Management Challenge 2: Fighting Fraud, Waste, and Abuse in Medicare Parts A and B

Why This Is a Challenge

To secure the future of health care for Medicare beneficiaries, the Department must be vigilant in reducing wasteful spending and promoting better health outcomes at lower costs. The Institute of Medicine estimated that 30 percent of U.S. health spending (public and private) in 2009 — roughly $750 billion — was wasted on unnecessary services, excessive administrative costs, fraud, and other problems.[2] Waste in health care programs is a multidimensional problem. HHS faces challenges—and opportunities—in each of the key areas of focus addressed below.

Reducing Improper Payments. CMS reported an improper payment rate of 12.7 percent for Medicare fee for service (Parts A and B), corresponding to an estimated $45.8 billion in improper payments in FY 2014. This measure includes payments for unnecessary services, billing or coding errors, and payments for claims that did not meet documentation or other Medicare coverage requirements. (For more information on improper payment rate measurement and reporting, see Management Challenge 4.)

Challenges affect every stage of the payment process, from making the initial payment accurately (including implementing appropriate payment edits) to recovering overpayments. High Medicare improper payment rates exist for various services, including home health, skilled nursing, and evaluation and management services. Audits of hospitals have uncovered and sought to remedy improper billing and payments for myriad issues, such as incorrect billing for transfers to post-acute care and inaccurate patient diagnosis codes. Furthermore, accurate billing by hospitals for short inpatient stays versus outpatient observation stays has been an area of considerable challenge and concern. CMS relies on contractors for most of these crucial functions; however, OIG has identified deficiencies in contractor performance and in CMS's oversight of these contractors. Medicare's recent transition to a new system of diagnosis codes, the ICD-10, may bring implementation challenges and potential increases in improper billing as providers and suppliers transition to the new codes. In the lead-up to implementation of ICD-10, CMS has issued guidance providing temporary flexibility in the claims auditing and quality reporting process in response to requests from the provider community.

The Department is facing significant challenges in adjudicating provider appeals of Medicare overpayments - which primarily include Parts A and B claims - including a substantial backlog of appeals at the administrative law judge (ALJ) level (third level of appeals, administered by the Office of Medicare Hearings and Appeals); inconsistent decisions among the ALJs and between the ALJs and Qualified Independent Contractors (second level of appeals, administered by CMS); and insufficient CMS participation in the appellate process.

Preventing and Deterring Fraud. Curbing fraud is vital to conserving scarce health care resources and protecting beneficiaries. Fraud schemes shift over time, but certain Medicare services have been consistent targets. They include services provided by durable medical equipment (DME) suppliers, home health and hospice agencies, community mental health centers, clinical laboratories, ambulance transportation suppliers, outpatient therapy providers, and chiropractors. CMS's contractors play a key role in fighting Medicare fraud.

However, CMS is not realizing the full potential of contractors to proactively identify fraud and address other program integrity concerns.

Fostering Economical Payment Policies. As a result of certain payment policies, Medicare pays significantly different amounts for the same services for similar patients in different settings. For example, Medicare pays significantly more for services performed in an outpatient hospital department than for the same services performed in an ambulatory surgical center (ASC). For low-risk patients who do not need hospital-level care at an outpatient hospital department, Medicare could save billions of dollars by paying for those services at ASC rates. In another example, Medicare could reduce expenditures by millions of dollars per year if infusion drugs administered in conjunction with DME were paid on the basis of average sales prices, as is the case with most other drugs covered by Medicare Part B.

Certain payment policies that create incentives for providers to bill for more expensive care instead of the appropriate levels of care result in billions of dollars in wasteful spending and compromised care for beneficiaries. For example, Medicare's payment policy for skilled nursing facility (SNF) beneficiaries who also need therapy give providers incentive to bill for higher levels of therapy than necessary.

