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MEDICARE ADVANTAGE ORGANIZATIONS' IDENTIFICATION OF POTENTIAL FRAUD AND ABUSE

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EXECUTIVE SUMMARY: MEDICARE ADVANTAGE ORGANIZATIONS' IDENTIFICATION OF POTENTIAL FRAUD AND ABUSE
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WHY WE DID THIS STUDY

The Medicare Advantage (MA) program has become a significant part of Medicare in both cost and enrollment. MA organizations offer plans under Medicare Part C that cover services a beneficiary would receive under Medicare Parts A and B; many plans also offer prescription drug coverage under Part D. MA organizations' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the MA program. Prior to this report, no study had examined potential fraud and abuse identified by MA organizations. CMS requires MA organizations to have compliance plans that include measures to detect, correct, and prevent fraud, waste, and abuse. However, CMS does not require MA organizations to report the results of their efforts to identify and address potential fraud and abuse incidents.

HOW WE DID THIS STUDY

We collected and reviewed data from 170 of 188 MA organizations that offered plans in 2009. These MA organizations represented 4,547 plans nationwide and accounted for 94 percent of all Medicare beneficiaries enrolled in MA plans in 2009. We collected and summarized the numbers of potential fraud and abuse incidents, inquiries, corrective actions, and referrals related to these plans in 2009. We also categorized the types of potential fraud and abuse incidents and corrective actions that MA organizations reported.

WHAT WE FOUND

Nineteen percent of MA organizations did not identify any potential fraud and abuse incidents related to their Part C health benefits and Part D drug benefits in 2009. MA organizations that identified potential fraud and abuse in 2009 reported between 1 incident and 1.1 million incidents. Three MA organizations identified 95 percent of the total 1.4 million reported incidents. Differences in the way organizations defined and detected potential fraud and abuse may account for some of the variability in the number of incidents they identified. While CMS requires MA organizations to initiate inquiries and corrective actions where appropriate, not all MA organizations took such steps in response to incidents they identified. Overall, MA organizations sent 2,656 referrals of potential fraud and abuse incidents to other entities for further investigation in 2009.

WHAT WE RECOMMEND

Our findings indicate that MA organizations lack a common understanding of key fraud and abuse program terms and raise questions about whether all MA organizations are implementing their programs to detect and address potential fraud and abuse effectively. Therefore, we recommend that CMS: (1) ensure that MA organizations are implementing programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans, so that all potential Part C and Part D fraud and abuse incidents are

identified; (2) review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries; (3) develop specific guidance for MA organizations on defining potential Part C and Part D fraud and abuse incidents and inquiries; (4) require MA organizations to report to CMS aggregate data related to their Part C and Part D antifraud, waste, and abuse activities; (5) ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents; and (6) require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities. CMS concurred with our first, third, and fifth recommendations. CMS did not concur or concurred in part with our second, fourth, and sixth recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To determine the extent to which Medicare Advantage (MA) organizations identify potential fraud and abuse related to their Part C and, if applicable, Part D plans.
2. To determine the extent to which MA organizations conduct inquiries, initiate corrective actions, and make referrals for further investigation in response to potential fraud and abuse incidents.

BACKGROUND

Medicare beneficiaries generally have the option to receive their benefits through the traditional Medicare fee-for-service program or through private plans. Private insurance companies, known as MA organizations, contract with the Centers for Medicare & Medicaid Services (CMS) under Medicare Part C to provide beneficiaries with private health plan options, including managed care plans. MA plans include coverage for services that a beneficiary would receive under Medicare Parts A and B and may cover additional services, such as outpatient prescription drugs. In 2010, 24 percent of Medicare beneficiaries were enrolled in MA plans.[1]

MA program expenses were $115 billion of the total $504 billion in Medicare benefit payment expenses in fiscal year 2010.[2] For 2011, the Medicare Payment Advisory Commission (MedPAC) estimates that CMS will spend approximately 10 percent more for beneficiaries enrolled in MA plans than CMS would have spent if the beneficiaries had stayed in fee-for-service Medicare.[3] In its *Fiscal Year 2010 Agency Financial Report*, the Department of Health and Human Services (HHS) reported a composite payment error rate of 14.1 percent for the MA program.[4]

The MA program has become a significant component of Medicare both in cost and enrollment; however, prior to this report, no study had examined potential fraud and abuse identified by MA organizations. This report provides details on the results of MA organizations' efforts to identify and address potential Part C and Part D fraud and abuse.

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[1] Kaiser Family Foundation (KFF), *Medicare Chartbook, Fourth Edition*, November 2010. Accessed at http://facts.kff.org/chart.aspx?cb=58&sctn=165&ch=1755 on July 7, 2011.

[2] CMS, *CMS Financial Report Fiscal Year 2010*, November 2010, p. 5. Accessed at http://www.cms.gov/CFOReport/Downloads/2010_CMS_Financial_Report.pdf on July 7, 2011.

[3] MedPAC, *Report to the Congress: Medicare and the Health Care Delivery System*, June 2011, p. 70. Accessed at http://www.medpac.gov/documents/jun11_entirereport.pdf on July 7, 2011.

[4] HHS, *FY 2010 Agency Financial Report*, November 15, 2010, p. III-18. Accessed at http://www.hhs.gov/afr/2010afr-fullreport.pdf on August 9, 2011.

Medicare Advantage Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) made several important changes to Medicare managed care and renamed the program Medicare Advantage.[5] The MMA also established Part D to provide an optional outpatient prescription drug benefit for all beneficiaries.[6] Many MA organizations offer managed care plans that provide beneficiaries with additional coverage for outpatient prescription drugs through Part D. In fact, MA organizations that offer plans such as health maintenance organizations (HMO) must offer at least one plan that includes Part D prescription drug coverage.[7] Therefore, many MA organizations operate as both Part C and Part D contractors.

In 2009, 188 MA organizations offered 4,718 plans across the Nation. Sixty-seven percent of the 10.9 million beneficiaries enrolled in MA plans in 2009 were in HMOs or local preferred provider organization plans. In the same year, 3,471 of 4,718 MA plans offered Part D prescription drug coverage. Eighty-seven percent of MA beneficiaries were enrolled in these MA Prescription Drug (MAPD) plans in 2009.

Detecting and Deterring Fraud and Abuse

MA organizations' processes and programs for identifying and addressing potential fraud and abuse are critical to protecting the integrity of the MA program. CMS requires MA organizations to have compliance plans that include measures to detect, correct, and prevent fraud, waste, and abuse.[8] Among other requirements, these compliance plans must include procedures for ensuring prompt responses to detected instances of fraud and abuse, such as conducting timely inquiries, initiating corrective actions (e.g., repayment of overpayments, disciplinary actions against responsible employees), and voluntarily self-reporting fraud and abuse to CMS.[9, 10] In a 2010 Call Letter to MA organizations, CMS announced that it planned to assess the effectiveness of MA organizations' compliance

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[5] MMA, P.L. 108-173 § 201, 42 U.S.C. § 1395w-21 note.

[6] MMA, P.L. 108-173 § 101, Social Security Act, title XVIII, part D, 42 U.S.C. § 1395w-101, et seq.

[7] 42 CFR § 422.4(c); 42 CFR § 423.104(f)(3); CMS, *Medicare Managed Care Manual*, Pub. No. 100-16 (Rev. 87, June 8, 2007), ch. 4, § 10.3.

[8] 42 CFR § 422.503(b)(4)(vi); 42 CFR § 423.504(b)(4)(vi).

[9] 42 CFR § 422.503(b)(4)(vi)(G); 42 CFR § 423.504(b)(4)(vi)(G).

[10] In the preamble to the December 5, 2007, Final Rule, 76 Fed. Reg. 68700, CMS stated that it is committed to adopting a mandatory self-reporting requirement. As of January 2012, CMS had not issued any regulation mandating such a requirement.

plans during 2010.[11] CMS conducted 27 of these fraud and abuse compliance plan audits in 2010.[12]

Although private managed care options have been available to Medicare beneficiaries for many years, CMS has only recently selected contractors to oversee and conduct reviews of MA program integrity. In 2008, CMS expanded the Medicare drug integrity contractors' (MEDIC) responsibilities to include not only Part D but also Part C program integrity activities.

