



# BILLING STATEMENT

PLEASE CHECK METHOD OF PAYMENT

Card Number	Exp. Date
Amount	
Signature	
Statement Date	
Account No.	57335

MAKE CHECKS PAYABLE TO

Family Care Associates  
105 Elm Street  
Anytown, ST 12345  
3333

REMIT TO

Family Care Associates  
105 Elm Street  
Anytown, ST 12345

ADDRESS

Mary Jones  
555 Oak Street  
Anytown, ST 12345

## Payment Police 2.0

How to stop paying bad Medicare and Medicaid claims

Marsha Simon May 2011





# Payment Police 2.0

## How to stop paying bad Medicare and Medicaid claims

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Marsha Simon   May 2011

### doing what works

CAP's Doing What Works project promotes government reform to efficiently allocate scarce resources and achieve greater results for the American people. This project specifically has three key objectives:

- Eliminating or redesigning misguided spending programs and tax expenditures, focused on priority areas such as health care, energy, and education
- Boosting government productivity by streamlining management and strengthening operations in the areas of human resources, information technology, and procurement
- Building a foundation for smarter decision-making by enhancing transparency and performance measurement and evaluation

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# Introduction and summary

Reducing health care fraud is the rare policy priority shared by both parties in an increasingly divided Washington. Just last summer strong majorities in the Senate and House of Representatives passed—without a single objection—a Medicare antifraud provision that cost hundreds of millions of dollars.<sup>1</sup>

For good reason. The federal government’s own estimates of Medicare and Medicaid payment error rates run as high as 52 percent for certain medical supplies.<sup>2</sup> The Government Accountability Office has declared Medicare, the government health insurance program for retirees, at high-risk for improper payments and fraud every year since 1990. Medicaid, the government health insurance program for the poor, joined the GAO’s high-risk list in 2003.<sup>3</sup>

In 2010, an estimated total of \$70.4 billion was made in improper payments for Medicare and Medicaid health services. This total includes \$34.3 billion for traditional Medicare fee-for-service (a 10.5 percent payment error rate), \$22.5 billion for Medicaid (a 9.4 percent payment error rate) and 13.6 percent for Medicare managed care alternative to fee-for-service (a 14.1 percent payment error rate).<sup>4</sup>

Billions of taxpayer dollars are clearly at stake.

Billions of dollars have also been spent to reduce improper payments. The federal government has spent nearly \$1 billion every year since 1997 on efforts to lower the Medicare payment error rate. Medicaid has likewise invested tens of millions of dollars in so-called “payment integrity” activities.

And yet the government makes virtually no effort to understand what payment integrity approaches work best, or what kinds of errors are most likely to harm poor, elderly, and severely disabled beneficiaries. Indeed, the Obama administration has dispatched its Medicare fraud-prevention task forces exclusively to areas with high concentration of low-income and minority populations, according to Toni Miles, a professor and expert on health disparities at the University of Louisville’s medical school.<sup>5,6</sup>

This paper explains how the design of the Medicare and Medicaid programs encourages improper payments and impedes detection and recoupment of these payments. It outlines a research and policy agenda to address these shortcomings. Specifically, we propose that the government:

- Develop an evidence-based research agenda to determine which approaches to reducing payment error work and which do not, and how to best protect beneficiaries from payment error
- Invest in better-integrated databases of medical claims
- Target payment review efforts on high-cost patients enrolled in both Medicare and Medicaid, and on high-risk providers
- Accelerate the deployment of the so-called “Medi-Medi” payment integrity program that examines patterns of improper payments not detectable by auditing just Medicare or Medicaid alone
- Immediately implement new screening requirements under the Affordable Care Act using independent contractors focused solely on that task
- Eliminate conflicts of interest between contractors who enroll providers, pay their Medicare claims, review the claims for errors, and handle appeals of these decisions
- Check providers and beneficiaries against state and federal death records and other public databases
- Require Medicare claim payment contractors to reimburse the government for errors they make
- Vigorously defend payment integrity contractors in appeals to administrative law judges

These recommendations will ensure that the Obama administration’s ramp up of hundreds of millions of additional dollars for payment integrity provides the greatest return on the taxpayer’s investment.<sup>7</sup>

# The ABCs of payment integrity

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## MACs, RACs, and ZPICs

The Medicare program is a \$500 billion a year enterprise, largely administered by private companies collectively referred to as “contractors.” These contractors carry out most of the program’s operations, including enrolling doctors and equipment suppliers; reviewing, paying and auditing claims; and adjudicating complaints. Most of the federal contractor dollars go to for-profit subsidiaries of Blue Cross Blue Shield insurance plans.

