



# HEALTH CARE FRAUD REPORT



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## PPACA Medicare Contracting Reforms Enable Random Prepayment Review, But Implementation Faces Obstacles



By W. BRUCE SHIRK

**R**andom prepayment review of health care claims is a critical element of any truly effective effort to combat the submission and payment of fraudulent health care claims.

This article addresses the recent history of such review in the context of the Medicare program, including Congress's prohibition of the practice in 2003, Congress's repeal of the prohibition in 2010, and the significance of these and related events to the effort to combat the submission and payment of fraudulent Medicare claims.

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Every year Medicare contractors process “more than 1 billion claims”<sup>1</sup> and may be paying up to \$80 billion<sup>2</sup>

<sup>1</sup> Medicare Program Integrity Manual, IOM 100-8, Chapter 1, *Medicare Improper Payments: Measuring, Correcting, and Preventing Overpayments and Underpayments*, Section 1.3.1 C., *Types of Contractors*, Issued 11-20-09; Effective/Implementation Date 12-21-09 (“Although CMS, ACs and MACs have undertaken actions to prevent future improper payments, it is difficult to prevent all improper payments, considering that more than 1 billion claims are processed each year. CMS uses the RAC program to detect and correct improper payments in the Medicare FFS program and provide information to CMS, ACs and MACs that could help protect the Medicare Trust Funds by preventing future improper payments.” (emphasis added).)

<sup>2</sup> Senator Tom Coburn (R. Oklahoma) states that “Medicare has at least \$80 billion worth of fraud a year. That’s a full 20 percent of every dollar that’s spent on Medicare goes to fraud.” Tom Coburn on Monday, August 24th, 2009 in Fox News Channel’s *On the Record With Greta Van Susteren*, cited in *PolitiFact.com* (available at: [COPYRIGHT © 2010 BY THE BUREAU OF NATIONAL AFFAIRS, INC. ISSN 1092-1079](http://www.politifact.com/truth-o-meter/statements/2009/aug/27/tom-coburn/coburn-</a></p></div>
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for fraudulent claims, most of which occur in the fee-for-service system<sup>3</sup> and whose “predominant forms” consist of claims for “overprovision of services based on false or exaggerated diagnoses” and “billing for services that were not actually provided.”<sup>4</sup>

Someone is, of course, submitting and receiving payment for these fraudulent claims and, as it turns out, there are three basic types of perpetrator of these forms of health care fraud:

- Non-providers who impersonate providers, billing for services that were never rendered;
- Providers who knowingly bill for services that were not rendered (and who may doctor the medical record to conceal this fact); and
- Providers who bill for services that were rendered, but which they knew to be medically unnecessary.

Each of these types of fraudulent provider presents enforcement with a different set of problems to solve. As to the first type—fraudulent non-providers masquer-

says-20-percent-every-medicare-dollar-goes-) Estimates of the cost of health care fraud vary widely, albeit most may be too low. “. . .the National Health Care Anti-Fraud Association estimates conservatively that at least 3 percent [of all health care expenditures]—or more than \$60 billion each year—is lost to fraud” Statement of Daniel R. Levinson, Inspector General, Office of the Inspector General, US Department of Health and Human Services on Combating Fraud, Waste, and Abuse in Medicare and Medicaid before the Special Committee on Aging United States Senate (May 6, 2009) (*available at* [http://oig.hhs.gov/testimony/docs/2009/05062009\\_testimony\\_aging.pdf](http://oig.hhs.gov/testimony/docs/2009/05062009_testimony_aging.pdf)). However, “[a]nother prominent figure in the field, Malcolm Sparrow, argues that estimates in the range of 3 percent are low—“ridiculously low,” he put it in an interview. Sparrow, a onetime fraud investigator and detective chief inspector with the British police service, is now a professor at Harvard’s Kennedy School of Government. <http://www.politifact.com/truth-o-meter/statements/2009/aug/27/tom-coburn/coburn-says-20-percent-every-medicare-dollar-goes-/>. In fact, Sparrow believes that “[t]he units of measure for losses due to health care fraud and abuse in this country are hundreds of billions of dollars per year. We just don’t know the first digit. It might be as low as one hundred billion. More likely two or three. Possibly four or five. But whatever that first digit is, it has eleven zeroes after it. . . .” Malcolm K. Sparrow, Testimony before the Senate Committee on the Judiciary; Subcommittee on Crime and Drugs, Hearing: “*Criminal Prosecution as a Deterrent to Health Care Fraud*.” May 20th, 2009; *available at* <http://www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony>.

<sup>3</sup> “Medicaid experience and data indicate that fraud and abuse is primarily a fee-for-service (FFS) system problem.” Florida Agency for Health Care Administration; *Cost Efficiencies in the Florida Medicaid Program*, Presentation by Roberta K. Bradford, Deputy Secretary for Medicaid and Phil E. Williams, Assistant Deputy Secretary for Medicaid Finance, Presented to the Senate Health and Human Services Appropriations Committed, January 21, 2010; at 4, *available at* [http://ahca.myflorida.com/Medicaid/deputy\\_secretary/recent\\_presentations/cost\\_efficiencies\\_florida\\_medicaid\\_program\\_012110.pdf](http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/cost_efficiencies_florida_medicaid_program_012110.pdf)

<sup>4</sup> That is not to say there is no “fraud and abuse” in managed care, where providers receive capitated payments. But fraud and abuse in managed care takes a different form, focusing on denial of services rather than overutilization or overbilling. Malcolm K. Sparrow, *Fraud in the U.S. Healthcare System: Exposing the Vulnerabilities of Automated Payments Systems*; Social Research, Vol 75: No 4: Winter 2008 at 1154-1155. Professor’s Sparrow’s insights inform many of the observations in this paper regarding the weaknesses in CMS claims processing systems.

ading as providers—the solution is difficult but straightforward: find them and shut them down.

The task of finding a solution to fraud perpetrated by the second type is complicated by their “split personalities” i.e., their identities as legitimate providers are known, but their identities as fraudulent providers are hidden because they are submitting two or more parallel but indistinguishable streams of claims, only one of which is legitimate.

The third type presents yet another difficulty because their fraud of choice entails submitting claims that straddle the fine line between knowing fraud and a legitimate difference of opinion about the medical necessity of a service.

The first two types of providers may only be detectable by statistical surveillance—their intent to commit fraud obviates any qualms they may have against falsifying patient records to support their phony claims. Surveillance for such hidden fraudulent providers is by far the most effective when implemented prior to payment, i.e. through random prepayment review of medical records.<sup>5</sup>

The above description of the types of fraudulent claims and the people who perpetrate them is necessarily general and omits significant details regarding their mode of operation, including their employment of constantly changing methodologies. In brief, however, it appears that they tend to be intelligent and creative criminals who, in the words of Professor Malcolm Sparrow of the Kennedy School of Government at Harvard University, “belong. . .naturally with drug smugglers, computer hackers, and terrorists . . .[who] constantly study the relevant defenses, adapt quickly to changes in those defenses, and thrive on novelty and surprise.”<sup>6</sup>

Some would argue that the estimate of \$80 billion for fraudulent claims is too high—even given the apparently considerable capacity of the criminals to adapt to enforcement initiatives. Others would say it is just about right, albeit the fact is that no one has undertaken to develop a “valid measurement” of health care fraud so no one really knows how much the payment of fraudulent claims is costing us either generally or as a component of the cost of Medicare, which was some \$468 billion in 2008 and growing at a rate of 2.4 percent each year.<sup>7</sup>

<sup>5</sup> I am indebted to Don Moran for the description of the types of fraudulent provider. Mr. Moran is President of The Moran Company and Executive Associate Director for Budget & Legislation at the U.S. Office of Management & Budget during the period 1982-1985 where he managed government-wide budget review operations, and managed OMB’s extensive involvement in the Congressional budget and appropriations processes for the Departments of Health & Human Services, Labor and Education. Mr. Moran has also provided valuable insights regarding Medicare issues. However, any errors of fact or judgment in this article are the responsibility of the author not Mr. Moran or anyone else.

<sup>6</sup> Malcolm K. Sparrow, *Fraud in the U.S. Healthcare System Exposing the Vulnerabilities of Automated Payments Systems*; Social Research, Vol 75: No 4: Winter 2008 at 1162

<sup>7</sup> *Id.* at 1161; Social Security Online, A Summary of the 2009 Reports Social Security and Medicare Boards of Trustees, *available at* <http://www.socialsecurity.gov/OACT/pubs.html>; Morris, Combating Fraud in HealthCare: An Essential Component of Any Cost Containment Strategy, *Health Affairs* 2009: 28: 1351-1356 (“the full extent of healthcare fraud cannot be measured precisely”).