Fraud and Abuse Incidents. In its *Medicare Program Integrity Manual*, CMS defined fraud as "the intentional deception or misrepresentation that [an] individual knows to be false or does not believe to be true, and the individual makes knowing that the deception could result in some unauthorized benefit to himself/herself or some other person."[13] CMS defined abuse as "[b]illing Medicare for services that are not covered or are not correctly coded."[14] MA organizations may identify potential fraud and abuse incidents through internal efforts, such as claim reviews and routine audits, or through external sources, such as complaints from beneficiaries and referrals from law enforcement agencies.[15]

Many different types of fraud and abuse may occur in MA organizations. Fraud may be committed by MA organizations themselves, within their network of contracted providers, or by beneficiaries. Examples of fraud and abuse within an MA organization include improper marketing and enrollment practices, such as misrepresenting covered benefits to prospective enrollees; arranging inappropriate payment and financial practices with contracted providers; and denying payment for Medicare-approved treatments. Examples of fraud and abuse by contracted providers include undertreating patients, placing unreasonable restrictions on referrals for specialists or ancillary services (e.g., x-ray, imaging, laboratory), and inappropriate prescription dispensing. Examples of fraud and abuse by beneficiaries include diverting prescriptions, stockpiling medications, and misrepresenting eligibility information to obtain services.

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[11] CMS, *2010 Call Letter*, March 30, 2009, p. 26. Accessed at http://www.cms.gov/PrescriptionDrugCovContra/Downloads/2010CallLetter.pdf on May 12, 2010.

[12] Director, Program Compliance and Oversight Group, CMS, presentation slides (pp. 4–7), *CMS Compliance Program Audits: Medicare Advantage & Prescription Drug Plan Sponsors*, July 6, 2011, for the HHS Office of Inspector General (OIG).

[13] CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, Exhibit 1-Definitions.

[14] Ibid.

[15] 42 CFR § 422.503(b)(4)(vi)(F); 42 CFR § 423.504(b)(4)(vi)(F).

Inquiries. MA organizations are required to conduct a timely, reasonable inquiry when evidence suggests potential fraud and abuse related to payment or delivery of items or services under the contract.[16]

Corrective Actions and Referrals. In response to potential fraud and abuse, MA organizations are required to carry out appropriate corrective actions.[17] Corrective actions are measures that an MA organization takes to correct a current incident of potential fraud and abuse or to reduce the risk that fraud and abuse will occur in the future. Examples of corrective actions are repayment of overpayments; provider education; procedure changes; and disciplinary action against responsible individuals, including termination from a network. An organization may perform multiple corrective actions in response to an incident of potential fraud and abuse, such as requiring a provider to repay an overpayment and subjecting the provider's future claims to prepayment review.

MA organizations may refer potential fraud and abuse incidents to a number of other entities for further investigation, including CMS, State agencies, State insurance commissioners, the Department of Justice (DOJ), OIG, and local law enforcement agencies. CMS also recommends that MA organizations have procedures in place to "voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee."[18]

Fraud and Abuse Reporting. In its comments on an October 2008 OIG report, CMS stated that it "believes that it is important for the government to have information on potential fraud, waste, and abuse as soon as possible …"[19] However, CMS does not require MA organizations to report information on their identification of potential fraud and abuse beyond the requirement to report the number of enrollee grievances related to fraud and abuse each quarter.[20] Beginning in calendar year 2010, MAPD plans may voluntarily report to CMS aggregate data related to their Part D antifraud, waste, and abuse activities, including the number of incidents of potential fraud and abuse identified, inquiries and corrective actions initiated, and potential fraud referrals made to CMS or law enforcement authorities.[21]

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[16] 42 CFR § 422.503(b)(4)(vi)(G)(1); 42 CFR § 423.504(b)(4)(vi)(G)(1).

[17] 42 CFR § 422.503(b)(4)(vi)(G)(2); 42 CFR § 423.504(b)(4)(vi)(G)(2).

[18] 42 CFR § 422.503(b)(4)(vi)(G)(3); 42 CFR § 423.504(b)(4)(vi)(G)(3).

[19] OIG, *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008, p. 25. Accessed at http://oig.hhs.gov/oei/reports/oei-03-07-00380.pdf on July 12, 2011.

[20] CMS, *Medicare Part C Plan Reporting Requirements Technical Specification Document*, May 7, 2011, pp. 30–32.

[21] CMS, *Medicare Part D Reporting Requirements*, January 1, 2010, § XIV.

Related OIG Work

In a 2008 report, OIG found that 24 of 86 stand-alone Part D plan sponsors did not identify any potential fraud and abuse incidents in the first 6 months of 2007.[22] OIG also found that not all stand-alone Part D plan sponsors that identified potential fraud and abuse incidents conducted inquiries, initiated corrective actions, or made referrals for further investigation. Stand-alone Part D plan sponsors are similar to MA organizations in that they are private companies that contract with CMS to offer health plans to beneficiaries. Both Part D plan sponsors and MA organizations contract with health care providers and facilities to create networks to provide health care services to Medicare beneficiaries.

In a 1998 report regarding CMS contractor fraud units, OIG found vulnerabilities in these contractors' efforts to identify potential fraud and abuse.[23] OIG found that the meaning of key words and terms related to fraud unit work varied across contractors and that this variation hindered CMS's ability to interpret data and measure fraud unit performance.

METHODOLOGY

Scope

We determined the extent to which MA organizations identified and addressed potential fraud and abuse in 2009. During this period, there were 188 MA organizations across the country. We did not include 14 MA organizations in our review that had active contracts in 2009 because the contracts were no longer active or the organizations were under investigation during the time of our data collection. We excluded data received from four MA organizations from our analysis because they could not separate incidents related to their MA and MAPD plans from incidents related to their other lines of Medicare or commercial business.

Of the 188 MA organizations in 2009, we reviewed data from 170, which provided information on potential fraud and abuse incidents related to their MA or MAPD plans.[24] These 170 organizations accounted for a total of 597 MA contracts, 4,547 MA plans, and 10,581,744 enrollees.

Data Collection

CMS. We downloaded the MA contract enrollment data files from CMS's Web site for 2009. These files contained the number of enrollees for each MA contract as well as information about the type of contract. We used these data to identify MA organizations with MA and MAPD contracts in

[22] OIG, *Medicare Drug Plan Sponsors' Identification of Potential Fraud and Abuse*, OEI-03-07-00380, October 2008.

[23] OIG, *Fiscal Intermediary Fraud Units*, OEI-03-97-00350, November 1998.

[24] One of the 170 MA organizations did not operate any MAPD plans in 2009.

2009. We excluded MA organizations that had only cost, demonstration, or Program of All-Inclusive Care for the Elderly (PACE) contracts.[25, 26, 27] We downloaded the compliance officer contact information from CMS's Health Plan Management System for the remaining MA organizations.

MA Organizations. We designed an electronic survey and sent it to MA organizations' Medicare compliance officers. We requested that MA organizations report how they identified potential fraud and abuse and the number of incidents of potential fraud and abuse they identified in 2009 for all of their MA contracts, including MAPD contracts. For these incidents, we asked MA organizations to report the types of potential fraud and abuse identified, the strategies that yielded the potential fraud and abuse incidents, the number of inquiries conducted, and the number and types of corrective actions initiated. We also requested the number of incidents they referred to CMS, MEDICs, law enforcement authorities, and other entities for further investigation. We received responses from all of the MA organizations we surveyed.

Our electronic survey software assigned an identification number to each MA organization in our review. We use these identification numbers in our report to enable the reader to identify information related to the same MA organization across the findings and in Appendix B while still maintaining the confidentiality of the organization.

Analysis

We included survey responses from 170 MA organizations in our analysis. We reviewed, coded, and summarized narrative information regarding strategies organizations used to identify potential fraud and abuse incidents. We calculated the number of potential Part C and Part D incidents identified across MA organizations in 2009. We grouped organizations into six size categories based on the number of enrollees. We categorized the types of incidents reported and calculated the total number of incidents of each type. We calculated the total number of inquiries conducted in response to incidents. We also calculated and summarized the number and types of corrective actions initiated in response to incidents. Finally, we calculated the total number of incidents referred to other entities for further investigation.

[25] Medicare payments for cost contracts are based on the reasonable costs of providing services to enrollees.

[26] Demonstration contracts test improvements in Medicare coverage, payment, and quality of care. These contracts usually operate for a limited time, for a specific group of people, and/or are offered only in specific areas.

[27] PACE is a benefit that features a comprehensive service delivery system and integrated Medicare and Medicaid financing.

Limitations

The information we received from MA organizations was self-reported. We did not collect from MA organizations any documentation relating to the potential fraud and abuse incidents, inquiries, corrective actions, or referrals they reported to verify their responses to our survey.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Nineteen percent of MA organizations did not identify any potential fraud and abuse incidents in 2009

All of the MA organizations in our review reported having compliance plans in place as required by CMS. These compliance plans must include a program to detect, correct, and prevent fraud, waste, and abuse.[28] However, the efforts of 19 percent of MA organizations (33 of 170) to detect fraud and abuse did not yield any potential incidents related to both their Part C health benefits and Part D drug benefits in 2009.