Who oversees Medicare providers to safeguard against payment errors? The conventional wisdom is that specialist companies known as zone program integrity contractors, or ZPICs, man the front lines against fraudulent and mistaken payments. In fact, the companies that receive the lion’s share of the more than \$720 million in antifraud funds doled out each year are the same contractors responsible for screening and enrolling Medicare health providers and suppliers, and paying their claims for medical services.<sup>8</sup>

These Medicare administrative contractors, or MACs, actually commit the errors measured by the official payment-error estimate, the Comprehensive Error Rate Testing program. MACs pay the roughly 1 billion annual claims generated by more than 600,000 physicians, hospitals, and other health care providers on behalf of the 41 million Medicare beneficiaries.<sup>9</sup> The reason MACs get payment integrity money is because they are responsible for ensuring that claims are legitimate before they pay them. But MACs, pay no penalties for the billions of dollars in mistaken payments, unlike similar contractors that pay the medical claims of Department of Defense employees.

After MACs pay claims, an alphabet soup of other contractors—PSCs, ZPICs, MEDICs, and RACs—review claims for fraud and error, and refer suspicious cases to the government for investigation, enforcement, and payment recovery.

Most of these other contractors are paid on a fee basis. The RACs, or recovery audit contractors, however, are paid on a “bounty hunter” scheme, collecting an average of 11 percent of the erroneous claims they help identify and recover.<sup>10</sup>

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## Problems with Medicare and Medicaid payment integrity efforts

Medicare and Medicaid claims payment systems are themselves fraught with problems, starting with widespread conflation of “fraud” with “error.” Here is a shortlist of problems:

### Misrepresentation of data

The White House and members of Congress from both parties constantly conflate payment fraud and payment error. For example, the Comprehensive Error Rate Testing program, which estimates the prevalence of payment error, is often cited as a measure of Medicare fraud alone—even though most errors are preventable billing mistakes. The CERT program, which is a statistical exercise, is often confused with activities to identify fraudulent billing.

For example, Sen. Charles Grassley (R-IA) last month described CERT as “central” to ensuring “that Medicare and Medicaid dollars are protected from fraud, waste, and abuse.”<sup>11</sup> In fact, because the CERT relies on reviewing a random sample of claims, it cannot detect patterns of fraudulent billing.

Compounding the confusion, Ron Klein, a former Democratic congressman from Florida conflated during a recent House hearing all health care fraud in the United States with Medicare fraud:

*It's deplorable to think that there are people out there preying on our seniors, but as everyone here knows, it's true. Some estimates say that Medicare fraud totals \$60 billion a year. That's money taken out of the system to line the pockets of criminals and thieves.*<sup>12</sup>

Klein's comment underscores another common confusion between Medicare and Medicaid-specific fraud and health care fraud in general.

## Insufficient oversight of payment integrity funds

Most of the funding that goes to payment integrity is not subject to annual appropriations review, has no sunset date, and is therefore subject to no review by the authorizing or appropriations committees. (See the appendix for a table of the history of payment integrity appropriations)

This lack of oversight has resulted, in 2009, in nearly three-quarters of the funding being awarded to contractors that carry out a range of activities, including paying claims, rather than those tasked solely with identifying and preventing payment errors. Before Congress can properly oversee the federal government's payment integrity efforts, the appropriations committees must begin, at a minimum, to annually review all of the funding.

## Multiple, uncoordinated Medicare and Medicaid databases

Both Medicare and Medicaid employ multiple, uncoordinated databases that are a “fragmented patchwork” according to a recent CMS report on modernizing its systems.<sup>13</sup>

Traditional Medicare fee-for-service employs 30 different, unsynchronized databases not including the managed care and drug components of the program.<sup>14</sup> For example, physicians and hospital claims databases are entirely separate. So a MAC cannot easily determine that a doctor's visit and a hospital stay for two entirely different diagnoses bear further scrutiny. Not surprisingly the ZPICs maintain their own, unique databases.

