



Program Integrity After the Enactment of Health Reform

No matter one's political leanings, mention the words "health reform" and the concept of program integrity is unlikely to come to mind. There has been a lot of publicity about health reform's individual mandate and its Medicaid expansion, yet the new

law's more immediate and pronounced effects on hospitals are likely to come from the program integrity provisions. By understanding the areas of new and enhanced program integrity focus required by the *Patient Protection and Affordable Care Act of 2010* (ACA)

as well as existing program integrity initiatives, hospitals will be better able to prepare for the greater oversight of their activities that is almost certain to occur and potentially avoid the cost and disruption that are often associated with those activities.

I. Background

Even before President Barack Obama took office, it was widely known that one of the top priorities for his Administration would be enacting broad health reform legislation. President Obama, like others before him, also took an early interest in eliminating fraud, waste, abuse and payment errors in federal health care programs, which could help reduce the cost of or "pay for" the health reform law. In November 2009, the President issued Executive Order 13520: Reducing Improper Payments, which was designed to help eliminate fraud, waste and abuse while enhancing transparency of the oversight process and increasing agency accountability for achieving oversight goals. It required the Director of the Office of Management and Budget to identify the federal programs

in which the highest dollar value or majority of government-wide improper payments occur and to work with the agency responsible for administering the high-priority program to establish targets for reducing improper payments associated with each program. When agencies submitted reports on their payment errors, Medicare fee for service, Medicaid and Medicare Advantage's error rates were among the highest.

Not surprisingly, the ACA contains many provisions intended to eliminate or reduce improper or fraudulent Medicare and Medicaid payments including reorganization of the Centers for Medicare & Medicaid Services (CMS), consolidation of the agency's enforcement efforts, expansion of the scope of program integrity activities and establishment of new requirements such

as overpayment disclosures and refund mandates.¹ Many of these provisions build upon program integrity initiatives already being pursued by CMS and its contractors, the Department of Health and Human Services (HHS) Office of Inspector General (OIG), the Department of Justice (DOJ), the Government Accountability Office (GAO) and law enforcement agencies. Indeed, many of the ACA provisions and current government initiatives harken back to efforts to reduce fraud, waste and abuse that began in the 1990s or earlier. Some might say that this is an attempt to put new wine in old bottles, but the fact remains that hospitals and other health care providers will continue to feel ever-increasing scrutiny associated with their participation in the Medicare and Medicaid programs.

II. CMS Activities

In the ACA, Congress mandated that CMS’ program integrity activities be centralized under one umbrella organization. That organization is the CMS Center for Program Integrity, established in April 2010, with over 200 employees headed by CMS Deputy Administrator Peter Budetti. According to CMS, the Center for Program Integrity “serves as CMS’ focal point for all . . . program integrity fraud and abuse issues,” with the goal of “integrating similar functions from the Medicare and Medicaid programs to improve intra-agency coordination and deployment of resources to address fraud, waste, and abuse. By housing all Program Integrity efforts in one Center, CMS staff will gain valuable insights and share best practices, which allow the Agency to fulfill the mission of ensuring effective, up-to-date health care coverage and promoting high-value,

quality care for our beneficiaries.”

Due in part to the ACA, CMS’ focus is changing to “preventing fraudulent transactions from ever occurring, rather than simply tracking down fraudulent providers and chasing fake claims.”² And the Center for Program Integrity’s “strategic direction’ is changing in other respects as well; see Chart 1.

As HHS Deputy Associate Secretary Marc Smolonsky stated, prevention is important because “you can’t prosecute your way out of fraud – there are always more of them.”³ To prevent these potential fraudulent transactions, as well as to identify fraud, waste or abuse that already may have occurred, CMS relies heavily on a range of contractors. The agency also is beginning to embrace the use of predictive analytics in its program integrity efforts.

