

GAO

Report to the Chairman, Committee on  
Finance, U.S. Senate

September 2006

**MEDICARE  
INTEGRITY  
PROGRAM**

**Agency Approach for  
Allocating Funds  
Should Be Revised**



G A O  
Accountability · Integrity · Reliability

# Highlights

Highlights of [GAO-06-813](#), a report to the Chairman, Committee on Finance, U.S. Senate

## Why GAO Did This Study

Since 1990, GAO has considered Medicare at high risk for fraud, waste, abuse, and mismanagement. The Medicare Integrity Program (MIP) provides funds to the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—to safeguard over \$300 billion in program payments made on behalf of its beneficiaries. CMS conducts five program integrity activities: audits; medical reviews of claims; determinations of whether Medicare or other insurance sources have primary responsibility for payment, called secondary payer; benefit integrity to address potential fraud cases; and provider education. In this report, GAO determined (1) the amount of MIP funds that CMS has allocated to the five program integrity activities over time, (2) the approach that CMS uses to allocate MIP funds, and (3) how major changes in the Medicare program may affect MIP funding allocations.

## What GAO Recommends

GAO recommends that CMS develop an approach for allocating funds that is based on the effectiveness of the activities, contractors' workload, and risk. CMS generally agreed with GAO's recommendation. CMS also stated that a quantitative measure can be an indicator of effectiveness, but emphasized that such a measure cannot serve as the sole basis for informing funding decisions.

[www.gao.gov/cgi-bin/getrpt?GAO-06-813](http://www.gao.gov/cgi-bin/getrpt?GAO-06-813).

To view the full product, including the scope and methodology, click on the link above. For more information, contact Leslie G. Aronovitz at (312) 220-7600 or [aronovitzl@gao.gov](mailto:aronovitzl@gao.gov).

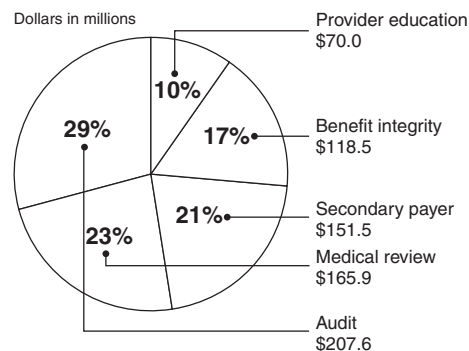
# MEDICARE INTEGRITY PROGRAM

## Agency Approach for Allocating Funds Should Be Revised

### What GAO Found

For fiscal years 1997 through 2005, CMS's MIP expenditures generally increased for each of the five program integrity activities, but the amount of the increase differed by activity. Since fiscal year 1997, provider education has had the largest percentage increase in funding—about 590 percent, while audit and medical review had the largest amounts of funding allocated. In fiscal year 2006, funding for MIP will increase further to \$832 million, which includes \$112 million in funds that CMS plans to use, in part, to address potential fraud and abuse in the new Medicare prescription drug benefit.

**MIP Expenditures for the Five Program Integrity Activities, Fiscal Year 2005**



Source: GAO analysis of CMS data.

CMS officials told us that they have allocated MIP funds to the five program integrity activities based primarily on past allocation levels. Although CMS has quantitative measures of effectiveness for two of its activities—the savings that medical review and secondary payer generate compared to their costs—it does not have a means to determine the effectiveness of each of the five activities relative to the others to aid it in allocating funds. Further, CMS has generally not assessed whether MIP funds are distributed to the contractors conducting each program integrity activity to provide the greatest benefit to Medicare.

Because of significant programmatic changes, such as the implementation of the Medicare prescription drug benefit and competitive selection of contractors responsible for claims administration and program integrity activities, the agency's current approach will not be adequate for making future allocation decisions. For example, CMS will need to allocate funds for program integrity activities to address emerging vulnerabilities that could affect the Medicare prescription drug benefit. Further, through contracting reform, CMS will task new contractors with performing a different mix of program integrity activities. However, the agency's funding approach is not geared to target MIP resources to the activities with the greatest impact on the program and to ensure that the contractors have funding commensurate with their relative workloads and risk of making improper payments.

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## Abbreviations

ACRP	Adjusted Community Rate Proposal
CMS	Centers for Medicare & Medicaid Services
COB	coordination of benefits
DAC	data analysis and coding
DME	durable medical equipment
DRA	Deficit Reduction Act of 2005
ESRD	end-stage renal disease
FBI	Federal Bureau of Investigation
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
MAC	Medicare administrative contractor
MEDIC	Medicare prescription drug integrity contractor
MedPAC	Medicare Payment Advisory Commission
MIP	Medicare Integrity Program
MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
NSC	National Supplier Clearinghouse
OIG	Office of Inspector General
PDE	prescription drug event
PPS	prospective payment system
PSC	program safeguard contractor
ROI	return on investment

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United States Government Accountability Office  
Washington, DC 20548

September 6, 2006

The Honorable Charles E. Grassley  
Chairman  
Committee on Finance  
United States Senate

Dear Mr. Chairman:

In 1990, we designated the Medicare program as high risk for fraud, waste, abuse, and mismanagement, in part because of its sheer size and complexity. Medicare is a federal program that now pays over \$300 billion a year to over 1 million providers to help more than 42 million elderly and certain disabled beneficiaries obtain a variety of health care services and items. One measure of the program's vulnerability is the billions of dollars in improper payments that Medicare makes each year to providers that participate in the program.<sup>1</sup> In November 2005, the Centers for Medicare & Medicaid Services (CMS)<sup>2</sup>—the agency that administers the Medicare program—reported that Medicare made an estimated \$12.1 billion in improper payments to providers.<sup>3</sup> To address Medicare's vulnerability, the Congress enacted a provision in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that established the Medicare Integrity Program (MIP).<sup>4</sup> MIP provides CMS with dedicated funds to identify and combat improper payments, including those caused by fraud and abuse.

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<sup>1</sup>Improper payments are payments made for unauthorized purposes or in excessive amounts and range from inadvertent errors to outright fraud and abuse.

<sup>2</sup>Until July 1, 2001, CMS was called the Health Care Financing Administration. We use the name CMS throughout this report.

<sup>3</sup>The estimated amount of \$12.1 billion represents gross dollars paid in error, which is calculated by adding estimated dollars paid in error that were due to overpayments to the estimated amount of underpayments. In 2004, Medicare paid an estimated \$11.2 billion in overpayments and underpaid claims by an estimated \$0.9 billion.

<sup>4</sup>Pub. L. No. 104-191, § 202, 110 Stat. 1996-98 (codified at 42 U.S.C. § 1395ddd (2000)).

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CMS pays MIP funds to its Medicare contractors to conduct five activities to safeguard Medicare payments.<sup>5</sup> These activities are (1) audits of cost reports, which are financial documents that hospitals and other institutions are required to submit annually to CMS; (2) medical reviews of claims to determine whether services provided are medically reasonable and necessary; (3) determinations of whether Medicare or other insurance sources have primary responsibility for payment, which is called secondary payer; (4) identification and investigation of potential fraud cases, which is called benefit integrity; and (5) education to inform providers about appropriate billing procedures.

Recent events have raised questions about how MIP funding is being used. In addition to establishing MIP, HIPAA established a fund to provide resources for the Department of Justice—including the Federal Bureau of Investigation (FBI)—and the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to investigate and prosecute health care fraud and abuse.<sup>6</sup> In 2005, we reported that the FBI could not adequately account for its share of these funds or demonstrate that its funds were being used to investigate health care cases.<sup>7</sup> This finding raises concerns about how CMS is using its MIP funds to conduct its program integrity efforts—also called program safeguard activities. Further, the Medicare program is undergoing significant changes that will alter the nature and scope of CMS’s program integrity efforts. For example, the new Medicare Part D prescription drug benefit will increase Medicare’s vulnerability to improper payments.

You expressed interest in CMS’s efforts to safeguard Medicare payments and ensure that MIP funds are used effectively. In this report, we (1) provide information on CMS’s allocation of MIP funds among its five program integrity activities over time, (2) examine the approach that CMS uses to allocate MIP funds among these activities, and (3) describe how major changes in the Medicare program may affect MIP funding allocations.

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<sup>5</sup>These payments include those made to participating Medicare providers of services, such as physicians, hospitals, and others.

<sup>6</sup>HIPAA § 201(b), 110 Stat. 1992 (codified at 42 U.S.C. § 1395i(k)(4) (2000)).

<sup>7</sup>GAO, *Federal Bureau of Investigation: Accountability over the HIPAA Funding of Health Care Fraud Investigations Is Inadequate*, [GAO-05-388](#) (Washington, D.C.: Apr. 22, 2005).

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In preparing this report, we interviewed CMS officials about their allocation of MIP funds among the five activities for fiscal years 1997 through 2005 and reviewed allocations of MIP funds to the five activities. We also reviewed related financial and other documentation, including budget, expenditure, and savings data for fiscal years 1997 through 2005, and budget proposals for fiscal years 2006 and 2007. Because most MIP expenditures are for activities related to Medicare Parts A and B,<sup>8</sup> our analysis focused on those expenditures;<sup>9</sup> however, we also collected some information about CMS's planned MIP expenditures for the new prescription drug benefit (Part D). In addition, the Deficit Reduction Act of 2005 (DRA), which was enacted in February 2006, established an additional activity under MIP and provided \$12 million in funding for this activity in fiscal year 2006.<sup>10</sup> We did not review allocations of funds for this activity because our review covered expenditures through fiscal year 2005.

We also interviewed CMS officials regarding the approach they use to make decisions on MIP funding allocations and reviewed related documentation, including CMS reports on dollars saved in relation to dollars spent. We did not independently examine the internal and automated data processing controls for CMS systems from which we obtained data used in our analyses, but we reviewed selected data for internal consistency and accuracy. CMS subjects its data to different levels

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<sup>8</sup>Medicare Part A covers inpatient hospital care, skilled nursing facility care, some home health care services, and hospice care. Part B services include physician and outpatient hospital services, diagnostic tests, mental health services, outpatient physical and occupational therapy, ambulance services, some home health services, and medical equipment and supplies.

<sup>9</sup>Under the traditional Medicare fee-for-service program, beneficiaries are usually charged for each health care service or item provided to them. Medicare Advantage plans, under Part C of Medicare, charge a fixed monthly fee per enrollee regardless of the number and mix of services they provide. In fiscal year 2005, about 87 percent of Medicare beneficiaries were enrolled in fee-for-service and about 13 percent were enrolled in Medicare Advantage.

<sup>10</sup>Pub. L. No. 109-171, § 6034(d), 120 Stat. 4, 77 (2006) (to be codified at 42 U.S.C. § 1395ddd(b)(6) and 1395i(k)(4)(D)). This activity is the Medi-Medi program, which is designed to identify improper billing and utilization patterns by matching Medicare and Medicaid claims information on providers and beneficiaries to reduce fraudulent schemes that cross program boundaries. The statute appropriates funds for CMS to contract with third parties to identify program vulnerabilities in Medicare and Medicaid through examining billing and payment abnormalities. The funds also can be used in connection with the Medi-Medi program for two other purposes: (1) coordinate actions by CMS, the states, the Attorney General, and the HHS OIG to protect Medicaid and Medicare expenditures and (2) increase the effectiveness and efficiency of both Medicare and Medicaid through cost avoidance, savings, and recouping fraudulent, wasteful, or abusive expenditures.



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of review and conducts periodic examinations of selected systems and controls over the data. The agency uses these data to support its management and budgetary decisions and expend funds to contractors. Therefore, we considered the data to be reliable for the purposes of our review. In addition, we interviewed CMS officials regarding changes in Medicare contracting that may affect MIP funding allocations, performance measures, and contractors' evaluations, and reviewed related agency documents. Appendix I contains a more detailed discussion of our scope and methodology. We performed our work from August 2005 through August 2006 in accordance with generally accepted government auditing standards.

