Federal Report Roundup: Health Care Anti-fraud Efforts Recover $2.4 Billion

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Health Benefits ABCs

The Administration for Community Living's (ACL) Fiscal Year (FY) 2017 budget justification to Congress highlighted the successes and limitations facing the Senior Medicare Patrol (SMP) program. Notably, it says, "The critically important role of the SMP program has continued to be recognized by partners in Medicare fraud prevention in the private and public sectors."

In FY 2014, projects engaged 5,249 active volunteers and educated 452,714 beneficiaries in group education settings, according to the July 2015 Performance Report from the Office of Inspector General (OIG). Projects have reached more than 30 million people since the program's start.

While total savings attributed to the projects are more than $122 million, OIG recognized that it is difficult to track actual savings to the government from the SMP program. There is also no current procedure to measure the preventative effects of education on beneficiaries.

ACL is working on resolving these limitations through a variety of means, including:

- Efforts to examine performance metrics and align these metrics using a program evaluation conducted in 2013.
- Coordinated efforts with the OIG to track fraud referrals.
- Research on how to measure and quantify the effect of prevention education. The results of this study should be available later this year.

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Takeaways for SMPs

- The SMP program netted $742,652 in savings and helped avoid $200,598 in health care expenditures in FY 2014, according to the HCFAC Report.
- Total savings attributable to the SMP program since its start are more than $122 million, according to the OIG Report.
- The return on investment for HCFAC programs was $6.10 for every dollar in FY 2013-2015, according to the HCFAC Report.
- The Medicare FFS improper payment rate for FY 2015 was 12.1 percent, representing $43.3 billion in improper payments, according to the CMS CERT Report.
- Medicare tops the current list of all federal program improper payments. The top three programs on the list of improper rates (percentage) have a combined estimated annual loss of $18.3 billion. This is less than half of the Medicare FFS losses, according to the OMB payment accuracy website.

HCFAC Releases its Annual Report

Released in February, the Health Care Fraud and Abuse Control (HCFAC) Program Annual Report, issued by the departments of Health & Human Services and Justice, noted that approximately $2.4 billion was returned to the federal government or private persons in FY 2015. These recoveries are the result of health care fraud judgments and settlements begun in FY 2015 and the preceding years. Of this about $1.6 billion was transferred to the Medicare Trust Funds, $385 million was returned to other federal agencies, and $414 million was awarded to relators (private persons who file lawsuits on behalf of the federal government under the False Claims Act).

In enforcement, DOJ began 983 new criminal fraud investigations and convicted 613 defendants of fraud-related crimes in health care during the year. As a result of HHS-OIG investigations, 800 criminal actions and 667 civil actions were taken.

The report also noted SMP accomplishments achieved using HCFAC funds. In FY 2014, SMP programs resolved 1,369 complex issues. In addition, 660 complex issues were referred to law enforcement, CMS integrity contractors, state Medicaid Fraud Control Units, or other entities with a value of over $933,603. Actions taken by the SMP program netted $742,562 in Medicare, Medicaid, and other savings and $200,598 in health care expenditures that were avoided, according to the OIG.

On average in FY 2013-2015, $6.10 was recovered for every dollar spent from the HCFAC program, according to the report. This was a decrease from the FY 2012-2014 return on investment (ROI) of $7.70 for every dollar spent. The ROI used is a three-year rolling average as each year varies based on the number and types of cases settled and adjudicated.

Small Drop in Medicare Error Rate Equals Big Savings

According to the most recent CMS Comprehensive Error Rate Testing Report, the FY 2015 Medicare Fee-for-Service (FFS) program improper payment rate was 12.1 percent, representing $43.3 billion in improper payments. This compares to the FY 2014 improper payment rate of 12.7 percent, which totaled $45.8 billion in improper payments. The table below outlines the improper payment rate and projected improper payment amounts for the Medicare FFS program for FY 2015.

Service Type	Improper Payment Rate	Improper Payment Amount
Part A - Inpatient Hospitals	6.2%	$7.0B
Durable Medical Equipment	39.9%	$3.2B
Physician/Lab/Ambulance	12.7%	$11.5B
Non-Inpatient Hospital Facilities	14.7%	$21.7B
Overall	12.1%	$43.3B

National overall error rates have varied from 3.6 percent to 13.6 percent from 2004 to present, primarily because of changes in how the rates are calculated.

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Error rates within each of the types of services vary dramatically. For instance, the lowest improper payment rate within the Part A service provider subset is 2.9 percent for rural facilities while the Part A home health improper payment rate is 59 percent. Among the top 20 service types, chest pain (45.9 percent); transient ischemia, which is the sudden loss of blood flow, causing stroke-like symptoms (44.9 percent); and back and neck procedures (34.6 percent) top the list of improper error rates.

For Part B, chiropractic services top the improper error rate list at 51.7 percent. In the DME category, the highest improper payment rates are for hospital beds (85.3 percent) and manual wheelchairs (81.3 percent).

Other improper error rates of interest, noted in the U.S. Health & Human Services' Annual Agency Financial Report:

Service Type	Improper Payment Rate	Improper Payment Amount
Part C – Medicare Advantage	9.5%	$14.1B
Part D – Prescription Drug Program	3.6%	$2.2B
Medicaid	9.8%	$29.1B
CHIP	6.8%	$632.1M

According to the Office of Management and Budget's (OMB) Payment Accuracy website, overall Medicare FFS improper payments top the list of improper payments among all federal programs. Even though there are several programs with a higher improper payment rate (percentage), the total cost of the Medicare FFS losses puts it atop the list. The program has the fourth highest improper payment rate across all federal programs. Total improper payment amounts for the top three programs (earned income tax credit, school breakfast, and national school lunch program) are less than half of the Medicare FFS losses, with a combined total of $18.3 billion.

What is an "improper payment"?

According to CMS, improper payments are amounts that should not have been made or payments made in an incorrect amount. This includes both overpayments and underpayments. The vast majority of improper payments are overpayments. Examples of improper payments include payment for ineligible services, duplicate payments, and payments for an incorrect amount.

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