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MEDICARE
INTEGRITY
PROGRAM

CMS Used Increased
Funding for New
Activities but Could
Improve Measurement
of Program
Effectiveness

U.S. Government Accountability Office



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ACCOUNTABILITY ★ INTEGRITY ★ RELIABILITY

Why GAO Did This Study

The Medicare program makes about \$500 billion in payments per year and continues to have a significant amount of improper payments—almost \$48 billion in fiscal year 2010. The Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program (MIP) is designed to identify and address fraud, waste, and abuse, which are all causes of improper payments. MIP's authorizing legislation provided funding for its activities and subsequent legislation provided additional funding.

GAO was asked to report on how effectively CMS is using MIP funding to address Medicare program integrity. GAO examined (1) how CMS used MIP funding to support the program's activities from fiscal years 2006 through 2010, (2) how CMS assesses the effectiveness of MIP, and (3) factors CMS considers when allocating MIP funding. GAO analyzed CMS budget and other documents, interviewed CMS officials, and examined the agency's method of calculating return on investment (ROI), a performance measure used by CMS to measure the effectiveness of MIP activities.

What GAO Recommends

GAO recommends that CMS communicate the linkage between MIP activities and the goals for reducing improper payments and that CMS expeditiously improve the reliability of data used to calculate ROI. The Department of Health and Human Services concurred with these recommendations.

View [GAO-11-592](#) or key components. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

MEDICARE INTEGRITY PROGRAM

CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness

What GAO Found

CMS used the increase in total MIP funding received, from \$832 million in fiscal year 2006 to \$1 billion in fiscal year 2010, to expand MIP's activities. The additional funding supported oversight of Medicare Part C (Medicare benefits managed through private plans) and Part D (the outpatient prescription drug benefit) and agency efforts to examine the claims of Medicare beneficiaries who also participate in Medicaid—a joint federal-state health care program for certain low-income individuals. CMS officials also reported that CMS was able to move some funding from activities, such as provider audit, to other activities because of savings achieved from consolidating contractors. The largest percentage increase from this redistribution went to benefit integrity activities, which aim to deter and detect Medicare fraud through proactive data analysis and coordination with law enforcement.

Although CMS has reported that the agency measures MIP's performance with goals related to reductions in the improper payment rates for Medicare fee-for-service, Part C, and Part D, CMS officials with direct responsibility for MIP generally do not connect measurements of effectiveness of MIP activities with the CMS goals of reducing improper payments. These goals to reduce improper payments, which were reported as goals previously and for fiscal year 2012, are particularly important in light of the President's Accountable Government Initiative, which aims to reduce overall improper payments by \$50 billion by the end of 2012. In interviews with GAO, CMS officials with direct responsibility for implementing MIP activities generally did not connect the measurement of effectiveness of MIP activities with these CMS goals to reduce improper payments and instead cited other measures of effectiveness. This suggests that CMS has not clearly communicated to its staff the relationship between the daily work of conducting MIP activities and the agency's improper payment reduction performance goals. Because MIP will be central to CMS's efforts to reduce Medicare improper payments, MIP staff need to understand how their work supports these goals. In addition, the Patient Protection and Affordable Care Act requires CMS to report annually on the use of funds for MIP and the effectiveness of the use of those funds. One way that CMS already measures MIP effectiveness is ROI, which CMS calculates as savings from an activity in relation to expenditures. CMS calculates ROI for most of its MIP activities, but the data it uses have two flaws. First, ROI calculations are not updated when program expenditure data, a key component in the ROI calculation, are updated, which may lead to an incorrect ROI. Second, CMS does not have reliable information to determine the amount of MIP spending by activity for one type of contractor that received about 22 percent of total MIP funding in fiscal year 2010. It will be important for CMS to correct these flaws to ensure reliability in ROI reporting.

CMS considers a variety of factors when allocating MIP funding. Based on a review of the documents submitted to justify funding of specific MIP activities, CMS may consider the prior year's funding level, the consequence of not funding, and the performance goal that the activity is intended to meet.

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Abbreviations

CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
CPI	Center for Program Integrity
DOJ	Department of Justice
DRA	Deficit Reduction Act of 2005
GPRA	Government Performance and Results Act
HEAT	Health Care Fraud Prevention and Enforcement Action Team
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
MAC	Medicare administrative contractor
MEDIC	Medicare drug integrity contractor
Medi-Medi	Medicare-Medicaid Data Match Project
MIP	Medicare Integrity Program
MSP	Medicare Secondary Payer
OFM	Office of Financial Management
OIG	Office of Inspector General
OMB	Office of Management and Budget
PPACA	Patient Protection and Affordable Care Act
PSC	program safeguard contractor
ROI	return on investment
ZPIC	zone program integrity contractor

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G A O

Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

July 29, 2011

The Honorable Thomas R. Carper
Chairman
The Honorable Scott P. Brown
Ranking Member
Subcommittee on Federal Financial Management,
Government Information, Federal Services, and
International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable John McCain
United States Senate

The Centers for Medicare & Medicaid Services' (CMS) Medicare Integrity Program (MIP) is designed to identify and address fraud, waste, and abuse,¹ which are all causes of improper Medicare payments. An improper payment is any that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. Medicare makes about \$500 billion in payments per year and continues to have a significant amount of improper payments. For example, in fiscal year 2010, the estimated improper payments for Medicare fee-for-service (Parts A and B) were about \$34.3 billion and for Medicare Advantage (Part C) were about \$13.6 billion.² We have designated Medicare as a high-risk program since 1990, in part because the program's complexity and size

¹*Government Auditing Standards* defines fraud as a type of illegal act involving the obtaining of something of value through willful misrepresentation. Abuse is defined as behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary business practice given the facts and circumstances. See GAO, *Government Auditing Standards*, [GAO-07-731G](#) (Washington, D.C.: July 2007).

²Medicare consists of four parts. Parts A and B are known as original Medicare or Medicare fee-for-service. Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services. Part C is Medicare Advantage, under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit. These estimates of improper payments do not fully measure improper payments in Medicare as a whole because an error rate for Part D will not be available until November 2011.

made it vulnerable to fraud, waste, and abuse. Since that time, Medicare has grown, and in 2006 a new benefit—the Medicare prescription drug benefit (Part D)—was added, making the task of addressing improper payments in a program of Medicare’s size even greater.

The Office of Management and Budget (OMB) is leading a governmentwide effort to reduce improper payments. MIP is important to this effort because of the size of the Medicare program. In fiscal year 2010, Medicare improper payments represented about 38 percent of all federal government improper payments.³ MIP was established, and provided with a dedicated source of mandatory funding from the Federal Hospital Insurance trust fund,⁴ in the Health Insurance Portability and Accountability Act of 1996 (HIPAA)⁵ to enhance efforts to address Medicare’s vulnerabilities to fraud, waste, and abuse.⁶

MIP is designed to better ensure the integrity of the Medicare program by identifying and addressing improper payments and helping to prevent and stop fraud and abuse through several types of activities, such as educating providers on proper billing practices, auditing reported costs used to set payments for hospitals and other institutional providers, and coordinating with law enforcement to target potential fraud. These activities are generally conducted by contractors working for CMS.

³This does not include improper payments from Part D because CMS did not report an improper payments estimate for Part D for fiscal year 2010.

⁴Mandatory funding refers to budget authority that is provided in laws other than appropriation acts and the outlays that result from such budget authority. In contrast, discretionary funding refers to funding provided in and controlled by appropriation acts. Financial transactions for Medicare Part A operate through the Federal Hospital Insurance trust fund. The main source of income for Medicare’s Federal Hospital Insurance trust fund is taxes on wages and self-employment income.

⁵Pub. L. No. 104-191 §§ 201(b), 202, 110 Stat. 1936, 1993 (codified at 42 U.S.C. §§ 1395i(K)(4), 1395ddd).

⁶Before 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. The level of funding available for program integrity activities during this period was constrained by the need to fund ongoing Medicare administrative activities and provisions in the Budget Enforcement Act of 1990, which required reductions in discretionary spending for other programs, such as immunizations or job training, in order to increase Medicare’s administrative budget. Pub. L. No. 101-508, title XIII, 104 Stat. 1388, 1388-573–1388-630. In the early and mid-1990s, we reported that such funding constraints had reduced Medicare contractors’ ability to conduct program integrity activities.