CMS uses different data systems to pay states the federal share of Medicaid medical claims, collect information on beneficiaries and providers, and monitor the accuracy of payment claims and the quality of services. There are two systems just to collect data on managed care program characteristics.<sup>15</sup>

## Conflicts of interest

The vast majority of the payment integrity funding has gone to the MACs that pay Medicare claims. The only review of the Medicare payment integrity funds, carried out by the White House's Office of Management and Budget in 2005,

found that over 90 percent of the funds went to the MACs.<sup>16</sup> And many of these contracts funded with Medicare payment integrity funds violate every federal definition of conflict of interest. For instance, some of these contractors are tasked simultaneously with:

- Screening and enrolling providers and suppliers
- Reviewing and paying claims
- Auditing claims for errors and fraud
- Writing software to screen claims
- Reviewing their own claims denials

Consider for example TriCenturion, LLC, a payment safeguard contractor jointly owned by three contractors serving as MACs: Trailblazers Health Enterprises, LLC; Palmetto, GBA; and First Coast Service Options. These three contractors are in turn owned by large Blue Cross and Blue Shield insurance plans. Another example is Blue Cross Blue Shield of Alabama, which serves as a parent company to Cahaba GBA and Cahaba Safeguard Services. Cahaba GBA serves as the Medicare administrative contractor in Alabama and Georgia, while Cahaba Safeguard Services simultaneously serves as a Program Safeguard Contractor in those two states.<sup>17</sup>

### Insufficient attention to the Medicare beneficiaries and providers most at risk for improper payments

The low-income seniors who qualify for both Medicare and Medicaid are the biggest users of program resources. The Centers for Medicare and Medicaid Services has recognized this by creating the “Medi-Medi” program that audits claims on behalf of dual eligibles to identify problems—such as billing both programs for the same service—that would not be detected by examining each program separately.<sup>18</sup> The program, however, has not grown beyond 10 states (and has recently shrunk to just eight in 2010).

### Insufficient attention to providers most prone to errors

There is also a failure to focus on the highest risk providers with the highest error rates, such as medical equipment companies that supply things like wheel chairs. The Health and Human Services’ inspector general recently urged that MACs review these claims more closely.<sup>19</sup>

## Insufficient attention to managed care plans and their marketing practices

The government's payment integrity efforts are focused almost exclusively on Medicare fee-for-service plans even though beneficiaries are increasingly in managed care plans. Enrollment in managed care plans more than doubled between 2005 and 2009, from 4.9 million people to 10.9 million people—or 24 percent of all Medicare beneficiaries.<sup>20</sup> The managed care plans are also often operated by Blue Cross Blue Shield members and other large health insurance companies such as United Health Group. Although the government's risk is limited when beneficiaries choose to enroll in a managed care plan, the customer's risk of being sold a plan that does not meet her needs by unscrupulous agents and brokers is not.<sup>21</sup>

## Insufficient attention to prescription drug errors

There is little government scrutiny of drug companies and of the more than \$80 billion paid by the federal government annually for prescription drugs.<sup>22</sup> The government has not even attempted to compare drug prices reported by pharmaceutical companies to the Medicaid discount program, to federally-funded public health clinics, and to the drug purchase program run by the Department of Veterans Affairs. Perhaps members of the pharmaceutical lobby are responsible for the biggest waste of the taxpayers' dollars, and not the so-called “phantom pharmacies” that Grassley claims successfully billed millions of dollars to Medicare.<sup>23</sup> Given the historic \$2.3 billion settlement between the Justice Department and Pfizer for fraudulent marketing in 2009, more scrutiny of prescription drugs is certainly warranted.

## Insufficient attention to Medicaid payment errors

There is an imbalance between the billions spent on Medicare integrity and the tens of millions on the Medicaid program. States that manage Medicaid services have failed to undertake oversight by themselves. There is little reason to expect they will step up enforcement now. In addition to their current fiscal distress, states are required to repay the federal share (at least 50 percent) of any payment errors identified, even if the money is never collected, creating perverse incentives for inaction.<sup>24</sup> Moreover, Medicaid beneficiaries—mostly poor children, their mothers, and the elderly poor—are especially vulnerable to fraudulent and unnecessary services.

Data from radiology benefit managers, for example, reveals overuse of advanced imaging on young children and excessive sonograms on pregnant women with uncomplicated pregnancies. Data on over-use of sonograms from 2007 and 2008 shows that very low income Medicaid beneficiaries are significantly more likely to receive excess services (almost one in six) than low-income beneficiaries (slightly more than one in ten).<sup>25</sup> In addition, specialty drug management companies have identified tens of millions of dollars paid to drug companies for human growth hormone injections into poor children paid for by the Medicaid program.