An additional 24 organizations identified Part C incidents but no Part D incidents. Another 11 MA organizations identified Part D incidents but no Part C incidents.

Enrollment in these 68 MA organizations totaled 571,623 beneficiaries and ranged from an organization with 114 members to an organization with 55,876 members. Fourteen of the sixty-eight organizations accounted for fewer than 1,000 enrollees each.

MA organizations that identified fraud and abuse reported between 1 incident and 1.1 million incidents; differences in the way MA organizations defined and detected potential fraud and abuse may account for some of this variability

One hundred thirty-seven MA organizations identified a total of 1,431,683 incidents of potential Part C and Part D fraud and abuse in 2009. The volume of incidents identified varied significantly. Fourteen organizations each identified more than 1,000 incidents. In contrast, 41 organizations each identified fewer than 10 incidents in 2009. Appendix A provides the total numbers of incidents identified across MA organizations. Appendix B provides the numbers of incidents reported by individual MA organizations.

Three MA organizations identified 95 percent of all potential fraud and abuse incidents in 2009

Three organizations were responsible for 1,358,184, or 95 percent, of all potential Part C and Part D incidents. The majority of these were related to two MA organizations' Part C health benefits. Table 1 provides specific information on the numbers of MA enrollees, potential Part C incidents, and potential Part D incidents for each of these three MA organizations.

[28] 42 CFR § 422.503(b)(4)(vi); 42 CFR § 423.504(b)(4)(vi).

Table 1: Three MA Organizations Were Responsible for 95 Percent of Potential Fraud and Abuse Incidents Identified in 2009

MA Organization Identifier	Number of MA Enrollees	Number of Potential Part C Fraud and Abuse Incidents	Number of Potential Part D Fraud and Abuse Incidents	Total Number of Potential Fraud and Abuse Incidents	Percentage of All Incidents Identified in 2009 (1,431,683)
178	Over 250,000	1,010,233	100,909	1,111,142	78%
34	20,000 to 49,999	200,111	2,377	202,488	14%
112	5,000 to 19,999	0	44,554	44,554	3%
Total		**1,210,344**	**147,840**	**1,358,184**	**95%**

Source: OIG analysis of MA organizations' survey responses and CMS enrollment data for 2009.

Ninety-five percent of the incidents (1,290,656 of 1,358,184) identified by these 3 MA organizations were associated with 3 types of potential fraud and abuse: improper coding (1,153,996 incidents), inappropriate billing for prescriptions (104,550), and inappropriate prescription dispensing (32,110). Appendix C contains a complete list of the number of incidents associated with each type of potential fraud and abuse reported by MA organizations for both Part C and Part D.

The remaining 134 MA organizations identified 73,499 potential Part C and Part D fraud and abuse incidents in 2009

Excluding the incidents identified by the 3 MA organizations described above, 134 organizations identified a total of 73,499 potential fraud and abuse incidents in 2009. Eighty-three percent of these were related to Part C. Specifically, 123 organizations identified 61,188 potential Part C fraud and abuse incidents, and 108 organizations identified 12,311 potential Part D fraud and abuse incidents.

These 134 organizations enrolled 9.9 million beneficiaries in 2009. All MA organizations with more than 50,000 enrollees identified at least 1 incident of potential fraud and abuse, yet some smaller MA organizations identified more incidents than their counterparts with larger enrollment. For example, an organization with more than 250,000 enrollees identified 37 potential Part C fraud and abuse incidents and 8 potential Part D incidents. Another organization, which had fewer than 5,000 enrollees, identified 7,787 potential Part C fraud and abuse incidents and 154 potential Part D incidents.

These 134 MA organizations reported 32 different types of Part C incidents in 2009. The most common type of incident related to their Part C health benefits was improper coding of services. MA organizations identified 25 different types of potential fraud and abuse incidents related to Part D; inappropriate prescription dispensing was the most common type.

Differences in the way MA organizations defined and detected potential fraud and abuse may account in part for the wide variation in the number of incidents identified

The number of potential fraud and abuse incidents reported by MA organizations may depend on how broadly they define potential fraud and abuse. MA organization 178 identified the highest number of incidents in 2009. This organization reported that it took "an expansive view" of potential fraud and abuse. It defined a potential fraud and abuse incident as any claim line flagged by its prepayment edit system. MA organization 34 also identified a high number of incidents and reported that it used claims editing and auditing software to screen claims for potential improper coding. This organization considered all claims identified by this software as potential fraud and abuse incidents. Other organizations also described using claims monitoring, prepayment reviews, and software packages specifically designed to screen claims to identify potential fraud and abuse. However, some of these MA organizations reported low numbers of incidents. Therefore, it would seem that not all MA organizations defined every item identified by these detection methods as a potential fraud and abuse incident.

Some MA organizations did not report using any proactive methods (e.g., claims monitoring) to identify their potential Part C and/or Part D fraud and abuse incidents. Many organizations indicated that they used hotlines and other reporting and complaint mechanisms, along with other types of fraud and abuse detection methods, to identify potential fraud and abuse. However, some organizations reported relying solely on hotlines and complaints to identify potential Part C and/or Part D incidents. These organizations identified 12 or fewer incidents in 2009.

CMS requires MA organizations to initiate inquiries and corrective actions where appropriate, but not all MA organizations took such steps in response to incidents they identified

CMS requires MA organizations to conduct a timely, reasonable inquiry when evidence suggests potential fraud or abuse related to payment or delivery of items or services under their contracts.[29] In addition, CMS requires MA organizations to carry out appropriate corrective actions in response to potential fraud and abuse.[30] However, 11 organizations did not initiate any inquiries in response to 14,681 potential Part C fraud and abuse incidents they identified in 2009; 19 organizations did not initiate

[29] 42 CFR § 422.503(b)(4)(vi)(G)(1).

[30] 42 CFR § 422.503(b)(4)(vi)(G)(2).

any inquiries in response to 3,387 Part D incidents. Furthermore, 25 organizations did not initiate any corrective actions in response to 5,300 Part C incidents they identified in 2009, and 39 organizations did not initiate any corrective actions for 2,979 Part D incidents. Appendix A provides the total numbers of potential Part C and Part D fraud and abuse incidents, inquiries, and corrective actions reported by MA organizations.

MA organizations reported initiating 1.2 million inquiries; however, MA organizations had different interpretations of what constitutes an inquiry

MA organizations initiated a total of 1,188,269 inquiries in response to the potential Part C and Part D fraud and abuse incidents they identified in 2009. MA organizations each initiated between 1 and 1,111,142 inquiries.

Differences in the ways some MA organizations defined and tracked inquiries may account for some of the variation in the number of inquiries they reported. For example, MA organization 178 reported that it initiated the same number of inquiries as the number of potential fraud and abuse incidents it identified. Specifically, this organization reported conducting 1,010,233 Part C inquiries and 100,909 Part D inquiries. This organization defined potential fraud and abuse incidents as all claim lines caught by its prepayment edit system and considered the automated remittance advice letters generated by the prepayment system to be inquiries.[31]

Although we did not ask all MA organizations to describe how they defined inquiries, we asked for descriptions from seven organizations that reported conducting more inquiries than the total number of potential fraud and abuse incidents they identified. One of these defined the number of inquiries it conducted as the number of internal staff members who investigated a particular potential fraud and abuse incident. Another organization defined inquiries as "the number of unique contacts that [their] organization made during the investigation of each incident." A third organization reported that some of the potential fraud and abuse incidents it identified were associated with "more than one type of suspicious activity which resulted in more than one inquiry." This organization defined an inquiry as an "investigative action."

[31] A remittance advice letter is a notice of payments and adjustments sent to providers of health care services. It explains the payments and adjustments made on the providers' processed claims.

MA organizations reported initiating 1.1 million corrective actions; 1 organization represented 98 percent of these

MA organizations reported initiating a total of 1,134,063 corrective actions in response to the potential fraud and abuse incidents they identified in 2009. Ninety-eight percent of these corrective actions were initiated by MA organization 178, which defined the prepayment claim edits it used to identify potential fraud and abuse as corrective actions. This organization reported that it initiated 1,111,140 corrective actions in response to the 1,111,142 potential Part C and Part D incidents it identified. Another 25 organizations initiated at least as many corrective actions as the number of incidents they reported in 2009. In contrast, 6 of the organizations that identified more than 1,000 potential fraud and abuse incidents initiated fewer than 8 corrective actions for every 100 incidents they identified. For example, MA organization 36 initiated 2 corrective actions in response to 12,512 incidents. Appendix D provides a complete list of the types of corrective actions initiated by MA organizations.