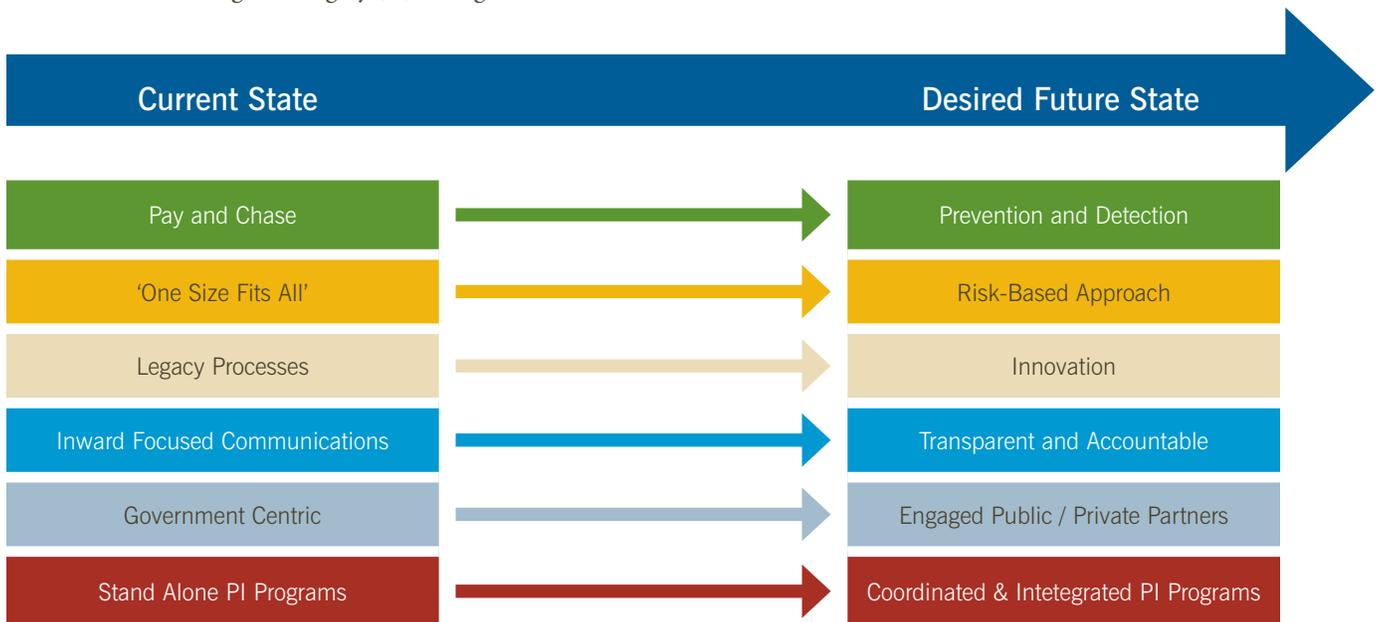
Medicare Contractors – MACs, ZPICs and RACs

CMS has responsibility for two of the largest federal programs – Medicare and Medicaid – and relies on contractors for many functions. Through the agency’s work with nearly a dozen different types of contractors, CMS oversees day-to-day administration of the Medicare program across the country as well as works to prevent and identify potential fraud, waste and abuse within the program.

CMS had long sought to combine the Medicare Part A and Part B functions in one contractor to improve efficiency and streamline operations. Legislation in 2003 allowed CMS to replace its Part A fiscal intermediaries and Part B carriers with Medicare Administrative Contractors (MACs). They serve as providers’ primary point of contact for enrollment and training on

CMS is changing the focus of its integrity efforts.

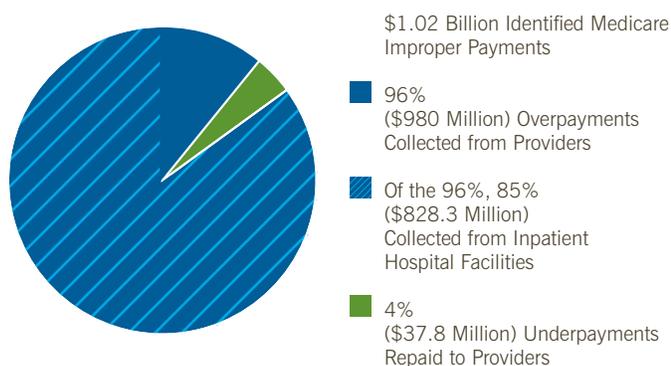
Chart 1: Center for Program Integrity (PI) Strategic Direction



Source: Budetti, Peter (2011). CMS Program Integrity and the Affordable Care Act presentation AHA State Issues Forum.

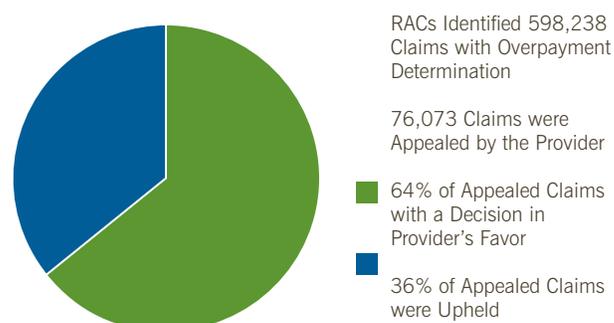
A look at Payment Determinations under the RAC Demonstration.

Chart 2: RAC Demonstration Project



Source: The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration, June 2008

Chart 2a: Provider Appeals of RAC Demonstration Project Overpayment Determinations



Source: The Medicare Recovery Audit Contractor (RAC) Program: Update to the Evaluation of the 3-Year Demonstration, June 2010

To date, the permanent Medicare RAC program has identified

\$365.8
MILLION

in overpayments and underpayments to providers.

Source: CMS Fee-for-Service Recovery Audit Programs as of March 2011.

Medicare for coverage, billing and the claims process.

Within each jurisdiction, the MAC is charged with reducing payment errors prospectively by preventing the initial payment of claims that do not comply

with Medicare's coverage, coding, payment and billing policies. If a MAC suspects fraud, it refers the case to a Zone Program Integrity Contractor (ZPIC) (formerly Program Safeguard Contractor or PSC). ZPICs operate in seven zones defined by CMS and work to identify cases of potential fraud, investigate them by conducting audits and data analysis and then refer suspected fraud to the OIG for further investigation.

