October 2013

MEDICARE PROGRAM INTEGRITY

Contractors Reported Generating Savings, but CMS Could Improve Its Oversight

Highlights of GAO-14-111, a report to congressional requesters

Why GAO Did This Study

GAO has designated Medicare as a high-risk program, in part because its size and complexity make it particularly vulnerable to fraud. To help detect and prevent potential Medicare fraud, CMS—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—contracts with ZPICs. These contractors are to identify potential fraud, investigate it thoroughly and in a timely manner, and take swift action, such as working to revoke suspect providers' Medicare billing privileges and referring potentially fraudulent providers to law enforcement.

GAO examined (1) ZPIC contract costs and how ZPICs use those funds, (2) the results of ZPICs' work, and (3) the results of CMS's evaluations of ZPICs' performance and aspects of CMS's evaluation practices. To do this, GAO examined ZPIC funding, contracts, and related documents; data on ZPICs' workloads, investigations, and results; and CMS evaluations of ZPICs as well as federal standards for performance measurement. GAO also interviewed CMS and ZPIC officials.

What GAO Recommends

GAO recommends that CMS collect and evaluate information on the timeliness of ZPICs' investigative and administrative actions, and develop ZPIC performance measures that explicitly link ZPICs' work to Medicare program integrity performance measures and goals. GAO requested comments from HHS on the draft report, but none were provided.

View GAO-14-111. For more information, contact Kathleen King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare and Medicaid Services (CMS) paid its Zone Program Integrity Contractors (ZPIC) about $108 million in 2012. ZPICs reported spending most of this funding on fraud case development, primarily for investigative staff, who in 2012 reported conducting about 3,600 beneficiary interviews, almost 780 onsite inspections, and reviews of more than 200,000 Medicare claims.

ZPICs reported that their actions resulted in more than $250 million in savings to Medicare in calendar year 2012 from actions such as stopping payment on suspect claims. ZPICs also reported taking other actions to protect Medicare funds, including having more than 130 of their investigations accepted by law enforcement for potential prosecution, and working to stop more than 160 providers from receiving additional Medicare payments in 2012. However, CMS lacks information on the timeliness of ZPICs' actions—such as the time it takes between identifying a suspect provider and taking actions to stop that provider from receiving potentially fraudulent Medicare payments—and would benefit from knowing if ZPICs could save more money by acting more quickly.

Cost-saving Zone Program Integrity Contractor Actions, 2012

Action	Number	Associated savings
Medicare claims reviewed and denied prior to payment[a]	176,079	$99,916,894
Auto-denial edits recommended[b]	7,264 (37,736 in effect)	$95,635,829
Overpayment determinations referred[c]	515	$56,403,080
Total reported savings from these actions		**$251,955,803**

Source: GAO analysis of CMS Analysis, Reporting, and Tracking System data.

[a]Provider-specific prepayment edits are used to identify claims for medical review and, based on those reviews, claims may be denied before they are paid.

[b]Auto-denial edits automatically deny payment for noncovered, incorrectly coded, or inappropriately billed services without further review, and can prevent payment for all services submitted by suspicious providers or certain types of services for beneficiaries identified as part of a fraud scheme.

[c]ZPICs refer Medicare claims to the contractors that process them to recover Medicare payments received by a provider in excess of amounts due and payable.

ZPICs generally received good ratings in annual reviews, with five of six eligible for incentive awards. CMS follows some best practices for ZPICs' oversight, but the agency does not clearly link ZPIC performance to agency program integrity goals. The majority of the measures CMS uses to evaluate ZPICs relate to the quality of their work because, according to CMS officials, quality is the most important element. However, evaluation of such measures, while a best practice, does not connect ZPIC work to agency performance measures. For example, CMS aims to increase the percentage of actions taken against certain high risk Medicare providers—work central to ZPICs—but does not explicitly link ZPICs' work to the agency's progress toward that goal, another best practice that would allow the agency to better assess the ZPICs' support of CMS's fraud prevention efforts.