In 2006, we reported that while funding for MIP had increased over time, the approach CMS used to allocate funding among MIP activities had weaknesses.⁷ Specifically, we found that allocations for MIP activities were generally based on historical allocation levels, not on risk for improper payments. We also noted that programmatic changes in Medicare, particularly the prescription drug benefit and Medicare contracting reform,⁸ would affect MIP funding allocations, and that the allocation approach was not adequate to address the associated emerging risks for improper payments. Finally, we found that CMS tracked dollars saved in relation to dollars spent—a useful quantitative measure that the agency calls return on investment (ROI)—to assess the effectiveness of some MIP activities, but did not attempt to objectively measure the effectiveness of all of its MIP activities. In our 2006 report, we recommended that CMS develop a method of allocating MIP funding based not only on the effectiveness of the program’s activities but also on contractor workloads and risk for improper payments.

Since our 2006 report, there have been changes in the funding and scope of MIP. Congress has appropriated discretionary MIP funding to supplement existing mandatory funding, in part to address increased responsibilities because of the addition of the Medicare prescription drug benefit. You requested that we report on how effectively CMS is using its MIP funding to address program integrity. Specifically, this report will examine (1) how CMS used its MIP funding to support the program’s activities from fiscal year 2006 through fiscal year 2010, (2) how CMS assesses the effectiveness of MIP, and (3) the factors CMS considers when allocating MIP funding.

To determine how CMS used its MIP funding to support the program’s activities from fiscal year 2006 through fiscal year 2010, we analyzed CMS budget documents and conducted interviews with officials from CMS’s Office of Financial Management (OFM) and officials who manage

⁷GAO, *Medicare Integrity Program: Agency Approach for Allocating Funds Should Be Revised*, [GAO-06-813](#) (Washington, D.C.: Sept. 6, 2006).

⁸As mandated under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS has been replacing about 50 claims administration contractors with 19 Medicare administrative contractors (MAC). Pub. L. No. 108-173, § 911, 117 Stat. 2066, 2378 (codified at 42 U.S.C. § 1395kk-1). These MACs process and pay claims, answer questions from Medicare providers, and implement Medicare coverage rules. CMS plans to further consolidate the number of contractors from 19 to 14 during the next round of contract awards and transitions over the next several years.

each of the MIP activities (whom we refer to as MIP activity managers). To determine the reliability of the budget data, we interviewed officials in OFM about the reconciliation process between CMS's budget and the accounting systems and reviewed an example of CMS's monthly reconciliation report. We determined that the data were sufficiently reliable for our purposes.

To determine how CMS assesses the effectiveness of MIP,⁹ we conducted interviews with the Deputy Administrator for CMS's Center for Program Integrity (CPI), the Director of the Medicare Program Integrity Group, MIP activity managers, and officials from OFM and CPI. We also interviewed officials from the Department of Health and Human Services (HHS) responsible for departmentwide program integrity efforts. We reviewed relevant documents that described specific processes CMS employs for determining whether MIP and its individual activities have been effective and compared these processes against GAO's criteria on agency strategic planning and performance measurement.¹⁰ We examined CMS's method for calculating the MIP ROI and interviewed MIP activity managers and OFM officials about the data sources and methods used to calculate the ROI figures.

To describe the factors CMS considers when allocating MIP funding, we reviewed MIP budget request documents for funded subactivities within the MIP activities for fiscal year 2010.¹¹ We also interviewed CMS officials, including those from OFM, as well as MIP activity managers, the Director of the Medicare Program Integrity Group, and the Deputy Administrator for CPI.

We conducted this performance audit from May 2010 through July 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our

⁹Effectiveness is the extent to which an activity fulfills its intended purpose or function.

¹⁰GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act*, [GAO/GGD-96-118](#) (Washington, D.C.: June 1996).

¹¹CMS provided us with 49 MIP budget request documents (which are called glossaries by CMS) for subactivities that requested MIP funding for fiscal year 2010. Of the 49 budget request documents we received, 13 were for subactivities that were not ultimately funded. Therefore, we did not include these 13 requests in our review. We also received budget request documents for MIP-funded information technology subactivities, but did not include these in our analysis because they are assessed for funding through a separate process.

findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

MIP Funding

CMS has indicated that the primary principle of program integrity is to pay claims correctly.¹² MIP is designed to address fraud, waste, and abuse, including improper payments, by (1) preventing fraud through effective enrollment of providers and through education of providers and beneficiaries; (2) detecting potential improper billing early through, for example, medical review and data analysis of claims; (3) coordinating closely with partners, including contractors and law enforcement agencies; and (4) implementing fair and firm enforcement policies.

HIPAA established mandatory funding for MIP that ensured a stable funding source for Medicare program integrity activities from the Federal Hospital Insurance trust fund not subject to annual appropriations. The amount specified in HIPAA rose for the first few years and then was capped at \$720 million per year in fiscal year 2003 and future years. CMS received increased and additional mandatory funding for MIP from the Federal Hospital Insurance trust fund in fiscal year 2006 under the Deficit Reduction Act of 2005 (DRA) and, in addition, received discretionary funding beginning in fiscal year 2009.

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) was signed into law. It included provisions that will provide MIP with a portion of an additional \$350 million, to be shared with the Department of Justice (DOJ) and HHS, for fiscal year 2011 through fiscal year 2020 for health care fraud and abuse control efforts.¹³ It also increases funding for MIP each year by the percentage increase in the consumer price index for all urban consumers.

¹²For the purposes of this report, we consider program integrity a component of the effective and efficient administration of government programs, which are entrusted with ensuring that taxpayer dollars are spent wisely. Efforts to ensure Medicare program integrity include processes directed at reducing payment errors to Medicare providers as well as activities to prevent, detect, investigate, and ultimately prosecute health care fraud.

¹³Pub. L. No. 111-148, § 6402(i), 124 Stat. 119, 760, as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1303, 124 Stat. 1029, 1057.

MIP Activities

MIP currently has eight activities, and each of these has multiple subactivities. As we reported in 2006, CMS undertook five original MIP activities required by HIPAA:

- **Benefit Integrity.** Aims to deter and detect Medicare fraud by conducting proactive data analysis of claims to identify patterns of fraud and taking other steps to determine whether fraud could be occurring. Potential fraud cases are documented and referred to law enforcement agencies.
- **Provider Audit.** Includes desk reviews, audits, and final settlement of institutional provider cost reports, such as those submitted by hospitals and skilled nursing facilities, which are used to establish payment rates.
- **Medicare Secondary Payer (MSP).** Identifies when beneficiaries have primary sources of payment—such as employer-sponsored health insurance, automobile liability insurance, or workers' compensation insurance—that should pay claims that were mistakenly billed to Medicare. MSP also involves recovering improper payments associated with such claims.
- **Medical Review.** Includes both automated and manual prepayment and postpayment reviews of individual Medicare claims to determine whether the services are provided by legitimate providers to eligible beneficiaries and are covered, medically reasonable, and necessary.
- **Provider Outreach and Education.** Provides training for providers, such as hospitals and physicians that serve Medicare beneficiaries, on appropriate billing practices to comply with Medicare rules and regulations.

Since 2006, CMS has begun three additional MIP activities:

- **Medicare-Medicaid Data Match Project (Medi-Medi).** Was added to MIP by DRA.¹⁴ DRA provided this activity with its own dedicated funding source through a separate appropriation. Medi-Medi is a joint effort between CMS and states that participate voluntarily to identify providers with aberrant Medicare and Medicaid billing patterns through analyses of claims for individuals with both Medicare and Medicaid coverage.

¹⁴Medicaid is a joint federal-state health care program for certain low-income individuals.

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- **Part C and D Oversight.** Consists of subactivities to address improper payments in Medicare Parts C and D. CMS began this activity in fiscal year 2006.
 - **Other Medicare Fee-For-Service.** Consists of a variety of subactivities related to Medicare fee-for-service not captured by the other activities, such as support for pilot programs and enhancements to CMS data systems that CMS officials told us will allow for better analysis. CMS began these subactivities in fiscal year 2009.

