Medicare & Medicaid Program Integrity: The Essentials

Every year billions of tax payer dollars are lost to fraud, waste and abuse in the Medicare and Medicaid programs. As the government looks for ways to reduce the Federal debt, strengthening the integrity of these programs is an area that requires a close examination by Congress. This area of healthcare, however, can be complicated by the numerous acronyms and programs that already have oversight of these programs.

Zone Program Integrity Contractors (ZPICs) *formerly known as Program Safeguard Contractor (PSCs)

ZPICs are responsible for identifying fraud in Medicare Parts A and B (hospital, skilled nursing, home health, provider and durable medical equipment claims) and coordination of Medicare-Medicaid data matches (Medi-Medi) in seven geographic zones. ZPICs are also responsible for ensuring the integrity of Medicare Part C (Medicare Advantage health plans) and Part D (prescription drug plans) but to date have not begun work in this area. ZPICs are paid directly by CMS on a contractual basis.

As of March 2012, ZPICs are active in all Zones except Zone 6.

ZPIC staff consist of data analysts and statisticians; medical review nurses and investigators. Because ZPICs are divided by geographic zone, they can perform such duties as looking for billing trends or patterns across all Medicare fee-for-service (FFS) claims that make a particular provider stand out from the other providers in that community. ZPICs report monthly statistics and data related to their program integrity activities, including ongoing investigations, case referrals, requests for information and administrative actions to CMS. CMS then monitors and analyzes the statistics.

ZPICs utilize statistical sampling and extrapolation to identity outlier providers. Medical review nurses determine any overpayment amount and work with the ZPIC investigators if there is potential fraud.

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Medicare RACs detect and correct past improper payments (both overpayments and underpayments) so actions can be taken to prevent future improper payments. The Tax Relief and Health Care Act of 2006 authorized the Recovery Audit program for Medicare Parts A and B. The Affordable Care Act expanded the program to Medicare Parts C and D, as well as to Medicaid.

Medicare RACs analyze claims data using proprietary software to identify claims that contain improper payments, as well as those that contain likely improper payments. The likely improper payments are subject to a medical review process in order to make final determination of whether an improper payment occurred. Medicare RACs are paid on a contingency fee basis, which is a percentage of the amount of the improper payment either recovered from providers (overpayments) or reimbursed to providers (underpayments).

Medicare RAC Results

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<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Overpayments Collected</td>
<td>$75.4M</td>
<td>$797.4M</td>
<td>$397.8M</td>
<td>$1.27B</td>
</tr>
<tr>
<td>Underpayments Returned</td>
<td>$16.9M</td>
<td>$141.9M</td>
<td>$24.9M</td>
<td>$183.7M</td>
</tr>
<tr>
<td>Total Corrections</td>
<td>$92.3M</td>
<td>$939.3M</td>
<td>$422.7M</td>
<td>$1.45B</td>
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Comprehensive Error Rate Testing (CERT)

The main objective of CERT contractors is to measure improper payments in the Medicare fee-for-service (FFS) program. CERT contractors select at random a sample of approximately 50,000 Medicare claims submitted to Carriers, Fiscal Intermediaries (FIs), and Medicare Administrative Contractors (MACs) during each reporting period. Documentation from providers/suppliers who submitted these claims is then requested for review by CERT clinicians. After the review process, CMS and CERT contractors analyze error rate data and produce a national Medicare FFS error rate.

Medicare FFS CERT Error Rates 2009-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>Error Rate</th>
<th>Total Dollars Paid</th>
<th>Total Improper Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>10.8%</td>
<td>$308.4B</td>
<td>$33.3B</td>
</tr>
<tr>
<td>2010</td>
<td>9.1%</td>
<td>$326.4B</td>
<td>$29.7B</td>
</tr>
<tr>
<td>2011</td>
<td>8.6%</td>
<td>$334.9B</td>
<td>$28.8B</td>
</tr>
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</table>
Health Care Fraud Prevention and Enforcement (HEAT)

HEAT was announced as a HHS/DOJ effort in May 2009 and is a joint task force consisting of top-level law enforcement agents, prosecutors, attorneys, auditors, evaluators, and other staff from DOJ and HHS and their operating divisions. HEAT is dedicated to joint efforts across government to both prevent fraud and enforce current anti-fraud laws around the country.

HEAT Strike Forces work with a number of entities including ZPICs to identify new enforcement initiatives and areas for increased oversight and fraud prevention. The HEAT program helps ensure the integrity of billing practices, and focuses on both Medicare and Medicaid providers whom HHS/DOJ believe are cheating the government.