MA organizations sent 2,656 referrals of potential Part C and Part D fraud and abuse incidents to other entities in 2009

MA organizations sent a total of 2,656 referrals of potential Part C and Part D fraud and abuse incidents to more than 13 different entities for further investigation in 2009. MA organizations may send the same incident to more than one entity. For example, one organization referred the same Part C incident to both DOJ and State and local law enforcement authorities. Appendix E provides the numbers of Part C and Part D referrals MA organizations sent to other entities in 2009.

Two of the three MA organizations that reported the highest numbers of incidents made only 40 referrals in 2009

Although MA organization 178 conducted over 1 million inquiries and initiated over 1 million corrective actions, it referred only 39 of the 1,111,142 potential fraud and abuse incidents it identified to other entities for further investigation. All but one of these referrals were directed to MEDICs. MA organization 34 referred only 1 of the 202,488 incidents it identified to a MEDIC for further investigation. MA organization 112 did not refer any of the 44,554 Part D incidents it identified in 2009.

The remaining MA organizations made 2,616 referrals of potential Part C and Part D incidents in 2009

Seventy MA organizations sent a total of 1,689 referrals of potential Part C fraud and abuse incidents to other entities for further investigation in 2009. MA organizations referred these Part C incidents to more than

12 different entities, including State insurance commissioners, OIG, and MEDICs. In contrast, 53 organizations that identified 35,779 potential Part C incidents in 2009 did not refer any incidents to other entities.

Fifty-six MA organizations made 927 referrals of potential Part D fraud and abuse incidents they identified in 2009 to other entities for further investigation. Most referred incidents were directed to MEDICs, DOJ, and State and local law enforcement agencies. Fifteen of these organizations each referred just one potential Part D incident. Fifty-two MA organizations identified 7,732 Part D incidents in 2009, but did not make any referrals for further investigation.

RECOMMENDATIONS

MA organizations' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the MA program. These organizations are required to have compliance plans in place that include programs to detect, correct, and prevent fraudulent and abusive activity. CMS, however, does not require MA organizations to report, nor does it routinely review, the results of organizations' efforts to identify and respond to potential fraud and abuse. Our review reveals that, in 2009, the efforts of 19 percent of MA organizations did not yield any potential Part C and Part D fraud and abuse incidents. Another 21 percent of organizations did not identify potential fraud and abuse in either Part C or Part D. These findings build upon the results of a prior OIG review that revealed that more than one-quarter of stand-alone Part D plan sponsors did not identify any potential fraud and abuse in 2007.

The volume of potential fraud and abuse incidents identified by MA organizations varied significantly. Eight organizations identified just 1 incident in 2009, and 1 organization identified over 1 million potential Part C and Part D fraud and abuse incidents. Also, not all organizations that identified incidents conducted inquiries, initiated corrective actions, or referred incidents to outside entities for further investigation.

These findings indicate that not all MA organizations have a common understanding of key fraud and abuse program terms, including "incident," "inquiry," and "corrective action." In a 1998 report, OIG identified similar issues relating to Medicare benefit integrity contractors' definitions of key fraud and abuse terms. OIG found that variation in the meaning of key words and terms across these contractors hindered CMS's ability to interpret their data and measure their performance.

In addition, our findings raise questions about whether all MA organizations are implementing their programs to detect and address potential fraud and abuse effectively.

Therefore, we recommend that CMS:

Ensure that MA organizations are implementing programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans, so that all potential Part C and Part D fraud and abuse incidents are identified

We recommend that CMS focus on the 33 MA organizations that did not identify any potential fraud and abuse incidents related to their Part C health benefits and Part D drug benefits in 2009 and the 35 MA organizations that identified incidents related only to Part C or only to Part D.

Review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries

From this review, CMS would be able to determine the extent to which the extreme variation in reporting is due to (1) the lack of a common understanding across MA organizations of key fraud and abuse terms; or (2) the quality of their programs to detect, correct, and prevent fraud, waste, and abuse.

Develop specific guidance for MA organizations on defining potential Part C and Part D fraud and abuse incidents and inquiries

CMS manuals and documents provide basic definitions of fraud and abuse incidents and inquiries. However, our review indicates that some MA organizations defined potential fraud and abuse incidents and inquiries quite differently. These differences may have contributed to the wide variation in the volume of incidents and inquiries MA organizations reported for 2009. Clear and specific guidance regarding fraud and abuse terms would promote common understanding across MA organizations and help CMS to ensure comparability of fraud and abuse information across MA organizations.

Require MA organizations to report to CMS aggregate data related to their Part C and Part D antifraud, waste, and abuse activities

MA organizations have had the option to voluntarily report aggregate fraud and abuse activity data to CMS for their Part D plans since 2010. CMS should require MA organizations to report this information for both their Part C and Part D plans. CMS should use these data to target audits and evaluate the effectiveness of MA organizations' fraud, waste, and abuse programs.

Ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents

As required by 42 CFR § 422.503(b)(4)(vi)(G), MA organizations must conduct timely, reasonable inquiries and take appropriate corrective actions in response to evidence of potential fraud and abuse. CMS may want to focus on the MA organizations that identified potential fraud and abuse incidents in 2009, but did not initiate any inquiries or take any corrective actions.

Require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities

Current regulations stipulate only that MA organizations "should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee."

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS stated that MA organizations' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the MA program. It concurred with our first recommendation, to ensure that MA organizations are implementing their programs to identify potential fraud and abuse. CMS stated that it conducted 33 compliance plan audits in 2010 and that its annual audit evaluation process uses various data to identify MA organizations that present risks to the Part C and Part D programs. In addition, CMS noted that it plans to provide an updated manual chapter to MA organizations with instructions and guidance on how to implement a program to detect, correct, identify, and prevent fraud, waste, and abuse.

CMS did not concur with our second recommendation, to review MA organizations to determine why certain organizations reported especially high or low volumes of potential fraud and abuse. CMS stated that, based on enhancements it has made to compliance plan audits and the age of the data used in OIG's report, it does not believe it is necessary to contact the MA organizations identified in the OIG study.

CMS performed audits of 27 MA organizations' compliance plans for the period 2006 through 2010. OIG agrees that these audits can provide valuable information about the performance of the individual organizations selected for review. However, the audits focused on a small number of organizations and have not provided CMS with the information it needs to identify trends and aberrancies and compare organizations' antifraud efforts across the MA program. Until CMS requires MA reporting of both Part C and Part D antifraud activities, the 2009 data collected by OIG are the only comprehensive source of this information for MA organizations. Therefore, OIG continues to recommend that CMS review the data and determine the reasons for such significant differences in the volume of fraud identification across MA organizations. This analysis could help CMS to determine whether differences are related to the quality of organizations' antifraud programs or to the lack of common understanding across organizations of key fraud and abuse terms.

CMS concurred with our third recommendation, to develop specific guidance for MA organizations on defining potential fraud and abuse incidents and inquiries. CMS noted that it is developing a Part C and Part D fraud handbook for sponsoring organizations about detecting and preventing fraud, to be available in fall 2012. CMS further stated that it has added more detailed regulatory requirements for the seven compliance program elements, effective January 1, 2011, including a specific requirement that MA organizations have an "effective" compliance program.

CMS concurred in part with our fourth recommendation, that it require MA organizations to report aggregate data related to their Part C and Part D antifraud, waste, and abuse activities. CMS stated that compliance program audit results may provide an indication of MA organizations' overall performance and allow CMS to target guidance and education. CMS also stated that it will explore the option of placing an additional burden on MA organizations by requiring them to report aggregate data on their antifraud activities.

While CMS's current audit approach is made up of assessments of the performance of individual MA organizations, we continue to recommend that CMS adopt a broader approach to review MA organizations' antifraud efforts. To assess the MA program as a whole, CMS must collect, examine, and compare data from all MA organizations on fraud and abuse incidents, inquiries, corrective actions, and referrals. Requiring all MA organizations to report data on their antifraud activities would enable CMS to explore the data in detail to identify potentially aberrant organizations and thereby enhance its ability to target audits and evaluate the effectiveness of antifraud activities across the entire MA program.

CMS concurred with our fifth recommendation, to ensure that all MA organizations respond appropriately to potential fraud and abuse. CMS stated that, in addition to publishing the updated manual chapter, it will consider developing outreach and education based on lessons it has learned from completed audits to improve organizations' performance in responding to potential fraud and abuse incidents.

CMS concurred in part with our sixth recommendation, to require MA organizations to refer potential fraud and abuse incidents that warrant further investigation to CMS or other entities. CMS stated that it does not have the regulatory authority to require MA organizations to self-report fraud and abuse incidents. However, CMS noted that it will explore this option and continue to encourage MA organizations through guidance and education to voluntarily self-report fraud and abuse incidents.