CPI is the CMS component responsible for oversight of all of CMS's program integrity efforts, including MIP, and is led by a deputy administrator. Formed in April 2010, CPI was created to enable CMS to pursue a more strategic and coordinated program integrity approach and to also allow the agency to build on and strengthen existing program integrity efforts. CPI has targeted several program areas to help identify, evaluate, and focus resources and projects. These areas are prevention, detection, recovery, and transparency and accountability. MIP is led by the Director of the Medicare Program Integrity Group within CPI. However, the MIP activity managers and their staff members are not all located within CPI. There are MIP activity managers located in CPI, the Center for Medicare,¹⁵ and OFM. For example, while the Benefit Integrity activity is managed by CPI, the Medical Review activity is managed by CMS's Provider Compliance Group within OFM. See appendix I for an organizational chart that identifies the CMS components responsible for the oversight of MIP activities.

CMS uses a variety of contractors to perform MIP activities, including a Comprehensive Error Rate Testing (CERT) contractor, an MSP contractor, Medicare administrative contractors (MAC), Medicare drug integrity contractors, the National Supplier Clearinghouse, program safeguard contractors, and zone program integrity contractors (ZPIC). For example, the MACs conduct provider audits, prepayment and postpayment review of Medicare claims, and some provider outreach and education. See appendix II for more information on these contractors and appendix III for the activities they perform.

¹⁵The Center for Medicare serves as CMS's focal point for the formulation, coordination, integration, implementation, and evaluation of national Medicare program policies and operations.

Funding Allocation Process

MIP's activity managers and Director participate in a process to recommend funding allocations for MIP's activities through the Budget Small Group.¹⁶ The MIP activity managers submit budget request documents to the MIP Budget Small Group to help guide the funding allocation process. The MIP Budget Small Group weighs each request and submits a draft MIP budget request to the CMS Chief Financial Officer and Chief Operating Officer. Following review by these officials, the MIP budget request goes to the CMS Administrator, who reviews the request and makes any desired changes. The MIP budget request is integrated into the agency's entire proposed budget, which is sent to the Secretary of Health and Human Services. A proposed budget for the entire department goes to OMB for consideration on the President's behalf. Adjustments may be made by OMB or the President before a final version is submitted to Congress, thus beginning the congressional appropriation process.

Performance Measurement

One way that agencies examine the effectiveness of their programs is by measuring performance as mandated by the Government Performance and Results Act of 1993 (GPRA), as amended by the GPRA Modernization Act of 2010.¹⁷ GPRA is designed to improve the effectiveness of federal programs by establishing a system to set goals for program performance and to measure results. Specifically, GPRA requires federal agencies to prepare multiyear strategic plans, annual performance plans, and annual performance reports that provide information on progress achieved. To meet GPRA requirements for fiscal year 2011, CMS established the following:

- Five high-level strategic objectives, which included the objective of "accurate and predictable payments."
- Agencywide GPRA goals, which included three specific to MIP. An agency's goals should flow from its strategic objectives and be limited to the vital goals that reflect the highest priorities of an agency.¹⁸

¹⁶The process of using "small groups" to make funding allocation decisions is used throughout the agency for all CMS programs and activities.

¹⁷Pub. L. No. 103-62, 107 Stat. 285, as amended by Pub. L. No. 111-352, 124 Stat. 3866 (2011).

¹⁸GAO, *Agencies' Annual Performance Plans Under the Results Act: An Assessment Guide to Facilitate Congressional Decisionmaking*, [GAO/GGD/AIMD-10.1.18](#) (Washington, D.C.: February 1998).

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- Performance measures, which included three specific to MIP, such as reducing the percentage of improper payments made under the Medicare fee-for-service and Part C program. Performance measures are generally more numerous than the GPRA goals and are used to measure progress toward the goals and objectives.

PPACA established additional reporting requirements for MIP. PPACA requires that MIP contractors provide the Secretary of Health and Human Services or the HHS Inspector General, upon request, performance statistics.¹⁹ These performance statistics may include the number and amount of overpayments recovered, the number of fraud referrals, and the ROI of activities the contractor undertakes. The act also requires the Secretary to evaluate MIP contractors at least once every 3 years and submit an annual report to Congress on the use of funds for MIP and the effectiveness of the use of those funds.²⁰

Increased MIP Funding and Contractor Consolidation Have Enabled CMS to Expand the Program from Fiscal Year 2006 through Fiscal Year 2010

CMS used increased funding it received in fiscal years 2006 through 2010 to expand MIP. From fiscal year 2006 through 2010, CMS received mandatory HIPAA funding along with new DRA funding, and additional discretionary funding in some years, to supplement its existing program integrity activities and support two new activities—Part C and D Oversight activities and Medi-Medi. Additionally, the agency was able to realize savings in some MIP activities, in part, because of the consolidation of claims administration contracts. CMS redistributed some of these savings to Part C and D Oversight and Benefit Integrity activities.

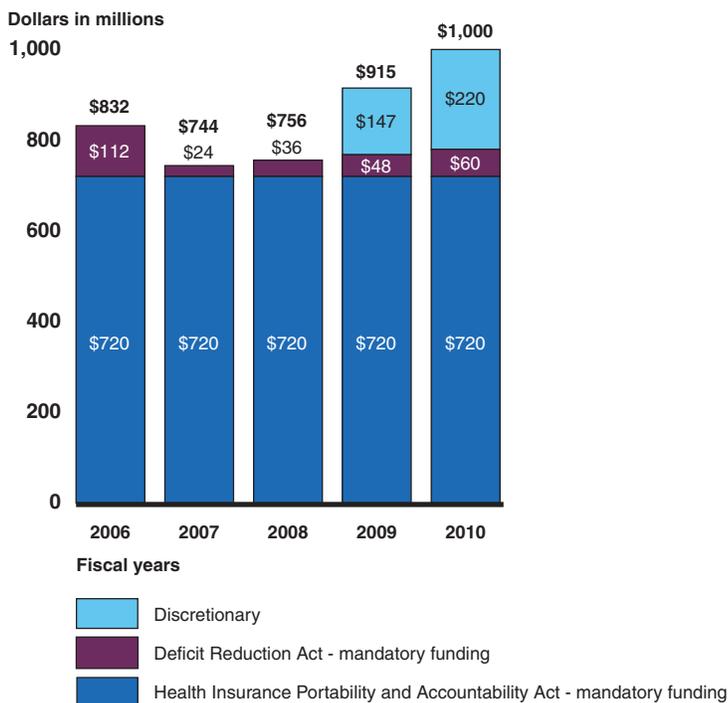
¹⁹Pub. L. No. 111-148, § 6402(j) 124 Stat. at 762 (codified at 42 U.S.C. § 1395ddd(c)(4)).

²⁰42 U.S.C. § 1395ddd(i). This report is due 180 days after the end of each fiscal year, beginning in fiscal year 2011.

Increased Funding Enabled CMS to Provide Additional Support to Existing Program Integrity Activities and Fund New Oversight Activities

CMS received additional MIP funding during fiscal years 2006 through 2010 that was used to support new activities or existing activities not previously supported by MIP. These activities included Part C and D Oversight, Medi-Medi, and Other Medicare Fee-For-Service activities. During fiscal year 2006 through fiscal year 2010, CMS received the maximum amount of mandatory funding stipulated under HIPAA, \$720 million per year, as well as additional discretionary and DRA mandatory funding. (See fig. 1.)

Figure 1: Medicare Integrity Program Appropriated Funding for Fiscal Years 2006 through 2010



Source: Centers for Medicare & Medicaid Services.

Prior to fiscal year 2006, CMS used mandatory HIPAA funding for the five original program activities—Benefit Integrity, Provider Audit, Provider Outreach and Education, Medical Review, and MSP. From fiscal year 2006 through fiscal year 2010, CMS continued to use mandatory HIPAA funding predominantly to support the five existing program integrity activities. In addition, beginning in fiscal year 2006, CMS received mandatory DRA funding, which it used to support two new MIP activities—Medi-Medi and Part C and D Oversight. DRA provided funding for Medi-Medi activities of \$12 million in fiscal year 2006, which increased

to nearly \$60 million by fiscal year 2010. CMS officials told us that the Medi-Medi funding was used to support the ZPICs that work directly with the states on the Medi-Medi project.²¹ State participation is voluntary, and states do not directly receive MIP funding.