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## Results in Brief

MIP funding allocated to the five program integrity activities has generally increased since fiscal year 1997, but the amounts of the allocations and the percentage increases varied by year and activity. For fiscal years 1997 through 2005, provider education received the largest percentage increase in funds, while audit and medical review received the largest share of funds. Among the five activities, from fiscal year 1997 to fiscal year 2005, CMS increased its allocation by about 45 percent for audits to \$207.6 million, 40 percent for medical review to \$165.9 million, 49 percent for secondary payer to \$151.5 million, and 89 percent for benefit integrity to \$118.5 million. CMS increased its allocation by about 590 percent for provider education to \$70 million. This increase was due, in part, to CMS's decision in fiscal year 2002 to use MIP funds for outreach activities to groups of providers, which had not previously been funded through MIP. In fiscal year 2006, CMS will be able to further increase expenditures to MIP activities because the \$720 million originally appropriated for fiscal year 2006 under HIPAA was increased by \$112 million under DRA.<sup>11</sup> CMS plans to use these additional funds, in part, to address potential fraud and abuse in the new Medicare prescription drug benefit.

CMS officials told us that they generally have allocated MIP funds to the five activities based predominantly on their past allocation levels. Although CMS has quantitative measures of effectiveness for two activities—the savings generated by medical review and secondary payer compared to their costs—it does not have similar measures to determine the effectiveness of each of its program integrity activities in relation to

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<sup>11</sup>DRA §§ 5204 and 6034(d), 120 Stat. 48 and 77 (to be codified at 42 U.S.C. § 1395i(k)(4)(C) and (D)).

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the others. In addition, CMS has generally not assessed whether MIP funds are allocated within the program integrity activities to address risks or provide the greatest overall potential benefit to Medicare. For example, distribution of medical review funds to individual contractors has not considered the size of a particular contractor's claims payment workload and its risk of making improper payments, based on the propensity of fraud in the area or past levels of improper payments. While agency officials told us that MIP allocations are generally historically based, in a few instances, CMS has modified its funding to respond to the agency's immediate priorities. For example, in fiscal year 2004, CMS began to increase funds to expand the scope of its annual study to estimate Medicare improper payment rates, and in fiscal year 2002, it increased its MIP allocation for contractors to better educate providers about Medicare.

As a result of significant changes that the Medicare program is undergoing, CMS will need to make new choices about how it should allocate its MIP funds to best address challenges that will occur. For example, in 2006, CMS implemented the new Part D prescription drug benefit. CMS may need to reallocate funds from program integrity activities for Parts A and B to conduct program integrity activities for Part D. Further, the agency is also reforming contracting practices for claims administration services, which include program integrity activities. As part of its contracting reform efforts, CMS plans to reduce the number of Medicare claims administration contractors from 51 to 23 by 2009, has established new jurisdictions for them and the program safeguard contractors (PSC) that will be working with them, and will require the contractors to perform different MIP activities from those they perform currently. While there is little precedent for CMS to follow in addressing these programmatic changes, its current allocation approach is not geared to best address future needs by targeting MIP funds to the activities with the greatest impact on the program and to ensure that the contractors have funding commensurate with their relative workloads and risk of making improper payments.

To better ensure that MIP funds are appropriately allocated among and within the five activities, we recommend that CMS develop a method of allocating funds based on the effectiveness of its program integrity activities, the contractors' workloads, and risk.

In its written comments on a draft of this report, CMS generally agreed with our recommendation. (See app. V). However, CMS expressed concern that the report appeared to emphasize the use of a quantitative measure that tracks dollars saved in relation to dollars spent as a way to allocate

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MIP funds. CMS stated that this quantitative measure can be an indicator of effectiveness, but noted that such a measure cannot serve as the sole basis for informing funding decisions. While our report does discuss the importance of quantitative measures of effectiveness, it also discusses other considerations for allocating MIP funds.

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## Background

Before 1996, Medicare program integrity activities were subsumed under Medicare's general administrative budget and performed, along with general claims processing functions, by insurance companies under contract with CMS, which led to certain problems. The level of funding available for program integrity activities was constrained, not only by the need to fund ongoing Medicare program operations—such as the costs for processing medical claims, but also by budget procedures imposed under the Budget Enforcement Act of 1990.<sup>12</sup> In the early and mid-1990s, we reported that such funding constraints had reduced Medicare contractors' ability to conduct audits and review medical claims.<sup>13</sup> HHS advocated for a dedicated and stable amount of program integrity funding outside of the annual appropriations process, so that CMS and its contractors could plan and manage the function on a multiyear basis. HHS also asserted that past fluctuations in funding had made it difficult for contractors to retain experienced staff who understood the complexities of, and could protect, the financial integrity of Medicare program spending.

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## HIPAA Established MIP and Provided Dedicated Funding

Beginning in fiscal year 1997, HIPAA established MIP and provided CMS with dedicated funding to conduct program integrity activities. HIPAA stipulated a range of funds available for these activities from the Medicare trust funds each year. For example, for fiscal year 1997, the law stipulated that at least \$430 million and not more than \$440 million should be used. The maximum amount of MIP funds rose from \$440 million in fiscal year

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<sup>12</sup>Pub. L. No. 101-508, tit. XIII, 104 Stat. 1388, 1388-573—1388-630. Under the Budget Enforcement Act, funding for Medicare administrative activities, including for program safeguard activities that were found to be very cost-effective, could be increased only if discretionary funding for other programs, such as immunizations or job training, were reduced.

<sup>13</sup>GAO, *Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments*, [GAO/HEHS-95-210](#) (Washington, D.C.: Sept. 19, 1995); *Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars*, [GAO/T-HRD-94-59](#) (Washington, D.C.: Nov. 12, 1993); and *Medicare: Funding and Management Problems Result in Unnecessary Expenditures*, [GAO/T-HRD-93-4](#) (Washington, D.C.: Feb. 17, 1993).

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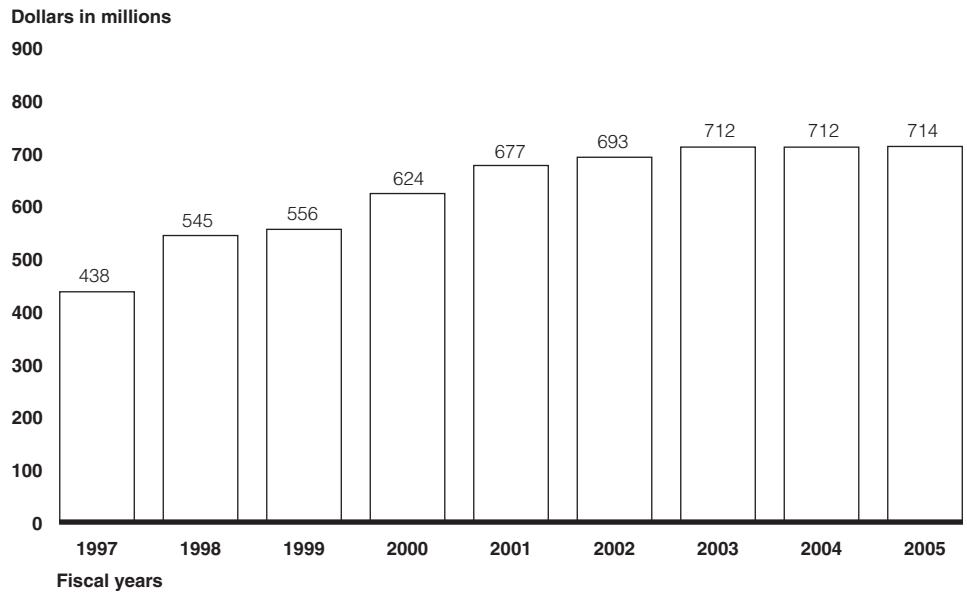
1997 to \$720 million in fiscal year 2003. For fiscal year 2003, and every year thereafter, the maximum amount that HIPAA stipulated for MIP was \$720 million. (See app. II, table 2, for additional information on the MIP funding ranges.) As a result of the increases stipulated in HIPAA, from fiscal years 1997 through 2005, total MIP expenditures increased about 63 percent—from about \$438 million to \$714 million, as figure 1 shows.<sup>14</sup> HIPAA authorized MIP funds to be used to enter into contracts to “promote the integrity of the Medicare program.” The statute also listed the various program integrity activities to be conducted by contractors.<sup>15</sup>

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<sup>14</sup>A CMS official told us that the agency typically spends about 1 percent less than the maximum appropriated amount to ensure that it can cover additional contractor expenses that may occur.

<sup>15</sup>These activities are (1) review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made (such as skilled nursing facilities and home health agencies), including medical and utilization review and fraud review; (2) audit of cost reports; (3) determinations as to whether payment should not be, or should not have been, made and recovery of payments that should not have been made; (4) education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues; and (5) developing (and periodically updating) a list of items of durable medical equipment (DME) that are subject to prior authorization. Concerning the fifth activity, CMS has published instructions related to the prior authorization of customized DME in the *Medicare Program Integrity Manual*, and contractors (Medicare administrative contractors and PSCs) are required to publish examples of the types of items for which prior authorization is available. The first activity listed above includes both medical review and benefit integrity.

**Figure 1: MIP Expenditures for Fiscal Years 1997 through 2005**



Source: GAO analysis of CMS data.

## MIP Funds Support Program Integrity Efforts

CMS allocates MIP funds primarily to support its contractors' program integrity efforts for the traditional Medicare program, known as fee-for-service Medicare.<sup>16</sup> Among these contractors are fiscal intermediaries (intermediaries), carriers,<sup>17</sup> PSCs, and Medicare administrative contractors (MAC).<sup>18</sup> MACs are a new type of contractor that will replace all intermediaries and carriers by October 2011, as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).<sup>19</sup> MMA required CMS to conduct full and open competition to select MACs. CMS refers to this change as contracting reform.

<sup>16</sup>In fiscal year 2005, about 1.6 percent of total MIP expenditures were used for program integrity efforts for Medicare Advantage plans.

<sup>17</sup>Intermediaries process Medicare Part A and Part B claims paid to hospitals and other institutions, such as home health agencies. Carriers process the majority of Part B claims for the services of physicians and other providers.

<sup>18</sup>In January 2006, CMS selected four MACs.

<sup>19</sup>Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378-86.

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CMS has contracted with intermediaries, carriers, and MACs to perform two types of activities—claims processing and program integrity. Their claims processing activities include receiving and paying claims. These activities are classified as program management and are funded through a program management budget. In addition, intermediaries and carriers have been charged with conducting some program integrity activities under MIP, including performing medical review of claims. The four MACs selected in January 2006 will not conduct medical review activities. CMS plans to assign responsibility for medical review of claims to the MAC selected in July 2006 and to the other MAC contracts to be awarded in the future. MIP provides funds to support these program safeguard efforts.

In addition, CMS uses MIP funds to support the activities of PSCs, which perform medical review of claims and identify and investigate potential fraud cases; a coordination of benefits (COB) contractor, which determines whether Medicare or other insurance has primary responsibility for paying a beneficiary's health care costs; the National Supplier Clearinghouse (NSC), which screens and enrolls suppliers in the Medicare program; and the data analysis and coding (DAC) contractor, which maintains and analyzes Medicare claims data for durable medical equipment (DME), prosthetics, orthotics, and supplies.<sup>20</sup>

Contractors receive MIP funds to perform one or more of the following five program integrity activities:

- Audits involve the review of cost reports from institutions, such as hospitals, nursing homes, and home health agencies. Cost reports play a role in determining the amount of providers' Medicare reimbursement.
- Medical review includes both automated and manual prepayment and postpayment reviews of Medicare claims and is intended to identify claims for noncovered or medically unnecessary services.

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<sup>20</sup>Medicare defines DME as equipment that serves a medical purpose, can withstand repeated use, is generally not useful in the absence of an illness or injury, and is appropriate for use in the home. DME includes items such as wheelchairs, hospital beds, and walkers. Medicare defines prosthetic devices (other than dental) as devices that are needed to replace a body part or function. Prosthetic devices include artificial limbs and eyes and cardiac pacemakers. Medicare defines orthotic devices to include leg, arm, back, and neck braces that provide rigid or semirigid support to weak or deformed body parts or restrict or eliminate motion in a diseased or injured part of the body. Medicare-reimbursed DME supplies are items that are used in conjunction with DME and consumed during the use of the equipment—such as drugs used for inhalation therapy—or items that need to be replaced on a frequent, usually daily, basis—such as surgical dressings.