OIG acknowledges that current regulations do not require MA organizations to self-report potential fraud and abuse incidents. However, CMS has the authority to amend the regulations to require that MA organizations report potential fraud and abuse incidents that warrant further investigation to appropriate entities. We also note that CMS stated in the preamble to a December 5, 2007, Final Rule that "although we have decided not to finalize the mandatory self-reporting provisions that we proposed, CMS remains committed to adopting a mandatory self-reporting requirement."

The full text of CMS's comments is provided in Appendix F.

APPENDIX A

Potential Fraud and Abuse Incidents, Inquiries, Corrective Actions, and Referrals for All Medicare Advantage Organizations in 2009

Table A-1: Potential Fraud and Abuse Incidents and Inquiries Reported by Medicare Advantage Organizations in 2009

	Top Three MA Organizations			Remaining MA Organizations		
	Potential Fraud and Abuse Incidents Identified in 2009	Number of Inquiries Conducted in 2009	Ratio of Inquiries to Incidents	Potential Fraud and Abuse Incidents Identified in 2009	Number of Inquiries Conducted in 2009	Ratio of Inquiries to Incidents
Part C	1,210,344	1,010,234	83%	61,188	24,928	41%
Part D	147,840	145,830	99%	12,311	7,277	59%
Total	**1,358,184**	**1,156,064**	**85%**	**73,499**	**32,205**	**44%**

Source: Office of Inspector General (OIG) analysis of Medicare Advantage (MA) organizations' survey responses.

Table A-2: Potential Fraud and Abuse Incidents and Corrective Actions Reported by MA Organizations in 2009

	Top Three MA Organizations			Remaining MA Organizations		
	Potential Fraud and Abuse Incidents Identified in 2009	Number of Corrective Actions Initiated in 2009	Ratio of Corrective Actions to Incidents	Potential Fraud and Abuse Incidents Identified in 2009	Number of Corrective Actions Initiated in 2009	Ratio of Corrective Actions to Incidents
Part C	1,210,344	1,010,235	83%	61,188	15,248	25%
Part D	147,840	103,769	70%	12,311	4,811	39%
Total	**1,358,184**	**1,114,004**	**82%**	**73,499**	**20,059**	**27%**

Source: OIG analysis of MA organizations' survey responses.

Table A-3: Potential Fraud and Abuse Incidents and Referrals to Other Entities Reported by MA Organizations in 2009

	Top Three MA Organizations			Remaining MA Organizations		
	Potential Fraud and Abuse Incidents Identified in 2009	Number of Referrals Sent in 2009	Ratio of Referrals Sent to Incidents	Potential Fraud and Abuse Incidents Identified in 2009	Number of Referrals Sent in 2009	Ratio of Referrals Sent to Incidents
Part C	1,210,344	39	<.01%	61,188	1,689	3%
Part D	147,840	1	<.01%	12,311	927	8%
Total	**1,358,184**	**40**	**<.01%**	**73,499**	**2,616**	**4%**

Source: OIG analysis of MA organizations' survey responses.

APPENDIX B

Fraud and Abuse Activities by MA Organization for 2009

This table provides the numbers of potential fraud and abuse incidents identified, inquiries conducted, corrective actions initiated, and incidents referred for each of the 170 Medicare Advantage (MA) organizations in our review. The data are sorted by the total number of incidents each MA organization identified.

Table B-1: Fraud and Abuse Activities by MA Organization for 2009

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
178	Over 250,000	Part C	1,010,233	1,010,233	1,010,233	38
		Part D	100,909	100,909	100,907	1
		Subtotal	1,111,142	1,111,142	1,111,140	39
34	20,000 to 49,999	Part C	200,111	1	2	1
		Part D	2,377	377	128	0
		Subtotal	202,488	378	130	1
112	5,000 to 19,999	Part C	0	*	*	*
		Part D	44,554	44,544	2,734	0
		Subtotal	44,554	44,544	2,734	0
74	20,000 to 49,999	Part C	14,558	0	7,047	0
		Part D	866	866	890	0
		Subtotal	15,424	866	7,937	0
36	20,000 to 49,999	Part C	10,675	2	2	0
		Part D	1,837	0	0	0
		Subtotal	12,512	2	2	0
174	Over 250,000	Part C	7,478	7,381	1,898	91
		Part D	712	631	102	45
		Subtotal	8,190	8,012	2,000	136
57	1,000 to 4,999	Part C	7,787	11	6	1
		Part D	154	0	0	0
		Subtotal	7,941	11	6	1
14	5,000 to 19,999	Part C	5,123	5,123	0	0
		Part D	25	25	0	1
		Subtotal	5,148	5,148	0	1

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
58	1,000 to 4,999	Part C	3,053	669	669	0
		Part D	26	26	26	0
		Subtotal	3,079	695	695	0
169	Over 250,000	Part C	2,251	2,251	1,236	432
		Part D	303	303	131	266
		Subtotal	2,554	2,554	1,367	698
33	Over 250,000	Part C	2,154	2,154	794	20
		Part D	51	51	44	6
		Subtotal	2,205	2,205	838	26
143	5,000 to 19,999	Part C	9	9	14	1
		Part D	2,040	2,040	2,043	1
		Subtotal	2,049	2,049	2,057	2
61	5,000 to 19,999	Part C	42	32	20	1
		Part D	1,532	101	101	0
		Subtotal	1,574	133	121	1
62	50,000 to 250,000	Part C	1,360	1,339	49	1
		Part D	75	75	0	0
		Subtotal	1,435	1,414	49	1
24	5,000 to 19,999	Part C	843	843	843	0
		Part D	1	1	0	0
		Subtotal	844	844	843	0
98	20,000 to 49,999	Part C	123	123	102	0
		Part D	714	714	247	0
		Subtotal	837	837	349	0
70	5,000 to 19,999	Part C	13	13	3	7
		Part D	799	0	88	0
		Subtotal	812	13	91	7
7	20,000 to 49,999	Part C	508	508	10	1
		Part D	226	0	0	0
		Subtotal	734	508	10	1
119	50,000 to 250,000	Part C	438	438	80	4
		Part D	289	289	13	2
		Subtotal	727	727	93	6
87	Over 250,000	Part C	438	438	11	0
		Part D	98	98	0	17
		Subtotal	536	536	11	17

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
81	5,000 to 19,999	Part C	1	1	0	0
		Part D	374	374	305	0
		Subtotal	375	375	305	0
176	50,000 to 250,000	Part C	310	310	127	78
		Part D	54	54	30	14
		Subtotal	364	364	157	92
95	50,000 to 250,000	Part C	263	263	86	0
		Part D	66	66	1	22
		Subtotal	329	329	87	22
76	Over 250,000	Part C	291	291	267	1
		Part D	35	35	28	3
		Subtotal	326	326	295	4
148	50,000 to 250,000	Part C	270	136	5	50
		Part D	1	1	0	1
		Subtotal	271	137	5	51
16	50,000 to 250,000	Part C	213	213	111	5
		Part D	49	159	49	3
		Subtotal	262	372	160	8
20	20,000 to 49,999	Part C	186	179	179	119
		Part D	21	21	26	18
		Subtotal	207	200	205	137
21	1,000 to 4,999	Part C	69	69	15	0
		Part D	104	104	25	0
		Subtotal	173	173	40	0
72	1,000 to 4,999	Part C	8	20	18	1
		Part D	163	163	26	0
		Subtotal	171	183	44	1
25	5,000 to 19,999	Part C	16	16	1	0
		Part D	153	0	0	0
		Subtotal	169	16	1	0
47	50,000 to 250,000	Part C	87	87	71	3
		Part D	79	79	22	3
		Subtotal	166	166	93	6
40	1,000 to 4,999	Part C	140	123	3	0
		Part D	24	0	0	0
		Subtotal	164	123	3	0