Nevertheless, it appears that deliberate fraud is one of several interrelated drivers of the ever-increasing costs of health care generally and of Medicare specifically, the others include technological change, more generous third-party payments, and an aging population.<sup>8</sup>

The payment of fraudulent health care claims is not a new phenomenon. In the early 1990s, health care experts were estimating that “as much as 10 percent of national health care spending is attributable to waste, fraud, and abuse”; in 1992, the General Accounting Office (“GAO”) added Medicare to its list of “high risk” government programs vulnerable to fraud.<sup>9</sup> Yet in 1999, the Healthcare Financing Administration (“HCFA”), now called the Center for Medicare & Medical Services (“CMS”—hereafter all references to the agency are “CMS”)<sup>10</sup> agreed to begin prohibiting its claims processing contractors from conducting random prepayment review of claims for overcharging or fraud, thereby agreeing to eliminate a proven anti-fraud procedure that enabled Medicare’s claim processing contractors to access and review medical records for indications of fraud prior to payment of a given claim and that, as noted above, is the only effective means of conducting statistical surveillance and enabling detection of hidden fraudulent providers prior to payment of claims.<sup>11</sup>

<sup>8</sup> Congressional Budget Office, *Technological Change and the Growth of Health Care Spending* (January 2009), at 15-20, available at: <http://www.ebo.gov/ftpdocs/89xx/doc8947/01-31-TechHealth.pdf>

<sup>9</sup> *Medicare Claims* (GAO/HR-93-6, December 1992); *Anti-fraud Technology Offers Significant Opportunity to Reduce Health Care Fraud* (GAO/AIMD-95-77, August 1995) at 1.

<sup>10</sup> The Health Care Financing Administration (HCFA) changed its name to Centers for Medicare and Medicaid Services (CMS in 2001, so as “[t]o improve its reputation and instill a “culture of responsiveness,” officials in the Bush administration have renamed and reorganized the Health Care Financing Administration . . . long criticized for overregulating and micromanaging physicians and hospitals, will now be known as the *Centers for Medicare and Medicaid Services*’ Internal Medicine News July 2001, available at: <http://www.thefreelibrary.com/HCFA+Changes+Name+in+Bid+to+Burnish+Reputation.-a077576251>

<sup>11</sup> The Health Care Financing Administration (HCFA), agreed to move towards eliminating random prepayment reviews after the American Medical Association passed a resolution urging its elimination in 1997. American Medical Association, *Report of the Council on Medical Service Subject Medicare Review Activities*; . . . CMS Report 11-A-99 (June 1999), available at <http://www.am-assn.org>.

CMS Transmittal AB-01-113, CHANGE REQUEST 1754, (August 16, 2001); SUBJECT: *Clarification of Comprehensive Error Rate Testing (CERT) Program Requirements for Medicare Contractor Operations Regarding Prepayment Random Medical Review*, available at <http://www.cms.gov/transmittals/downloads/AB01113.pdf> (“CMS interprets the statement in CR 1173 to mean that intermediary, carrier, DMERC, RHHI, and PSC prepayment random medical review requirements contained in the FY 2001 BPR will be eliminated when CERT is fully implemented for the contractor. CMS considers CERT to be fully implemented when the first sample is drawn for the contractor. The first sample is usually drawn approximately two months after the first claims universe file is submitted by the contractor. The delay is needed to insure that the claims in the sample have been adjudicated by the contractor and that all needed information on claims adjudication is available for submission to CMS . . . CMS allowed DMERCs to cease pre-

CMS confirmed its decision to progressively eliminate prepayment review in 2001; and, in 2003, Congress placed statutory limitations on the conduct of random and nonrandom prepayment review, prohibiting both except under severely limited conditions that effectively precluded review of claims for fraud prior to payment.

CMS now had a statutory rationale for its earlier prohibition of random prepayment review, and in early 2004, CMS implemented the statutory restriction of both types of prepayment review so that, as a general rule, the effort to detect and identify specific fraudulent claims now commences only after they are paid.<sup>12</sup>

This policy is called “pay and chase” and it is deeply annoying to the Department of Health and Human Services Office of Inspector General (“OIG”), whose representatives believe it could be costing U.S. taxpayers billions each year for payment of fraudulent claims and has in recent years placed resumption of prepayment review at the top of its ‘wish list’ of anti-fraud reforms so as to enable “real-time” access to Medicare claims data, i.e. access “as soon as the claim is submitted to Medicare.”<sup>13</sup>

Accepting the OIG’s views, the President’s FY 2011 Budget proposed modification of those “statutory provisions that currently limit random medical review and place statutory limitations on the application of Medi-

payment random medical review on September 1, 2000. We allowed carriers on the VIPS system to cease prepayment random medical review January 1, 2001. CMS allowed carriers who were on the EDS-MCS system as of April 1, 2001, to cease prepayment random medical review June 1, 2001. All other contractors must continue to perform prepayment random medical review throughout FY 2001 until CMS specifically notifies them that they may stop. *All contractors must cease prepayment random medical review when CERT is fully implemented for them (emphasis added)*.

<sup>12</sup> Medicare Integrity Manual, IOM 100-08, Section 3.3.5; Change Request 3569, **Prepayment Review of Claims for MR Purposes**; Effective date December 1, 2004; available at: <http://www.cms.gov/transmittals/Downloads/R90PI.pdf>

<sup>13</sup> Interview of Deputy Inspector General Lewis Morris, C-SPAN, date, available at: <http://www.c-span.org/search.aspx?For=Lewis%20Morris> On March 4, 2010, HHS-OIG Inspector-General Daniel Levinson testified before the Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, House Appropriations Committee, that:

‘. . . [a]ccess to “real-time” claims data—that is, as soon as the claim is submitted to Medicare—is critical to identifying fraud as it is being committed. With “real time” knowledge, we would be better able to stop the fraud more quickly and to bring the perpetrator to justice and recoup the stolen funds before the criminal or the money disappears. Timely data is also essential to our agile response as criminals shift their schemes and locations to avoid detection. Although we do not yet have access to comprehensive real-time claims data, we have made important strides in obtaining data more quickly and efficiently. On a pilot basis, CMS recently provided several OIG investigators and analysts access to a Medicare data system that includes much of the real-time claims data that law enforcement needs. OIG, DOJ, and CMS have also worked together to develop a data request template so that CMS contractors can process our data requests faster and with more efficiency.’ (emphasis added.) available at: <http://oig.hhs.gov/testimony/docs/2010/3-4-10LevinsonHAppropsSub.pdf>

See also Morris, *Combating Fraud in Healthcare: An Essential Component of Any Containment Strategy*; Health Affairs 2009; 28: 1351-1356

care prepayment review.”<sup>14</sup> Congress agreed with the proposal and repealed the prohibition when it passed “health care reform,” i.e. the Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and the related reconciliation bill (Pub. L. No. 111-152; hereafter together as “PPACA”), in March of this year.<sup>15</sup>

The above bare chronological discussion of prepayment review<sup>16</sup> in the Medicare program may imply that CMS and Congress, having inexplicably deprived the program of a much-needed enforcement tool by prohibiting it, have now seen the error of their ways and recanted so that prepayment review can readily be re-implemented as an effective tool for anti-fraud enforcement. Such an implication obscures a complicated reality.

Looking back, it is clear that the prohibition of prepayment review was not inexplicable—it happened because both CMS and Congress were responding to, among other things, powerful objections from the provider community that, because random sampling entailed forcing physicians to provide medical records and submit to questioning without prior indication of impro-

priety, its use by Medicare contractors was both unfair and disruptive of the delivery of care.

That problem will again afflict any effort to re-implement pre-payment review as will others that have emerged since its prohibition in 2003. In short, effective re-implementation of pre-payment review will be neither easily undertaken nor quickly completed.

This brief article attempts to provide an overview of the issues facing CMS in re-implementing prepayment review by addressing (i) the historic role of Medicare claims processing contractors, including generally the nature of random prepayment review, its role in contractor operations and its proven functionality as a cost-saving mechanism, (ii) the reasons CMS and Congress acted to limit and effectively prohibit its use, thereby establishing the policy of “pay and chase,” (iii) CMS’s continued use of other forms of prepayment review<sup>17</sup>, (iv) developments in Medicare since its prohibition in 2003, including the increase in provider use of Electronic Health Records and the growing recognition—at least outside of CMS and the OIG—that efficiency and accuracy in processing of claims serves to enhance the probability of successful fraud, (v) the significance of Congress’s repeal of the prohibition on prepayment review as enabling the only proven cost-savings mechanism<sup>18</sup> included in the health care reform legislation and (vi) the obstacles to successful re-implementation.<sup>19</sup>

## What is Prepayment Review of Claims for Fraud or Overcharging?

There are essentially two forms of prepayment review of claims for fraud or overcharging. The first type of review—and the type that is the principal subject of

<sup>17</sup> Broadly speaking, there are two forms of post-service prepayment review of claims for fraud or overcharging: The first type of review—and the type discussed in this article—is random medical review of utilization based on random sampling of claims prior to payment, which entails (i) use of a simple algorithm to assure that the sample of claims submitted by a given type of provider, e.g., physician, is sufficient to be statistically reliable and that all providers have an equal chance of being selected, (ii) requests for access to medical records relating to the claims, (iii) medical review of the records and, in some cases, (iv) interviews or audits of the providers who submitted the selected claims. The program structure more commonly used in the private sector—and since 2003 used by Medicare—is to identify problem providers based on retrospective review of claims, and then placing those individual providers on 100 percent pre-payment review. In this regard, note that the private sector’s problems with fraudulent claims differs from that of Medicare in that private sector insurers have better—though far from absolute—control both of enrollment of beneficiaries and, where networks are involved, selection of providers authorized to submit claims or otherwise receive payment from the insurer.