Additional MIP funding also went toward Part C and D Oversight. DRA provided CMS with a onetime amount of \$100 million in fiscal year 2006, part of which CMS used to perform new Part C and D Oversight. In fiscal years 2007 and 2008, CMS requested but did not receive discretionary funding to perform Part C and D Oversight. As a result, CMS officials told us that mandatory HIPAA funding for MIP was moved from other MIP activities in fiscal years 2007 and 2008 to the Part C and D Oversight activity. In fiscal years 2009 and 2010, CMS received \$147 million and \$220 million, respectively, in discretionary funding and used more than half of that funding for Part C and D Oversight. In fiscal year 2009, CMS used about \$85 million of the discretionary funding (or 58 percent of the \$147 million) to perform Part C and D Oversight that addressed CMS's priority to deter fraud in the Medicare Part C and D programs. For example, CMS contractors conducted reviews of health care plans entering the Part C and D programs, and program and financial audits of the health care plans participating in the Part C and D programs. In fiscal year 2010, CMS used about \$142 million (about 65 percent of the \$220 million) to continue performing Part C and D Oversight. CMS moved the remaining discretionary funding, about \$62 million (42 percent of \$147 million) in fiscal year 2009 and \$45 million (20 percent of \$220 million) in fiscal year 2010, to the Other Medicare Fee-For-Service activity. CMS used the funding in the Other Medicare Fee-For-Service activity, in part, to fund the system that collects and stores enrollment information for all Medicare providers and suppliers in a national database.

Contractor Consolidation Enabled the Agency to Redistribute Mandatory Funding among MIP Activities

CMS officials stated that contractor consolidations resulted in some workload efficiencies and cost savings, which enabled the agency to redistribute some mandatory MIP funding to the Part C and D Oversight and Benefit Integrity activities. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required CMS to transfer all Part A and B claims administration work previously conducted by 51 claims administration contractors to MACs. As a result, from fiscal year

²¹ZPICs perform benefit integrity subactivities for claims under Parts A, B, C, and D of the Medicare program.

2006 through May 2011, CMS awarded contracts to 15 MACs, which generally covered larger jurisdictions, and replaced most of the contracts with previous claims administration contractors. CMS designed the MAC jurisdictions to achieve operational efficiencies through consolidation. Further, in response to one of our previous recommendations,²² CMS also consolidated its postpayment recovery efforts into one MSP recovery contractor in October 2006, thereby increasing the efficiency of the MSP activity.²³

CMS officials stated that the operational efficiencies and cost savings resulting from the contractor consolidations enabled the agency to decrease mandatory MIP funding to four of the five existing MIP activities and redistribute those funds to the Part C and D Oversight and Benefit Integrity activities. Specifically, from fiscal years 2006 through 2009, CMS redistributed MIP funding from the Provider Outreach and Education, Medical Review, MSP, and Provider Audit activities because these activities were less costly with fewer contractors performing the work. For example, CMS officials told us that the Provider Outreach and Education activity had less overhead and other administrative costs with fewer contractors, which resulted in reduced program expenditures. Provider Outreach and Education spending decreased from almost \$65 million in fiscal year 2006 to about \$42 million in fiscal year 2010—about 35 percent. Provider Outreach and Education had the largest percentage decrease in MIP funding. CMS officials stated that another factor in the decrease in Provider Outreach and Education spending was a realignment of some of its activities in fiscal year 2007. CMS officials also told us that under the consolidation into MAC jurisdictions, CMS required only one medical director for each MAC jurisdiction, instead of having one medical director for each state, which lowered the cost to perform the

²²See GAO, *Medicare Secondary Payer: Improvements Needed to Enhance Debt Recovery Process*, [GAO-04-783](#) (Washington, D.C.: Aug. 20, 2004). In this report, we recommended that CMS improve the efficiency of MSP payment recovery by consolidating its efforts under fewer contracts.

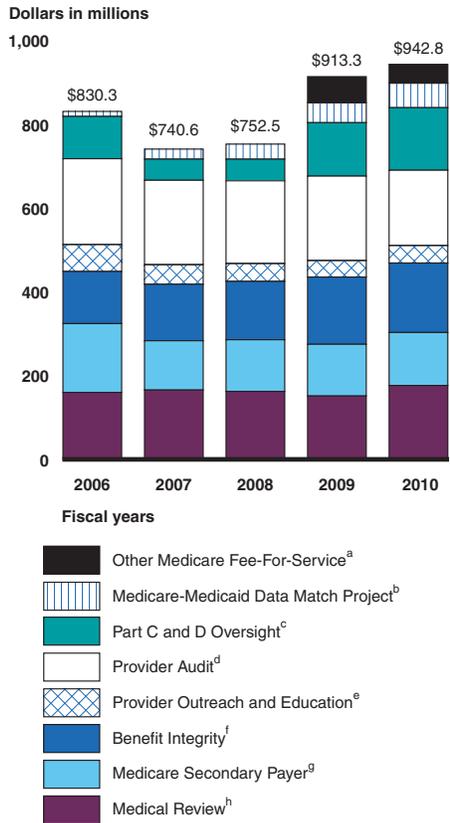
²³Formerly, the identification and recovery of funds due to MSP issues was one of several activities conducted by about 50 claims administration contractors.

Medical Review activity.²⁴ CMS officials stated that reduced costs allowed CMS to use some of the newly available MIP mandatory funding to address other priorities, such as funding Part C and D Oversight in fiscal years 2007 and 2008, when the agency received no discretionary funding. In addition, the MSP consolidation allowed CMS to reduce MIP funding for the MSP activity beginning in fiscal year 2007, and the agency used the savings to fund other MIP activities. Based on the funding information provided by CMS, we estimated that the agency saved about \$86 million from fiscal year 2006 through fiscal year 2010 by consolidating contracted functions within the MSP activity.

Benefit Integrity spending increased as a result of the redistribution among program activities. For fiscal years 2006 through 2010, Benefit Integrity had the largest percentage increase in mandatory HIPAA funding among the original five MIP activities, in part, because of cost efficiencies from contractor consolidation being redistributed to this activity. (See fig. 2.) For this period, CMS increased the amount of mandatory MIP HIPAA funds spent on the Benefit Integrity activity, from about \$125 million in fiscal year 2006 to about \$166 million in fiscal year 2010—about 33 percent. Benefit Integrity funds, among other subactivities, the work of a CMS contractor responsible for reviewing enrollment applications from durable medical equipment suppliers and conducting site visits to confirm these suppliers' compliance with Medicare regulations. This followed a period when we and HHS's Office of Inspector General (OIG) had highlighted problems with fraud in the Medicare program, including problems with suppliers of durable medical equipment. It also occurred during a period, starting in 2009, when HHS and DOJ were increasing coordination on investigating and prosecuting health care fraud through the Health Care Fraud Prevention and Enforcement Action Team, an initiative that marshals resources across the government to prevent health care fraud, waste, and abuse; crack down on those who commit fraud; and enhance existing partnerships between HHS and DOJ.

²⁴Medical Review spending decreased from fiscal year 2006 to fiscal year 2009, and then increased in fiscal year 2010. According to CMS officials, Medical Review costs were reduced, from almost \$160 million in fiscal year 2006 to about \$151 million in fiscal year 2009, partially as a result of the contractor consolidation. However, Medical Review spending increased in fiscal year 2010 to \$176.3 million—up about 17 percent from fiscal year 2009. CMS officials told us that the increased spending was for information technology to support Medical Review and a change in the funding method for the CERT program that calculated the fee-for-service improper payment rate.

Figure 2: Spending for the Medicare Integrity Program Activities for Fiscal Years 2006 through 2010



Source: Centers for Medicare & Medicaid Services.

^aOther Medicare Fee-For-Service includes a variety of Medicare fee-for-service–related subactivities not captured by other activities.

^bMedicare-Medicaid Data Match Project is a joint effort between CMS and states that participate voluntarily to analyze claims for individuals with both Medicare and Medicaid coverage to identify providers with aberrant Medicare and Medicaid billing patterns.

^cPart C and D Oversight includes subactivities designed to address improper payments in Medicare Parts C and D.

^dProvider Audit includes desk reviews, audits, and final settlement of institutional provider cost reports.