Medicare Recovery Audit Contractors (RACs) were established under a three-year demonstration project authorized by the *Medicare Modernization Act of 2003*. As reflected in chart 2, the success of that demonstration project in recovering overpayments (RACs, by definition, review claims on a post-payment

basis) led Congress to expand the RAC program in the *Tax Relief and Healthcare Act of 2006* by requiring CMS to establish a permanent and nationwide RAC program no later than 2010. Currently, RACs operate in four jurisdictions and review Medicare Parts A and B claims using either automated review (no medical record needed) or complex review (medical record required). When overpayments are identified, RACs issue a demand letter for recoupment. When they identify overpayments or underpayments, they are paid on a contingency fee basis, which varies by RAC based on its contract with CMS. The ACA expanded the RAC program to include Medicare Parts C and D as well as Medicaid.

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from the field

“The RAC program adds an enormous additional layer of cost and complexity to all of the other efforts by CMS and Medicare contractors to recover payments from hospitals. Dealing with RAC medical record requests and tracking RAC audits has become a full-time job for hospitals. Not to mention the burdensome appeals process, which is often not worth pursuing even though we know the RAC determination was inappropriate.”

David R. Aplington, Vice President & Deputy General Counsel, BJC HealthCare

The national error rate for Medicare fee for service claims.

Chart 3: National Medicare Payment Error Rate and Related Overpayments and Underpayments to Providers.



Source: HHS Office of Inspector General (1996-2002). CMS (2003-2009).

During the RAC demonstration program, providers expressed concerns to CMS about several RAC processes that needed improvement. For example, they reported that RACs were “inconsistent in documenting their ‘good cause’ for reviewing a claim,” and that the lack of physician RAC staff members led to claims being improperly denied. As a result, CMS required RACs as well as ZPICs, among other things, to document their “good cause” for reviewing a claim and to hire physician medical directors. The RAC demonstration project led to the identification of roughly \$1 billion in improper payments and recovery of \$980 million from providers – 85% of which came from hospitals. In addition, Associate Deputy Secretary Smolonsky has stated that lessons learned from ZPICs and RACs will be used to change MAC claims processing edits to avoid paying certain claims in the first place.

The Comprehensive Error Rate Testing Program (CERT)

In 2003, CMS became responsible for the Comprehensive Error Rate Testing (CERT) program whose goal is to esti-

mate the national error rate for Medicare fee-for-service claims. Chart 3 shows the trend in the national error rate and the related estimate of overpayments and underpayments. From 1996-2002 that responsibility had belonged to the OIG, which sampled 6,000 claims each year in making its national Medicare error rate estimate. Over time, CMS made significant changes to the CERT methodology, including substantially increasing the size of the claims sample (to more than 120,000 claims) in order to measure the performance of the MACs (and legacy carriers and fiscal intermediaries) and providers (in preparing claims for submission) as well as to gain insight about the causes of errors. In 2009, CMS changed the way it reviewed inpatient hospital claims for error rate measurement. Inpatient claims had been reviewed under the separate Hospital Payment Monitoring Program or HPMP, which CMS then consolidated into the CERT program.

Almost as soon as CMS assumed responsibility for the CERT program, Sen. Charles Grassley (R-IA) raised concerns about the agency’s CERT method-

ology and those concerns grew over the succeeding years.⁴ As part of the annual CMS Chief Financial Officer’s audit, the OIG audits the CERT process and recommends refinements to CMS. In its 2008 audit, the OIG reported suspicious findings regarding CMS’ calculation of the fiscal year 2006 error rate for durable medical equipment claims.

In a November 2009 report, CMS responded to the concerns that had been raised by Sen. Grassley and the OIG. Notably, the 2009 report showed an error rate of 7.8 percent (\$24.1 billion) – more than twice as large as the 3.6 percent (\$10.4 billion) for the year before. CMS attributed that increase to, among other things, requiring claim reviewers to enforce Medicare policies more strictly. The agency also explained that the CERT program cannot be considered a measure of fraud because claim reviewers “are often unable to see provider billing patterns that indicate potential fraud when making payment determinations.”

It remains unclear whether the OIG and Congress have been satisfied by CMS’ changes to the CERT methodology. CMS has yet to publish error rates for 2010, but

it is unlikely that anyone will be satisfied with the national error rate that CMS finds given the billions of dollars in overpayments represented by that error rate.

Medicaid Contractors (MICs) and Program Integrity Initiatives

CMS also oversees contractors charged with maintaining the integrity of the Medicaid program. *The Deficit Reduction Act of 2005* increased federal resources to fight fraud, waste and abuse in Medicaid and created the Medicaid Integrity Program. The legislation required CMS to contract with entities to review provider claims, audit providers, identify overpayments and educate providers, payers and beneficiaries about program integrity. It also created Medicaid Integrity Contractors (MICs), which operate in five jurisdictions, to perform one of three functions: audit, review, or education.