Bottom line: Medicare and Medicaid payment integrity efforts need to be cleaned up and realigned. Our focus should be on errors that threaten the long-term health of patients, such as abusive use of expensive, advanced imaging services that endanger seniors' and children's health.

We next propose a research agenda that will ensure payment integrity dollars are funneled toward approaches that have been proven to work.

# Recommendations for reform

The Obama administration has rightly emphasized evidence-based decision making in designing its health care policies. This sound approach is applied to topics as diverse as clinical practice and payment policy—but not to efforts to reduce payment error in the Medicare and Medicaid programs. As the General Accounting Office reported this year, payment integrity efforts by contractors “did not focus on error-prone providers for review and corrective action.”<sup>26</sup>

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## Develop an evidence-based research agenda to protect beneficiaries from payment error

The administration should develop a research effort to determine:

- Which payment integrity approaches reduce errors and which do not
- Whether structural problems in Medicare or Medicaid encourage fraud and payment error, and how to correct them

More research is also needed to identify data problems in federal databases such as the Social Security death index and the reason for the long delay of the Integrated Data Repository of Medicare claims, a centralized government source of Medicare and Medicaid waste, fraud, and abuse activities.

And we must examine the impact of Medicare and Medicaid fraud on low-income beneficiaries. As Toni Miles asks: “Is there evidence that medical fraud has the potential to *cause* poor outcomes for specific conditions?”<sup>27</sup> The government should start by funding an epidemiological study examining the successfully litigated \$1.4 billion Eli Lilly Zyprexa and \$301 million Pfizer Geodon whistleblower cases to determine whether Medicare and Medicaid beneficiaries were harmed by the off-label use of powerful antipsychotic drugs.<sup>28,29</sup>

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## Refocus payment integrity policies now

While it conducts this important research program the federal government should also immediately refocus its payment integrity policies along the following lines:

### Integrate databases of medical claims

We need significant well-managed database improvements in both the Medicare and Medicaid systems. Medicare provider and beneficiary databases must be integrated. Meanwhile, the long-awaited single claims database is still not online, and Medicaid beneficiary and provider data is held by each state with its own “uniquely formatted recipient and provider files.”<sup>30</sup> No uniform antifraud or payment error reduction effort, or even an accurate accounting of the error rate, can succeed until these systems are modernized and integrated.

### Collect payment error data on “dual eligibles”

The federal government should report to state Medicaid programs information on Medicare errors affecting so-called “dual eligibles,” or low-income seniors enrolled in both the Medicare and Medicaid programs. Such errors have been identified by payment safeguard contractors, but Medicaid’s share has never been collected. The approximately nine million dual eligibles comprise only 21 percent of Medicare enrollees but account for 36 percent of Medicare spending.<sup>31</sup> Similarly, in the Medicaid Program, dual eligibles comprise 15 percent of the Medicaid population but account for 39 percent of Medicaid spending.<sup>32</sup> Because it is more expensive to care for, the dual-eligible population is particularly vulnerable to payment errors.

### Accelerate the “Medi-Medi” payment integrity program

The federal government should more quickly deploy the so-called “Medi-Medi” payment integrity program to allow states to cooperatively review claims of dual eligibles. Cash-poor states should get federal funding to allow them to be active partners in this program. Surely focusing on the most expensive and most vulnerable beneficiaries is as appropriate as the administration’s current use of Medicare fraud “strike forces” in poor communities.

## Immediately implement provider-screening requirements in health reform law

The federal government should immediately implement the rigorous screening and re-screening of Medicare and Medicaid providers as required under the new health reform law. The screening effort should focus on identifying providers who have lost one state license—because of criminal or licensure reasons, for example—and “hopped” to another state. A 2006 Medicare demonstration of screening technology, for example, identified thousands of providers who were convicted sex offenders.

## Eliminate conflicts of interest

The government should not allow the same contractors to screen and enroll beneficiaries, and also review their claims. The Obama administration is now beginning to rebid conflicting MAC contracts, so the time is ripe to create a new class of truly independent contractors who will review providers and suppliers before they ever submit a single claim.

## Check beneficiaries and providers against death records and other public databases

The government should crosscheck Medicare Part C and Part D enrollees against Social Security and local death records to ensure that premiums are paid only for living beneficiaries. All Medicare claims should also be matched against beneficiary and provider death records.