^eProvider Outreach and Education includes training for providers, such as hospitals and physicians that serve Medicare beneficiaries, on procedures to comply with Medicare rules and regulations.

^fBenefit Integrity includes subactivities designed to deter and detect Medicare fraud by conducting data analysis of claims.

^gMedicare Secondary Payer includes subactivities designed to identify claims that were mistakenly billed to Medicare when beneficiaries have primary sources of payment that should have paid the claims.

^hMedical Review includes both prepayment and postpayment reviews of individual Medicare claims to determine whether legitimate services are covered, medically reasonable, and necessary.

Not All MIP Officials Connect MIP Activities with CMS's Goals of Reducing Improper Payments; Data Used to Calculate ROI Are Flawed

Although CMS measures MIP effectiveness by using the improper payment rates for the Medicare fee-for-service, Part C Medicare Advantage, and Part D prescription drug programs, CMS officials with direct responsibility for MIP generally do not connect the MIP activities and the CMS goals of reducing improper payments. CMS added two new GPRA performance goals for MIP for fiscal year 2012 and is also developing other performance metrics based on PPACA requirements. One way that CMS measures MIP effectiveness is ROI, but the data the agency currently uses to calculate this measure are flawed.

MIP Officials Generally Do Not Connect Program Activities with CMS's Goals of Reducing Improper Payments

Three of CMS's GPRA goals for MIP in fiscal year 2012 are to reduce the improper payment rates in each part of the Medicare program,²⁵ which could contribute to the governmentwide effort to reduce improper payments. The GPRA goals, which were also goals in previous fiscal years, are to reduce the percentage of improper payments made in the Medicare fee-for-service, Part C Medicare Advantage, and Part D prescription drug programs. Each goal has a corresponding performance measure. These goals and related measures are particularly important because, as part of the Accountable Government Initiative, the President set goals for federal agencies to reduce overall improper payments by \$50 billion and recapture at least \$2 billion in improper contract payments and overpayments to health providers by the end of 2012. Because of its size, Medicare represented 38 percent of the governmentwide fiscal year 2010 improper payments. Therefore, CMS's actions to reduce payment errors in Medicare will affect the success or failure of the governmentwide effort. To respond to the President's goals, as stated in its performance plan, CMS adopted a target to reduce its improper fee-for-service error rate from 10.5 percent in fiscal year 2010 to 6.2 percent in fiscal year 2012 and the Part C error rate from 14.1 percent in fiscal year 2010 to 13.2 percent in fiscal year 2012.

Although CMS has established these GPRA goals as an important way to measure the effectiveness of MIP, our interviews with CMS officials with direct responsibility for MIP activities indicate that these officials generally do not connect MIP activities with the CMS goals of reducing improper

²⁵Centers for Medicare & Medicaid Services, *FY 2012 Online Performance Appendix*, <http://www.cms.gov/performancebudget/> (accessed Feb. 14, 2011).

payments. Only one of the five MIP activity managers²⁶ stated that CMS uses the improper payment rates to assess MIP's overall effectiveness. Some of the remaining four MIP activity managers told us that they were not aware of any overall CMS measures of MIP effectiveness. In addition, some MIP activity managers told us that the improper payment rates did not clearly assess the work done in their activities. MIP activity managers told us that they used a number of other performance measures to assess the effectiveness of the activities for which they had responsibility, including assessments of individual contractors, survey results measuring customer satisfaction, feedback from provider associations, savings from claims processing, funds recovered, and ROI.

The statements by agency officials indicate that CMS has not clearly communicated to its staff the relationship between the daily work of conducting MIP activities and the agency's higher-level performance measures for improper payment reduction. Our prior work has established that responsibility for meeting performance measures should be linked directly to the offices that have responsibility for making programs work. A clearly communicated connection between performance measures and program offices helps to reinforce program managers' accountability and ensure that managers keep in mind the outcomes their organization is striving to achieve.²⁷ Within MIP, however, activity managers generally did not connect the activity-specific performance measures they use to assess their activity's effectiveness and the agencywide GPRA performance goals for reducing improper payments. Our prior work found that leading organizations try to link the goals and performance measures for each organizational level to successive levels and ultimately to the organization's strategic goals. These leading organizations recognized that without clearly communicated, hierarchically linked performance measures, managers and staff throughout the organization will lack straightforward road maps showing how their daily activities can contribute to attaining organizationwide strategic goals.²⁸

²⁶Of the eight MIP activities, only Other Medicare Fee-For-Service does not have an activity manager. One person serves as the activity manager for Provider Audit and MSP, and one person serves as the activity manager for Benefit Integrity and Medi-Medi.

²⁷GAO/GGD/AIMD-10.1.18, 11.

²⁸GAO/GGD-96-118, 24.

CMS Added MIP Performance Goals for Fiscal Year 2012 and Is Developing Other Metrics Based on PPACA Requirements, but Their Linkage to Measures Used by MIP Activity Managers Is Not Clear

In its *FY 2012 Online Performance Appendix*, CMS added two new MIP performance goals to the goals related to the improper payment rate for Medicare fee-for-service, Part C, and Part D, but it is also not clear how they link with performance measures currently used by MIP activity managers.²⁹ (See table 1.) The first new performance goal is related to increasing the number of law enforcement personnel with training and access to near real-time CMS data.³⁰ The second new performance goal aims to strengthen CMS's provider enrollment actions to prevent fraudulent providers and suppliers from enrolling in Medicare and ensure that existing providers continue to meet enrollment requirements. The performance measure associated with this goal will be an increase in the percentage of Medicare enrollment site visits to "high-risk" providers and suppliers that result in administrative actions.³¹ It is not clear how the revised GPRA goals relate to the performance measures used by MIP activity managers to assess the effectiveness of their activities because CMS has not established such a linkage. Such linkage is helpful to effectively communicate how performance is measured within the agency.

²⁹CMS, *FY 2012 Online Performance Appendix*.

³⁰Law enforcement personnel include agents from the HHS OIG, DOJ Assistant U.S. Attorney, Federal Bureau of Investigation, and OIG Railroad Retirement Board. As part of the Health Care Fraud Prevention and Enforcement Action Teams (HEAT) initiative, law enforcement personnel involved with HEAT use CMS data to examine claims payment data for aberrancies, to identify suspicious billing patterns, and to conduct surveillance of target providers and suppliers under investigation for potentially fraudulent practices. HEAT is an interagency partnership between HHS and DOJ in seven areas across the country focused on health care fraud.

³¹In a final rule published on February 2, 2011, CMS assigned provider types to three levels of risk: limited, moderate, and high. According to CMS, provider types assigned to higher risk levels will receive greater oversight and review. Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers, 76 Fed. Reg. 5,862 (Feb. 2, 2011).

Table 1: Government Performance and Results Act Performance Goals and Associated Performance Measures for the Medicare Integrity Program, Fiscal Year 2012

Performance goal	Associated performance measure	New or existing performance goal
Reduce the percentage of improper payments made under the Medicare fee-for-service program.	Reduce the percentage of improper payments made under the Medicare fee-for-service program to 6.2 percent.	Existing
Reduce the percentage of improper payments made under the Part C Medicare Advantage program.	Reduce the percentage of improper payments made under the Part C Medicare Advantage program to 13.2 percent.	Existing
Reduce the percentage of improper payments made under the Part D Prescription Drug program.	Report a composite error rate for Part D program that is lower than the composite error rate reported for fiscal year 2011. ^a	Existing
Increase the number of law enforcement personnel with training and access to near real-time Centers for Medicare & Medicaid Services (CMS) systems data.	All law enforcement personnel referred by the Health Care Fraud Prevention and Enforcement Action Team initiative for training and access to near real-time CMS systems data receive the training and access. ^b	New
Prevent Medicare fraud and abuse by strengthening CMS's provider enrollment actions.	Fifteen percent of Medicare enrollment site visits to "high-risk" providers and suppliers result in administrative actions. ^c	New

Source: GAO analysis of information in *CMS FY2012 Online Performance Appendix*.

^aThe Centers for Medicare & Medicaid Services (CMS) is in the process of developing a composite error rate for Medicare Part D that takes into account measures of error in four separate parts of the Part D program.