<sup>18</sup> This statement is the view of the author based on a review of the legislation, albeit comments from the Director of the Congressional Budget Office do not appear to contradict it. See, e.g., CBO Director’s Blog, *The Effects of Health Reform on the Federal Budget* April 12, 2010, available at: <http://cboblog.cbo.gov/?p=650>

<sup>19</sup> The assertion regarding effective cost-savings mechanisms is opinion based on review of the legislation. Historical facts adduced and agency guidance discussed elsewhere in the paper are, to the best of my ability, presented accurately in this article, albeit the discussion of the chronology of random prepayment review is necessarily limited and may omit events that knowledgeable people might view as significant.

<sup>14</sup> President’s FY 2011 Budget; available at: <http://www.whitehouse.gov/sites/default/files/summary-presidents-proposal.pdf>.

<sup>15</sup> “Patient Protection and Affordable Care Act”, Pub. L. No. 111-148 (2010); “Health Care and Education Reconciliation Act of 2010” Pub. L. No. 111-152 (2010); Section 1302.

The repealed provision:

42 U.S.C. § kk-1(h);

(1) Conduct of random prepayment review.

(A) In general. A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

(B) Use of standard protocols when conducting prepayment reviews. When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

(C) Construction. Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

(D) Random prepayment review. For purposes of this subsection, the term “random prepayment review” means a demand for the production of records or documentation absent cause with respect to a claim.

(2) Limitations on non-random prepayment review.

(A) Limitations on initiation of non-random prepayment review. A Medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error under section)].

(B) Termination of non-random prepayment review. The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review. Social Security Act, Title XVIII, Part E. § 1974 as added and amended Dec. 8, 2003, P.L. 108-173, Title 10, Subtitle B, § 912(a)

Repealed: H.R. 4872, Health Care and Education Reconciliation Act of 2010, . SEC. 1302. MEDICARE PREPAYMENT MEDICAL REVIEW LIMITATIONS.

<sup>16</sup> When used in this article without modifiers, the term “prepayment review” refers generally to the types of review addressed in 42 U.S.C. § kk-1(h), paragraphs (1) Conduct of random prepayment review and (2) Limitations on non-random prepayment review.

this article—is random medical review of utilization based on random sampling of provider claims prior to payment, which entails (i) use of an algorithm to assure that the sample of claims submitted by a given type of provider, e.g., physician, is sufficient to be statistically reliable and that all providers have an equal chance of being selected, (ii) requests for access to medical records relating to the claims, (iii) medical review of the records and, in some cases, (iv) interviews or audits of the providers who submitted the selected claims.

The program structure more commonly used in the private sector—and since 2003 used by Medicare—is to identify problem providers based on retrospective review of claims, and then placing those individual providers on 100 percent pre-payment review.<sup>20</sup>

### Prepayment Review Successfully Utilized in The Past

For many years Medicare Intermediaries, who administered Medicare Part A, and Carriers who administered Part B<sup>21</sup> on behalf of CMS and its predecessor agency (HCFA), were tasked not only with payment of Medicare claims but with every aspect of Medicare claims processing—including but by no means limited to prepayment and post payment review of claims for overcharges, fraud, and medical necessity, maintaining benefits integrity, compliance with the Medicare Secondary Payer/Medicare coordination of benefit rules, beneficiary and provider relations and, for the Intermediaries administering Part A, provider audit.

Stated otherwise, these contractors performed all the functions a commercial health insurer or a Blue Cross/Blue Shield or other not-for-profit plan ordinarily performs in the course of conduct of its business plus additional functions required by their Medicare contracts.

During the 42 years from 1965 until early 2008, when almost all Intermediaries and Carriers had been replaced by the new Medicare Administrative Contractors (MACs), the Carrier/Intermediary approach to administration of Medicare produced scores of contractor executives whose broad responsibilities required them to develop a firm grasp and understanding of the Medicare program and the complex interplay of the functions necessary to operate it.

This broad grasp of the program paid dividends in connection with the exercise of responsibility for prepayment and postpayment review of claims for fraud because that responsibility required, among other things, that the contractor randomly—and non-randomly—sampled claims prior to payment for improprieties and, when potential improprieties were identified, to make the best use of the contractor’s capabilities to conduct a multidisciplinary review to determine whether the claims were improper and, if so, appropriate for suspension of payment to the provider or providers in question or referral to law enforcement or both.

<sup>20</sup> Note that the private sector’s problems with fraudulent claims differs from that of Medicare in that private sector insurers have better—though far from absolute—control both of enrollment of beneficiaries and, where networks are involved, selection of providers authorized to submit claims or otherwise receive payment from the insurer.

<sup>21</sup> The functions of Intermediaries for Medicare Part A and Carriers for Part B have, with some exceptions that still exist pending resolution of protests and possible re-issuance of solicitations, been consolidated under the new Medicare Administrative Contractors (“MACs”).

For example, a multi-disciplinary approach that incorporated prepayment review was used to good effect in a number of instances, one example being Operation Restore Trust, announced by President Clinton in May 1995 as a two-year demonstration project and generally regarded as highly successful, which identified a total of more than \$187.5 million in fines, recoveries, settlements, audit disallowances, and civil monetary penalties owed to the Federal Government.<sup>22</sup>

In fact, Operation Restore Trust was the direct result of work by the then-Medicare Part B Carrier for Southern Florida, whose nurses and fraud investigators collaborated to focus the attention of CMS and HHS-OIG on the appalling abuses in home health care then rampant in Southern Florida.

The GAO recognized that prepayment review worked, reporting in 2000 that CMS estimated FY 99 prepayment and post-payment review for overcharging and fraud saved the Medicare program more than \$17 for each dollar spent in FY ‘99—about 55 percent or \$9.35 of which was from prepayment activities—a return on investment, one might say, of a whopping 935 percent.

The GAO noted that, in light of these returns, “CMS’s decision to concentrate its program safeguard resources on prepayment, rather than postpayment, activities in recent years is justified given the cost-effectiveness of error prevention “but emphasized that contractor review of claims is most effective when pre and post-payment reviews are coordinated.”<sup>23</sup>

But despite the employment of both prepayment and post-payment review techniques, Medicare’s vulnerability to fraud increased throughout the 1990s, in part because both the number of claims processed and the number of claims submitted electronically rose “dramatically” during that period, the latter having the dual effect of enhancing efficiency while increasing “the need for more innovative controls to curtail fraud.”<sup>24</sup> Medicare’s controls against fraud did not, however, keep pace during this period with the growing need to curtail it.<sup>25</sup>

### The Cost of Prepayment Review; Resentful Providers, Political Pressure

CMS’s high returns on its investment in prepayment review had a cost in the form of political pressure. As noted above, random prepayment review entailed forcing physicians to provide medical records and, sometimes, to submit to questioning without prior indication of impropriety, all of which can be disruptive to their practices and delay payments while review is underway even if no impropriety is ultimately identified. And where the review has identified sufficient evidence to raise a presumption of impropriety, then payment of that provider’s claims might be suspended.

Physicians who were innocent of wrongdoing and perhaps even of error understandably resented prepay-

<sup>22</sup> HHS OIG/HCFA Press Offices *FACT SHEET, OPERATION RESTORE TRUST ACCOMPLISHMENTS*, May 20, 1997, available at: <http://www.hhs.gov/news/press/1997pres/970520d.html>

<sup>23</sup> GAO, *HCFA Could Do More To Identify And Collect Overpayments*, HEHS/AIMD-00-304 (September 2000) at 14.

<sup>24</sup> GAO, *Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud* (GAO/AIMD-95-77, August 1995) at 2.

<sup>25</sup> *Id.*

ment review, whose impact on their practices ranged from minor inconvenience to major disruption.