- The secondary payer activity seeks to identify primary sources of payment—such as employer-sponsored health insurance, automobile liability insurance, and workers’ compensation insurance—that should be paying claims mistakenly billed to Medicare. Secondary payer activities also include recouping Medicare payments made for claims not first identified as the responsibility of other insurers.
- Benefit integrity involves efforts to identify, investigate, and refer potential cases of fraud or abuse to law enforcement agencies that prosecute fraud cases.
- Provider education communicates information related to Medicare coverage policies, billing practices, and issues related to fraud and abuse both to providers identified as having submitted claims that were improper, and to the general provider population.

CMS also uses MIP to fund support for the five activities, such as certain information technology systems, fees for consultants, storage of CMS records, and postage and printing. The agency allocates the cost of this support to the five activities, depending on which of the activities is receiving support. Table 1 provides information on specific MIP activities performed by the contractors. Appendix III provides examples of key tasks performed by each of these contractors.

**Table 1: MIP Activities Performed by Specific Types of Medicare Contractors**

Activity	Intermediaries	Carriers	MACs <sup>a</sup>	PSCs	COB contractor	NSC	DAC contractor
Audit <sup>b</sup>	●	○	○	●	○	○	○
Medical review	●	●	○	●	○	○	○
Secondary payer	●	●	●	○	●	○	○
Benefit integrity <sup>c</sup>	○	○	○	●	○	●	●
Provider education	●	●	●	●	○	○	○

Source: GAO analysis of CMS information.

Legend: ● Contractor performs this activity; ○ Contractor does not perform this activity or supports other contractors that have primary responsibility for performing this activity.

<sup>a</sup>This information pertains to the four MACs that were selected by CMS in January 2006. The MAC selected in July 2006 will perform audit, medical review, secondary payer, and provider education activities. This contractor will also support a PSC that performs the benefit integrity activity.

<sup>b</sup>Audits of cost reports are conducted for the benefits paid under Part A, the part of the program that pays for the services of institutional providers, such as hospitals. All of the other activities are conducted for both Parts A and B.

<sup>c</sup>Intermediaries, carriers, and MACs do not have primary responsibility for benefit integrity, but they do provide support to the PSCs that perform this activity.

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## MIP Funding for All Five Activities Has Generally Increased over Time

For fiscal years 1997 through 2005, CMS generally increased the amount of funding for each of its five program integrity activities, but the amount of the funding provided and the percentage increase have varied among the activities. Provider education received the largest percentage increase in funds, while audit and medical review received the largest amount of funds overall. (See fig. 2.) CMS increased its allocation for provider education by about 590 percent from fiscal year 1997 through fiscal year 2005. This increase was due, in part, to CMS's decision in fiscal year 2002 to use MIP funds for outreach activities to groups of like providers, which had not previously been funded through MIP. CMS will be able to further increase expenditures for program integrity in fiscal year 2006. In addition to the maximum of \$720 million originally appropriated under HIPAA for fiscal year 2006, DRA increased the maximum by an additional \$112 million, for a total of \$832 million.<sup>21</sup> CMS plans to use some of the \$112 million to address potential fraud, waste, and abuse in the new Medicare prescription drug benefit.<sup>22</sup>

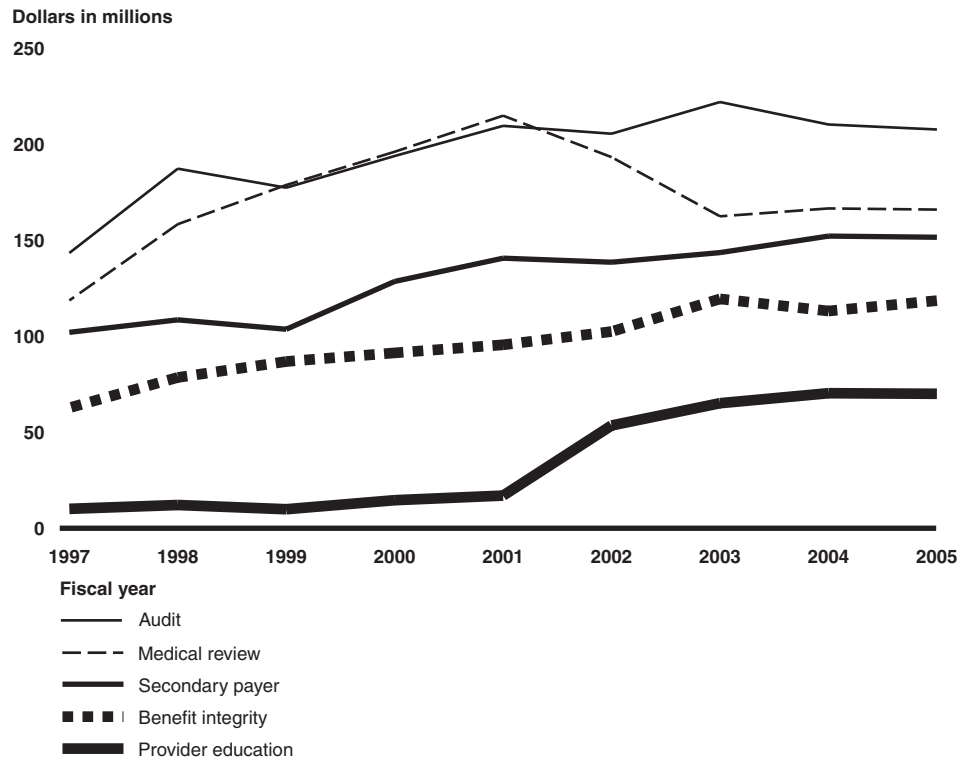
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<sup>21</sup>For fiscal year 2006, DRA appropriated \$100 million to MIP in general and \$12 million for the Medi-Medi program, for a total of \$112 million. In addition to the \$12 million appropriated in fiscal year 2006 for the Medi-Medi program, the statute also appropriated \$24 million for fiscal year 2007, \$36 million for fiscal year 2008, \$48 million for fiscal year 2009, and \$60 million for fiscal year 2010 and each subsequent fiscal year for the Medi-Medi program.

<sup>22</sup>The President's budget for fiscal year 2007 has proposed funding for MIP beyond the HIPAA-specified maximum amount of \$720 million. The proposal is part of a governmentwide effort to provide a specified level of discretionary funding for a defined period for program integrity activities.



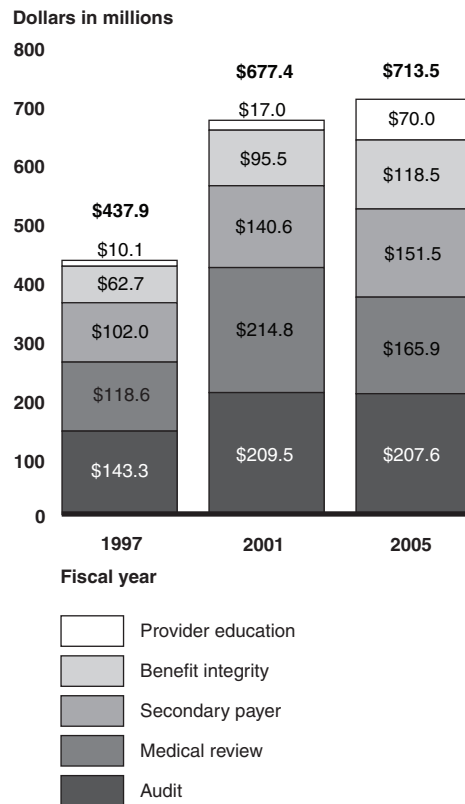
**Figure 2: MIP Expenditures by Activity, Fiscal Years 1997 through 2005**



Source: GAO analysis of CMS data.

In each year from fiscal year 1997 through fiscal year 2005, CMS generally increased the amount of MIP funds spent for each of its five program integrity activities, as figure 2 shows. In addition to the increase in the amount of funding for provider education, the expenditures for audit increased 45 percent during the same period. As figure 3 shows, expenditures for medical review increased from fiscal year 1997 to fiscal year 2001 to almost \$215 million—about 81 percent—and, since fiscal year 2001, decreased to about \$166 million, or about 23 percent. Overall, expenditures for medical review increased 40 percent from fiscal year 1997 to fiscal year 2005. During this period, expenditures for secondary payer increased 49 percent, and for benefit integrity, expenditures increased 89 percent. (See fig. 3 for the amount of expenditures by activity in fiscal years 1997, 2001, and 2005 and app. II, table 3, for more detailed information on the amount of expenditures for each activity in each year.)

**Figure 3: Spending for the Five MIP Activities for Fiscal Years 1997, 2001, and 2005**



Source: GAO analysis of CMS data.

Note: The total expenditures for fiscal year 1997 (\$437.9 million) include \$1.2 million in “other” expenditures that CMS did not include under a particular MIP activity.

Increased spending for provider education stemmed, in part, from provider concerns about an increased burden on them in the medical review process. In 2001, we reported that as CMS increasingly focused on ensuring program integrity, providers were concerned about what they considered to be inappropriate targeting of their claims for review.<sup>23</sup> Further, providers asserted that they may have billed incorrectly because of their confusion about Medicare’s program rules. To address these concerns, CMS developed a more data-driven approach for conducting medical review and also increased its emphasis on provider education.

<sup>23</sup>GAO, *Medicare Management: CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs*, [GAO-01-1014T](#) (Washington, D.C.: July 26, 2001).

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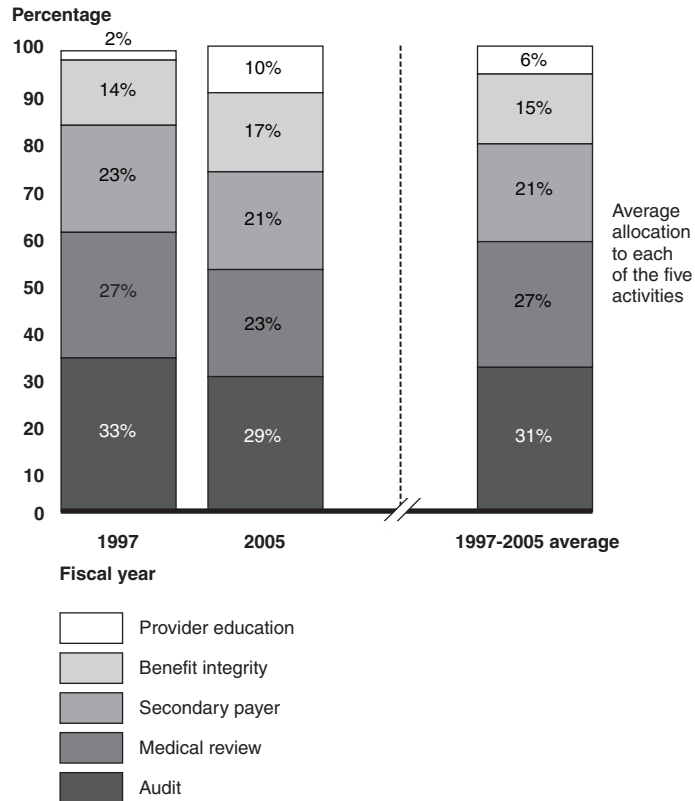
CMS officials explained that medical review would help identify providers that were billing inappropriately, and provider education would focus on individuals' specific billing errors to eliminate or prevent recurrence of the problems. In addition, beginning in fiscal year 2002, spending for the provider education activity increased significantly because CMS began to use MIP funds for what the agency called provider outreach. Provider outreach focuses on communicating with groups of providers about Medicare policies, initiatives, and significant programmatic changes that could affect their billing. This information is conveyed through seminars, workshops, articles, and Web site publications. Previously, provider outreach had been funded outside of MIP, as part of CMS's program management budget. Provider education spending increased from \$17 million in fiscal year 2001—before provider outreach was added to the provider education activity—to \$53.5 million in fiscal year 2002. In fiscal year 2005, funding for the provider education activity reached \$70 million.<sup>24</sup>

In comparing the share of funds spent on each program integrity activity, from fiscal year 1997 through fiscal year 2005, we found that CMS generally spent the largest share on audit, averaging about 31 percent, and on medical review, averaging about 27 percent. CMS spent less on secondary payer, averaging 21 percent, and benefit integrity, averaging 15 percent. In contrast, during this period, CMS spent the smallest percentage on provider education, which averaged about 6 percent of MIP expenditures. See figure 4 for information on the percentage of funds allocated to each activity. (For more detail, see table 4 in app. II.)