^bThe Health Care Fraud Prevention and Enforcement Action Team initiative is an interagency initiative by the Department of Health and Human Services and the Department of Justice to combine the resources of the two agencies and focus them toward identifying fraud, prosecuting criminals, and recovering fraudulently taken taxpayer dollars.

^cIn a final rule published on February 2, 2011, CMS assigned provider types to three levels of risk: limited, moderate, and high. According to CMS, provider types assigned to higher risk levels will receive greater oversight and review. 76 Fed. Reg. 5, 862 (Feb. 2, 2011).

In addition to expanding the GPRA performance goals, CMS officials told us that they hired a contractor to develop agencywide performance metrics in response to PPACA requirements. The performance metrics being developed by the contractor include performance metrics for MIP. CMS officials did not provide a date when the new performance metrics will be completed. According to the Director of the Medicare Program Integrity Group, the PPACA performance metrics are broader than the GPRA goals but generally are consistent with the GPRA goals.

In addition to the efforts at CMS to increase program integrity within the Medicare program, HHS officials told us that they are developing a departmentwide strategy to address program integrity in all HHS programs. An official noted that measuring the effectiveness of any program integrity effort is a challenge. She said it is difficult to quantify

instances where fraud or abuse was avoided because of program integrity efforts. For instance, Provider Outreach and Education on proper billing practices is a MIP activity, but it would be difficult to quantify how much more improper billing would occur without this education.

CMS Calculates ROI for Most MIP Activities, but the Data CMS Uses in Its Calculation Have Flaws

PPACA requires CMS to report annually on the use of funds for MIP and the effectiveness of the use of those funds. One way that CMS measures program effectiveness is through calculation of ROI. CMS already calculates ROI for each MIP activity, with the exception of Provider Outreach and Education. An overall ROI for MIP is reported to Congress annually in the agency's budget justification. ROI is calculated as program savings from the activity divided by program expenditures from the activity. The Director of the Medicare Program Integrity Group told us that the current methodology used by MIP for calculating ROI is likely the method the agency will use to meet the PPACA reporting requirements.

The data CMS currently uses to calculate the ROI have two flaws. First, CMS calculates the ROI for each activity in January of each year for the prior fiscal year, but contractors can change expenditure data via the submission of additional invoices or corrections through the time they are audited, which can occur up to 2 years after the end of the fiscal year. The ROI figures calculated based on this information are not subsequently updated. When we compared the expenditure data used to calculate activity-level ROIs and final expenditure data provided by OFM, we found differences up to \$9.7 million. Given that these dollar amounts are used as the denominator for the ROI, the ROI amounts would likely change if they were updated with final expenditure data. In the case of the \$9.7 million difference, for example, the difference represented a 6.4 percent increase in the program expenditures. Second, ROIs for activities conducted by MACs are potentially inaccurate because MACs have discretion to direct MIP funding among the activities they perform, and CMS does not have reliable information to determine the exact amount spent by each MAC on individual MIP activities.³² CMS officials told us that they were aware of the issue and were making changes to the data collection system so that CMS could calculate actual spending data.

³²Because MACs are involved with multiple aspects of Medicare operations, they received funds to conduct aspects of each of several MIP activities. In fiscal year 2010, they received about \$207 million for MIP activities, or about 22 percent of the total MIP funds spent.

As of May 2011, these officials were unable to estimate when the change to the data collection system would be implemented.

CMS Considers a Variety of Factors, Including Potential Effect on Improper Payments, When Allocating Funding

Decisions about recommendations for how MIP funding should be allocated among the various activities and subactivities are based on a variety of factors. Based on the budget request documents we reviewed, the CMS MIP Budget Small Group may consider any or all of the following factors:

- prior year's approved funding levels and requested levels for the current and following fiscal year;
- rationale for the increase or decrease in requested funding;
- description and justification of the subactivity;
- agency performance goals, including the strategic objective and GPRA goal, that the subactivity is intended to meet; and
- consequence of not funding the subactivity.

We reviewed 36 budget request documents for subactivities funded in fiscal year 2010 and found that 11 cited the reduction of the fee-for-service improper payment rate as the GPRA goal the subactivity was intended to meet.

It is difficult to determine the factors CMS considers when allocating MIP funds beyond those listed in the budget request documents. There is no record of why submitted subactivities were funded or not funded. Also, CMS has no policies or procedures in place that outline how decisions about funding allocations should be made for MIP. CMS officials told us that a subactivity's effectiveness may be discussed orally at the meetings, though there is no documentation substantiating this. A budget official in CMS told us that when allocating MIP funds, the MIP Budget Small Group tries to focus on where the problems are in each area and then determines how to efficiently spend the money. For instance, he said that in the past the process for allocating MIP funding within the Part C and D Oversight activity had been difficult because the subactivities were new, and consequently, there were no baseline ROI data available. This same official said that he thought the allocation process for Part C and D Oversight would become more data driven as program savings data become available, which will allow the agency to calculate ROIs for the Part C and D Oversight subactivities.

Conclusions

The administration has made reducing the governmentwide improper payment rate a priority. CMS must play a strong role in this effort because, even without Part D, Medicare's improper payments constitute more than a third of total federal government improper payments. As the CMS program with the goal to reduce Medicare's improper payments, MIP will be central to the agency's effort to reduce the Medicare improper payment rates. CMS will need a strong, concerted effort on the part of staff and contractors working on MIP activities to achieve the improper payment reduction goals the agency has set for itself, and MIP staff will need to understand how their work supports these goals and any additional goals developed in response to PPACA requirements. Further, a clear focus on reducing improper payments should be central to MIP budget allocations. Because at least some information is presented orally at the MIP Budget Small Group meetings, we cannot determine the extent to which the risk of improper payments and effectiveness of MIP activities in addressing that risk are discussed during the process. We continue to believe that consideration of how MIP activities will reduce the risk of improper payments and their effectiveness in doing so should be an important part of the funding process and encourage CMS to make that a priority.

As we noted in our 2006 report, ROI is a useful method for assessing the effectiveness of MIP activities. However, such reporting is valuable only if the ROI figures reported are reliable. Currently, the data used to calculate the ROI are flawed because the ROI calculations are not updated beyond the end of a fiscal year to account for changes in MIP expenditure data, and CMS does not currently have a way to account for the exact amount of MIP funds MACs spend on individual MIP activities. CMS officials acknowledged the shortcomings of the MAC expenditure data and noted that they were implementing changes to the applicable data collection system to more accurately capture MAC expenditures. Expediently completing this task and ensuring that final expenditure data are used to update ROI calculations will be essential to ensuring reliability in ROI reporting.

Recommendations for Executive Action

We are making three recommendations to CMS. To enhance accountability and sharpen the focus of the agency on reducing improper payments, we recommend that the Administrator of CMS clearly communicate to staff the linkage between GPRA and PPACA performance measures related to the reduction in improper payments and other measures used to determine the performance of MIP activities.

To enhance the reliability of data used to calculate the MIP ROI, we recommend that the Administrator of CMS take the following two actions

- periodically update ROI calculations after contractor expenses have been audited to account for changes in expenditure data reported to CMS and publish a final ROI after data are complete and
- expeditiously complete the implementation of data system changes that will permit CMS to capture accurate MAC spending data, thereby helping to ensure an accurate ROI.

Agency Comments

We provided a draft of this report to HHS for review, and in its written comments, HHS concurred with our recommendations. (HHS's written comments are reprinted in app. IV.) HHS noted that CMS has expanded its efforts to ensure that GPRA goals become an integral part of its overall management culture, including management of MIP activities. In addition, HHS stated that with the introduction of PPACA, the department is developing performance metrics that are in addition to, and align with, GPRA goals.

CMS concurred with our recommendation to clearly communicate to staff the linkage between GPRA and PPACA performance measures related to the reduction in improper payments and other measures used to determine the performance of MIP activities. CMS stated that the agency recently established the position of the Chief Performance Officer to provide leadership, technical direction, and guidance in the development, implementation, communication, and operation of a comprehensive, CMS-wide performance management program. CMS also summarized other agency activities under way to assess program effectiveness, such as developing a new online data tool to report on the progress of key performance indicators, including those related to program integrity.