Audit MICs conduct post-payment audits, which are a combination of field and desk audits, of Medicaid claims. They also conduct fee-for-service, cost report and managed care audits. When an audit identifies an overpayment, however, it is the state's responsibility to collect the overpayment and adjudicate any provider appeals. Review MICs analyze Medicaid claims data to identify high-risk areas and potential vulnerabilities. They look for providers with aberrant billing practices and provide leads to the audit MICs. Education MICs use findings from the audit and review MICs to identify areas where education is needed. They develop training materials and awareness campaigns and conduct provider training on prevention of Medicaid fraud, waste and abuse.

As noted above, in 2010, the ACA added an additional layer of oversight to the Medicaid program through Medicaid RACs. States were required to submit amendments to their state Medicaid plans to include Medicaid

RACs by December 31, 2010, and full implementation of Medicaid RACs is required later in 2011.

Hospitals should bear in mind that implementation of the Medicaid RACs is not the only program integrity activity occurring at the state level. States frequently have their own Medicaid audit programs, as do individual Medicaid managed care plans. As a result, hospital claims may be subject to review by several different Medicaid auditors.

The Payment Error Rate Measurement Program (PERM)

Deputy CMS Administrator Budetti has stated that the Administration's goal is to cut federal health care programs' improper payments rate in half by 2012. The *Children's Health Insurance Program Reauthorization Act of 2009* enacted improvements to CMS' Payment Error Rate Measurement (PERM) efforts to reduce payment error rates in Medicaid and the Children's Health Insurance Program (CHIP). The PERM program

measures improper payments in 17 states annually and produces national-level error rates for each program (see chart 4). During that process, it also identifies and refers to states for correction specific cases of payment error. In final regulations issued in 2010, CMS implemented a number of operational changes to the PERM to enhance the review process and improve the ability of providers and states to submit documentation and corrective action plans when errors are identified.

Under the PERM program, each state is reviewed every three years. During the PERM review process, a sample of 500 fee-for-service claims is pulled from all claims during the previous fiscal year. A PERM review contractor requests medical records from providers for all 500 claims in that sample, and providers have 75 days from the date of the request to provide those records. If insufficient documentation is provided, providers are contacted and then have 14 days in which to submit additional documentation. Timely submission of accurate, complete and legible

The PERM program measures improper Medicaid and CHIP payments.

Chart 4: PERM reviews each State every three years.

FY 2008	FY 2009	FY 2010
Alaska	Arkansas	Alabama
Arizona	Connecticut	California
Washington DC	Delaware	Colorado
Florida	Idaho	Georgia
Hawaii	Illinois	Kentucky
Indiana	Kansas	Maryland
Iowa	Michigan	Massachusetts
Louisiana	Minnesota	Nebraska
Maine	Missouri	New Hampshire
Mississippi	New Mexico	New Jersey
Montana	North Dakota	North Carolina
Nevada	Ohio	Rhode Island
New York	Oklahoma	South Carolina
Oregon	Pennsylvania	Tennessee
South Dakota	Virginia	Utah
Texas	Wisconsin	Vermont
Washington	Wyoming	West Virginia

records to the PERM review contractor is important because claims with insufficient documentation are likely to be determined to have been paid in error. If insufficient claim records are submitted or the PERM review contractor determines that payment on a claim was made in error, a report of the error is sent to the state. The state Medicaid agency is then responsible for returning the federal share of the errant payment to CMS and may recover the improper payment from the provider. The provider may appeal such a recovery.

Predictive Modeling of Claims Data

In September 2010, as part of the Small Business Jobs Act, Congress mandated that HHS use “predictive modeling techniques” to identify and prevent fraud, waste and abuse in Medicare.⁵ It relies on predictive modeling of claims data to identify improper Medicare claims. The legislation requires the program to be in place by July 1, 2011 in the 10 states identified by the Secretary of HHS as having the highest risk of fraud, waste or abuse in the Medicare fee-for-service program.⁶ By October 1, 2012, the Secretary must expand the predictive modeling program to an additional 10 states, and by January 1, 2014, the Secretary must expand the program to any state not already identified. By April 1, 2015, the program must be expanded to apply to Medicaid and CHIP.

Predictive modeling has been used successfully in the financial and telecommunication sectors and the government

believes it is applicable to Medicare. CMS is engaged in predictive modeling and other data analytics in-house through its analytics laboratory.⁷ Through these data analytics, CMS looks at provider and beneficiary activities across states to identify any provider billing or beneficiary utilization patterns or provider networks that represent a high risk of fraud. Predictive modeling technologies analyze large data sets for suspicious patterns, anomalies or other factors that may be linked to fraud, waste or abuse.

Associate Deputy Secretary Smolonsky has said that predictive modeling will “allow CMS to look at hospitals in new ways – which could be either good or bad for hospitals.” Hospitals may be targeted because they generate a large number of high-dollar Medicare claims. And interest in applying predictive modeling to hospitals may not be limited to the government.