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
173	5,000 to 19,999	Part C	155	74	29	20
		Part D	0	*	*	*
		Subtotal	155	74	29	20
51	50,000 to 250,000	Part C	143	166	76	7
		Part D	1	1	0	0
		Subtotal	144	167	76	7
78	50,000 to 250,000	Part C	29	15	0	7
		Part D	107	39	0	22
		Subtotal	136	54	0	29
123	5,000 to 19,999	Part C	121	6	2	1
		Part D	9	0	9	0
		Subtotal	130	6	11	1
144	1,000 to 4,999	Part C	124	109	23	1
		Part D	2	2	2	0
		Subtotal	126	111	25	1
29	50,000 to 250,000	Part C	1	1	1	0
		Part D	124	124	2	98
		Subtotal	125	125	3	98
137	1,000 to 4,999	Part C	2	2	0	1
		Part D	116	35	3	0
		Subtotal	118	37	3	1
38	Over 250,000	Part C	76	68	77	41
		Part D	41	33	62	10
		Subtotal	117	101	139	51
52	50,000 to 250,000	Part C	34	34	29	5
		Part D	79	81	73	8
		Subtotal	113	115	102	13
179	50,000 to 250,000	Part C	50	51	45	43
		Part D	58	58	1	32
		Subtotal	108	109	46	75
180	5,000 to 19,999	Part C	106	24	24	5
		Part D	1	1	1	0
		Subtotal	107	25	25	5
75	50,000 to 250,000	Part C	89	89	68	12
		Part D	15	15	11	7
		Subtotal	104	104	79	19

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
69	Over 250,000	Part C	81	79	98	28
		Part D	22	20	14	2
		Subtotal	103	99	112	30
73	20,000 to 49,999	Part C	13	13	10	1
		Part D	85	85	107	0
		Subtotal	98	98	117	1
147	50,000 to 250,000	Part C	82	58	90	7
		Part D	13	0	0	13
		Subtotal	95	58	90	20
1	50,000 to 250,000	Part C	70	70	278	1
		Part D	24	24	54	0
		Subtotal	94	94	332	1
121	50,000 to 250,000	Part C	88	88	83	72
		Part D	5	5	4	2
		Subtotal	93	93	87	74
107	1,000 to 4,999	Part C	72	72	9	1
		Part D	21	21	1	0
		Subtotal	93	93	10	1
71	50,000 to 250,000	Part C	64	55	49	13
		Part D	28	28	0	25
		Subtotal	92	83	49	38
106	50,000 to 250,000	Part C	65	6	8	6
		Part D	24	3	3	9
		Subtotal	89	9	11	15
120	20,000 to 49,999	Part C	82	67	67	1
		Part D	5	4	2	1
		Subtotal	87	71	69	2
124	5,000 to 19,999	Part C	66	66	12	0
		Part D	16	16	3	0
		Subtotal	82	82	15	0
118	5,000 to 19,999	Part C	0	*	*	*
		Part D	76	76	48	0
		Subtotal	76	76	48	0
122	1,000 to 4,999	Part C	74	74	74	72
		Part D	1	1	0	0
		Subtotal	75	75	74	72

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
64	20,000 to 49,999	Part C	7	7	20	7
		Part D	60	60	20	0
		Subtotal	67	67	40	7
108	5,000 to 19,999	Part C	51	49	53	1
		Part D	13	7	7	3
		Subtotal	64	56	60	4
86	50,000 to 250,000	Part C	7	0	1	0
		Part D	57	0	0	1
		Subtotal	64	0	1	1
9	5,000 to 19,999	Part C	0	*	*	*
		Part D	56	18	18	0
		Subtotal	56	18	18	0
53	50,000 to 250,000	Part C	37	23	22	0
		Part D	18	18	2	0
		Subtotal	55	41	24	0
19	5,000 to 19,999	Part C	51	0	0	0
		Part D	0	*	*	*
		Subtotal	51	0	0	0
89	Fewer than 1,000	Part C	0	*	*	*
		Part D	48	0	0	0
		Subtotal	48	0	0	0
31	Over 250,000	Part C	37	37	2	1
		Part D	8	8	16	4
		Subtotal	45	45	18	5
41	5,000 to 19,999	Part C	36	36	13	0
		Part D	9	9	1	4
		Subtotal	45	45	14	4
42	Fewer than 1,000	Part C	0	*	*	*
		Part D	40	40	0	0
		Subtotal	40	40	0	0
90	20,000 to 49,999	Part C	31	31	3	18
		Part D	8	8	0	6
		Subtotal	39	39	3	24
11	20,000 to 49,999	Part C	29	31	3	4
		Part D	9	13	1	1
		Subtotal	38	44	4	5

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
162	5,000 to 19,999	Part C	1	1	0	0
		Part D	37	11	36	11
		Subtotal	38	12	36	11
167	5,000 to 19,999	Part C	36	6	13	0
		Part D	NA[2]	*	*	*
		Subtotal	36	6	13	0
102	20,000 to 49,999	Part C	32	27	48	0
		Part D	3	2	4	0
		Subtotal	35	29	52	0
12	50,000 to 250,000	Part C	13	13	13	5
		Part D	19	19	19	4
		Subtotal	32	32	32	9
117	20,000 to 49,999	Part C	14	8	12	1
		Part D	18	18	10	6
		Subtotal	32	26	22	7
5	50,000 to 250,000	Part C	22	22	22	0
		Part D	7	7	7	7
		Subtotal	29	29	29	7
132	5,000 to 19,999	Part C	22	22	15	1
		Part D	7	7	1	0
		Subtotal	29	29	16	1
22	20,000 to 49,999	Part C	22	22	5	1
		Part D	2	2	2	2
		Subtotal	24	24	7	3
136	1,000 to 4,999	Part C	7	7	0	0
		Part D	15	0	0	0
		Subtotal	22	7	0	0
146	1,000 to 4,999	Part C	0	*	*	*
		Part D	22	0	0	0
		Subtotal	22	0	0	0
157	1,000 to 4,999	Part C	20	20	2	0
		Part D	1	1	0	0
		Subtotal	21	21	2	0
100	20,000 to 49,999	Part C	18	3	3	1
		Part D	3	0	0	0
		Subtotal	21	3	3	1

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
168	20,000 to 49,999	Part C	18	22	22	17
		Part D	2	4	4	2
		Subtotal	20	26	26	19
116	20,000 to 49,999	Part C	18	18	28	3
		Part D	2	2	1	2
		Subtotal	20	20	29	5
88	50,000 to 250,000	Part C	11	11	11	1
		Part D	8	8	1	7
		Subtotal	19	19	12	8
160	20,000 to 49,999	Part C	16	16	4	0
		Part D	2	2	0	0
		Subtotal	18	18	4	0
93	1,000 to 4,999	Part C	2	2	0	0
		Part D	16	0	16	0
		Subtotal	18	2	16	0
92	1,000 to 4,999	Part C	14	14	10	0
		Part D	1	1	0	0
		Subtotal	15	15	10	0
154	Fewer than 1,000	Part C	12	12	6	7
		Part D	3	3	2	2
		Subtotal	15	15	8	9
164	5,000 to 19,999	Part C	14	14	2	0
		Part D	1	1	0	0
		Subtotal	15	15	2	0
111	5,000 to 19,999	Part C	12	12	5	2
		Part D	2	2	4	2
		Subtotal	14	14	9	4
115	20,000 to 49,999	Part C	14	14	7	4
		Part D	0	*	*	*
		Subtotal	14	14	7	4
6	5,000 to 19,999	Part C	12	7	2	0
		Part D	1	1	1	0
		Subtotal	13	8	3	0
126	50,000 to 250,000	Part C	12	0	0	0
		Part D	0	*	*	*
		Subtotal	12	0	0	0

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
67	5,000 to 19,999	Part C	12	0	0	0
		Part D	Unavailable[3]	*	*	*
		Subtotal	12	0	0	0
37	1,000 to 4,999	Part C	1	1	0	1
		Part D	9	9	0	0
		Subtotal	10	10	0	1
113	1,000 to 4,999	Part C	5	5	0	0
		Part D	5	5	0	0
		Subtotal	10	10	0	0
48	5,000 to 19,999	Part C	10	0	0	0
		Part D	0	*	*	*
		Subtotal	10	0	0	0
170	1,000 to 4,999	Part C	2	2	0	0
		Part D	7	7	6	0
		Subtotal	9	9	6	0
138	20,000 to 49,999	Part C	7	7	7	1
		Part D	1	1	1	1
		Subtotal	8	8	8	2
140	5,000 to 19,999	Part C	3	3	0	3
		Part D	5	5	0	4
		Subtotal	8	8	0	7
46	5,000 to 19,999	Part C	7	0	0	7
		Part D	1	1	2	1
		Subtotal	8	1	2	8
129	20,000 to 49,999	Part C	7	0	0	0
		Part D	1	1	0	1
		Subtotal	8	1	0	1
171	1,000 to 4,999	Part C	4	0	0	0
		Part D	4	0	0	0
		Subtotal	8	0	0	0
18	Fewer than 1,000	Part C	8	0	0	0
		Part D	0	*	*	*
		Subtotal	8	0	0	0
159	20,000 to 49,999	Part C	3	3	4	3
		Part D	4	4	11	0
		Subtotal	7	7	15	3