Previous efforts to validate Medicare physician-identification numbers exposed payments to fraudulent providers who used the Medicare identifiers of deceased doctors. A Senate staffer uncovered \$76.6 million in Medicare payments to deceased doctors five years after CMS hired a team of contractors including the AMA to create a registry of dead physicians.<sup>33</sup> More recently, the federal health department’s inspector general found that CMS and its contractors are still failing to identify and recoup all payments made for services claimed for dead beneficiaries.<sup>34</sup>

## Compare drug prices paid by government programs

The government should build on the health reform bill's requirement that the HHS inspector general compare prescription drug prices paid under Medicare Part D to those paid under state Medicaid programs. The government should match the pricing data among federal and state payers to identify discrepancies and ensure the government is truly receiving the lowest prices.<sup>35</sup>

## Make MACs pay for errors

The government should require Medicare administrative contractors to reimburse the Medicare program a percentage of payments made in error. That would align the Medicare payment integrity system with the Defense Department's health care program, TriCare, in which contractors pay fines calculated from payment errors discovered in audits.

## Aggressively defend payment error findings

As of June 2010, more than two-thirds of improper payment findings were reversed if they reached the final administrative law judge appeals level.<sup>36</sup> Payment integrity contractors are not parties to the appeals proceedings, and cannot cross-examine witnesses or present evidence in the hearings. It's up to the government, therefore, to vigorously defend its payment integrity contractors when they discover errors.

# Conclusion

The Obama administration should be commended for beginning to push for more rigorous screening of high-risk Medicare suppliers, but it is still neglecting systemic problems in the operation of the claims payment system.<sup>37</sup> The administration is also overselling its new Medicare claims database and software “analytics.”

As the long-delayed Integrated Data Repository initiative shows, it’s unclear when there will be a single, workable integrated database of Medicare claims. And the “predictive analytics” to identify high-risk providers’ claims before they are paid is just being piloted now. These databases are not ready for prime time, much less ready to provide the “real time” access to data that administration witnesses have touted.

Moreover, Medicare Integrity Program funds need to be re-deployed to focus on high-risk providers and suppliers’ request for payments. The administration is again moving in this direction but has a long way to go before they can say they have changed the way the MACs perform the taxpayer’s business. The recent error rate, just released (but without supporting detail), was touted by the White House as proving the value of their payment integrity campaign. But when over 1 in 10 payments are in error at a cost of \$34.3 billion, how can the administration defend the MACs’ performance?<sup>38</sup>

Fighting health care fraud and error makes good fiscal and political sense but policymakers must fix the structural flaws in the current claims payment system. As Sen. Tom Harkin (D-IA), now chair of two key health policy committees, has long argued: If these health programs are not well run, Congress cannot successfully persuade voters of the need to spend hundreds of billions of dollars on Medicare and Medicaid. The Obama administration can do better.

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## About the author

**Dr. Marsha Simon** is an expert in legislative strategy, nonprofit management, and public policy research, with over 20 years of experience, including nearly a decade working for the United States Senate. She served as senior committee staff to Sens. Edward M. Kennedy (D-MA), Tom Harkin (D-IA), and Robert C. Byrd (D-WV), advising them on public health and welfare policy, as well as on the budget and appropriations processes. These staff positions included minority staff director for the Senate Appropriations Committee's Subcommittee on Labor, Health, and Human Services, Education and Related Agencies for Sen. Tom Harkin; and chief policy advisor for Budget and Health Policy for the Senate Committee on Health, Education Labor, and Pensions for Sen. Edward Kennedy. Sen. Harkin is now chair of the Appropriations Subcommittee, as well as of the Health, Education, Labor, and Pensions Committee that is responsible for public health measures, including biomedical research and food and drug law.

In addition to her experience working for the U.S. Senate, Dr. Simon has managed government relations for diverse health, income security, and welfare stakeholders, including for the Jefferson Consulting Group, a lobbying and federal business development firm; the American College of Obstetrics and Gynecology; and public interest groups, including Families USA, the Food Research and Action Center, the Housing Assistance Council, and Rural America (now the Community Transportation Association of America).

Dr. Simon served on Barack Obama's health advisory committee during his presidential campaign. She also served as a policy advisor on Gov. Howard Dean's campaign and drafted his long-term care platform. She was also a member of the Clinton administration's National Task force on Health Care Reform.

Dr. Simon earned a Ph.D. and an M.S. in political science from the Massachusetts Institute of Technology. In addition to her work at Simon & Co., Dr. Simon is also an adjunct professor in the Department of Health Policy at George Washington University.

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