For example, while engaged in a labor dispute with Southern California hospital chain Prime Healthcare, the Service Employees International Union (SEIU) conducted a computer analysis of Prime Healthcare’s Medicare billings and alleged that Prime Healthcare had engaged in fraudulent billing practices by “upcoding” their septicemia diagnoses to draw higher reimbursement.⁸ The SEIU alleges that its modeling shows that Prime Healthcare’s septicemia rate was triple the national average among Medicare patients, but that the hospitals’ septicemia death rate

was 38% lower than the national average, which suggests upcoding. Representatives of Prime Healthcare have stated that the Medicare fraud allegations raised by the SEIU are “part of an effort by the union to extort concessions from Prime Healthcare in contract negotiations,”⁹ but both state and federal authorities are investigating the claims. Regardless of the investigation’s outcome, the SEIU’s analysis demonstrates that computer modeling of claims data can be a powerful tool to identify suspected fraud, waste and abuse in hospitals.¹⁰

In addition, claims data analysis performed by DOJ appears to have been used in at least one location to form the basis for alleged liability under the federal False Claims Act (FCA). The U.S. Attorney’s Office for the Western District of New York apparently has “seized upon data analysis that flags billing errors and/or over-utilization and converted it into a presumption of FCA liability,” and some hospitals are concerned that aggressive FCA investigations are being initiated upon the discovery of evidence of a mistake, overutilization or even a difference in medical judgment, “making FCA enforcement through negotiated ‘settlement’ a self-fulfilling prophecy.”¹¹ As evidenced by these examples, predictive modeling is a potentially fearsome weapon: It has the potential to increase hospitals’ compliance costs, take valuable staff time and resources away from other projects and damage hospitals’ reputations.

III. Agency Collaboration to Address Fraud, Waste and Abuse

Congress and HHS are not limiting their fraud-fighting efforts to single-agency initiatives. Regulators are devoting substantial resources to inter-agency collaborations to identify and prevent fraud, waste and abuse. Agencies within HHS as well as DOJ, the Federal Bureau of Investigation (FBI) and state law enforce-

ment personnel are working together on several program integrity efforts.

Overpayment Refund Mandate

CMS is also targeting erroneous payments as a result of the ACA’s requirement to return Medicare and Medicaid overpayments within a specified number

of days after they are identified (or the date of any corresponding cost report).¹² Organizations that retain overpayments past the later of the ACA’s 60-day repayment deadline or CMS’ 90-day quarterly credit balance requirement are subject to FCA prosecution by DOJ under the *Fraud Enforcement and Recovery Act*

of 2009. Overpayments not reported and returned within the 60- or 90-day required time periods are now considered “obligations” under the FCA and can be the basis for the imposition of civil money penalties.

Organizations also are more vulnerable to qui tam lawsuits based on overpayments under the ACA’s changes to the FCA because relators (whistleblowers) can bring actions more easily than before.

Medicare Fraud Strike Force

Since March 2007, the DOJ Criminal Division’s fraud section has worked with local U.S. Attorneys’ offices and federal, state and local law enforcement agencies to prosecute individuals and entities that defraud Medicare and other federal health care programs. As a DOJ employee explained, “[t]he idea behind the strike forces was to pair investigators with prosecutors from the start of the case [to] target high-fraud areas.”¹³ These areas are rife with health fraud that would rarely involve hospitals, but might instead be sites of bogus durable medical equipment companies or “Medicaid mills.”

The first Medicare Fraud Strike Force was created in Miami-Dade County, Florida, and the next Strike Forces were established in Los Angeles, Detroit,

Houston and New York City. More recently, the Strike Forces expanded to Tampa, Baton Rouge, Chicago and Dallas. The Strike Forces utilize resources and personnel from DOJ, the FBI and OIG and use data analysis, agent-driven investigations, search warrants and sources and cooperators to identify and analyze potential fraud. The initiatives target individuals involved in ongoing fraud and any proceeds of fraud or assets purchased using those proceeds are seized and sold to return the funds to the Medicare Trust Fund.

As of November 2010, the Medicare Fraud Strike Force program had charged 836 defendants, obtained 490 guilty pleas, and achieved a 97% conviction rate.¹⁴ Between fiscal years 2007 and 2009, 94% of Strike Force defendants were sentenced to prison terms and their prison sentences exceed the national average in a federal health care fraud case by 20%.¹⁵ Strike Forces have prosecuted Medicare fraud totaling \$2.1 billion, which includes \$1 billion for durable medical equipment, \$500 million for infusion, \$200 million for mental health and \$150 million for physical and occupational therapy.¹⁶

Health Care Fraud Prevention and Enforcement Action Team (HEAT)
In May 2009, DOJ and HHS