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<sup>24</sup>In fiscal year 2005, expenditures for the provider education activity totaled \$70 million, which consisted of \$36.7 million for provider outreach and \$33.3 million for provider education.

**Figure 4: Percentage of MIP Funds Allocated to the Five Program Integrity Activities, Fiscal Years 1997 and 2005, and Average for Fiscal Years 1997 through 2005**



Source: GAO analysis of CMS data.

Note: Percentages for fiscal year 1997 exclude the \$1.2 million in “other” expenditures, which accounted for less than 1 percent of the total allocation for that fiscal year.

## CMS’s Current MIP Funding Allocation Approach Has Weaknesses

CMS officials told us that they generally had allocated MIP funds to the five activities based predominantly on historical funding, but sometimes considered high-level priorities. However, this approach does not take into account data or information on the effectiveness of one activity over the other in ensuring the integrity of Medicare or allow CMS to determine if activities are yielding benefits that are commensurate with the amounts spent. For example, while CMS has noted that benefit integrity and provider education activities have intangible value, the agency has not routinely collected information to evaluate their comparative effectiveness. Furthermore, CMS has not fully assessed whether MIP funds are appropriately allocated within the audit, medical review, benefit

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integrity, and provider education activities. For example, audit's role has changed as Medicare's payment methods have changed in the last decade, but it continues to have the largest share of MIP funding.

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### MIP Funds Allocated Primarily on a Historical Basis

According to agency officials, CMS allocates funds for the five activities based primarily on an analysis of previous years' spending and may also consider other information when developing the MIP budget, such as current expenditures by individual contractors.<sup>25</sup> CMS officials told us that they may also consider the agency's high-level priorities. For example, in fiscal year 2004, CMS began to increase funds to expand the scope of its annual study to estimate Medicare improper payment rates, and in fiscal year 2002, it increased its MIP allocation for provider education.

CMS does not have a means to compare quantitative data or qualitative information on the relative effectiveness of MIP activities that it could use in allocating funds. Instead, it calculates the quantitative benefits for two, and assesses the qualitative benefits—which are not objectively measured—for the other three. In fiscal year 2005, for its medical review and secondary payer activities, CMS tracked dollars saved in relation to dollars spent—a quantitative measure that the agency calls a return on investment (ROI).<sup>26</sup>

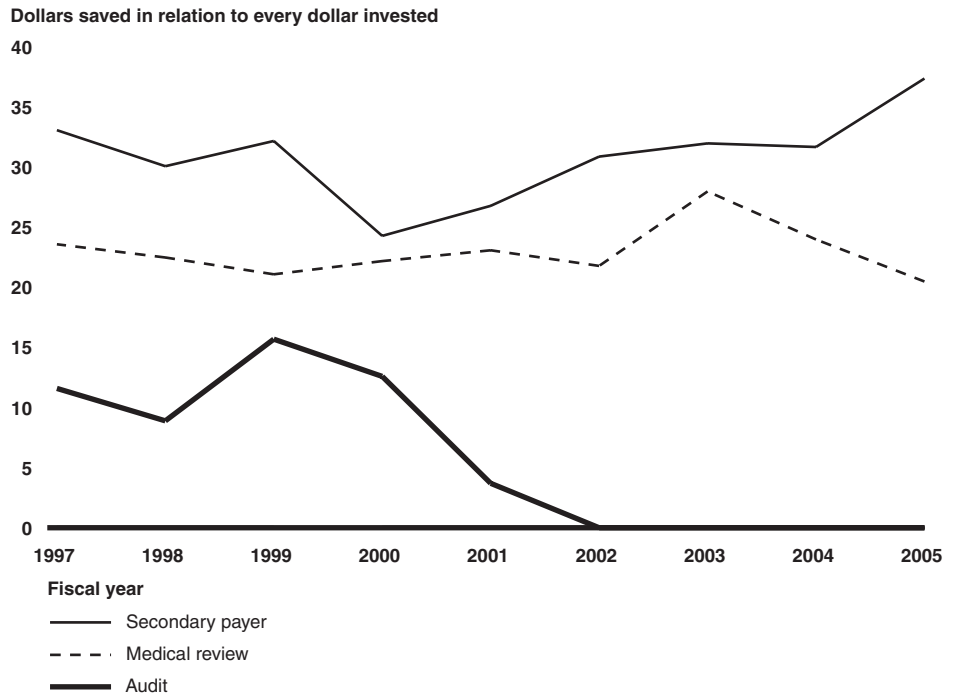
Having an ROI figure is useful because it measures the effectiveness of an individual activity so that its value can be compared with that of another activity. As of fiscal year 2005, secondary payer had an ROI of \$37 for every dollar spent on the activity, and medical review had an ROI of \$21 for every dollar spent. CMS tracked the ROI for audit, but by fiscal year 2002, audit's reported contribution to ROI fell to almost zero. (See fig. 5 and app. II, table 5, for additional ROI details.)

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<sup>25</sup> According to CMS officials, before determining budget amounts for medical review, they analyze both last year's and current expenditures by individual contractor. A contractor might not be spending the full amount allocated to it for various reasons, such as staff turnover.

<sup>26</sup> A CMS official also indicated that the agency considers medical review to have a sentinel effect in discouraging providers that might be considering defrauding Medicare. However, this effect is not possible to measure.

**Figure 5: CMS Reported ROI for Secondary Payer, Medical Review, and Audit, Fiscal Years 1997 through 2005**



Source: GAO analysis of CMS data.

CMS officials told us that the decrease in the ROI for audit was due to the implementation of prospective payment systems (PPS),<sup>27</sup> under which Medicare pays institutional providers fixed, predetermined amounts that

<sup>27</sup>In 1983, legislation required the establishment of PPS for inpatient hospital services. Social Security Amendments of 1983, Pub. L. No. 98-21, § 601(e), 97 Stat. 65, 152-62. Before then, Medicare had generally paid providers based on their reported costs, and audit disallowances of reported costs led to savings. Under PPS, payment rates are generally not based on individual providers' costs, but are typically set for groups of services, with payment amounts varying by the intensity of need for care by patients served. From 1998 through 2002, CMS implemented PPS for skilled nursing facilities (nursing homes), hospital outpatient departments, home health agencies, and inpatient rehabilitation facilities.

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vary according to patients' need for care.<sup>28</sup> Until fiscal year 2001, audits had achieved an ROI that was generally \$9 or more for every dollar spent conducting them, by disallowing payment for individual costs that should not have been paid by Medicare under the previous payment method. Under PPS, CMS's methods for paying providers changed. However, the information system that had been used to track ROI began to incorrectly calculate the savings from audit because it had not been adjusted for the new payment method. According to agency officials, CMS is implementing a different way to track audit savings, and an overall ROI. It will focus on the savings from disallowing items that directly affect an individual provider's payment under a PPS, such as bad debts and the number of low-income patients hospitals serve. It will track the amounts related to these add-on payments actually paid by Medicare to, or recouped from, the provider after an audit. The difference between the amount paid prior to the audit and the amount paid after the audit (assuming there has been an adjustment) would be the savings.

However, all audit functions do not result in measurable savings. For example, in its written comments on a draft of this report, CMS noted that many audit functions funded by MIP do not have an ROI. CMS stated that these include processing cost reports for data collection purposes, correcting omissions on providers' cost reports, implementing court decisions, and issuing notifications concerning Medicare payments. In addition, CMS stated that some of these activities are mandated by law, while others have significant value to the Medicare Payment Advisory Commission (MedPAC), which is an independent federal commission; providers; provider associations; and actuaries.

From fiscal year 1997 through fiscal year 2005, CMS developed qualitative assessments of the impact of benefit integrity and provider education. According to CMS, the agency develops such assessments when the savings generated by MIP activities are impossible or difficult to identify. Nevertheless, CMS officials told us that these activities provide value to the program in helping to ensure proper Medicare payments. For example,

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<sup>28</sup>For example, the basic PPS payment for hospitals is determined by the diagnoses of the patients that they serve, with the specific diagnosis-related payments based on the average weighted costs of hospitals to provide care to patients in 1981, adjusted upwards over time. In addition, a hospital's payment rates are further adjusted based on factors specific to the hospital, including providing an additional payment to hospitals that treat an unusually large number of low-income patients or that offer graduate medical education. Certain items, such as bad debt expense, are also paid based on a hospital's reported costs.

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CMS officials said that benefit integrity contributes to the work of federal law enforcement agencies, which investigate and prosecute Medicare fraud and abuse. CMS officials also noted that they consider benefit integrity to have a sentinel effect in discouraging entities that may be considering defrauding the Medicare program, but this effect is impossible to measure.

CMS indicated that trying to measure the results of the contractors' benefit integrity activities could create incentives that undermine the value of their work. For example, counting the number of cases referred to law enforcement for further investigation could lead the contractors to refer more cases that were less fully developed. However, other agencies that investigate or prosecute fraud, such as HHS and the Department of Justice, keep track of their successful cases, recoveries, and fines to demonstrate their results. Similarly, CMS could assess the degree to which each of its contractors had contributed to HHS and the Department of Justice's successful investigations and prosecutions.

In regard to educating providers on appropriate billing practices, CMS may be missing opportunities to evaluate its contractors' performance. Provider education can help reduce billing errors, according to CMS. However, according to an OIG report, CMS has not evaluated the strategies used to modify the behavior of providers through education to determine if these strategies are achieving desired results.<sup>29</sup>

CMS has noted the intangible value inherent in benefit integrity and provider education activities, but the agency has not routinely collected information to evaluate their comparative effectiveness in ensuring program integrity. Further, as discussed earlier, correct information on audit's effectiveness, based on an ROI, has not been available for the last several years. Consequently, CMS is not able to determine if some of the funds spent for benefit integrity, provider education, and audit—about \$396 million, or 56 percent of MIP funds in fiscal year 2005—could be better directed to secondary payer or medical review. Nevertheless, CMS officials told us that they plan to decrease the allocation to medical review and increase the allocation to provider education.

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<sup>29</sup>Department of Health and Human Services, Office of Inspector General, *Carrier Medical Review Progressive Corrective Action*, OEI-02-03-00300 (Washington, D.C.: October 2005).



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CMS officials stated that they are developing two initiatives that will give the agency objective measures of the results of the audit and provider education activities. As discussed earlier, CMS is implementing a revised methodology for calculating the ROI for audit. In addition, it is trying to develop information on the effectiveness of provider education. A CMS official explained that the agency is adding a provider education component to its program integrity management reporting system.<sup>30</sup> This component will potentially allow CMS to develop an ROI figure for provider education by correlating educational efforts to a decrease in claim denials and provide a measure of the quantitative benefits of this activity. This component is scheduled to begin operating in the summer of 2006.

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### CMS Does Not Ensure That Funds Are Allocated in an Optimal Way within Activities

After CMS has allocated funds to each of the five MIP activities, it must decide how to further distribute those funds to pay contractors that carry out each one. For example, in fiscal year 2004, after CMS allocated about \$135 million for medical review to be conducted by intermediaries and carriers, it then distributed those funds to pay 28 intermediaries and 24 carriers that were conducting medical review at that time. However, given vulnerabilities for improper payment, contractor workload, and the relative effectiveness of activities performed, CMS has not always taken steps to ensure that it has allocated funds in an optimal way within its activities. Nevertheless, CMS has used information on relative savings to decide on funding allocations within the secondary payer activity.

