO-02-731: Medicare, Health Care Fraud and Abuse Control Program for Fiscal Years 2000 and 2001, June 2002). Health care fraud cases typically cross several health care programs, making it difficult to attribute expenses and recoveries to separate programs.

[49] HCFAC Annual Report for 2008.

Figure 1. HCFAC Fraud Recoveries and Transfers to the Medicare HI Trust Fund for FY1998-FY2008

Dollars in billions



Source: HCFAC Annual Reports, FY1998-FY2008.

Recoveries are amounts won or negotiated by the OIG and DOJ in any given year. They include criminal fines, civil monetary penalties, forfeitures, civil settlements and judgments. Recoveries vary annually depending on the number and types of fraud cases that are prosecuted. Between 1999 and 2003, recoveries steadily increased from $0.5 to $1.8 billion. Recoveries then dropped over $1 billion between 2003 and 2004. Recoveries rose again from $0.6 billion in 2004 to a high of $2.2 billion in 2006. Recoveries have since dropped again to $1.0 billion in 2008. The considerable increase in recoveries in 2006 can be attributed to a large settlement negotiated with Tenet Healthcare Corporation, operator of the nation's second largest hospital chain. Tenet agreed to pay the United States more than $900 million over a four-year period for unlawful billing practices impacting the Medicare, Medicaid, and TRICARE programs.

Transfers are amounts collected resulting from HCFAC enforcement efforts. Between fiscal years 1998 and 2002, transfers to the Trust Fund steadily increased from $0.3 billion dollars in 1998 to $1.4 billion dollars in 2002. After a drop to $0.7 billion in 2003, returns again increased between 2004 and 2006, holding relatively steady at approximately $1.5 billion. Transfers again dropped in FY2007 to $0.8 billion only to accelerate over $1 billion dollars in FY2008 to $1.94 billion – the largest amount collected over the program's ten year existence. According to the November 2009 HCFAC report, federal health care fraud enforcement activities have returned over $13.1 billion dollars to the Medicare Trust Funds since 1997.

Table 4 shows the number of enforcement actions, including new criminal and civil health care fraud investigations and program exclusions for fiscal years 1999 through 2008. The number of new civil and criminal investigations has accelerated over the past ten years. However, there is debate as to whether this rise in enforcement actions is actually the result of more fraud and abuse in Medicare. Some experts contend that the increase is the result of having more resources to fight and detect illegal behavior, as opposed to an actual increase in the amount of fraud. Others note that the definition of what constitutes health care fraud has expanded over the years, making it appear as though fraud has escalated when the actual level has remained relatively steady.[50]

Table 4. Summary of Health Care Fraud Enforcement Actions for FY1999-FY2008

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
New Criminal Investigations	371	457	445	361	870	1,002	935	836	878	957
New Civil Investigations	91	233	188	221	231	868	778	915	776	843
Program Exclusions	2,976	3,350	3,746	3,448	3,275	3,293	3,804	3,422	3,308	3,129

Source: HCFAC Annual Reports, FY1999-FY2008.

GAO HCFAC Reports

HIPAA also required that GAO submit a report to Congress every two years on HCFAC appropriations and deposits. Starting in June 1998, GAO released four reports using data from the HCFAC annual reports for years 1997 through 2003. The most recent and final report, released in April 2005, reviewed HCFAC activities for years 2002 and 2003.[51] Similar to the HCFAC annual reports, these studies do not include MIP in their analysis. In all four reports, GAO noted that while HCFAC deposit amounts reported to the HI Trust Fund were consistent with the HIPAA legislation, HHS included a measure of cost savings resulting from health care fraud enforcement efforts that could not entirely be attributed to the HCFAC program.[52] In addition, because fraud investigation and litigation can take several years, savings may not be realized until future years.

The Office of Management and Budget (OMB) echoed a similar finding in its Program Assessment Rating Tool (PART) evaluation of the HCFAC program in 2004 (see description below). Despite this weakness, GAO consistently found HHS and DOJ's accounting of HCFAC deposits and expenditures to be fiscally appropriate and accurate.

[50] Health Care Fraud and Abuse: Practical Perspectives, Chapter 4, 2004.

[51] GAO-05-134, *Health Care Fraud and Abuse Control Program: Results of Review of Annual Reports for Fiscal Years 2002 and 2003*, April 2005, http://www.gao.gov/new.items/d05134.pdf.

[52] The OIG defines cost savings as funds put to better use as a result of implemented legislative or other program initiatives.

OMB Program Assessment Rating Tool (PART)[53]

In 2002, OMB evaluated the HCFAC and MIP programs separately using the PART, a 25-question survey addressing federal agency management and performance. The agency noted conflicting assessments for both programs. HCFAC received a "results not demonstrated" rating and criticized the OIG for not having sufficient performance measures to assess the program's progress in reducing fraud, waste, and abuse. Specifically, OMB noted that savings is not a good indicator of performance because it is too difficult to ascertain how much of the reported savings is the direct result of HCFAC activities conducted during the previous year.

In contrast, the agency gave MIP an "effective" rating—the highest rating a program can receive. OMB attributes this largely to the OIG and CMS's measurement and reduction of the annual Medicare improper payment rate. CMS often cites the improper payment rate as a measure of its performance in protecting Medicare from fraud, waste, and abuse. In the PART report, OMB notes that at the time MIP was created in 1996, OIG estimated the improper payment rate at 14.2%. By 2006, the rate had dropped to 4.4% and by 2008 to 3.6%. However, as noted in Table 3, the Medicare improper payment rate rose to 7.8% in 2009.