Source: AHA RACTrac, February 2011

announced the creation of the Health Care Fraud Prevention and Enforcement Action Team (HEAT), which performs functions similar to the Medicare Fraud Strike Force in both the Medicare and Medicaid programs. According to DOJ, the mission of the HEAT is to gather resources across the federal government to prevent fraud, waste and abuse in the Medicare and Medicaid programs, reduce health care costs and improve quality of care by identifying individuals engaged in fraudulent activity, highlighting best practices by providers and public sector employees and building upon existing partnerships between DOJ and HHS, such as the Medicare Fraud Strike Force.¹⁷

IV. Transparency

The ACA includes additional requirements designed to enhance transparency in all health industry sectors. One such mandate is a new screening

requirement for providers applying to participate in the Medicare and Medicaid programs. The screening program is designed to ensure

that only legitimate entities participate in the programs. Medicare and Medicaid providers and suppliers also must include their National Provider

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from the field

“It’s not unusual to have the same medical record requested by more than one reviewer. We’ve had instances where we defended the same case three or four times...and with different results. These uncoordinated audits require large chunks of time and resources unnecessarily and diverts clinicians’ time away from patient care.”

Paul G. Neumann, Senior Vice President and General Counsel, Trinity Health

Identifier (NPI) on all program applications and claims. In addition, each hospital operating in the United States must publish a list of its standard charges for items and services provided by the hospital.

The law imposes an additional disclosure requirement (previously contained in the *Physician Payment Sunshine Act*) on device, drug, medical

supply and biologic companies regarding their dealings with physicians and hospitals. “Applicable manufacturers” of covered devices, drugs, biologics and medical supplies for which payment is available from certain federal health care programs must report any payment or other transfer of value to physicians and hospitals of \$10 or more, or \$100 in aggregate in a calendar year.

The ACA also requires all providers and suppliers participating in Medicare, Medicaid and CHIP to implement compliance programs. The goal of a mandated compliance program “is to compel organizations to police their own activities. It shifts the burden to the provider to be vigilant about the legality of activities [or] potentially pay a price for not doing so.”¹⁸

V. Are Program Integrity Initiatives Working Effectively?

The Obama Administration has made reducing fraud, waste and abuse in federal health care programs part of its core mission, but it is not the first administration to do so. Coordinated government fraud-fighting efforts have occurred with relative frequency, which suggests that it is more difficult to eradicate fraud than it is to make fraud fighting a priority. For example, the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) contained health care fraud provisions and many statements were made during the Clinton Administration about the importance of devoting resources to fraud fighting, similar to those statements that the Obama Administration has made in the past two years.¹⁹ Similarly, the Medicare supplier standards in place now were implemented as part of a mid-1990s focus on preventing fraud rather than using the “pay and chase” model recently decried by CMS’ Budetti and others in Washington.²⁰

Government Analyses

Recently, several government oversight agencies have voiced skepticism about the effectiveness of CMS and its contractors at fighting fraud, waste and abuse. In March 2010, the GAO published a report examining CMS’ oversight of RACs and the agency’s progress in addressing RAC-identified vulnerabilities in the Medicare provider

payment system. The GAO report on the Medicare RAC Demo analyzed the extent to which CMS developed a process and took corrective actions to address vulnerabilities in the payment system identified by RACs. It also evaluated the coordination between RACs and the Medicare claims administration contractors and methods CMS used to oversee RAC review accuracy. The report concluded that CMS should improve its corrective action process by designating responsible personnel to evaluate and promptly address RAC-identified vulnerabilities to reduce improper payments, and CMS agreed with these recommendations.²¹

The OIG also published a study on the Medicare RACs’ fraud referrals to CMS during the demonstration project and the training provided by CMS to RACs regarding fraud identification and referral. Although RACs are not charged with identifying fraud, while reviewing claims for improper payments they may come across instances where overpayments appear to include fraudulent activity, and they are required to refer these cases to CMS. While RACs receive contingency fees for the overpayments they identify, they do not receive contingency fees for cases that are determined to be fraud. The OIG noted that this may serve as a disincentive for RACs to refer

cases of potential fraud. The OIG report found that only two cases of potential fraud were referred to CMS during the RAC demonstration project; however, CMS reported to OIG that it did not receive specific provider referrals from RACs during that period. OIG recommended that CMS conduct follow-up research to determine the outcomes of the two referrals made during the demonstration and implement a database system to track the fraud referrals it receives from RACs. It also recommended that CMS require RACs to receive training on identifying and referring fraud.²² In response to these findings, CMS has proposed a requirement that Medicaid RACs report suspected fraud as well as overpayments, but the extent to which that requirement will change the RACs’ behavior is not yet clear.

Provider Frustrations

While oversight agencies such as GAO and OIG have criticized CMS for not doing enough to reduce fraud, waste and abuse, providers have voiced frustration with CMS and its contractors for other reasons. The most common provider complaints are of apparent confusion and duplication of efforts among the contractors. For example, MACs, ZPICs and RACs are charged with reviewing hospital Medicare claims, and hospitals

may be required to respond to simultaneous audits of the same claims or to duplicative record requests.