Progress in Addressing the Challenge

Overall, the Department has taken steps, including implementing many of OIG's recommendations, to combat Medicare waste, including fraud, resulting in cost savings, improved program operations, and enhanced protections for beneficiaries. The Health Care Fraud and Abuse Control Program (a joint program of the Department, CMS, OIG, and the Department of Justice (DOJ) to fight waste, fraud, and abuse in Medicare and Medicaid) returned $7.70 for every $1 invested. In FY 2014, OIG audits and investigations resulted in expected recoveries of $4.9 billion in improperly spent federal health care dollars. In addition, OIG reported estimated savings of more than $15 billion from legislative, regulatory, and administrative actions supported by OIG recommendations.

CMS has moved to improve the integrity and accuracy of billing for numerous types of services. For example, CMS implemented a provision of the *Affordable Care Act* that practitioners who certify Medicare patients as eligible for home health services must document their face-to-face encounters with those patients. CMS modified this requirement, effective January 1, 2015, and is continuing to work to improve this requirement's low rates of compliance. Additionally, CMS started a demonstration project that requires prior authorization for scooters and power wheelchairs in seven states with high incidences of fraud and improper payments, and in FY 2015 expanded this demonstration project to include an additional 12 states. CMS continues to work to address hospital billing for short inpatient stays and outpatient observation stays, which significantly affects Medicare spending, beneficiary cost-sharing, and hospital revenue.

CMS reports that it is working to identify potential alternatives to the existing methodology used to pay for therapy services under the SNF Prospective Payment System (PPS). CMS initiated the SNF PPS Payment Model Research project and reports that it is working to identify potential alternative SNF payment models for further analysis.

In connection with the International Classification of Diseases, 10th Revision (ICD-10), CMS reports that it has established an ICD-10 Coordination Center for monitoring the implementation of ICD-10, identifying and triaging issues for resolution, and responding to inquiries. It also has named an ICD-10 ombudsman to help receive and deal with provider issues.

OIG noted reductions in Medicare billing and payments for certain services and geographic areas known for fraud risks. For example, following law enforcement activities and administrative actions by CMS, billing and payments for home health services and community mental health services declined significantly in fraud hot spots. CMS also instituted temporary moratoria on the enrollment of new home health agencies and ambulance transportation suppliers in select cities and known fraud hot spots. Additionally, CMS continues to develop its Fraud Prevention System (FPS), which had a $133 million in adjusted actual and projected savings in its third

implementation year, and represented a positive return on investment of $2.84 for every $1 spent that was certified by OIG.

CMS reported improvements in its oversight and measurement of its contractors' performance and its follow-up on improper payment vulnerabilities that contractors identify. The Department also continues to focus on resolving the backlog of Medicare appeals by providers. CMS reports that it has taken steps toward this goal.

What Needs To Be Done

Despite progress in key areas, more needs to be done to protect Medicare from waste, including fraud. CMS needs to better ensure that Medicare payments are accurate and appropriate. When Medicare improper payments occur, CMS needs to identify and recover them in a timely manner. CMS must also implement safeguards, as needed, to prevent recurrence. CMS relies on contractors for most of these crucial functions; therefore, ensuring effective contractor performance is essential. Finally, the Medicare appeals system needs fundamental changes to resolve appeals efficiently, effectively, and fairly. OIG has recommended numerous actions to advance these outcomes.

Key OIG Resources

- OIG Testimony, Fraud in Medicare, March 2015
- OIG Testimony, Medicare Program Integrity: Screening Out Errors, Fraud, and Abuse, June 2014
- OIG Testimony, Medicare Mismanagement: Oversight of the Federal Government Efforts to Recapture Misspent Funds, May 2014
- OIG Compendium of Unimplemented Recommendations, March 2015
- OIG Report, The Medicare Payment System for Skilled Nursing Facilities Needs To Be Reevaluated, September 2015

Footnotes

[2]Institute of Medicine, Best Care at Lower Cost: The Path to Continuously Learning Health Care in America, September 6, 2012. The Institute of Medicine report includes fraud and abuse as components of waste.

Management Challenge 3: The Meaningful and Secure Exchange and Use of Electronic Information and Health Information Technology