Other GAO Reports

Subsequent GAO reports released over the last few years have raised questions about how HCFAC and MIP funding are being used. An April 2005 report on HCFAC funding for the FBI found that the agency could not adequately demonstrate that its share of HCFAC expenditures for FY2000-FY2003 were used for health care investigations. The study showed that funds previously devoted to fighting health care fraud at the FBI had been shifted to counterterrorism activities.[54]

In a report released in September 2006, the GAO identified weaknesses in CMS's approach for allocating MIP funds across the various program integrity activities (cost report auditing, medical review, benefit integrity, Medicare secondary payer, and provider education).[55] GAO noted that CMS bases its MIP allocation decisions on historical funding levels, as opposed to examining the relative effectiveness of one activity to another in ensuring Medicare program integrity. For example, despite receiving the largest share of MIP funds in FY2005, CMS has not yet developed a reliable quantitative measure to assess the impact of cost report audits of Part A providers on preventing fraud, waste, and abuse. GAO recommended that CMS develop additional methods for allocating MIP funds that take into account the effectiveness of MIP activities, as well as contractor performance, particularly in light of new vulnerabilities related to the prescription drug benefit.

[53] See Office of Management and Budget Program Assessment Rating Tool website at http://www.whitehouse.gov/omb/rewrite/part/index.html for PART assessments of the MIP and HCFAC programs.

[54] GAO-05-388, *Federal Bureau of Investigation: Accountability over the HIPAA Funding of Health Care Investigations is Inadequate*, April 2005, http://www.gao.gov/new.items/d05388.pdf.

[55] GAO-06-813, *Medicare Integrity Program, Agency Approach for Allocating Funds Should be Revised, September 2006*, http://www.gao.gov/new.items/d06813.pdf.

OIG Audit and Evaluation Reports

Every year the OIG conducts audits, evaluations, and investigations of HHS programs. The recommendations that result from these assessments help lawmakers determine policies to improve the management and operations of these programs. In addition to individual audit and evaluation reports, the agency develops a number of annual reports synthesizing the outcomes of its work. For example, in its FY2009 Compendium of Unimplemented OIG recommendations, the agency identified the following priority recommendations for HHS to strengthen Medicare program integrity: implementing safeguards to prevent and detect fraud and abuse in Medicare Part D, ensuring DME Suppliers' compliance with Medicare standards, modifying payments to managed care organizations, improving CMS's performance evaluation process for PSCs, and improving oversight of hospices.[56] The OIG also produces an annual work plan describing the reviews and audits it plans to pursue in the coming year. For FY2010, the agency plans to conduct over 100 studies and audits related to Medicare, the majority of which are related to Medicare Parts A and B.[57]

Concluding Observations

Program integrity activities encompass a broad set of strategies and processes designed to meet numerous objectives, including preventing improper payments, identifying and detecting fraud, investigating individuals suspected of committing Medicare fraud, and prosecuting offenders. To carry out the six main types of program integrity activities, CMS contracts with a number of different private organizations. The effectiveness of these efforts depends on close collaboration and coordination between CMS, its contractors, the OIG, and federal and state law enforcement agencies.

The implementation of HCFAC and MIP in 1996 provided CMS and Medicare enforcement agencies with a dedicated funding source to coordinate Federal, state, and local activities to fight health care fraud. From 1999 through 2009, resources available for program integrity and anti-fraud efforts increased from an estimated $0.8 billion in FY1999 to approximately $1.4 billion in FY2009, and the number of new civil and criminal fraud enforcement actions more than tripled. Furthermore, the amount of money transferred to the Medicare Trust Funds as a result of health care fraud enforcement activities has been steadily increasing. These statistics, however, do not apply to MIP activities, which receive the largest share of HCFAC funding. Recent GAO reports have raised questions about how MIP funding is being used and have recommended CMS develop more quantitative measures to assess the impact of MIP program integrity activities in the future.

Protecting Medicare from improper payments, fraud, and abuse is a complex and challenging undertaking for a number of reasons. To begin with, there are no reliable estimates on the actual amount of health care fraud, which makes it challenging for policy makers to determine the extent of resources needed to respond to the problem. Furthermore, fraud perpetrators are quick to adapt to investigative techniques and are continually devising more sophisticated schemes to defraud the system. Therefore, policymakers and administrators need to invest in a diverse mix of

[56] The OIG Compendium of Unimplemented Office of Inspector General Recommendations can be accessed at: http://www.oig.hhs.gov/publications/compendium.asp.

[57] The annual OIG Work Plan can be accessed at: http://www.oig.hhs.gov/publications/workplan.asp.

preventive and investigative program integrity methods to reduce Medicare's vulnerability to fraudulent activity. In recent years, fraud experts have urged CMS to adopt more preventive techniques to protect the program, such as increasing the volume of claims it reviews on a pre-payment basis, applying stricter standards when reviewing provider enrollment applications, and conducting background checks on providers prior to allowing them to bill the Medicare program. In its FY2011 budget request, the agency indicates that it plans to direct at least $10.5 million in discretionary funding to conduct site visits and background checks of providers prior to enrollment.

As Medicare continues to grow in size and complexity, developing innovative strategies to ensure the integrity of the program become increasingly important. Both the House and Senate health care reform bills contain numerous provisions designed to strengthen Medicare's program integrity activities. For example, both bills would increase funding for the HCFAC program, introduce new penalties for fraudulent behavior, subject providers and suppliers to enhanced screening before allowing them to participate in Medicare, and require providers to establish compliance programs. The President's health reform proposal also includes provisions directed at reducing health care fraud, including requiring the establishment of a database to store information on health care fraud sanctions and modifying statutory requirements related to the pre-payment review of claims.

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