Providers whose payment was suspended based on evidence obtained from prepayment review of course didn't like it either and frequently fought it by any means necessary, including filing litigation in federal court and, sometimes, bringing pressure to bear on their congressman who brought pressure to bear on the agency, who continued the downhill roll by bringing pressure on the contractor in question.

Some congressmen didn't hesitate to call contractors directly on behalf of their clients and, in the words of one former contractor executive, the agency sometimes "threw us under the bus." At least one such executive was called before a congressional committee and publicly raked over the coals by a congressman from a large Midwestern state for attempting to discipline a wayward provider in his district.

Despite the magnitude of its mission, CMS has never been a large or, compared with some others, a particularly well-funded agency<sup>26</sup> and simply lacked the capacity to consistently resist pressure brought by lawmakers expressing outrage on behalf of the provider constituents. In the view of many of the agency's contractors, this lack of capacity meant some of the worst offenders identified through prepayment review got away.

Providers also manifested their understandable distaste for random prepayment review through their membership organizations. In 1997, the American Medical Association passed a resolution urging CMS to stop prepayment review, simultaneously asserting their view that the practice was damaging to their practices and inimical to the delivery of care directly to both Congress and the agency.

During this period, the AMA Council on Medical Service asserted in writing that medical review activities "seek to create a hostile environment"—a perhaps understandable sentiment but not one calculated to endear the Council on Medical Service to CMS.

At the same time, physicians also pressed the agency to emphasize "the level of physician education and the feedback that physicians receive from carriers," and, as noted above, the agency responded by committing to eliminate random prepayment reviews over time<sup>27</sup> and

<sup>26</sup> CMS is responsible for the management of both Medicare and Medicaid. In 2008 Medicare's "outgo" was \$440 billion—nearly half a trillion dollars. Yet, as noted above, neither CMS nor its predecessor agency HCFA has been funded at a level commensurate with its responsibilities. In the case of Medicare, this underfunding is in part the result of Congress's decision to fund program benefits through the sham Medicare Trust Fund, which is actually an indefinite appropriation not subject to the appropriations process while funding CMS's operating or administrative costs, which include the funds CMS provides to its Medicare contractors, through an annual appropriation. This structure enables Congress to pretend it is controlling the costs of Medicare by squeezing CMS administrative budget, which has had the twin effects of (a) limiting the resources available to CMS for management of the Medicare program and, as any honest Medicare contractor will tell you, (b) incentivizing the agency to place a higher value on control of contractor administrative costs than on control of the costs of benefits.

<sup>27</sup> HCFA's commitment immediately raised concerns as to its potential impact on fraud enforcement. The AMA's Council on Medical Service reported in June 1999 that, "[w]ith the elimination of random case reviews, concerns have grown regarding the ability of HCFA to detect appropriate payment.

had eliminated the practice altogether by the end of 2001.<sup>28</sup>

It also moved to increase accuracy both of provider submission and contractor review of claims, developing the Comprehensive Error Rate Testing (CERT), which quite appropriately aimed at increasing the accuracy of both provider submissions and contractor review of claims and continues in full force today.

CMS also addressed physician complaints about medical review by working with the AMA to develop a program memorandum entitled "Medical Review Progressive Corrective Action" issued in August 2000, that sought to "ensure" that carrier medical review procedures are "fair and consistent" and strengthened its programs for education of providers relating to all aspects of the Medicare program, specifically including accuracy of claims submitted for payment.<sup>29</sup> As discussed above, in 2003 Congress followed yielded to pressure from its provider constituents and passed legislation limiting prepayment review, whether random or non-random in nature.<sup>30</sup> CMS interpreted the provision limiting prepayment review to *prohibit* such review absent substantial evidence of wrongdoing.<sup>31</sup> While probably correct, this interpretation worked together with the requirement that contractors pay all "clean"<sup>32</sup> claims within 30 days of submission to effectively require Medicare contractors to make payment within 30 days of any claim that on its face met the criteria for payment, effectively precluding any possibility of systematic prepayment review of claims for overcharging or fraud.<sup>33</sup>

This is not to imply that payment of clean claims is easy or that Medicare contractors have no function other than to unquestioningly pay claims. That would be both inaccurate and unfair—Medicare claims are frequently rejected for payment because they are erroneous or don't provide the information necessary to assure Medicare that the needed service was provided in the appropriate manner—and MACs continue to apply a range of prepayment review techniques other than random case review.<sup>34</sup> However, the application of

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The 'error rate' identified in the Office of the Inspector General's (OIG) Chief Financial Officer's (CFO) annual audits includes everything from inadvertent mistakes to outright fraud and abuse. However, what portion of the error rate is directly attributable to fraud cannot be quantified." AMA Report of the Council on Medical Service, Medical Review Activities, Subject: *Medicare Integrity Program, and Carrier Post Payment Audit Processes* (June 1999)

<sup>28</sup> See fn 5, *supra*

<sup>29</sup> AMA Council on Medical Service, Status Report on Medicare Review Activities, (December 2000), available at: <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-medical-service/reports-house-delegates-meeting/december-2000-interim-meeting.shtml>

<sup>30</sup> See: fn 12, *supra*

<sup>31</sup> Medicare Prescription Drug Improvement and Modernization Act of 2003, P.L. 108-173, (2003) Section 921(c)(2); Social Security Act, Section 1874A(h), 42 U.S.C. 1395kk-3a(h) **Conduct of prepayment review**

<sup>32</sup> A "clean claim" is "a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. . ." (42 C.F.R. § 422.500)

<sup>33</sup> See, e.g., 42 U.S.C. 1395h (a) 2 (b)

<sup>34</sup> See, e.g., CMS, *Medicare Claim Review Programs: MR, NCCI Edits, MUEs, CERT, and RAC* (October 2008) available

these techniques does not serve to detect previously unidentified fraud prior to payment of a fraudulent claim and, to its credit, CMS explicitly eschews any notion that it does.<sup>35</sup>

### Repeal of Prohibition of Prepayment Review

The historical success of prepayment review suggests that the repeal of its effective prohibition has genuine promise of ultimately generating significant savings, albeit we have no Congressional Budget Office (CBO) estimate of potential savings because CBO scoring rules preclude scoring provisions that would provide “direct spending for administrative or program management activities.”<sup>36</sup>

Yet while Congress has removed the statutory rationale for CMS prohibition of prepayment review, it has left to the agency the decision as to whether and how to re-implement it.<sup>37</sup>

That CMS will re-implement seems clear—the language in the FY 2010 budget proposal indicates that both the president and HHS secretary expect the re-implementation of prepayment review. That said, how CMS undertakes to do so is another question, the answer to which will determine whether the health care reform legislation recently enacted into law will yield any sort of meaningful savings over the next 10 years.

The Congressional Budget Office projects that PPACA will generate cost savings leading to deficit reduction of \$143 billion in the first 10 years and \$1.2 trillion over the next two decades.<sup>38</sup>

Proponents of “health care reform” tout these projections as proof PPACA has achieved the administration’s goal of “bending the cost curve.” But these projections are at best questionable—the CBO itself notes that its

estimates don’t include the potential impact of the legislation on discretionary spending, “which would be subject to future appropriation action” and that its calculations reflect assumptions—such as those holding a number of health care provider rates below the level of inflation—“that might be difficult to sustain over a long period of time.”<sup>39</sup>

For example, CBO’s projections assume Congress will take no action to allow Medicare physician payments keep up with inflation at a CBO-estimated cost of \$250 billion over 10 years. Yet legislation to do just that is presently pending before Congress—and there isn’t anyone on Capitol Hill who will tell you it isn’t going to pass.<sup>40</sup> When it does, the \$143 billion reduction in deficit reduction will morph into a \$107 billion deficit increase.<sup>41</sup> And physician payments are only one of the several types of providers whose rates are unrealistically projected to be held below the level of inflation. So much for bending the cost curve.

### Obstacles to Implementation of Effective Prepayment Review

#### *Effective Prepayment Review in the Current Environment*

If prepayment review is to be effective in the current environment, it must be performed in the context of a strategic approach to fraud enforcement that includes activities that CMS currently performs through its MIP contractors, including the post-payment review of claims, investigation of complaints, data mining, and analysis to detect previously unidentified patterns or instances of fraud and abuse, and the like.<sup>42</sup>

Coordination between CMS’s claims processing contractor performing the prepayment review and its MIP contractors must be seamless and enable both the MIP contractors and the OIG to have real-time access to evidence of fraud generated by the claims processing contractor. These characteristics will serve to enable the enforcement agencies to identify and attack both forms of fraudulent claims and all three types of fraudulent provider.

That said, the non-provider who submits claims for nonexistent services may at present be the biggest danger to Medicare because the extent to which their activities pervade the system is simply not known. In these circumstances it is, again to quote Professor Sparrow, imperative that the system be able to “bite back” when prepayment review identifies a claim as potentially submitted by a nonexistent provider for services that were never delivered.

at: [http://www.cms.gov/MLNProducts/downloads/MCRP\\_Booklet.pdf](http://www.cms.gov/MLNProducts/downloads/MCRP_Booklet.pdf).