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
2	5,000 to 19,999	Part C	7	7	12	0
		Part D	0	*	*	*
		Subtotal	7	7	12	0
130	20,000 to 49,999	Part C	5	0	0	1
		Part D	2	0	0	0
		Subtotal	7	0	0	1
96	20,000 to 49,999	Part C	2	2	1	0
		Part D	4	4	4	4
		Subtotal	6	6	5	4
35	1,000 to 4,999	Part C	6	6	3	0
		Part D	0	*	*	*
		Subtotal	6	6	3	0
135	1,000 to 4,999	Part C	4	3	3	3
		Part D	2	2	2	1
		Subtotal	6	5	5	4
45	20,000 to 49,999	Part C	0	*	*	*
		Part D	5	5	10	5
		Subtotal	5	5	10	5
101	1,000 to 4,999	Part C	5	5	5	1
		Part D	0	*	*	*
		Subtotal	5	5	5	1
99	1,000 to 4,999	Part C	5	5	5	0
		Part D	0	*	*	*
		Subtotal	5	5	5	0
172	1,000 to 4,999	Part C	4	3	3	1
		Part D	1	1	0	1
		Subtotal	5	4	3	2
141	20,000 to 49,999	Part C	2	1	1	2
		Part D	3	3	1	3
		Subtotal	5	4	2	5
97	Fewer than 1,000	Part C	4	4	3	2
		Part D	0	*	*	*
		Subtotal	4	4	3	2
49	Fewer than 1,000	Part C	3	3	1	2
		Part D	1	1	1	1
		Subtotal	4	4	2	3

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
103	1,000 to 4,999	Part C	4	4	2	0
		Part D	0	*	*	*
		Subtotal	4	4	2	0
23	1,000 to 4,999	Part C	4	3	10	3
		Part D	0	*	*	*
		Subtotal	4	3	10	3
150	1,000 to 4,999	Part C	3	6	0	0
		Part D	0	*	*	*
		Subtotal	3	6	0	0
66	20,000 to 49,999	Part C	3	3	3	0
		Part D	0	*	*	*
		Subtotal	3	3	3	0
104	5,000 to 19,999	Part C	1	1	0	1
		Part D	2	2	0	2
		Subtotal	3	3	0	3
156	5,000 to 19,999	Part C	2	2	0	0
		Part D	1	1	0	0
		Subtotal	3	3	0	0
56	1,000 to 4,999	Part C	0	*	*	*
		Part D	3	2	2	1
		Subtotal	3	2	2	1
79	Fewer than 1,000	Part C	0	*	*	*
		Part D	3	0	0	0
		Subtotal	3	0	0	0
50	1,000 to 4,999	Part C	2	2	2	0
		Part D	0	*	*	*
		Subtotal	2	2	2	0
131	1,000 to 4,999	Part C	2	2	2	0
		Part D	0	*	*	*
		Subtotal	2	2	2	0
158	5,000 to 19,999	Part C	2	2	1	0
		Part D	0	*	*	*
		Subtotal	2	2	1	0
83	50,000 to 250,000	Part C	Unavailable[4]	*	*	*
		Part D	2	2	0	0
		Subtotal	2	2	0	0

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
127	1,000 to 4,999	Part C	1	1	1	0
		Part D	1	0	0	1
		Subtotal	2	1	1	1
30	5,000 to 19,999	Part C	1	1	5	0
		Part D	0	*	*	*
		Subtotal	1	1	5	0
177	5,000 to 19,999	Part C	1	1	5	0
		Part D	0	*	*	*
		Subtotal	1	1	5	0
125	20,000 to 49,999	Part C	1	1	2	1
		Part D	0	*	*	*
		Subtotal	1	1	2	1
114	1,000 to 4,999	Part C	0	*	*	*
		Part D	1	1	1	1
		Subtotal	1	1	1	1
165	5,000 to 19,999	Part C	1	1	1	0
		Part D	0	*	*	*
		Subtotal	1	1	1	0
94	5,000 to 19,999	Part C	1	1	0	1
		Part D	0	*	*	*
		Subtotal	1	1	0	1
152	5,000 to 19,999	Part C	1	1	0	0
		Part D	0	*	*	*
		Subtotal	1	1	0	0
28	1,000 to 4,999	Part C	0	*	*	*
		Part D	1	0	0	0
		Subtotal	1	0	0	0
17	20,000 to 49,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
134	20,000 to 49,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
8	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
10	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
15	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
39	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
85	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
109	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
110	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
142	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
151	5,000 to 19,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
4	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
26	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
59	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
60	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
77	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
91	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
105	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
128	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
145	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
153	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
161	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
163	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
166	1,000 to 4,999	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
13	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
27	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
32	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*

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Table B-1: Fraud and Abuse Activities by MA Organization for 2009 (Continued)

MA Organization Identifier	Enrollment Category		Total Number of Potential Fraud and Abuse Incidents Identified	Total Number of Inquiries Conducted	Total Number of Corrective Actions Initiated	Total Number of Incidents Referred to Other Entities[1]
55	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
68	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
82	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
133	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
139	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
155	Fewer than 1,000	Part C	0	*	*	*
		Part D	0	*	*	*
		Subtotal	0	*	*	*
		Part C Total	**1,271,532**	**1,035,162**	**1,025,483**	**1,307**
		Part D Total	**160,151**	**153,107**	**108,580**	**723**
		Grand Total	**1,431,683**	**1,188,269**	**1,134,063**	**2,030**

Source: Office of Inspector General analysis of MA organizations' survey responses and Centers for Medicare & Medicaid Services enrollment data.

*These MA organizations did not identify any potential fraud and abuse incidents in 2009.

[1]This column represents the number of incidents referred to other entities, not the number of referrals. One potential fraud and abuse incident may be referred to multiple entities for further investigation.

[2]MA organization 167 did not operate any Medicare Advantage Prescription Drug plans in 2009.

[3]MA organization 67 could not provide information about potential Part D fraud and abuse incidents separate from incidents related to its other lines of business.

[4]MA organization 83 could not provide information about potential Part C fraud and abuse incidents separate from incidents related to its other lines of business.

APPENDIX C

Types of Potential Part C and Part D Fraud and Abuse Identified by Medicare Advantage Organizations in 2009

The examples cited in Tables C-1 and C-2 were derived from Chapter 9 of the Centers for Medicare & Medicaid Services' (CMS) *Prescription Drug Benefit Manual*; CMS's *Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care*, issued October 2000; and Medicare Advantage (MA) organizations' responses to our survey.

Table C-1: Types of Potential Part C Fraud and Abuse Identified by MA Organizations in 2009

Type of Fraud and Abuse	Number of Incidents		Examples
	Top Three MA Organizations	Remaining MA Organizations	
Improper coding	1,145,196	39,451	• By using the wrong billing code or separately billing for codes that could be included in a larger, more inclusive set of codes, the health care provider is reimbursed at a higher rate than if the correct billing codes were used and the services were billed together.
Marketing schemes	45	8,003	• Plan sponsor, first-tier entity, or downstream entity violated Medicare marketing guidelines or other Federal or State laws, rules, and regulations to improperly enroll beneficiaries in an MA plan.
Billing for ineligible consumers	0	5,521	• Misrepresentation of beneficiary's personal identity or eligibility information, medical condition, or plan enrollment information.
Services never rendered	0	3,522	• Provider submits claims or encounter data for services that were never provided to beneficiary.
Failure to provide medically necessary services	0	1,236	• Plan sponsor, health care provider, or other entity fails to provide medically necessary items or services that it is required to provide under law or under the contract, and that failure adversely affects or is substantially likely to affect the beneficiary.
Double billing or balance billing	65,056	963	• The provider receives more than one payment for the same service and keeps the money, or bills the beneficiary directly for the total amount of the bill including the amount of the charge that the provider has agreed to write off after the MA organization has paid.
Suspect billing	0	387	• Questionable or suspicious billing practices. • Overutilization.
Attempts to steal beneficiary identity/money	38	338	• Individual or organization poses as part of Medicare or Social Security with intent to steal beneficiary's identity or money. • Individual uses/steals another person's Medicare or MA card.
Overcharging beneficiary	0	316	• Overcharging beneficiary for improper coinsurance or premiums.
Billing errors/issues	0	245	• Member complaints of improper provider billing. • Billing incorrect carrier. • Other insurance primary. • Billing wrong contract number. • Failure to disclose overpayment. • Charges exceed contract. • Entity overcharging the MA plan.