### Allocations for Medical Review, Provider Education, and Benefit Integrity Are Not Based on Vulnerabilities

Medical review, provider education, and benefit integrity are activities for which allocation of MIP funds may not be optimal, because our analysis suggests that CMS has not allocated funds within these activities based on information concerning contractor vulnerabilities. Such vulnerabilities include the potential for fraudulent billing in different locations and the amount of potential benefit payments at risk in the contractor's jurisdiction. For example, CMS estimated that the contractor that handled claims for DME, orthotics, prosthetics, and supplies in a jurisdiction that included Texas and Florida—two states experiencing high levels of fraudulent Medicare billing—improperly paid 11.5 percent of its 2004 claims—or \$474.9 million—which was a higher improper payment rate than that of other contractors paying these types of claims. As we

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<sup>30</sup>CMS began implementing the first phase of this system in 2000 and fully implemented it in 2004.

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previously reported, our analysis indicated this contractor received almost a third less funds for medical review per \$100 in submitted claims in fiscal year 2003 than the amount given to contractors in other regions with less risk of fraudulent billing.<sup>31</sup> Our most recent analysis indicated that the imbalance in fund allocation did not change in fiscal years 2004 and 2005. We could not determine the rationale for this allocation beyond what was historically budgeted for this contractor.

The amount of medical review funds allocated to individual contractors is not directly tied to the amount of benefits that they pay, which is a key measure of potential risk. For example, in fiscal year 2004, one contractor paid out \$66 million in benefits and received about 28 cents in medical review funds for each \$100 in benefits paid. In contrast, another contractor paid out considerably more in benefits—about \$5 billion in fiscal year 2004—and received about 7 cents in medical review funds for each \$100 in benefits paid.

Further, CMS has not adjusted the amount of funding for individual contractors to educate providers based on their relative risks. A CMS official told us that the amount of provider education funding is generally aligned with the amount allocated for medical review, regardless of the value of the benefits that the contractor pays.

Similarly, the amount of MIP funds provided to PSCs is not directly tied to the amount of benefits paid in jurisdictions for which they have responsibility for benefit integrity. For example, CMS spent about \$75 million for work performed by PSCs under 13 benefit integrity task orders. The PSCs averaged about 3 cents for each \$100 in paid claims in the jurisdictions for which they conducted benefit integrity tasks.<sup>32</sup> However, the amount of MIP funding paid to the PSCs to conduct benefit integrity activities varied from about 1 cent to about 7 cents for each \$100 in claims paid. Further, our analysis showed no clear relationship between funds provided to PSCs and their responsibilities for conducting benefit integrity activities in jurisdictions with high incidences of fraudulent Medicare billing. For example, one PSC received about 4 cents for conducting benefit integrity work for each \$100 in paid claims for benefit

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<sup>31</sup>GAO, *Medicare: CMS's Program Safeguards Did Not Deter Growth in Spending for Power Wheelchairs*, [GAO-05-43](#) (Washington, D.C.: Nov. 17, 2004).

<sup>32</sup>Task orders were effective for about 1 year, and beginning task order dates ranged from November 1, 2004, through January 25, 2005.

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Audit's Role Has Changed, but  
Funding Allocations May Not  
Be Optimal

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integrity work in a jurisdiction that included Florida, which is at high risk for fraudulent billing. In contrast, PSCs received the same level of funding to conduct benefit integrity work in states at lower risk for fraudulent billing, including Iowa, Montana, Pennsylvania, and Wyoming.

During the last decade, Medicare has significantly changed how it pays institutional providers—such as hospitals and nursing homes—that it audits.<sup>33</sup> To align with the payment method changes, CMS has modified its audit focus to items in the cost report that can affect payments under a PPS. However, these audits can affect a much smaller proportion of Medicare's payments under a PPS than audits of costs under the previous payment method. Given the magnitude of the payment method change, CMS has not evaluated whether funds within the audit activity should be further reallocated to potentially generate greater savings to the Medicare program by addressing the accuracy of reported costs that may be used to determine payment increases.

CMS distributes funds to its contractors to conduct certain tasks, such as inputting data from; reviewing; and, if needed, auditing cost reports submitted by its institutional providers in order to settle, or agree upon, the reported costs.<sup>34</sup> CMS's audit contractors are also required to conduct wage index reviews<sup>35</sup> and assist with intermediary hearings and appeals of settled cost reports. For several years, CMS has had a backlog of cost reports to settle, and the agency has made a priority of reducing the backlog. Other priorities include more closely scrutinizing those providers that are still paid based on their costs—such as critical access hospitals—and conducting required audits.

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<sup>33</sup>CMS officials indicated that although the hospital inpatient PPS was implemented in 1983, the major changes to payment methods occurred beginning in 1998 and later as prospective payment was introduced for skilled nursing facilities, hospital outpatient departments, and home health agencies.

<sup>34</sup>Institutional providers are required to submit cost reports and CMS is required to settle them, even though most institutional providers are paid through a prospective payment method.

<sup>35</sup>As part of the methodology for determining prospective payments to hospitals, CMS is required to adjust standardized amounts for area differences in hospital wage levels by a factor, which is known as the wage index. The wage index reflects the relative hospital wage level (in the geographic area of the hospital) compared to the national-average hospital wage level. Through a survey, CMS obtains hospital wages and wage-related costs. As part of the process of adjustment, contractors conduct reviews of the submitted data and the supporting documentation.

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For providers paid under a PPS, CMS has shifted its audit focus to the few items that could affect a provider's payments if disallowed. These include bad debt, payments for graduate medical training, and the number of low-income patients that hospitals serve. CMS has also shifted more audit resources to hospitals because more items on their cost reports can affect calculations of a provider's add-on payments.

CMS does not know the amount of MIP funds that are associated with audits of different types of providers or specific issues, such as bad debt. However, in fiscal year 2004, CMS began to separately track some audit costs, such as those for desk reviews,<sup>36</sup> audits, and wage index reviews. This provided some information on how audit funds were being spent. According to CMS officials, tracking the costs of individual audits at a provider or issue level would be difficult and costly because multiple issues are audited at the same time and the complexity of individual audits varies for the same provider type. Nevertheless, more detailed information on audit costs—such as at the provider level—than CMS currently tracks could provide it with a better understanding of the value of its current mix of tasks, particularly if it could associate the costs with the savings from the audits. This could provide CMS with information on whether it needs to change the balance of funding for those tasks—for example, whether it should focus more attention on bad debt or other areas of the cost report for specific types of providers.

Further, CMS's audit function continues to focus on verifying specific aspects of the provider's cost report that affect its individual payment. This type of audit generally addresses a small portion of providers' Medicare payments, while under a PPS, a much greater portion of the payments are based on overall industry costs.<sup>37</sup> Each year, MedPAC advises the Congress on whether the Medicare PPS rates for institutional providers should increase, decrease, or remain constant. However,

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<sup>36</sup> A desk review determines the acceptability of the cost report; the need for audit; and if needed, the depth of audit to be performed.

<sup>37</sup> CMS audit priorities include reviewing providers under PPS for non-PPS payments made through the cost report, including those associated with bad debts; graduate medical education; indirect medical education; disproportionate share hospitals, which provide care to an unusually large proportion of low-income patients; and organ acquisition. Priorities also include focusing on providers not recently audited and on specific types of providers, including those still reimbursed on a cost basis, such as critical access and cancer hospitals and end-stage renal disease facilities. Under the Balanced Budget Act of 1997, CMS is required to audit end-stage renal disease facilities every 3 years (Pub. L. No. 105-33, § 4558(a), 111 Stat. 251, 463).

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MedPAC generally does not have a set of audited cost reports that validate the information it uses in its assessments of providers, such as hospitals' allocations of their costs. According to MedPAC, the current audit process reveals little about the accuracy of the Medicare cost information.<sup>38</sup> For example, while CMS audits individual providers through full or partial audits, it does not allocate funds to audit a panel of providers, such as hospitals, which could provide a means to highlight areas where cost reporting accuracy is problematic. Without accurate information, CMS cannot ensure that payments to hospitals properly reflect their costs and provide reliable information that can be a factor in determining whether rates should change or remain constant.

CMS might find it cost-effective to gather additional information because audits have the potential to give the Congress better information on hospitals' costs. For example, by law, CMS is required to periodically conduct audits of end-stage renal disease (ESRD) facilities, which care for patients who must rely on dialysis treatments to compensate for kidney failure. CMS broadened its audit plan for these facilities to include a review not only of bad debts, but also to validate the costs of a selected number of items that are paid through PPS.<sup>39</sup> CMS officials indicated that their audits of these facilities generated only limited savings, usually related to bad debts, so they did not consider these audits very valuable. However, as a result of these audits, MedPAC officials stated in 2005 that these facilities had a greater margin—or ratio of Medicare payments to

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<sup>38</sup>Medicare Payment Advisory Commission, *Report to the Congress: Sources of Financial Data on Medicare Providers* (Washington, D.C.: June 2004). This report mentions several possibilities for using audit to obtain more accurate data, including making that an objective of the audit, focusing audit attention on the section of the cost report that deals with a hospital's total financial performance data, conducting full scale audits—which MedPAC estimates can take from 1,000 to 2,000 hours of auditors' time to complete, or targeting audits to suspected areas within cost reports to determine reporting accuracy.

<sup>39</sup>Contractors typically develop an "audit program," or plan, which identifies the audit objectives, issues, transactions, or cost report entries to audited, reviewed, or verified; the audit steps to be performed; and the tests to be applied.

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CMS Used Savings Information  
to Optimize Allocation of  
Secondary Payer Funds

costs—than their cost reports suggested.<sup>40</sup> This information was factored into MedPAC's recommendation about the amount of payment increase needed in calendar year 2007. Setting appropriate payment increases for hospitals is potentially more important to Medicare than for ESRD facilities because payments to participating inpatient hospitals represented about \$116 billion, or about 40 percent of Medicare's benefit payments in fiscal year 2004. CMS officials agreed that gathering this information might be valuable, but indicated that they did not currently have sufficient funding to conduct this data validation in addition to their current efforts funded as part of audit.

In contrast to provider education and audit, CMS collects information on the relative savings from specific secondary payer functions and has used this information to decide on funding allocations within the secondary payer activity. CMS allocates funds to, and calculates savings for, about 16 secondary payer functions. Among these functions are (1) a data match that helps identify instances when a Medicare beneficiary was covered by other insurance and (2) the initial enrollment questionnaire, which gathers insurance information on beneficiaries before they become eligible for Medicare. Within secondary payer, for fiscal year 2005, savings for the 16 functions ranged from less than 1 percent to 49 percent of savings of over \$5 billion for all of the functions.

CMS officials told us that they have used relative savings information for secondary payer functions as one factor in determining whether to increase, decrease, or terminate funding for the functions within this activity. For example, according to CMS officials, in fiscal year 2005, savings for one secondary payer function—voluntary reporting of primary payer information to CMS by health insurance companies—increased by about 65 percent over fiscal year 2004. Further, savings from this effort continue to increase. CMS is planning to maintain or expand funding to it. However, CMS officials said that after confirming their relatively low savings, they had terminated certain other efforts to identify secondary payer claims. The terminated efforts included (1) a second questionnaire

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<sup>40</sup>The margin—the difference between Medicare payments and providers' costs for services to Medicare beneficiaries expressed as a percentage of payments—is one of the factors MedPAC uses in developing a recommendation. MedPAC reported in 2004 that preaudit costs for ESRD facilities were 4 percent higher than postaudit costs in 1996 based on the audited cost reports it reviewed. Audits reveal the difference between allowable and nonallowable costs. There is generally a several year time lag during which CMS's contractors receive and audit cost reports, which is why MedPAC had to rely upon the 1996 audited cost reports in 2004.

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sent as follow-up to determine whether a beneficiary who is claiming Medicare benefits for the first time has other health insurance that would be responsible for paying the claim and (2) an effort to determine whether certain trauma codes contained in a claim could indicate that another insurer, such as worker's compensation, could be the primary payer.

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## Future Programmatic Changes Will Affect MIP Funding Allocations

The Medicare program is undergoing significant changes for which there is little precedent. These include the addition of the new Part D prescription drug benefit and the reform of Medicare contracting. Both will require CMS to make new choices in how it should allocate its MIP funds to best address its program integrity challenges. CMS's current allocation approach—which agency officials characterized as primarily relying on previous fiscal year funding allocations for each activity, and to each contractor, to determine current allocations—will not be adequate to address emerging program integrity risks and ongoing programmatic changes. In addition, as contracting reform proceeds, CMS intends to increase its use of MIP funds to reward contractors to encourage superior performance. However, the usefulness of award payments as a tool to encourage contractors to perform MIP tasks effectively depends on how well CMS can develop, and consistently apply, performance measures to gauge differences in the quality of performance.