In 2011, the joint healthcare fraud efforts of HHS and DOJ resulted in the agencies recovering approximately $4.1 billion. The agencies were also responsible for the largest-ever federal healthcare fraud crackdown in 2011, which involved 115 defendants in nine cities for a $240 million Medicare fraud scheme.

Medicaid Integrity Contractors (MICs)

MICs are contracted by CMS to review Medicaid provider activities, audit claims, identify overpayments, and educate providers/others on Medicaid integrity issues. CMS has established three types of MICs over five regions. MICs are paid on a contracted basis by CMS.

Review-of-Provider MICs analyze claims to identify potential vulnerabilities; provide leads/target audits to Audit MICs; use data-driven (data mining) approaches to focus on aberrant billing practices; and work with the CMS Division of Fraud Research and Detection.

Audit MICs conduct post-payment audits, perform field audits and desk reviews, and identify overpayments. Audit MICs make referrals to HHS and OIG, which, in turn share with state Medicaid Fraud Control Units (MFCUs).

» Audit and Review MICs by Region

Education MICs develop training materials and awareness campaigns to highlight value in preventing fraud and abuse. Strategic Health Solutions, LLC fulfills this goal by:

» Creating gap analyses of existing education/training efforts

» Developing fraud, waste and abuse education and training resources and materials for accurate billing of services; and

» Developing educational curriculum to educate Medicaid providers about Medicaid integrity and quality of care.
Payment Error Rate Measurement (PERM) Program

The PERM Program measures improper payments in Medicaid and the Children’s Health Insurance Program (CHIP) and produces error rates for each program. CMS uses a national contracting strategy consisting of three contractors to perform statistical calculations, medical records collection and medical/data processing review of selected state Medicaid and CHIP and Managed Care claims. Groups of states are selected for PERM Program participation on a rotating basis once every three years.

Annual Medicaid PERM Rates 2009-2011

<table>
<thead>
<tr>
<th>Year</th>
<th>PERM Cycle</th>
<th>Overall</th>
<th>FFS</th>
<th>Managed Care</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Cycle 3 – FY 2008</td>
<td>8.7%</td>
<td>2.6%</td>
<td>0.1%</td>
<td>6.7%</td>
</tr>
<tr>
<td>2010</td>
<td>Cycle 1 – FY 2009</td>
<td>9.0%</td>
<td>1.9%</td>
<td>0.1%</td>
<td>7.6%</td>
</tr>
<tr>
<td>2011</td>
<td>Cycle 2 – FY 2010</td>
<td>6.7%</td>
<td>3.6%</td>
<td>0.5%</td>
<td>4.0%</td>
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Medicaid Recovery Audit Contractors (Medicaid RACs)

Medicaid RACs were established by Congress as part of the Affordable Care Act as a result of the success of the Medicare RAC program. Medicaid agencies are required to contract with a qualified vendor to identify provider overpayments and underpayments and to recover overpayments. States must also develop processes for provider entities to appeal RAC determinations, and to coordinate RAC efforts with other Federal and state law enforcement agencies.

The state’s contract with the Medicaid RAC contractor must be made on a contingency fee basis, which is not to exceed the highest contingency fee rate paid to Medicare RACs.

CMS estimates that the Medicaid RAC program will facilitate a net savings of $2.13 billion over five years.

As of March 2012, approximately 25 states have established Medicaid RAC programs. Updated information on Medicaid RAC activity can be found at [www.medicaid-rac.com](http://www.medicaid-rac.com)

For more information on Medicaid and Medicare program integrity please contact HMS’s Government Relations Office at

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The Acronyms

CERT = Comprehensive Error Rate Testing (Medicare only)
CMS = Centers for Medicare & Medicaid Services
DOJ = U.S. Department of Justice
FFS = Fee-For-Service claims
HEAT = Healthcare Fraud Prevention & Enforcement Task Force
HHS = U.S. Department of Health and Human Services
MAC = Medicare Administrative Contractor
MEDIC = Medicare Drug Integrity Contractor
MIC = Medicaid Integrity Contractor
MFCU = Medicaid Fraud Control Unit
OIG = Office of Inspector General at CMS
PERM = Payment Error Rate Management (Medicare only)
PSC = Program Safeguard Contractor (Medicare only)
RAC = Recovery Audit Contractor (Medicare and Medicaid)
ZPIC = Zone Program Integrity Contractor (Medicare only)