<sup>35</sup> See, e.g., <http://www3.cms.gov/CERT/http://www3.cms.gov/CERT/>. Note that CERT grew out of a project aimed at developing an improved metric for measuring contractor medical review performance as part of the contractor performance evaluation. The approach adopted was that contractor performance should be measured in terms of reductions in the underlying rate of improper payments, an approach that was appropriate at the time because it enabled CMS to establish a base line for identification of improper payments, of which the vast majority at the time resulted from “insufficient documentation”; that is, insufficient information in the medical record to determine whether a service was either (a) actually performed, or (b) medically necessary. CMS has greatly improved the accuracy of submission of legitimate claims. I am again indebted to Mr. Don Moran, in this case, for providing me insight into the historical origins and purpose of CERT.

<sup>36</sup> CBO Scorekeeping Guideline 14 provides: “No increase in receipts or decrease in direct spending will be scored as a result of provisions of law that provides direct spending for administrative or program management activities.” Of course, even if CBO were not constrained by this rule it could not have estimated the effect of the repeal of prepayment review because it is not yet known how CMS will go about implementing it.

<sup>37</sup> As we have seen, both CMS and its predecessor agency, HCFA, allowed and prohibited such review prior to Congress’s 2003 action limiting it. But its authority to do so was delegated to it by the secretary of health and human services, who will in this instance almost certainly direct CMS to resume prepayment review.

<sup>38</sup> Congressional Budget Office, Letter to Speaker Pelosi, March 20, 2010, at 10-12; available at: <http://www.cbo.gov>

<sup>39</sup> Id. at 13-14.

<sup>40</sup> See, e.g., *Summary of the Reconciliation Act of 2010*, available at: <http://marchant.house.gov/News/DocumentSingle.aspx?DocumentID=179173>

<sup>41</sup> A more accurate estimate of the deficit increase would like be in the neighborhood of \$562 billion. Holtz-Eakin, *The Real Arithmetic of Health Care Reform*, New York Times, March 20, 2010; available at: <http://www.nytimes.com/2010/03/21/opinion/21holtz-eakin.html> (“In reality, if you strip out all the gimmicks and budgetary games and rework the calculus, a wholly different picture emerges: The health care reform legislation would raise, not lower, federal deficits, by \$562 billion.”)

<sup>42</sup> Levinson, HHS OIG, “Medicare’s Program Safeguard Contractors: Activities to Detect and Deter Abuse” OEI-03-06-00010 (July 2007)

He urges that in such circumstances, e.g., the provider purportedly submitting the claim is, in fact, dead, “[a]ll assumptions of trust should be dropped immediately . . . [a]ll other claims from the same source should . . . be put on hold” and all relevant enforcement methods should be used, including “surveillance, arrest, or dawn raids.”<sup>43</sup>

### **Multiple Constituencies, Conflicting Interests**

Effective re-implementation of prepayment review presents CMS with the arduous and painful task of addressing the concerns of multiple constituencies, each of whom has at least one ox that CMS must gore to do it right and, with the possible exception of its own contractors, will not be shy about complaining when that happens.

Legitimate health care providers—all of whom are with good reason themselves crying out for the government to clamp down on health care fraud—will express legitimate fears that re-implementation will result in “[i]nnocent billing errors . . . [being] prosecuted as intentional fraud” and will inevitably again experience inconvenience and, sometimes, disruption of their practices.<sup>44</sup>

Organizations representing retirees and the elderly will urge CMS to “[t]ake a balanced approach to fraud and abuse control activities to avoid negative effects on patient health care” and to minimize the inevitable disruption of the work of legitimate providers.<sup>45</sup>

The OIG may well argue that CMS efforts to respond to these concerns by taking a balanced approach will interfere with effective prepayment review and limit the OIG’s “real-time access” to Medicare claims data.

For its part, Congress as a whole will press the agency to be aggressive and to take all possible steps to minimize the payment of fraudulent claims while individual lawmakers using designated “attack staff” will assault the agency and the cognizant contractor every time a provider constituent complains that CMS’s implementation of prepayment review is abusive and unfair as to him or her.

CMS contractors will conduct prepayment review as directed but secretly and occasionally openly complain that CMS doesn’t really believe in the policy it is implementing, has no idea what it is doing, does nothing to protect them when the congressional staff aide calls, and generally lacks backbone.

And that is just the color commentary—actually playing the game on the field will be even worse because (i) the assumptions underlying CMS claims processing and payment policy—the paramount of accuracy and efficiency—are appropriate for a “safety net” program, and therefore, immutable, yet (ii) those assumptions give rise to the very obstacles that will impede effective re-implementation.

<sup>43</sup> Malcolm K. Sparrow; Testimony before the Senate Committee on the Judiciary; Subcommittee on Crime and Drugs, Hearing: “*Criminal Prosecution as a Deterrent to Health Care Fraud.*” May 20th, 2009; available at: <http://www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony>.

<sup>44</sup> Lind, *Reduce Waste, Fraud, and Abuse in Health Care*, AARP Public Policy Institute, July 2009 available at: [http://www.aarp.org/research/ppi/health-care/health-costs/articles/fs158\\_fraud.html](http://www.aarp.org/research/ppi/health-care/health-costs/articles/fs158_fraud.html).

<sup>45</sup> *Id.*

Said another way, implementation of truly effective prepayment review is inconsistent with the basic thrust of CMS’s core enterprise; therefore, foreign to CMS’s conception of the claims payment process.<sup>46</sup>

In that sense its implementation is analogous to transplantation of an organ belonging to one person into the body of another, i.e., there is always the risk of rejection.

### **Enhancing Accuracy, Efficiency of Claims Processing Enhances the Opportunity for Fraud**

As noted above, CMS has focused its prepayment efforts on improving accuracy and efficiency of claims submission and payment rather than on fraud detection, even to the point of undertaking extensive education programs for providers that include instruction as to how to submit accurate and complete Medicare claims.

The elimination of prepayment review for fraud is consistent with, and was in fact a key element of, this approach, which emphasizes working with providers to make delivery of care more efficient so that, for example, virtually all of the prepayment review currently being performed is data integrity and validation-focused.

Systems like CERT are designed to ensure that “claims are presented correctly and processed accurately, rule-based software checks that the prices charged are within appropriate limits, and that the treatments lie within the bounds of policy coverage.”<sup>47</sup>

This approach does wonders for efficiency—and it certainly has helped honest physicians and other providers receive timely payment for their Medicare claims. But it does nothing to prevent fraud and in fact enhances opportunities to commit it because Medicare claims processing systems are so designed that a smart crook can submit carefully constructed phony claims in limited numbers for a long time with little risk of tripping contractor guidelines.<sup>48</sup>

Malcolm Sparrow, a Professor at the John F. Kennedy School of Government, who specializes in operational risk control, characterizes this state of affairs as one where “fraud perpetrators, who may choose to submit claims that are totally unwarranted or fictitious . . . [understand] that they must take great care to submit their bogus claims *correctly*. . . . They can fabricate entire medical episodes and submit the resulting bills without the patients knowledge.” (italics in original)<sup>49</sup>

<sup>46</sup> Malcolm K. Sparrow, *Fraud in the U.S. Healthcare System Exposing the Vulnerabilities of Automated Payments Systems*; Social Research, Vol 75: No 4: Winter 2008 at 1165

<sup>47</sup> *Id.* at 1154. The statement describes the claims processing practices of the U.S. health insurance industry generally not Medicare specifically. But the description is apt for and can be applied equally to Medicare programs, e.g., CERT. Cf: <http://www3.cms.gov/CERT/>

<sup>48</sup> Cf: GAO; *Medicare; Improvements Needed to Address Improper Payments in Home Health* (February 2009)

<sup>49</sup> fn 37, supra at 1155; On Wednesday, May 20th, 2009, Professor Sparrow stated this proposition another way in testimony before the Senate Committee on the Judiciary: Subcommittee on Crime and Drugs:

On the whole the [health insurance industry does] a good job using modern process improvement strategies to ensure payment accuracy—by which I mean making sure that the claims as presented were processed correctly and according to all the relevant rules. But the industry did a terrible job of crime control, with almost no procedures in place to routinely verify



Professor Sparrow continues to observe that “desk-audit” medical reviews are virtually useless when the fraud has a “brain” behind it, noting that “[a]ll but the least sophisticated perpetrators routinely generate matching medical records at the same time they produce their fraudulent claims, just in case anyone ever asks to see them.”<sup>50</sup>

In other words, sophisticated claims processing systems like those used by Medicare are not only susceptible to fraud, they may actually be enhancing the likelihood of its success by making it easy for perpetrators to submit claims that mimic the correct responses to system requirements but that, as to care delivered to the beneficiary in question, represent exactly nothing.<sup>51</sup>

In sum, one of the defining criteria for successful health care fraud is the capacity to mimic the very characteristics that CMS must encourage and incentivize in the interest of the predictability, transparency, speed, and accuracy of payment. Thus, fraudulent claims are not camouflaged versions of legitimate claims but are, rather, claims that meet the system’s every criteria for payment, i.e., they are “clean” claims, hence *claims that the system perceives to be legitimate*.