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## CMS's Current MIP Allocation Approach Is Not Adequate to Address Emerging Risks

CMS's current allocation approach will not be adequate to address Medicare's emerging program integrity risks related to the prescription drug benefit. Over the next 10 years, total expenditures for the prescription drug benefit, which was implemented in January 2006, are projected to be about \$978 billion, while total expenditures for the Medicare program are projected to be about \$6.1 trillion.<sup>41</sup> CMS and others have stated that the prescription drug benefit is at risk for significant fraud and abuse. In December 2005, an assistant U.S. attorney noted that the Medicare prescription drug benefit would be vulnerable to a host of fraud and abuse schemes unless better detection systems are developed. According to CMS, the prescription drug benefit may be vulnerable to fraud and abuse in particular areas, including beneficiary eligibility, fraud by pharmacies, and kickbacks designed to encourage certain drugs to be

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<sup>41</sup>Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds* (Washington, D.C.: May 1, 2006).

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included by the plans administering the benefit. To respond to these challenges, CMS has selected eight private organizations, called Medicare prescription drug integrity contractors (MEDIC), to support CMS's benefit integrity and audit efforts.<sup>42</sup>

Because the Medicare prescription drug benefit is in the early stages of implementation, CMS does not yet have data to estimate the level of improper payments or information to determine the level of program integrity funds needed to address emerging vulnerabilities. As a result, it is not clear whether, in the future, CMS will need to shift funds from program integrity activities for Parts A and B to protect the Part D drug benefit from potential fraud and abuse. For fiscal year 2006, \$112 million beyond the HIPAA limit of \$720 million has been appropriated for CMS to support program integrity activities. The President's Budget for fiscal year 2007 has also proposed additional funds for fiscal year 2007 and fiscal year 2008. CMS plans to use some of the additional funding provided under DRA for fiscal year 2006 to support Part D program integrity efforts. For example, CMS plans to spend \$14 million over the next fiscal year to fund efforts by MEDICs to protect the prescription drug benefit by performing selected tasks, such as analyzing data to identify instances of potential fraud and abuse. In addition, CMS plans to spend about \$33 million on Part D information technology systems to track data related to beneficiary eligibility and to collect, maintain, and process information on Medicare covered and noncovered drugs for Medicare beneficiaries participating in Part D. See appendix IV for more information.

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## Medicare Contracting Changes Will Affect MIP Allocations

Another significant programmatic change that will affect future MIP funding allocations is Medicare contracting reform. MMA required CMS to transfer all claims administration work, which includes selected program integrity activities, to MACs by October 2011. CMS plans to transfer all work to the MACs by July 2009—about 2 years ahead of MMA's specified time frame. Contracting reform will affect MIP funding allocations because

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<sup>42</sup>Some of the main functions of the MEDICs will include identifying and investigating potential fraud and abuse, developing cases for referral, acting as liaisons to law enforcement agencies, and providing audit services. MEDICs may be assigned various types of audits, such as audits of the information provided to CMS by the plans administering the Part D benefits, the plans' required fraud and abuse compliance plans, and plans' services to beneficiaries. In addition, CMS plans to determine an improper payment rate for the prescription drug benefit, and at least one of the MEDICs may assume that task. CMS used start-up funds in fiscal year 2005 for the prescription drug benefit, which were not part of MIP funds, to conduct the competition to select the MEDICs.



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of (1) changes in contractors' responsibilities for program integrity activities and their jurisdictions, (2) the potential for operational efficiencies, and (3) increasing use of MIP funds for contractor award payments.

The transition to MACs will change some contractors' program integrity responsibilities and require reallocation of MIP funds among them. The new MACs will be responsible for paying claims that were previously processed by intermediaries and carriers, but CMS has decided that MACs will not be performing all of the MIP activities that they previously conducted. For example, PSCs performed medical reviews of claims in some contractors' jurisdictions, but this activity will be performed by almost all of the MACs in the future.<sup>43</sup> Further, contractors' jurisdictions will change as 23 MACs assume the work previously performed by a total of 51 Medicare intermediaries and carriers, within the confines of 15 newly designated geographic jurisdictions.<sup>44</sup> The PSCs conducting benefit integrity work will be aligned with the MACs in the 15 jurisdictions. In some cases, one PSC may be aligned with more than one MAC jurisdiction.

According to CMS officials, Medicare contracting reform will lead to operational efficiencies and savings that would mostly be due to more effective medical review. For example, CMS anticipates that greater incentives for MACs to operate efficiently and adopt industry innovations in the automated medical review of claims will result in total estimated trust fund savings of \$650 million for Medicare from fiscal year 2006 to fiscal year 2011. Having program integrity activities operate more effectively could give CMS additional flexibility to reallocate some funding while achieving reductions in improperly paid claims. However, we have not validated CMS's estimate, and in our August 2005 report on CMS's plan for implementing Medicare contracting reform, we raised concerns about

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<sup>43</sup>The first four MACs selected in January 2006 will process DME, prosthetics, orthotics, and supply claims and will not be responsible for medical review of the claims they process. Three PSCs will conduct medical review for these claims.

<sup>44</sup>Fifteen MACs will each process both Part A and Part B claims in 1 of the 15 jurisdictions. In addition, 4 MACs will process DME, prosthetics, orthotics, and supply claims, and 4 MACs will process home health and hospice claims in 4 jurisdictions that encompass the 15 Part A and Part B jurisdictions.

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the uncertainty of savings estimates, which were based on future developments that are difficult to predict.<sup>45</sup>

As part of contracting reform, CMS plans to increase its allocation of MIP funds that are used as award payments to encourage superior performance of program integrity activities by contractors. Award payments that are tied to appropriate performance measures could encourage contractors to conduct MIP activities effectively and introduce innovations, such as developing new analytical approaches to enhance the medical review process. Intermediaries and carriers, both of which conduct some program integrity activities, are currently paid on the basis of their costs, generally without financial incentives to encourage superior performance.<sup>46</sup> In contrast, CMS currently offers award payments to other types of contractors that conduct program integrity activities, including four MACs that were selected in January 2006, PSCs, the COB contractor, NSC, and the DAC contractor. As early as 2009, or when all administrative work has been transferred to MACs, CMS will be offering the opportunity to be selected for award payments to all contractors that conduct program integrity activities.<sup>47</sup>

The usefulness of using MIP funding for award payments to encourage contractors to conduct program integrity tasks effectively depends on how well CMS can develop, and consistently apply, performance measures to gauge differences in the quality of performance. In 2004, CMS conducted a study to evaluate whether the agency could reduce improper payments by using award payments for contractors to lower their paid claims error rates, which represent the amount of claims contractors paid in error compared with their total fee-for-service payments. According to CMS, the outcome of that pilot was positive, and CMS plans to use award payments in the future as part of its strategy for reducing improper payments. However, as we reported in March 2006, CMS will need to refine its measure of contractor-specific improper payments, which would enhance its ability to evaluate their performance of medical review and provider

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<sup>45</sup>GAO, *Medicare Contracting Reform: CMS's Plan Has Gaps and Its Anticipated Savings Are Uncertain*, [GAO-05-873](#) (Washington, D.C.: Aug. 17, 2005).

<sup>46</sup>Prior to MMA, CMS's authority to contract using other payment methods was restricted.

<sup>47</sup>In addition to the 4 MACs that were selected in January 2006 and 1 that was selected in July 2006, CMS plans to select 18 MACs from September 2007 through September 2008.

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education activities.<sup>48</sup> Further, even when CMS has developed measures to assess the performance of contractors that conduct MIP activities, it has not always effectively or consistently applied them. For example, the OIG recently reviewed the extent and type of information provided in evaluation reports on PSCs' performance in detecting and deterring fraud and abuse. The OIG found that although the evaluation reports were used as a basis to assess contractors' overall performance, they did not consistently include quantitative information on the activities contractors performed or their effectiveness.

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## Conclusions

We designated the Medicare program as high risk for fraud, waste, abuse, and mismanagement in 1990, and the program remains so today. To address this ongoing risk and reduce the program's billions of dollars in improper payments, CMS must use Medicare's program integrity funding as effectively as possible. Further, Medicare's susceptibility to fraud is growing, as it addresses the challenges of adding a prescription drug benefit to the program. Despite Medicare's increasing vulnerability, CMS has generally not changed its allocation approach for MIP funding. In 2006, a decade after MIP was established to support Medicare program integrity activities, CMS officials state that the primary basis for their allocation of funds is how they have been allocated in the past. However, programmatic changes for Medicare's contractors and emerging risks for the Part D prescription drug benefit suggest that CMS needs to modify its approach for deciding on funding allocations for—and within—the five program integrity activities. Also supporting the need for CMS to assess its current allocation approach is that the agency's funding decisions do not routinely take into account quantitative data or qualitative information on the relative effectiveness of its five program integrity activities or contractors' vulnerabilities. Without considering information or data, CMS cannot judge whether funds are being spent as effectively as possible or if they should be reallocated. CMS is developing two new measures that may help the agency evaluate the relative effectiveness of provider education and the audit activity. Better information about MIP activities' effectiveness should assist CMS in making more prudent management and funding allocation decisions.

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<sup>48</sup>GAO, *Medicare Payment: CMS Methodology Adequate to Estimate National Error Rate*, [GAO-06-300](#) (Washington, D.C.: Mar. 24, 2006).

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## Recommendation for Executive Action

To better ensure that MIP funds are appropriately allocated among and within the five program integrity activities, we recommend that CMS develop a method of allocating funds based on the effectiveness of its program integrity activities, the contractors' workloads, and risk.

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## Agency Comments and Our Evaluation

In its written comments on a draft of this report, CMS stated that it generally agreed with our recommendation to develop a method of allocating MIP funds based on the effectiveness of the agency's program integrity activities, Medicare contractors' workloads, and risk. However, the agency expressed concern that the report appeared to emphasize the use of ROI, a quantitative measure that tracks dollars saved in relation to dollars spent, as a way to allocate funds. CMS stated this quantitative measure can be an indicator of effectiveness, but noted that such a measure cannot serve as the sole basis for informing funding decisions. The agency stated that some of its MIP activities had benefits that could not be easily quantified. CMS agreed on the value of allocating funds based on risk and provided information on programmatic changes that would help it do so. The agency also noted the efforts it had recently made to strengthen program integrity.

CMS expressed concern about our discussion in the draft report concerning the use of ROI as a way to quantitatively measure effectiveness and to allocate MIP funds. CMS stated that the agency cannot provide funding based exclusively on an ROI because some activities, including benefit integrity, do not lend themselves to an ROI measurement and others, such as audit, are governed by statutory requirements. CMS also stated that in allocating MIP funds, it is critical that it consider factors other than ROI, including historical funding, because MIP funding has not increased since 2003.

Our report indicates that an ROI is an important factor that should be considered in allocating funds, but cannot be the sole consideration. Our conclusions reflect our support of an approach that takes into account the qualitative benefits of program integrity activities. Our report discusses agency officials' views on the difficulty of developing quantitative measures for the benefit integrity activity. We also provide information on CMS officials' qualitative assessments of the positive impact of benefit integrity and provider education. For example, our report notes that according to CMS officials, these benefits include discouraging entities that may be considering defrauding the Medicare program and helping to ensure proper Medicare payments. Both quantitative and qualitative assessments of effectiveness—to the extent they can be developed—could

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help CMS determine whether MIP funds are being wisely invested or if they should be reallocated.

CMS also commented on the allocation of MIP funds to Medicare contractors based on workload and risk. CMS noted that contracting reform and the introduction of MACs will result in contractors' workloads being more evenly distributed. In addition, CMS noted that it is developing award fee measures for contractors' medical review activities, including establishing performance goals for the Comprehensive Error Rate Testing program contractor-specific error rate. CMS agreed with us that risk is a factor that should be considered in allocating funds.