Hospitals have reported problems with Medicare RACs, including receiving audit requests for the wrong hospital, receiving excessive medical document requests, and having inpatient rehabilitation facilities and critical access hospitals audited without CMS approval. Hospitals also have complained about RACs’ disproportionate focus on recovering overpayments. During the RAC demonstration period, Medicare RACs identified and collected or corrected over \$1 billion in improper payments, 96% of which were overpayments. Reconciliation of underpayments continues to pose a problem for hospitals, but there appears to be little focus by CMS or the individual RACs on it. Moreover, in its

proposed regulations, CMS requires states to pay Medicaid RACs on a contingency fee basis for any overpayments identified, but the agency leaves payment for any underpayments identified to the states’ discretion. Thus, Medicaid RACs are unlikely to have the same incentive to identify underpayments as they do overpayments.

Just as the Medicare RACs may duplicate efforts of the ZPICs and MACs, Medicaid RACs also may duplicate efforts of other Medicaid auditors. In its proposed regulations implementing the Medicaid RAC program, CMS requires states to “maintain their existing program integrity efforts uninterrupted with respect to levels of funding and activity,” emphasizing that Medicaid RACs are a supplement to existing program integrity initiatives. And, while

CMS has discretion to grant exceptions to Medicaid RAC program requirements, CMS has not indicated that it would exempt a state from the requirement to establish a Medicaid RAC program even if that state had already implemented a Medicaid audit program that performed equivalent functions. States seeking exemptions from the Medicaid RAC requirement must submit written justifications to CMS, and CMS anticipates granting those exemptions “rarely, and only under the most compelling of circumstances.”

Tension with Existing Interpretations of the Fraud and Abuse Laws

Some have expressed concern about a conflict between fighting fraud and the overarching desire to “bend the cost curve.” The ACA authorizes pilot

Recovery Audit Contractors add to CMS redundancy and complexity.

Chart 5: Overlap Between Recovery Audit Contractors (RACs) and Other Contractors.

	Incorrectly Billed Claims	Processing Errors	Medical Necessity	Incorrect Payment Amounts	Non-covered Services	Incorrectly Coded Services	Duplicate Services
Recovery Audit Contractors (RACs)	✓	✓	✓	✓	✓	✓	✓
Medicare Administrative Contractors (MACs)	✓	✓	✓	✓	✓	✓	✓
Zone Program Integrity Contractors (ZPICs)			✓	✓	✓	✓	✓
Comprehensive Error Rate Testing Program (CERT)			✓	✓	✓	✓	✓

Sources: AHA analysis of CMS programs. CERT Overview. <http://www.cms.hhs.gov/cert>; Government Accountability Office. September 2006). *Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised*. Washington, DC; Fedor, F. (2005). Recovery Audit Contractors “RAC” Up Another Challenge for Providers. *Healthcare Financial Management*, 59(9), 52-56; Stockdale, H. (October 2007). *Medicare Program Integrity: Activities to Protect Medicare from Payment Errors, Fraud, and Abuse*. Washington, DC: Congressional Research Service; Office of the Inspector General. <http://oig.hhs.gov/oas/oas/cms.html> and http://www.oig.hhs.gov/publications/docs/workplan/2008/Work_Plan_FY_2008.pdf.

projects such as the Medicare Shared Savings Program that uses accountable care organizations (ACOs) in which participating hospitals and physicians coordinate care delivery and share in any savings that result. The ACA also grants HHS authority to waive statutory fraud and abuse provisions that otherwise would prohibit financial and treatment collaborations between hospitals and doctors.²³ Such waivers will

be necessary because existing interpretations of the basic fraud and abuse statutes have traditionally rejected financial collaborations between hospitals and doctors involving patient treatment regardless of whether the goal is to reduce costs or improve care.²⁴

Risk of Changing Existing Practices

When ever CMS clarifies policy guidance, hospitals that change their

practices in an effort to comply may face liability for overpayments or even under the FCA. This risk is increased as more and more CMS contractors scrutinize individual claims using predictive modeling. In addition, a whistleblower may allege that a change in practice demonstrates that a hospital has been submitting incorrect or false claims throughout the time period preceding those changes.

VI. Conclusion

Despite problems and redundancies that hospitals and others have identified in federal health care program integrity efforts, the Administration's strong emphasis on fighting fraud, waste and abuse and the issue's bipartisan appeal suggest that these initiatives will not be temporary and that hospitals must seek to improve program

integrity operations for the indefinite future. In June 2010, President Obama committed to reducing the improper payment rate in Medicare fee-for-service by 50% by 2012 – a seemingly insurmountable undertaking. Precisely how the government will go about achieving that goal is not clear, but HHS has indicated a desire

to work with hospitals to prevent and detect fraud. For example, Associate Deputy Secretary Smolonsky has stated that “hospitals are an untapped resource with which CMS needs to communicate better and increase its education and partnership efforts.” Plans for such collaboration remain to be developed, however.

POLICY QUESTIONS

- How can the Executive Branch coordinate its fraud and abuse efforts to reduce redundancy?
- Hospitals want to help reduce fraud and abuse and the government says it is looking for providers to be its partner in that endeavor. How can hospitals collaborate with the government to reduce fraud and abuse?