Seen in this light, the elimination of random prepayment review from the Medicare claims payment process in response to provider pressure is ironic. Congress’s attempt to stop what they perceived to be bureaucratic harassment of legitimate providers in their districts appears to have deprived enforcement of the only tool that enables effective statistical surveillance for fraud, i.e., is the only tool that works to identify (i) non-providers impersonating providers and submit claims for services that were never rendered and (ii) supposedly legitimate providers who knowingly bill for services that they have not rendered.

Stated otherwise, Congress removed from a highly efficient process for paying claims the only effective mechanism, albeit from the physician’s perspective an inefficient one, for detecting perpetrators of fraudulent claims. And to enhance the irony, the agency’s response to provider pressure, which coupled elimination of prepayment review with the initiation of well-meant and necessary programs to educate providers in accurate submission of their honest claims, has likely helped educate fraudulent providers in the error-free submission of fraudulent ones.

### **The Related Entity Issue**

When Congress limited prepayment review, it left to CMS to decide the best way to approach review of claims for fraud. The agency’s chosen approach appears to have been influenced by a perception among some within CMS that contractors who pay claims have a “related entity problem,” i.e., an organizational conflict of interest when they also investigated claims for propriety of payment through prepayment review, whether that review entailed coordination of benefits, fraud, Medical review, or other audit.

that the claims presented were actually true, or that services provided were medically necessary.

Available at: <http://www.hks.harvard.edu/news-events/news/testimonies/sparrow-senate-testimony>

<sup>50</sup> Sparrow, *Fraud in the U.S. Healthcare System*. . . , fn at 1154.

<sup>51</sup> The GAO would, I think, agree with this assertion. See, e.g., fn 20.

A related entity issue did and indeed continues to exist since all Carriers and Intermediaries were and all current MACs are divisions or subsidiaries of health insurance companies whose payment of claims must often be coordinated with Medicare.

In CMS’s view, this relationship necessarily impairs the objectivity of the MACs when reviewing claims with which their parent companies may be involved, placing them at high risk of yielding to the temptation to decide questions of propriety of payment in favor of the parent. The problem is exacerbated in CMS’s eyes by the fact that many state-based health insurance plans have practicing physicians who submit claims to Medicare serving on their boards of directors.

CMS ultimately resolved this perceived problem by taking advantage of the authority previously granted it under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 to engage specialized contractors to improve identification of overpayments by transferring all overpayment review to such contractors, thereby drawing a bright line between the payment functions and “safeguard” or integrity functions noted above.

These specialized contractors are authorized under the Medicare Integrity Program and are of three basic types: Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDICs), and Zone Program Integrity Contractors (ZPICs), each of which was originally assigned different combinations of safeguard functions, albeit in 2008 CMS began consolidating all the functions under ZPIC.<sup>52</sup>

But however denominated, the functions of a MIP contractor are, with some limited exceptions, performed post-payment and reflect the agency’s commitment to the “pay and chase” strategy or model for cost control with the MACs paying and the MIP contractors chasing.

If CMS chooses its claims processing contractors—the MACs—to implement prepayment review, it will be taking a step directly contrary to both the “pay and chase” strategy and, since the review would be performed by a contractor other than a ZPIC, to the logic of CMS’s organizational response to its related entity concerns, which requires that claims processors be essentially excluded from investigative decision-making vis-a-vis review of claims prior to payment.

That said, CMS cannot reasonably be expected to dismantle the existing pay and chase structure and return to the consolidated model of the Intermediary and Carrier era because (i) doing so would be extraordinarily costly and (ii) the MACs no longer have the capacity to perform the broad range of functions performed by Carriers and Intermediaries.

### <sup>52</sup> Safeguard Contractors, LLC; **Zone Program Integrity Contracts (ZPIC)**

In 2008, CMS began the process of consolidating the scope of all Program Safeguard Contractor (PSC) and Medicare Prescription Drug Integrity Contractor (MEDIC) contracts into ZPIC contracts. The ZPIC contracts include work for all claim types including Part A, Home Health, Hospice, Part B, Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), Managed Care (Part C), Part D Medicare Prescription Drug, and Medicare and Medicaid Data Matching. Part A cost report audit and reimbursement will also be added under the scope of a ZPIC contractor.

available at <http://www.edssafeguardservices.edss-gov.com/zpic.asp>

Nor can CMS reasonably create another specialized contractor to perform the prepayment review function—the segregation of functions inherent in the pay and chase structure has already fractured the system to the point that efficient coordination is difficult; another specialized contractor would only make matters worse.

### **CMS ‘Cultural Reluctance’ to Recognize Pervasiveness of Deliberate Fraud**

There is an apparent reluctance on the part of some elements within CMS to accept the likelihood that the agency is the target of systematic fraud perpetrated by numerous people with sizeable brains.<sup>53</sup> In this regard, some may perceive CMS’s embrace of “pay and chase” as indicative of a failure to grasp the importance of prepayment detection of fraudulent claims. This perception may be unfair but it is unfortunately supported by explicit and somewhat surprising language the agency issued on Nov. 20, 2009, and subsequently incorporated into its *Medicare Program Integrity Manual* (“PIM”) on Dec. 21, 2009, stating that the principal cause of improper payment of Medicare claims is provider error in filling out claim forms, thereby certainly minimizing and arguably dismissing deliberate fraud as a significant cause of the submission and payment of improper claims:

... The CMS has determined that most improper payments in the Medicare FFS program occur because a provider did not comply with Medicare’s coverage, coding, or billing rules. The cornerstone of the ACs’ and MACs’ efforts to prevent improper payments is each contractors’ Error Rate Reduction Plan (ERRP), which includes initiatives to help providers comply with the rules. . . . (emphasis added.)<sup>54</sup>

The above statement is disturbing for several separate though obviously related reasons. First, the statement cannot be dismissed as a simple mistake. It has indicia of a deliberate statement of position vis-a-vis the cause of “most improper payments,” e.g., the use of the word “determined” and the explicit reference to the action being taken to “prevent improper payments,” the “cornerstone” of which is “to help providers comply with the rules. . . .”

Second, CMS has estimated that in FY 2009 some 7.8 percent of the Medicare fee-for-service claims it paid (\$24.1 billion) did not meet program requirements,<sup>55</sup> which suggests that someone in CMS believes the largest portion of the estimated \$24 billion is the result not of fraud but of procedural errors on the part of the providers.

Third, the use of the word “determined” implies finality, thus suggesting a refusal to consider the possibility that a true measure of the “improper payments” situation would yield an additional number somewhere between \$20 billion to \$60 billion in such payments, virtually all of which are due to intentional fraud.<sup>56</sup>

<sup>53</sup> See endnote 44, *supra*

<sup>54</sup> See fn 50, *supra*

<sup>55</sup> Department of Health and Human Services, Office of Inspector General; *Recovery Audit Contractors’ Fraud Referrals*; OEI-03-09-00130 (February 2010) available at <http://oig.hhs.gov/oei/reports/oei-03-09-00130.pdf>

<sup>56</sup> See: fn 2, *supra*.

Fourth, since neither the OIG nor anyone else in the United States government has ever attempted to separately identify and measure the amount of fraud against Medicare, it appears that the statement incorporates an assumption that Medicare’s claims processing systems generate all the information and data necessary to identify the cause of improper payments.

Yet such an assumption is in direct opposition to the reality that the nature of CMS claims processing systems is to conceal deliberate fraud and render it invisible. In other words, the statement is bottomed on one of the most common of cognitive biases: the absence of evidence of something—in this case of deliberate fraud—being taken as proof that it doesn’t exist.<sup>57</sup>

CMS Strategic Action Plan for 2006-2009 (“CMS Plan” or “the Plan”) provides another indication of the agency’s reluctance deliberate fraud as a key driver of ever-increasing Medicare costs—deliberate fraud whose efficacy is enabled by the very systems CMS has worked so hard to put in place. The Plan sets out five key objectives, all of which are completely appropriate, laudable but none of which appear related to detection of fraud and one of which—“accurate and predictable payments”—paradoxically operates to enhance the opportunities for successful fraud.<sup>58</sup> As indicated by its strategic objectives CMS’ “core task” is to provide funding for health care for Medicare and Medicaid beneficiaries, “not to carry out fraud control.”<sup>59</sup>

It is therefore not surprising that there is currently no reference to fraud control in the agency’s strategic plan for 2006-2009. Nor would it be surprising if the agency’s strategic plan for 2010 and later years contained no such reference. But its absence would be unfortunate and perhaps a negative predictor regarding effective implementation of prepayment reviews.<sup>60</sup>

<sup>57</sup> Heuer, *Psychology of Intelligence Analysis*, Center for the Study of Intelligence, Central Intelligence Agency (1999) at 115-116; Taleb, *The Black Swan*, Random House (2007) at 100-101 (“We call this the problem of silent evidence.”)