CMS concurred with our recommendation to periodically update ROI calculations after contractor expenses have been audited to account for changes in expenditure data reported to CMS and publish a final ROI after data are complete. According to CMS, the agency will update the ROI when there has been a material change in the data used in the calculation and, at a minimum, will revisit the ROI annually to account for revisions in contractor cost reports and updated savings information. CMS also highlighted the complexities of estimating cost data for the MACs for purposes of the ROI.

CMS also concurred with our recommendation to complete the implementation of data systems changes that will permit CMS to capture accurate MAC spending data, thus helping to ensure the accuracy of the

ROI. CMS stated that the agency will convene an internal work group consisting of staff from several components to explore more efficient ways to accumulate MAC cost data and calculate ROI performance statistics. CMS also noted that some changes to the cost reporting system for contractor cost submissions have already been completed, particularly in the area of medical review cost reporting. However, the agency plans to pursue a full assessment of the costs reported across all of the MIP functions performed by the MACs to ensure that any additional changes are identified and implemented.

We are encouraged by CMS's plans to implement our recommendations and believe that doing so will lead to a better understanding by the agency and Congress of MIP's effectiveness.

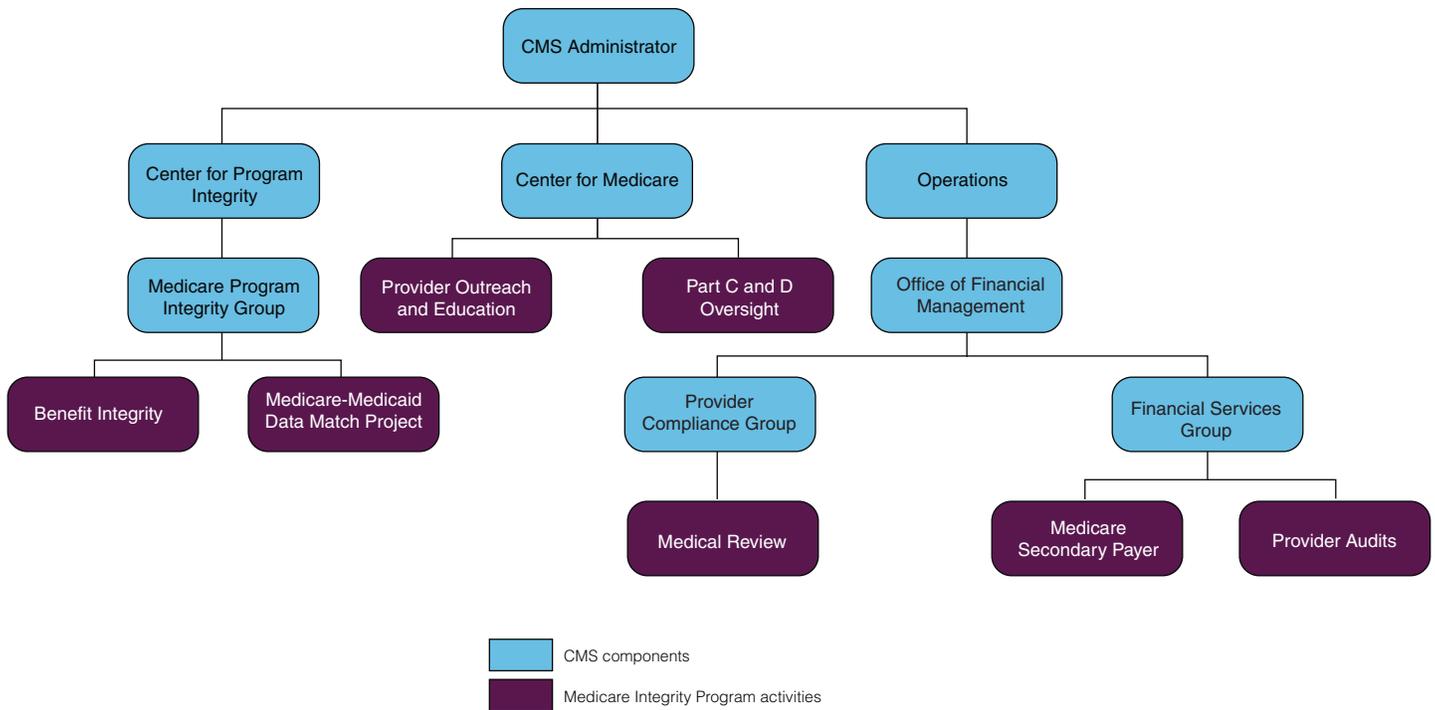
As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies of this report to the Secretary of Health and Human Services, Administrator of CMS, appropriate congressional committees, and other interested parties. The report also will be available at no charge on the GAO Web site at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or kingk@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 listed in appendix V.



Kathleen M. King
Director, Health Care

Appendix I: Centers for Medicare & Medicaid Services (CMS) Oversight of the Medicare Integrity Program



Source: GAO analysis of information from CMS.

Appendix II: Medicare Integrity Program (MIP) Contractors

MIP contractors include:¹

- The **Comprehensive Error Rate Testing (CERT)** contractor establishes error rates and estimates of improper payments for Medicare, which the Centers for Medicare & Medicaid Services (CMS) uses to assess the performance of MIP.
- **Medicare administrative contractors (MAC)**² perform medical review of claims, identification and recovery of improper payments, provider audits, provider education, and screening of beneficiary complaints related to alleged fraud. MACs use information generated by the CERT contractors to identify how to target their improper payment prevention activities. In addition to performing these program integrity activities, MACs process Medicare claims and conduct other claims-related activities, such as answering provider inquiries and recouping overpayments.
- **Medicare drug integrity contractors (MEDIC)** are tasked with identifying potential fraud and abuse in Part C and D of the Medicare program and referring cases to the Department of Health and Human Services' Office of Inspector General (OIG) or Department of Justice as necessary. MEDICs are also responsible for auditing the fraud, waste, and abuse compliance programs that are a requirement for participation as a Part D provider.
- The **Medicare secondary payer (MSP)** contractors are responsible for researching and conducting all MSP claim investigations. In addition to this role in MIP, the MSP contractor identifies all health insurance held by Medicare beneficiaries and coordinates the payment process.
- The **National Supplier Clearinghouse** is responsible for reviewing enrollment applications from durable medical equipment suppliers and

¹Although they are not supported by MIP funds, recovery audit contractors also were created by the statute establishing MIP. Recovery audit contractors are private organizations that contract with CMS to identify and collect improper payments in the Medicare fee-for-service program.

²MACs are replacing the fiscal intermediaries and carriers. Historically, fiscal intermediaries performed claims administration functions for Medicare Part A and Part B claims to hospitals, other institutions, and home health agencies, and carriers performed claims administration functions for Medicare Part B providers.

conducting site visits to confirm these suppliers' compliance with Medicare regulations.

- **Program safeguard contractors (PSC)** perform benefit integrity subactivities for Parts A and B of Medicare to identify cases of suspected fraud and take action to ensure that Medicare funding is not inappropriately paid and that any mistaken payments are identified. Cases of potential fraud are referred to the Department of Health and Human Services' OIG.
- **Zone program integrity contractors (ZPIC)** will eventually be responsible for performing benefit integrity subactivities for claims under Parts A, B, C, and D of the Medicare program. CMS is currently in the process of replacing the PSCs with ZPICs.³

³In May 2011, an official from CMS informed GAO that CMS was in the midst of transitioning work from the PSCs to the ZPICs. An October 2008 CMS press release stated that the MEDICs would also transition to ZPICs, but CMS officials could not confirm whether this transition would take place.

Appendix III: Contractor Types Performing Medicare Integrity Program Activities for Fiscal Year 2010

Activity	Comprehensive Error Rate Testing contractor	Medicare administrative contractors	Medicare drug integrity contractors	Medicare secondary payer contractors ^a	National Supplier Clearinghouse	Program safeguard contractors	Zone program integrity contractors
Benefit Integrity ^b		X			X	X	X
Provider Audit ^c		X				X	
Medicare Secondary Payer ^d		X		X			
Medical Review ^e	X	X					
Provider Outreach and Education ^f		X					
Medicare-Medicaid Data Match Project ^g							X
Part C and D Oversight ^h			X				
Other Medicare Fee-For-Service ⁱ							

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information.