CMS stated that it is committed to identifying and investigating better approaches to allocate resources to support critical agency functions, including using its new contracting authority to introduce incentives for Medicare fee-for-service claims processing contracts and consolidating Medicare secondary payer activities. CMS also noted that it is using state-of-the-art systems and expertise to aggressively fight waste and abuse in the program, continues to work closely with its contractors to help ensure that providers receive appropriate education and guidance in areas where billing problems have been identified, and has expanded oversight of the new Medicare Part D prescription drug benefit. In addition, CMS discussed recent program integrity efforts and successes, including reducing the number of improper fee-for-service Medicare payments and addressing fraud across all provider types by coordinating the activities of CMS, law enforcement, and Medicare contractors in Los Angeles, California, and Miami, Florida.

We have reprinted CMS's letter in appendix V. CMS also provided us with technical comments, which we incorporated in the report where appropriate.

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As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its date. At that time, we will send copies to the Secretary of HHS, the Administrator of CMS, appropriate congressional committees, and other interested parties. We will also make copies available to others upon request. This report will also be available at no charge on GAO's Web site at <http://www.gao.gov>.

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If you or your staff have any questions about this report, please contact me at (312) 220-7600 or [aronovitzl@gao.gov](mailto:aronovitzl@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are Sheila K. Avruch, Assistant Director; Hazel Bailey; Krister Friday; Sandra D. Gove; and Craig Winslow.

Sincerely yours,

A handwritten signature in black ink that reads "Leslie G. Aronovitz". The signature is written in a cursive style with a large initial 'L' and 'A'.

Leslie G. Aronovitz  
Director, Health Care

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# Appendix I: Objectives, Scope, and Methodology

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To provide information on the amount of funds allocated to the five Medicare Integrity Program (MIP) activities over time, we interviewed officials from the Centers for Medicare & Medicaid Services (CMS). We obtained information concerning MIP funding allocations for audit, medical review, secondary payer, benefit integrity, and provider education for fiscal years 1997 through 2005. We also analyzed allocations within these activities. Further, we obtained and analyzed related financial information, including CMS's planned and actual expenditures, savings, and return on investment (ROI) calculations for fiscal year 1997 through fiscal year 2005; CMS financial reports; and presidential and Department of Health and Human Service (HHS) budget proposals for fiscal years 2006 and 2007. Because most MIP expenditures are for activities related to the Medicare fee-for-service plan, our analyses focused on those expenditures. We reviewed relevant legislation, such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA); the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA); and the Deficit Reduction Act of 2005 (DRA). We reviewed pertinent reports and congressional testimony, including our own and those of CMS and the HHS Office of Inspector General (OIG), related to program integrity requirements.

To examine the approach that CMS uses to allocate MIP funds, we interviewed CMS officials regarding factors they consider when allocating MIP funds. We reviewed related documentation provided to us by CMS, including budget development guidelines; manuals, such as the *Financial Management Manual*; operating plans; and selected workload data. We also reviewed information on individual projects, such as information technology systems. We also reviewed pertinent GAO reports and testimony and Medicare Payment Advisory Commission reports. We did not independently examine the internal and automated data processing controls for CMS systems from which we obtained data used in our analyses. CMS subjects its data to limited reviews and periodic examinations and relies on the data obtained from these systems as evidence of Medicare expenditures and to support CMS's management and budgetary decisions. Therefore, we considered these data to be reliable for the purposes of our review.

In addition, we interviewed CMS officials regarding changes in the Medicare program that may affect MIP funding allocations, including CMS's plans to support activities to detect fraud and improper billing for the new Part D prescription drug benefit and MIP activities to be performed by contractors in the future. We also interviewed CMS officials concerning performance measures and evaluations of contractors. We

reviewed related documentation, including the statement of work for the Medicare prescription drug integrity contractors; plans for Medicare contracting reform; policies and procedures associated with CMS's measurement of contractor performance; standards and performance measures, such as the Comprehensive Error Rate Testing program; various manuals, including the *Medicare Program Integrity Manual*; and an OIG report on performance evaluations of program safeguard contractors (PSC). We also reviewed CMS's evaluations of contractor performance. We performed our work from August 2005 through August 2006 in accordance with generally accepted government auditing standards.



# Appendix II: Information on MIP Funding, Expenditures, and ROI

The following tables contain details on MIP funding, expenditures, allocations, and ROI. Table 2 shows MIP funding ranges under HIPAA. Table 3 shows the amounts of MIP expenditures allocated to each of the program integrity activities. Table 4 shows the percentage of MIP funds allocated to the program integrity activities. Table 5 shows the ROI for three of the program integrity activities.

**Table 2: Fiscal Year MIP Funding Ranges under HIPAA**

Dollars in millions							
Amount	1997	1998	1999	2000	2001	2002	2003 and later years
Not less than	\$430	\$490	\$550	\$620	\$670	\$690	\$710
Not more than	440	500 <sup>a</sup>	560	630	680	700	720 <sup>b</sup>

Source: GAO analysis of HIPAA and DRA.

<sup>a</sup>This amount does not include the \$50 million in supplemental program integrity funds made available by HHS's fiscal year 1998 appropriation.

<sup>b</sup>This amount does not include the \$112 million for fiscal year 2006, which was included in DRA.

**Table 3: Amount of MIP Expenditures Allocated to the Five Program Integrity Activities, Fiscal Years 1997 through 2005**

Dollars in millions									
Activity	1997	1998	1999	2000	2001	2002	2003	2004	2005
Audit	\$143.3	\$187.2	\$177.3	\$193.8	\$209.5	\$205.4	\$221.9	\$210.2	\$207.6
Medical review	118.6	158.3	178.7	196.0	214.8	193.2	162.4	166.5	165.9
Secondary payer	102.0	108.5	103.6	128.5	140.6	138.5	143.5	152.1	151.5
Benefit integrity	62.7	78.5	86.8	91.3	95.5	102.4	119.4	113.1	118.5
Provider education	10.1	12.1	9.9	14.6	17.0	53.5 <sup>a</sup>	65.1	70.3	70.0
<b>Total</b>	<b>\$437.9<sup>b</sup></b>	<b>\$544.6</b>	<b>\$556.3</b>	<b>\$624.2</b>	<b>\$677.4</b>	<b>\$693.0</b>	<b>\$712.3</b>	<b>\$712.2</b>	<b>\$713.5</b>

Source: GAO analysis of CMS data.

<sup>a</sup>From fiscal year 2002, provider education includes amounts for both provider education and provider outreach.

<sup>b</sup>Fiscal year 1997 total also includes \$1.2 million for "other" MIP expenditures.

**Appendix II: Information on MIP Funding,  
Expenditures, and ROI**

**Table 4: Percentage of MIP Funds Allocated to the Five Program Integrity Activities, Fiscal Years 1997 through 2005**

<b>Activity</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>Average</b>
Audit	33	34	32	31	31	30	31	30	29	31
Medical review	27	29	32	31	32	28	23	23	23	27
Secondary payer	23	20	19	21	21	20	20	21	21	21
Benefit integrity	14	14	16	15	14	15	17	16	17	15
Provider education	2	2	2	2	3	8	9	10	10	6
<b>Total</b>	<b>100<sup>a</sup></b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>

Source: GAO analysis of CMS data.

Notes: These amounts also include supporting activities, such as information technology. Numbers do not always add to 100 percent because of rounding.

<sup>a</sup>Percentages for fiscal year 1997 exclude \$1.2 million in "other expenditures" for that year, which accounted for less than 1 percent of the total.

**Table 5: Reported ROI for Audit, Medical Review, and Secondary Payer Activities, Fiscal Years 1997 through 2005**

<b>Activity</b>	<b>1997</b>	<b>1998</b>	<b>1999</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Audit	\$11.6	\$8.9	\$15.7	\$12.6	\$3.7	\$0.0	\$0.0	\$0.0	\$0.0
Medical review	23.6	22.5	21.1	22.2	23.1	21.8	28.0	24.0	20.5
Secondary payer	33.1	30.1	32.2	24.3	26.8	30.9	32.0	31.7	37.4

Source: GAO analysis of CMS data.

Notes: Based on dollars saved in relation to dollars invested. CMS does not track ROI for benefit integrity or provider education activities.

# Appendix III: Key Tasks Performed by Contractors That Conduct MIP Activities

Activity	Medicare contractors conducting activity	Examples of key tasks performed
Audits	Fiscal intermediaries (intermediaries), one PSC, and MAC selected in July 2006	<ul style="list-style-type: none"> <li>Hospitals, nursing homes, home health agencies, and other institutional providers that are—or have been— paid on a cost reimbursement basis submit cost reports to CMS. Cost reports provide a detailed accounting of what costs have been incurred, what costs the provider is charging to the Medicare program, and how such costs are accounted for by the provider.</li> <li>Contractors review all or part of the cost report to assess whether costs have been properly allocated and charged to the Medicare program.</li> <li>Contractors determine if the cost report is acceptable or if it needs further review.</li> <li>In some instances, contractors may conduct on-site cost report audits, which include the review of financial records and related documentation supporting costs and charges.</li> </ul>
Medical review	Intermediaries, carriers, and PSCs, and MAC selected in July 2006	<ul style="list-style-type: none"> <li>Contractors identify billing errors made by providers through analysis of claims data; take action to prevent errors, address identified errors, or both; and publish local coverage policies to provide guidance to the public and medical community concerning items and services that are eligible for Medicare payment.</li> <li>Most medical reviews do not require a manual review of medical records. Often contractors conduct medical reviews simply by examining the claim itself, usually using automated methods.</li> </ul>
Secondary payer	Coordination of benefits (COB) contractor, intermediaries and carriers, and Medicare administrative contractors (MAC)	<ul style="list-style-type: none"> <li>The COB contractor collects, manages, and maintains information regarding health insurance coverage for Medicare beneficiaries.</li> <li>To gather information to properly adjudicate submitted claims, the COB contractor sends questionnaires to newly enrolled Medicare beneficiaries and employers to solicit information about beneficiaries' health insurance coverage.</li> <li>The COB contractor also collects secondary payer data from providers, insurers, attorneys, and some state agencies.</li> <li>The COB contractor uses data match programs to identify claims that should have been paid by another insurer. When information indicates that a beneficiary has other health insurance, the COB contractor initiates a secondary payer claims investigation.</li> <li>Intermediaries and carriers also conduct secondary payer operations, including prepayment activities in conjunction with the COB contractor, and they recover erroneous secondary payer payments.</li> </ul>

**Appendix III: Key Tasks Performed by  
Contractors That Conduct MIP Activities**

<b>Activity</b>	<b>Medicare contractors conducting activity</b>	<b>Examples of key tasks performed</b>
Benefit integrity	PSCs, the National Supplier Clearinghouse (NSC), and the data analysis and coding (DAC) contractor	<ul style="list-style-type: none"> <li>• Contractors are tasked with preventing, detecting, and deterring Medicare fraud.</li> <li>• PSCs conduct medical reviews to support fraud investigations, analyze data to support medical reviews, process fraud complaints, develop fraud cases, conduct provider education related to fraud activities, and support law enforcement entities.</li> <li>• Once a case is developed, PSCs refer it to the OIG or to law enforcement for prosecution.</li> <li>• NSC reviews and processes applications from organizations and individuals seeking to become suppliers of medical equipment and supplies in the Medicare program.</li> <li>• NSC verifies suppliers' application information; conducts on-site visits to the prospective suppliers; issues supplier authorization numbers, which allow suppliers to bill Medicare; and maintains a central data repository of information concerning suppliers.</li> <li>• NSC also periodically reenrolls active suppliers and uses data to assist with fraud and abuse research.</li> <li>• The DAC contractor conducts ongoing data analysis and reporting of trends related to supplier billing for medical equipment and supplies and provides ongoing feedback to the PSCs.</li> </ul>
Provider education	Intermediaries, carriers, MACs, and PSCs	<ul style="list-style-type: none"> <li>• When billing problems are identified through medical reviews, contractors take a variety of steps to educate providers about Medicare coverage policies, billing practices, and issues related to fraud and abuse.</li> <li>• Contractors may conduct group training sessions, including seminars and workshops; send informational letters to providers; arrange for teleconferences; conduct site visits; and provide information on their Web sites.</li> </ul>

Source: GAO analysis of CMS documents.