<sup>58</sup> The 2010 plan has apparently not yet been posted. The key objectives for the 2006-2009 plan are:

1. Skilled, Committed, and Highly-Motivated Workforce
2. Accurate and Predictable Payments
3. High-Value Health Care
4. Confident, Informed Consumers
5. Collaborative Partnerships

available at: [http://www1.cms.gov/MissionVisionGoals/Downloads/CMSStrategicActionPlan06-09\\_061023a.pdf](http://www1.cms.gov/MissionVisionGoals/Downloads/CMSStrategicActionPlan06-09_061023a.pdf)

<sup>59</sup> Sparrow, *Fraud in the U.S. Healthcare System*. . . , fn at 1165

<sup>60</sup> Interestingly, CMS did not prepare the contractors who performed the original demonstration work on the Recovery Audit Contract (RAC) program any formal instruction on referral of potential fraud cases to enforcement authorities. The OIG reported in this regard.

During the [RAC] demonstration project, CMS did not provide any formal training to RACs regarding the identification and referral of potential fraud; however, CMS did provide the permanent RACs with a presentation about fraud. CMS did not provide RACs in the demonstration with formal training regarding the identification and referral of potential fraud. CMS did provide the permanent RACs with a presentation about fraud, which discussed the need for the RACs to be knowledgeable about fraud in Medicare, the definition of fraud, and examples of potential Medicare fraud. CMS is planning to provide the permanent RACs with further education and training on the identification of potential fraud. In addition, two of the three RACs reported providing informal training to their staff regarding the identification and referral of potential fraud.

## **Congressional Bullying Regarding Administrative Costs**

CMS is responsible for the management of both Medicaid and Medicare. This is a huge responsibility. In 2008, the “outgo” for Medicare alone was \$440 billion—nearly half a trillion dollars and only \$40 billion shy of the base budget for the entire Department of Defense for that year.<sup>61</sup>

Yet, as noted above, neither CMS nor its predecessor agency HCFA has historically not seen fit to provide the agency operating funds at a level remotely commensurate with its responsibilities.<sup>62</sup>

In 2008, for example, funds budgeted for program management and Medicare integrity totaled some \$2.9 billion—less than three quarters of a percent of Medicare outgo for that year. In the case of Medicare, this underfunding is in large part the result of Congress’s decision to fund program benefits through the sham Medicare Trust Fund, which is actually an indefinite appropriation not subject to the appropriations process while funding CMS’s operating or administrative costs, which include the funds CMS provides to its Medicare contractors, through an annual appropriation.

This structure enables Congress to pretend it is controlling the costs of Medicare by squeezing CMS administrative budget, which has had the twin effects of (a) limiting the resources available to CMS for management of the Medicare program and, as any honest Medicare contractor will tell you, (b) incentivizing the agency to place a higher value on control of contractor administrative costs than on control of the costs of benefits.<sup>63</sup>

<sup>61</sup> Office of the Undersecretary of Defense (Comptroller), “Fiscal Year 2010 Budget Request” (May 2009) available at [http://comptroller.defense.gov/defbudget/fy2010/fy2010\\_BudgetBriefing.pdf](http://comptroller.defense.gov/defbudget/fy2010/fy2010_BudgetBriefing.pdf)

<sup>62</sup> In 2008, Medicare’s budget for Medicare Operations, i.e., program management, was about \$2.1 billion and its budget for Medicare Integrity Program activities was \$744 billion for a total of some \$2.9 billion. Department of Health and Human Services, FY 2010 Budget in Brief: available at <http://dhhs.gov/asfr/ob/docbudget/2010budgetinbriefp.html>; Expect More.gov. “Detailed Information on the Medicare Integrity Program Assessment”; available at <http://www.whitehouse.gov/omb/expectmore/detail/10000470.2002.html>

<sup>63</sup> CMS personnel are dedicated and hard-working—necessarily so in light of the agency’s modest funding. And in fairness it should be pointed out that in an area relating to the costs of benefits, CMS employees have worked long, hard, and successfully to minimize incorrect benefits payments and saved considerable monies. That area is coordination of benefits where a few CMS employees have labored for years to develop mechanisms and programs that assure private plans pay the benefits for Medicare beneficiaries they cover. This effort has been substantially successful. But for the dedicated CMS employees who gave their working lives to it that would not have been the case. It is a bureaucratic success story of the first order. It must also be said that CMS Grants & Acquisition personnel have “rolled out” Medicare Contracting Reform in a surprisingly short period of time . . . beating the congressionally-imposed deadlines for several years. Mistakes were made and, as discussed elsewhere in this paper, there are questions about the resulting structure of Medicare contracting. But the fact remains that the agency managed to put a major program in place with very limited resources and this achievement cannot be gainsaid.

As to Medicare, then, CMS is an agency with a huge responsibility for Medicare that has historically been given a minuscule budget to fulfill it.<sup>64</sup>

## **Electronic Health Records and the ‘Perfect Storm’**

Implementation of truly effective prepayment review for fraud would require randomly selected physicians to provide patient records to Medicare contractors for medical review, a practice that physicians would likely view with disfavor now as they did before its prohibition in 2001.

But the irritation and disruption physicians previously experienced would almost certainly be compounded were CMS and the OIG to take the necessary step of combining the previous “desk audit” of medical records with actual visits to the physician’s offices and interviews with physicians and staff to verify that the medical practice that submitted the records actually exists and is legitimate.<sup>65</sup>

Physician perception that their practices are being unreasonably disrupted may be further compounded by other factors, including the ongoing process of implementation of electronic health records (EHR), a process that CMS has for years pressed the medical profession to adopt, utilizing the promise of both incentives and penalties to motivate physicians’ “meaningful use” of this technology.

There is, of course, no question that implementation of electronic health records, and health information technology generally, including electronic medical records for individual patients is critical to improving the efficiency of delivery of quality health care.

But there have been serious “glitches” along the way, arising from a combination of factors, including vendor development and marketing of EHR systems that were non-compliant with the requirements for entry of, for example, Evaluation and Management (“E/M”) coding with the consequence that four physician practices who purchased them submitted non-compliant E/M claims subsequently identified in audits conducted by Recovery Audit Contractors or the OIG.

The practices in question were required to pay heavy fines and penalties even though innocent of any wrongdoing and—setting aside their understandable failure to comprehend that the vendors with whom they were dealing were not responsible—were not negligent.<sup>66</sup> “For at least one of the practices, the audit also [resulted in the imposition of a] . . . requirement of prepayment review for 100 percent of all future Medicare claims.”<sup>67</sup>

These events took place in the middle years of the last decade and were publicly reported in an August 2008 article written by four highly qualified medical

<sup>64</sup> That said, the current administration has increased funding for the Medicare Integrity Program but it remains to be seen whether CMS will be able to apply any portion of that increase effectively vis-a-vis implementation of prepayment review.

<sup>65</sup> The potential issues discussed here apply to a lesser or greater extent to all providers, not just physicians. In the interest of brevity I have focused on physicians.

<sup>66</sup> Levinson, Grider, Linker and Thurston, *The Perfect Storm*, Practical Medical Economics, (August 2008); available at: <http://www.practicalcm.com/perfectstorm.htm>

<sup>67</sup> Id. at 5

compliance specialists who suggest that CMS's approach to implementation of EHR was "internally contradictory" and "diabolical" in its promotion of EHRs that can lead to financially punitive audits by Medicare carriers or the OIG."<sup>68</sup> Fortunately, CMS appears to be addressing these concerns both formally in the rule-making process—e.g., by establishing appropriate processes for certification of EHR—and less formally through meetings and conferences aimed at, among other things, addressing problems that have been and will be encountered.<sup>69</sup>

Nevertheless, the confluence of the continuing rollout of EHR with the very significant incentives contained in the American Recovery and Reinvestment Act to implement may well result in a "[r]ush to qualify for federal funds" despite "unrealistic deadlines and confusion about what to do first," which could be "highly disruptive" and contribute to a perception on the part of physicians that prepayment review will be "the straw that broke the camel's back" and to resume their previously very effective resistance to it.<sup>70</sup>

### **CMS Can Implement Effective Prepayment Review for Fraud**

CMS can implement effective prepayment review for fraud despite the difficult obstacles confronting it. The agency has more than once overcome its limited resources in ways that enabled significant achievements. The rollout and implementation of Medicare Contract Reform was, for example, a huge and costly effort with congressionally-imposed deadlines that, at least to some outside observers, initially appeared impossible to meet.