^aIncludes the coordination of benefits contractor, the workers compensation review contractor, and the Medicare secondary payer recovery contractor.

^bBenefit Integrity includes subactivities designed to deter and detect Medicare fraud by conducting data analysis of claims.

^cProvider Audit includes desk reviews, audits, and final settlement of institutional provider cost reports.

^dMedicare Secondary Payer includes subactivities designed to identify claims that were mistakenly billed to Medicare when beneficiaries have primary sources of payment that should have paid the claims.

^eMedical Review includes both automated and manual prepayments and postpayment reviews of individual Medicare claims to determine whether legitimate services are covered, medically reasonable, and necessary.

^fProvider Outreach and Education includes training for providers, such as hospitals and physicians that serve Medicare beneficiaries, on procedures to comply with Medicare rules and regulations.

^gMedicare-Medicaid Data Match Project is a joint effort between CMS and states that participate voluntarily to analyze claims for individuals with both Medicare and Medicaid coverage to identify providers with aberrant Medicare and Medicaid billing patterns.

^hPart C and D Oversight includes subactivities designed to address improper payments in the Medicare private health plan program (Part C) and outpatient prescription drug benefit (Part D).

ⁱOther Medicare Fee-For-Service includes a variety of Medicare fee-for-service-related subactivities not captured by other activities.

Appendix IV: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street N.W.
Washington, DC 20548

JUL 15 2011

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) draft report entitled: "MEDICARE INTEGRITY PROGRAM: CMS Used Increased Funding for New Activities But Could Improve Measurement of Program Effectiveness" (GAO-11-592).

The Department appreciates the opportunity to review this report before its publication.

Sincerely,

A handwritten signature in black ink that reads "Jim R. Esquea".

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE INTEGRITY PROGRAM: CMS USED INCREASED FUNDING FOR NEW ACTIVITIES BUT COULD IMPROVE MEASUREMENT OF PROGRAM EFFECTIVENESS" (GAO-11-592)

The Department appreciates the opportunity to review and comment on this draft report.

In this report, GAO evaluated: 1) how the Centers for Medicare & Medicaid Services (CMS) used Medicare Integrity Program (MIP) funding to support the program's activities from fiscal years 2006 through 2010, 2) how CMS assesses the effectiveness of MIP, and 3) factors CMS considers when allocating MIP funding.

CMS has expanded its efforts to ensure that its Government Performance and Results Act (GPRA) goals become an integral part of its overall management culture, including management of MIP activities. We are dedicated to making our employees aware of our commitment to the use of performance information to manage our programs and resources, especially regarding the reduction of improper payments. With the introduction of the Affordable Care Act (ACA), we are developing performance metrics that are in addition to, and align with, GPRA goals. We are working toward a corporate-level perspective of our performance management program as well as strengthening performance management coordination throughout our organization.

Creating a strong strategic management framework around what we do will ensure our success and the accomplishment of our strategic goals. We will continue to work to ensure that limited resources are used wisely, operational risks are identified and mitigated, and that employees are held accountable for achieving results.

In addition, we are committed to identifying improvements to the current approaches used to allocate MIP funding, as well as, the process for calculating the Return on Investment (ROI) for MIP activities. We will continue to investigate data collection methods to ensure accurate accounting of spending information and outcomes achieved for MIP funded activities.

GAO Recommendation No. 1

To enhance accountability and sharpen the focus of the Agency on reducing improper payments, we recommend that the Administrator of CMS clearly communicate to staff the linkage between GPRA and PPACA performance measures related to the reduction in improper payments and other measures used to determine the performance of MIP activities.

CMS Response

CMS concurs. To improve communication and coordination of performance measures throughout CMS, we recently established the position of the Chief Performance Officer (CPO). The role of the CPO is to provide leadership, technical direction, and guidance in the development, implementation, communication, and operation of a comprehensive CMS-wide performance management program. The CPO reports to the Chief Operating Officer (COO) and Deputy Chief Operating Officer (DCOO) to bolster its independent, cross-cutting Agency support role.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE INTEGRITY PROGRAM: CMS USED INCREASED FUNDING FOR NEW ACTIVITIES BUT COULD IMPROVE MEASUREMENT OF PROGRAM EFFECTIVENESS" (GAO-11-592)

Our GPRA performance measures are representative of the broad scope of Agency activities and are used to communicate Agency efforts to Congress and the public through the Federal budget process. Included in our GPRA program are numerous program integrity goals that reflect the publicly stated program integrity mission of the Agency.

As noted in your report, there are many other measures and ongoing activities apart from the GPRA goals that assess program effectiveness and are communicated to staff. For example, we have implemented a state-of-the-art project management system to track the status of all ACA provisions, including those relating to program integrity. It is widely used by CMS leadership and is a critical tool in helping us monitor progress, identify areas of risk, and report on performance. Other efforts include developing a new online data reporting tool that will report on the progress of key performance indicators, including those relating to program integrity. In addition, we developed a CMS strategic plan which aligns with the HHS Strategic Plan goals. The CMS Strategic Plan highlights CMS' many mission-critical activities, including those relating to program integrity that support the DHHS Goal 4 "Fight Fraud and Work to Eliminate Improper Payments." These goals are discussed during Senior Staff meetings, and the status of each goal is updated on a monthly basis.

GAO Recommendation No. 2

To enhance the reliability of data used to calculate the MIP ROI, we recommend that the Administrator of CMS:

- Periodically update the ROI calculations after contractor expenses have been audited to account for changes in expenditure data reported to CMS and publish a final ROI after data is complete.

CMS Response

CMS concurs. The ROI calculation will be updated when there has been "a material change" in the data used in the calculation. At a minimum, CMS will revisit the calculation annually to account for revisions in contractor cost reports and updated savings information.

The basis for the cost half of the ROI equation is financial obligations made through the end of the fiscal year. This data includes the amounts awarded to Medicare Administrative Contractors (MACs). It should be noted that MAC contracts cross fiscal years. As such, the amount obligated, the contract award, will not match amounts expended in a given fiscal year.

The amount in the end of fiscal year obligation data for each MAC represents the total amount of the contract and is not broken down into the basic MIP categories. The business proposals of the MACs do distribute the funding, however, the MACs have authority to reprogram funds during the year. To account for this reprogramming, actual MAC expenses incurred during the fiscal year, as reported in their monthly cost reports, are used as a proxy for obligations.

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S (GAO) DRAFT REPORT ENTITLED, "MEDICARE INTEGRITY PROGRAM: CMS USED INCREASED FUNDING FOR NEW ACTIVITIES BUT COULD IMPROVE MEASUREMENT OF PROGRAM EFFECTIVENESS" (GAO-11-592)

The cost report data for the same 12 month period as the end of fiscal year obligation data report is summarized and the percentage of total cost for each MIP category is determined. This percentage is applied to the MAC obligations in the SOF in order to allocate the costs for ROI purposes. FY 2010 was the first year that actual MAC costs were taken into consideration using this methodology.

GAO Recommendation No. 3

To enhance the reliability of data used to calculate the MIP ROI, we recommend that the Administrator of CMS:

- Expediently complete the implementation of data system changes that will permit CMS to capture accurate MAC spending data, thereby helping to ensure accurate ROI.

CMS Response

CMS concurs. We recognize that having different periods of performances and different funding years for each MAC have made it challenging to compile national cost data on a fiscal year reporting basis. CMS will convene an internal workgroup consisting of staff from several components to explore more efficient ways to accumulate MAC cost data and calculate ROI performance statistics. While some changes to the cost reporting system for contractor cost submissions have been completed already, particularly in the area of medical review cost reporting, CMS will pursue a full assessment of the costs reported across all of the MIP functions performed by the MACs to assure that any additional changes are identified and implemented. We believe that this will support the activity-specific ROI calculations.

Appendix V: GAO Contact and Staff Acknowledgments

Contact

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Staff Acknowledgments

In addition to the contact named above, key contributors to this report were Kay L. Daly, Director; Sheila Avruch, Assistant Director; Phillip McIntyre, Assistant Director; Sabrina Springfield, Assistant Director; Lori Achman; Nicole Dow; Emily Loriso; Chelsea Lounsbury; Roseanne Price; Andrea Richardson; and Jennifer Whitworth.

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