# Appendix IV: CMS's Planned Spending of \$100 Million Provided by DRA

For fiscal year 2006, DRA provided \$112 million in MIP funds beyond the annual HIPAA limit of \$720 million. Of this amount, DRA specified that \$12 million was for the Medi-Medi program and \$100 million was for MIP in general. Table 6 provides information on CMS's planned spending of \$100 million in general MIP funds provided by DRA, including spending related to the Part D prescription drug benefit.

**Table 6: CMS's Planned Spending of MIP Funds Provided by DRA**

Category	Amount	Description
Information technology	\$33,100,000	<p>CMS developed several information technology systems to implement the prescription drug benefit. These MIP funds from DRA are partially supporting these systems. They include the following:</p> <ul style="list-style-type: none"> <li>• <b>Medicare Drug Data Processing System</b> contains summary prescription drug claim information on all Medicare covered and noncovered drug events, including non-Medicare drug events, for Medicare beneficiaries. Each time a beneficiary fills a prescription drug covered under Part D, plans must submit a summary record called the prescription drug event (PDE) record to CMS. The PDE record contains prescription drug cost and payment data that will enable CMS to make payments to plans and otherwise administer the Part D benefit.</li> <li>• <b>Medicare Advantage Prescription Drug System</b> will be a stand-alone system that will include the processing of all enrollment and disenrollment transactions associated with the Part D benefit.</li> <li>• <b>Medicare Beneficiary Database</b> tracks data related to beneficiary eligibility for Part D.</li> </ul>
Reviews of requested exceptions to therapy cap	20,000,000	<p>Medicare has financial limitations on payments for certain types of therapy services provided to a beneficiary during a calendar year—called therapy caps.<sup>a</sup> DRA allows CMS to grant exceptions to these therapy caps, as long as the services are medically necessary for the beneficiary. CMS will use these DRA funds to review supporting documentation for requests for exception to the therapy cap amounts to determine whether the services are medically necessary and whether the exception should be granted.</p>
Information technology infrastructure	15,000,000	<p>CMS is consolidating data generated by Medi-Medi and Parts B and D into an integrated data repository.<sup>b</sup> MIP funds are to be used to help develop the information technology infrastructure to achieve this task.</p>
Medicare prescription drug integrity contractor (MEDIC)	14,000,000	<p>In November 2005, CMS awarded one task order to the enrollment and eligibility MEDIC, which is tasked with identifying and addressing potential fraud, waste, and abuse in the early implementation of the Part D benefit. This task order will be in effect until CMS selects three regional MEDICs and one MEDIC to act as a data integrator. CMS plans to select these MEDICs later this summer.</p>
Part D and Medicare Advantage activities	8,749,732	<p>These funds are to be used to monitor and audit Part D and Medicare Advantage activities. Several types of audits are to be carried out for Part D.<sup>c</sup> Funds, for example, will be used for Part D compliance monitoring and auditing activities.</p>

**Appendix IV: CMS's Planned Spending of  
\$100 Million Provided by DRA**

<b>Category</b>	<b>Amount</b>	<b>Description</b>
Audits of Adjusted Community Rate Proposals (ACRP)	4,077,000	A Medicare Advantage plan's ACRP identifies the health services that will be provided to beneficiaries, the estimated costs of providing these health services, and the estimated payments the plan will receive—so that CMS can ensure that the plans are using any excess payments as allowed by law. CMS will use these DRA funds to conduct required audits in order to evaluate the reasonableness of ACRPs. <sup>d</sup> Prior to this year, these audits were paid by MIP funds provided through HIPAA.
Contingency funds	5,073,268	CMS is reserving these funds to be allocated later in the fiscal year.
<b>Total</b>	<b>\$100,000,000</b>	

Source: GAO analysis of CMS and DRA information.

<sup>a</sup>The term therapy caps refers to limitations on Medicare payments for certain outpatient rehabilitation services, which were initiated by the Balanced Budget Act of 1997. Pub. L. No. 105-33, § 4541(c), 111 Stat. 251, 456-57. As of January 1, 2006, caps are in effect for occupational therapy and outpatient physical therapy and speech-language pathology received by Medicare beneficiaries. For services received in 2006, beneficiaries may request an exception to the caps based on medical necessity. In addition, such necessity will be deemed present if a decision is not made on a request within 10 business days of its receipt. DRA § 5107, 120 Stat. 4, 42 (to be codified at 42 U.S.C. § 1395l(g)(5)).

<sup>b</sup>This amount does not include the \$12 million specifically provided for the Medi-Medi program by DRA for fiscal year 2006.

<sup>c</sup>CMS will do regularly scheduled audits and do focused and targeted audits when questionable findings are identified through contractor activities, such as data analysis. In instances of allegations of fraud, waste, or abuse, MEDICs will conduct audits. Also, CMS has planned a 3-year comprehensive, regularly scheduled audit cycle for Part D plans, because MMA required audits of financial records for at least one-third of all Part D prescription drug plans each year. MMA § 101(a)(2), 117 Stat. 2100 (to be codified at 42 U.S.C. § 1395w-112(b)(3)(C)).

<sup>d</sup>CMS is required to audit the financial records of at least one-third of the participating Medicare Advantage Plans (formerly called Medicare+Choice Plans) annually. 42 U.S.C. § 1395w-27(d)(1) (2000).

# Appendix V: Comments from the Centers for Medicare & Medicaid Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** AUG - 7 2006

**TO:** Leslie G. Aronovitz  
Director, Health Care  
Government Accountability Office

**FROM:** Mark B. McClellan, M.D., Ph.D.  
Administrator

**SUBJECT:** Government Accountability Office's (GAO) Report: "Medicare Integrity Program, Agency Approach for Allocating Funds Should Be Revised" (GAO-06-813)

Thank you for the opportunity to review the GAO's report entitled "Medicare Integrity Program, Agency Approach for Allocating Funds Should Be Revised." In this report, the GAO evaluated: (1) the amount of Medicare Integrity Program (MIP) funds that CMS has allocated across the five program integrity activities (medical review, cost report audit, benefit integrity, Medicare Secondary Payer, and provider education) over time; (2) the approach that CMS uses to allocate MIP funds; and (3) how major changes in the Medicare program may affect MIP funding allocations.

The Centers for Medicare & Medicaid Services (CMS) has expanded its efforts in aggressively fighting waste and abuse in Medicare by using state of the art systems and expertise to identify problems before they occur and those efforts are paying off. CMS continues to monitor information and work across the Agency to identify program vulnerabilities faster and more efficiently. The Agency's goal is to address and resolve problems timely and effectively. CMS continues to work closely with the Medicare contractors to make sure appropriate education and guidance is given to the provider community on billing problems identified.

CMS' recent efforts support existing and successful activities including:

- Aggressively overseeing and improving CMS' overall program integrity efforts have reduced the number of improper fee-for-service Medicare claims payments by half in one year, from 10.1 percent in 2004 to 5.2 percent in 2005, a \$9.5 billion reduction in Medicare improper payments.
- Continuing to coordinate efforts among the CMS satellite offices, in Los Angeles and Miami, CMS regional offices, law enforcement and contractors

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to address fraud across all provider types. One of these recent efforts resulted in Medicare savings of over \$500 million related to beneficiary identity theft.

- Revoking over 100 Medicare billing numbers, based on Program Safeguard Contractor (PSC) activities.
- Continuing to focus projects by the CMS contractors on areas of potentially fraudulent payments in their respective jurisdictions. One recent project identified over \$30 million in improper claims related to DRG code combinations.

**Recommendation:** To better ensure that MIP funds are appropriately allocated, GAO recommends that CMS develop a method of allocating funds based on the effectiveness of the activities, contractors' workloads, and risk.

In general, CMS agrees with the report recommendation. CMS is committed to identifying and investigating better ways to efficiently allocate our resources to support the critical functions of our Agency. We continually review our activities to ensure efficient and effective use of resources through consolidation and expansion of activities. For example, CMS is developing a strategy to use the new contracting authority provided by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) to introduce incentives into the Medicare fee-for-service claims processing contracts and the use of recovery auditor contracts. CMS is also beginning an effort to consolidate our Medicare Secondary Payer activities to further achieve program efficiencies.

Additionally, in the report, the GAO states that vulnerabilities have increased as a result of various programmatic initiatives (e.g., the prescription drug program) and that it has become increasingly critical that funds be used effectively and efficiently. We agree and, like the GAO, recognize that additional MIP funding is necessary. However, we have already taken steps to expand our oversight efforts to include the Medicare Part D program. CMS contracted with program integrity contractors, the Medicare Drug Integrity Contractors (MEDICs), to support our anti-fraud and abuse efforts with the new Prescription Drug Benefit. These contractors will perform data analysis related to fraud and abuse, conduct fraud complaint investigations and refer cases to the appropriate law enforcement agency as needed.

Following are CMS' general comments on this report:

**Effectiveness of Program Activities:** CMS spends a considerable amount of time evaluating the effectiveness of its fraud, waste, and abuse program activities, including the five activities funded through MIP. For example, as the report indicates, we have utilized the savings-to-costs ratios associated with Medicare Secondary Payer activities in the budget allocation process. However, it is also critical that CMS consider other



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factors, including historical funding, in part because MIP funding has been flat-lined since 2003.

Contractors have built infrastructures and a workforce to address CMS goals and meet performance standards across all of these five MIP program areas. A significant shift in the allocation of MIP funds would result in the deterioration of those already built infrastructures and already trained and hired staff. Without an influx of new money, contractors can not keep up with inflation, let alone address new vulnerabilities. That said, CMS does re-program funds to areas of greatest need or vulnerability by routinely shifting funds, throughout the fiscal year, to activities with demonstrated results.

Further, CMS is concerned about the emphasis this report placed on return on investment (ROI) as a way to measure effectiveness and thereby allocate funding. While the use of ROI is certainly one indicator of effectiveness, CMS can not provide funding based on the ROI alone since some of these functions, such as benefit integrity, do not lend themselves to an ROI measurement and other functions, such as audit, are governed by statutory requirements. Further, while the ROI identifies quantifiable benefits that are commensurate with the amount spent, it fails to capture benefits that accrue as a result of the sentinel effect of program safeguard activities. For example, cost report audits result in hundreds of millions of dollars returned to the trust funds annually.

As part of our ongoing review of Medicare Secondary Payer program operations, CMS is initiating a consolidation of postpay activities at one site, rather than at each individual Medicare contractor site. We expect the introduction of the Medicare Secondary Payer Recovery Contractor will allow for a more efficient approach to recover mistaken Medicare payments and will likely increase our ROI for this MIP function.

**Contractors' Workloads:** First, it is important to note that CMS' allocation of MIP funds to the contractor community will be changing pursuant to the contracting reform changes required in the MMA. With the implementation of Medicare Administrative Contractors, (MACs), contractors' workloads will be more evenly distributed across MACs than at present and budgets will be negotiated through the Federal Acquisition Regulation contract processes.

Additionally, award fee measures are being developed. For example, an award fee for medical review activities is being developed based on attaining specific performance metrics designed to measure the effectiveness of medical review activities, such as (but not limited to) setting goals for the Comprehensive Error Rate Testing (CERT) contractor-specific error rate.

**Risk:** With respect to the allocation of funds based on risk, CMS agrees this is a good idea. Based upon our experience with the Miami satellite office in identifying fraudulent activities in Florida, we established a second CMS satellite office in Los Angeles to

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reduce the unusually high rates of improper payments identified in the Medicare and Medicaid programs in California. Our oversight efforts and data analysis identified many operations set up to defraud the Medicare and Medicaid programs by billing for services never provided. Due to the success of such satellite offices, CMS is considering further expanding such satellite offices in other high risk areas. In addition, we plan to enhance our data analysis function to ensure our MIP efforts focus on high risk activities.

Again, we thank the GAO for the time and effort spent on this report.

Attachment

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## GAO's Mission

The Government Accountability Office, the audit, evaluation and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

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