Yet CMS Grants & Acquisition personnel have "rolled out" Medicare Contracting Reform in a surprisingly short period of time . . . beating the congressionally-imposed deadline by some two years. Mistakes were made in the procurement process and, as discussed elsewhere in this paper, there are questions whether the structure "reform" has imposed on Medicare contracting is in fact appropriate.

But that does not detract from the basic achievement, which is that the agency implemented congressional direction in a timely—in this case more than timely—manner, which is what federal agencies are supposed to do.

Another example of significant—and unsung—agency achievement against the odds is a in the area of coordination of Medicare benefits, also known as

"Medicare Secondary Payer." CMS personnel whose names will never be known publicly have worked hard for years to correct flaws in the structure of the Medicare program that allowed Medicare to pay benefits that should have been paid by private sector funds.

Their work entailed, among other things, experimentation with mechanisms and programs and is ongoing. Much remains to be done but it is fair to say that the efforts of these employees have over time saved Medicare billions of dollars. But for the dedicated CMS employees who gave much of their working lives to this effort, that would not have happened.

Medicare Secondary Payer is far from perfect—but it is nevertheless a bureaucratic success story of the first order. So, if past is really prologue, then CMS can implement effective prepayment review. If, that is, its leadership can imbue the agency with a desire and commitment to do it, which is a tall order.

First and foremost, the agency must rid itself of the belief that accurate payment of claims is a meaningful approach to detection and rooting out of fraud. It is not—the opposite is of course the case. But eliminating this belief requires recognition of its existence—and efforts to do so will inevitably be met with outraged assertions that the agency's commitment to fraud enforcement is unquestionable, as demonstrated by the resources it has devoted to the Medicare Integrity Program and the successes that program has enjoyed, pointing to the return on investment averaging \$14 for each \$1 spent over the last three years.<sup>71</sup>

But the successes of the MIP program, while real, are beside the point—which is that, despite the agency's obvious commitment to detection of fraudulent claims *after* payment which, in turn, enables prevention of payment of such claims *prior* to their payment, there is no commitment to detection of fraud prior to payment.

And, worse, there is a clear belief within the agency that the mechanisms developed to assure and that to a large extent do assure accuracy of payment, e.g., CERT, are also mechanisms that are effective means of controlling fraud prior to payment, to the extent it exists.

On examination, it becomes clear that the agency's position on fraudulent claims is internally contradictory to the point of being schizophrenic. Effective implementation of prepayment review depends on the successful resolution of this condition. Assuming its schizophrenic acceptance and denial of fraud can be resolved, the agency can commence addressing and overcoming the remaining obstacles, albeit in parallel rather than the order in which they are discussed below.

Obviously the agency must develop and implement a strategy for management of political pressure that will inevitably be brought to bear once prepayment review is implemented. Here the choices appear straightforward. Either the agency makes and sticks with a commitment to resist congressional pressure on a consistent basis or, better, Congress makes the unlikely decision to remove itself from the Medicare claims payment process entirely, rendering it illegal for a congressman or senator to intervene through CMS in contractor payment determinations.

<sup>71</sup> Statement of Bill Corr, Deputy Secretary, U.S. Department of Health and Human Services on Effective Strategies for Preventing Health Care Fraud Before the Senate Judiciary Committee, October 28, 2009, available at <http://judiciary.senate.gov/pdf/10-28-09%20Corr%20Testimony.pdf>

<sup>68</sup> Id. at 11

<sup>69</sup> See, e.g., <http://www.blsmeetings.net/cmshealthhit2010.cfm>

<sup>70</sup> According to some reports, the rollout of Electronic Health Records combined with the American Recovery and Reinvestment Act incentives to implement Electronic Health Records may be highly disruptive.

Hospitals and physicians in the United States have until 2015 to deploy comprehensive electronic health records (EHR) and the accompanying technology to meet federal guidelines and qualify for billions of dollars in reimbursements. But some health care experts are concerned that the quality of e-health systems might be at risk because of unrealistic deadlines and confusion about what to do first.

Mearian, Computer World, "Deadline for e-health rollout may do more harm than help" (March 10, 2010). available at [http://www.computerworld.com/s/article/9162438/Deadline\\_for\\_e\\_health\\_rollout\\_may\\_do\\_more\\_harm\\_than\\_help?taxonomyId=18&pageNumber=](http://www.computerworld.com/s/article/9162438/Deadline_for_e_health_rollout_may_do_more_harm_than_help?taxonomyId=18&pageNumber=)

The choices for renovation of the pay and chase model arising from the related entity issue are not so straightforward. CMS cannot reasonably be expected to dismantle the existing and return to the consolidated model of the Intermediary and Carrier era because (i) doing so would be extraordinarily costly, and (ii) the MACs no longer have the capacity to perform the broad range of functions performed by Carriers and Intermediaries.

Nor can CMS reasonably create another specialized contractor to perform the prepayment review function—the segregation of functions inherent in the pay and chase structure has already fractured the system to the point that efficient coordination is difficult; another specialized contractor would only make matters worse.

A practicable approach might be to replicate the multidisciplinary approach historically taken by Carriers and Intermediaries while retaining much of the existing structure, perhaps by authorizing the MACs to use random sampling to conduct prepayment review to identify potential overcharges and fraudulent claims, after which they would conduct a thorough review of the claim and supporting documentation.

If the claim contains indicia of fraud, the MAC would refer it a specialized Program Safeguard Contractor to determine whether it is actually improper or fraudulent and, if so, whether payment should be suspended and the provider referred to enforcement authorities. This approach would require CMS to develop a working definition of “clean claim”—either through the regulatory process or congressional action—that would allow MACs 90 days to pay a claim if, based on evidence developed during initial random sampling, they assert a need to conduct a thorough review of the claim and supporting documentation.

Implementation of this suggestion would not be easy for two reasons. First, it would likely require CMS to address and resolve more operational issues that are identified in the above schematic description. But CMS has recently previously used an analogous approach in connection with Regional Home Health Intermediary (RHHI) conduct of limited prepayment review of claims of Home Health Agencies which, when identified as potentially improper, are referred to the relevant PSC for further development. Cf: GAO; *Medicare; Improvements Needed to Address Improper Payments in Home Health* (February 2009) at 23-24. The agency therefore likely has the wherewithal to develop the necessary contractual requirements and operating protocols.

Second, the approach would also arguably entail some risk of “related entity” conflict on the part of the MAC, but, to the extent such conflicts exist, they would be mitigated by referral to the ZPIC. In any event, CMS’s preoccupation with the related entity question—

which may well have contributed to its willingness to eliminate random prepayment review of claims even before Congress got around to outlawing it—is a distortion of reality.

Stated otherwise, the agency’s emphasis on these problem vis-a-vis health insurers is “penny-wise and pound-foolish”—the vast majority of claim-related fraud is perpetrated either by providers or persons masquerading as providers, not insurers. The risk of claim-related fraud on the part of health insurers is modest by comparison—health insurers are, like Medicare, payers of claims hence often the victims and rarely the perpetrators of such fraud.

Moreover, virtually all of the organizations with competency to perform complex claims processing work will have at least a theoretical organizational conflict of interest of one sort or another. Reasonable parties can effectively address such conflicts through disclosure and reasonable steps in mitigation, including monitoring of potential conflicts on both the personal and organizational levels.

Finally, CMS must develop and implement a strategy to minimize the potential for prepayment review to disrupt physician practices and negatively impact patient access to care. While identifying such a strategy is far beyond the scope of this paper, it seems clear that its basic thrust must be that, working with the OIG, the agency must “[t]ake a balanced approach to fraud and abuse control activities to avoid negative effects on patient health care.”

Among other things, both agencies must do a better job of monitoring enforcement activities “to ensure that they remain appropriate and do not adversely affect patient access to care.”

In this regard, a key component of any effort to obtain the cooperation of the medical community in implementing effective prepayment review is to establish controls that assure that, wherever possible, providers are given the benefit of the presumption of innocence as both a practical and legal matter, which is to say that absent clear evidence of an intention not to cooperate with an audit, inquiry, or investigation, investigators will presume that providers are innocent of intentional wrongdoing and accord them treatment consistent with that presumption.

Given the problems that are certain to arise with the continuing rollout of EHR—specifically including submission of erroneous claims until the inadequate EHR software has been expunged from the system—the consistent application of this principle is critical even where there is evidence of significant overpayment. Attention to this presumption and commensurate treatment is critical to physician support of the prepayment review.