ENDNOTES

- 1 Patient Protection and Affordable Care Act of 2010, available at: <http://www.healthcare.gov/law/about/index.html>.
- 2 Budetti, P. (September 22, 2010). *Cutting Waste, Fraud, and Abuse in Medicare and Medicaid*. Testimony before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health.
- 3 Interview with Marc Smolonsky, Associate Deputy Secretary, HHS. Washington, DC (December 8, 2010).
- 4 On August 25, 2008, Senator Grassley sent a letter to CMS regarding the OIG's findings in which he said "it appears that CMS may have deliberately instructed the contractor to take the unusual step of undertaking a limited review of the available data so as to make the error rate calculation far smaller than it was in reality." Access at: <http://finance.senate.gov/newsroom/ranking/release/?id=c2b6e859-6ee8-4775-a0d4-f5737c474899>. Senator Grassley also asked the OIG to review the FY 2008 error rates when they became available and sent a letter to CMS asking the agency to account for what it had done to address controversy over the CERT methodology. Access at: http://grassley.senate.gov/news/Article.cfm?customel_dataPageID_1502=24547
- 5 Small Business Jobs Act of 2010, Section 4241.
- 6 The Secretary has not yet identified the ten states with the highest fraud and abuse risk, but CMS did issue a solicitation for a predictive modeling contractor on December 16, 2010. On March 30, 2011, in a hearing before the Senate Appropriations Committee, HHS Secretary Sebelius said implementation of predictive modeling had been delayed.
- 7 Presentation by Peter Budetti to the American Hospital Association (January 19, 2011).
- 8 Access to SEIU report at <http://www.seiu-uhw.org/assets/pdf/Septicemia-Prime-Hospitals-2008.pdf>.
- 9 Williams, L. and Jewett, C (2010). U.S., California probe Prime Healthcare. *Los Angeles Times*. Access at: <http://articles.latimes.com/print/2010/oct/12/local/la-me-prime-healthcare-20101012>.
- 10 The SEIU analyzed CMS Medicare Provider Analysis and Review (MedPAR) data. To receive access to these data, requesters must show that they propose to use the data for a research purpose that ultimately could improve the care provided to Medicare patients or the policies that govern that care. (This includes projects related to improving the quality of life for Medicare beneficiaries or improving the administration of the Medicare program and would encompass payment-related projects and the creation of analytical reports.) Thus, it appears that any member of the public who intends to use CMS hospital data for research purposes that could arguably improve Medicare policy or the care provided to Medicare beneficiaries could qualify to receive access to MedPAR data and perform his or her own analysis. See https://www.cms.gov/PrivProtectedData/10_LimitedDataSets.asp.
- 11 American Hospital Association (2010). Letter to Department of Justice. Access at: <http://www.aha.org/aha/letter/2010/100907-let-HEAT-FCA.pdf>.
- 12 Patient Protection and Affordable Care Act of 2010, Section 6402. Presumably, the timetable for repayment where there is a specified process such as that governing Medicare RACs would control.
- 13 BNA Health Care Fraud Report (2010). *Medicare Fraud Strike Forces Have 97 Percent Conviction Rate, DOJ Says*.
- 14 *Ibid.*
- 15 *Ibid.*
- 16 *Ibid.*
- 17 Corr, W. (March 4, 2010). *Efforts to Combat Health Care Fraud and Abuse*. Testimony before the U.S. House of Representatives Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies.
- 18 Iglehart, J.K. (2010). The ACA's New Weapons Against Health Care Fraud. *The New England Journal of Medicine*. Access at: <http://healthpolicyandreform.nejm.org/?p=3671>.
- 19 See, e.g., Health Insurance Portability and Accountability Act of 1996, Section 202 (authorizing CMS to contract with entities to fulfill Medicare integrity functions). See also Hyman, D.A. (2002). HIPAA and Health Care Fraud: An Empirical Perspective. *Cato Journal*, 22:1, 151 (quoting Bruce Vladeck, then-administrator of the Health Care Financing Administration, that there had been "an enormous increase in health care fraud and program abuse . . . [and] considerable temptations are cropping up for those unable to resist the quick buck").
- 20 December 22, 2010 news report quoting Peter Budetti. Access at: <http://www.wtop.com/?sid=2209604&nid=111>.
- 21 United States Government Accountability Office (2010). *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*. Washington, DC: Government Accountability Office.
- 22 Department of Health and Human Services Office of Inspector General (2010). *Recovery Audit Contractors' Fraud Referrals*. Washington, DC: Department of Health and Human Services Office of Inspector General.
- 23 Patient Protection and Affordable Care Act of 2010, Section 3022.
- 24 These new models may run afoul of existing fraud and abuse provisions and stakeholders will need to work through any conflicts as they arise. Iglehart, J.K (2010). The supercharged federal effort to crack down on fraud and abuse. *Health Affairs*, 29, no. 6, 1093-5.

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