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Table C-1: Types of Potential Part C Fraud and Abuse Identified by MA Organizations in 2009 (Continued)

Type of Fraud and Abuse	Number of Incidents		Examples
	Top Three MA Organizations	Remaining MA Organizations	
Adverse selection	2	212	• Selecting/denying beneficiaries based on illness profile or other discriminatory factors.
Falsification of health care provider credentials	0	210	• This can occur either at the MA organization or downstream. Falsification of provider credentials may result in improper payment for the services of a provider who does not meet required professional qualifications.
Request for information	0	104	• Law enforcement request for information. • Request for assistance from external entity.
Improper cost reporting or cost shifting	0	102	• Providers submit inflated reports of patient traffic and treatment costs to induce payers to increase future per-patient payments.
Enrollment/disenrollment issue	5	96	• Questionable enrollment. • Improper disenrollment or enrollment activity. • Attempted enrollment without beneficiary approval. • Falsified enrollment information.
Outside scope of practice	0	70	• Physicians provide services outside their scope of practice.
Medical necessity or appropriateness issue	0	44	• Member complaints of testing being ordered by physician that the member did not feel was necessary. • Provider billing for unnecessary services.
Inducements, kickbacks, bribes, or tying agreements	0	38	• Inappropriate discounts, support services, educational grants, or research funding. • Improper entertainment or business courtesies. • The MA organization may subcontract with entities that have expertise in a particular area. If the subcontractor requires the MA organization to contract with other entities as a condition for the subcontractor to provide services, the MA organization could incur inflated costs.
Investigations	0	36	• Provider indicted for Medicare fraud. • Provider under State/Federal investigation.
Unauthorized services or provider	0	33	• Patient seen after termination. • Fraudulent billing for unauthorized poststabilization inpatient services at several noncontracted hospitals that are part of a commonly owned chain. • Provider's license was revoked. • Provider referring lab services to a nonparticipating vendor. • Billing for items/tests not ordered or covered. • Out of geographical service area. • Noncredentialed provider—incorrect reporting of rendering provider.
Falsification of financial solvency	0	26	• A first-tier or downstream entity can purport to have sufficient assets to cover claims when, in fact, it lacks financial solvency.
Falsification of records or other data	0	25	• Falsification of medical record or dates of service. • Member falsification of a medical referral. • Forged physician's signature. • Forged or altered durable medical equipment (DME) prescription.

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Table C-1: Types of Potential Part C Fraud and Abuse Identified by MA Organizations in 2009 (Continued)

Type of Fraud and Abuse	Number of Incidents		Examples
	Top Three MA Organizations	Remaining MA Organizations	
Beneficiary abuse of benefits	0	18	• Member sold DME to another party. • Fraudulent use of benefits. • Illegal use/sale of prescription drugs. • Alteration of claim by member. • Beneficiary, a former practicing physician, wrote a prescription for his own use.
Quality of care issue	0	10	• Member complaint of poor quality of products, services.
Inappropriate physician incentive plans	0	9	• Under a capitated arrangement, specialists may be paid by a primary care physician (PCP) using a portion of the PCP's capitation payment if a referral is made. Fraud can occur if the PCP receiving capitation payment does not reimburse specialists or does not refer members to specialists even if medically necessary.
Providing data to CMS that lack integrity	1	8	• Failure to generate or report complete and accurate information upon which Government reimbursement depends, in whole or in part. • Improperly reporting enrollment/disenrollment data to CMS to inflate prospective payments.
Health Insurance Portability and Accountability Act issue	0	8	• Member received another member's identification card.
Collusion among providers	1	7	• Competing providers agree on minimum fees charged and capitation rates accepted.
Provider misconduct	0	7	• Self-referral. • Improper soliciting by DME provider. • Provider requires prospective patients to sign a form prior to treatment that they are waiving their constitutional rights as provided in Article I Section 21 of the Florida Constitution.
Drug-seeking beneficiary	0	3	• Member drug-seeking behavior.
Possible member abuse	0	3	• Possible physical or psychological abuse of member.
Waiver of member copayment	0	3	• Routinely waiving copayments and deductibles to misrepresent a provider's actual charge.
Unspecified	0	139	• For these incidents, MA organizations did not specify the type of fraud, reported the type as miscellaneous, or provided a description that was too vague to categorize.
Total	**1,210,344**	**61,193[1]**	

Source: Office of Inspector General (OIG) analysis of MA organizations' survey responses.
[1]The total number of incidents identified was 61,188. However, five MA organizations reported two types of fraud for one potential fraud and abuse incident.

Table C-2: Types of Potential Part D Fraud and Abuse Identified by MA Organizations in 2009

Type of Fraud and Abuse	Number of Incidents		Examples
	Top Three MA Organizations	Remaining MA Organizations	
Inappropriate billing for prescriptions	104,550	2,338	• Billing for brand-name drugs when generics are dispensed. • Billing for noncovered prescriptions as covered items. • Billing for prescriptions that are never picked up.
Inappropriate prescription dispensing	32,110	3,764	• Dispensing expired or adulterated prescription drugs. • Dispensing without a prescription. • Splitting: pharmacist or mail-order pharmacy splits prescription to receive additional dispensing fee.
Improper coding	8,800	1	• Using the wrong billing code or unbundling the codes included in a larger, more inclusive set of codes, the health care provider is reimbursed at a higher rate than if the correct billing codes were used and the services were billed together.
Doctor shopping, potential drug abuse, or stockpiling	1,200	3,101	• Beneficiary consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs. • Beneficiary attempts to game her/his drug coverage by obtaining and storing large quantities of drugs and then disenrolling.
Inappropriate prescribing	800	637	• Physicians write prescriptions outside the boundaries of their scope of practice. • Prescriber is on the OIG exclusion list.
Marketing schemes	0	695	• Misrepresentation of plan benefits. • Misrepresentation of services. • Member received unwanted mail from another plan. • Competitors cold-calling Medicare Part D members, i.e., inappropriate soliciting.
Overcharging beneficiary for prescriptions	0	492	• Pharmacy asking beneficiary to pay uncompensated amounts. • Bait-and-switch pricing, i.e., beneficiary is led to believe a drug will cost one price, but at point of sale is charged a higher amount.
Double billing or balance billing	377	2	• Provider receives more than one payment for the same service and keeps the money, or the provider bills the beneficiary directly for the total amount of the bill including the amount of the charge that the provider has agreed to write off after the MA organization has paid.
Prescription errors/issues	0	310	• Potential fraud scenarios referred by the beneficiaries in response to their monthly Part D explanation of benefits discrepancies: members allege they did not receive dispensed prescriptions which were registered under their contract. • Missing or invalid prescriptions.
Attempts to steal beneficiary identity to obtain prescriptions	2	190	• Individual uses another person's Medicare or insurance card to obtain prescriptions.
Inappropriate prescribing of controlled substances	0	182	• Physicians identified as prescribing high volume of controlled substances.
Pharmacy unresponsive to audit request	0	151	• Pharmacy did not respond to desk audit or in-store audit request.

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Table C-2: Types of Potential Part D Fraud and Abuse Identified by MA Organizations in 2009 (Continued)

Type of Fraud and Abuse	Number of Incidents		Examples
	Top Three MA Organizations	Remaining MA Organizations	
Failure to provide medically necessary prescription drugs	0	124	• Plan sponsor or health care provider fails to provide medically necessary prescriptions that the organization is required to provide under law or under the contract, and that failure adversely affects or is likely to affect the beneficiary.
Forged or altered prescriptions or other documents	0	102	• Prescriptions are forged or altered by someone other than the prescriber or pharmacist without prescriber approval to increase quantity or number of refills.
Diverting prescriptions	0	46	• Beneficiary obtains prescription drugs from a provider and gives or sells this medication to someone else. • Inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.
Enrollment/disenrollment issue	0	38	• Ineligible member. • Member had two insurance plans.
Medical necessity or appropriateness issue	0	20	• Medical appropriateness. • Provider billing for unnecessary services.
Theft of prescriber's prescription pad or prescriber number	0	17	• In context of e-prescribing, includes theft of provider's login information.
Request for information	0	13	• Cases opened as a result of law enforcement request for data in support of investigations. • Request for assistance from external entity. • Request from Attorney General on member and prescribers--top 10 by cost/volume.
Investigations	0	11	• Drug Enforcement Administration fraud investigation. • Other type of investigation.
Inducements, kickbacks, or bribes	0	5	• Prescriber is offered inappropriate discounts, support services, educational grants, research funding, improper entertainment, or business courtesies.
Providing data to CMS that lacks integrity	1	4	• Submitting inaccurate or incomplete Prescription Drug Event data or Part D plan quarterly data. • Inappropriate documentation of pricing information.
Beneficiary true out-of-pocket (TrOOP) costs or low-income subsidy manipulation	0	3	• Incorrect TrOOP calculation that results in improper payments by CMS or beneficiary. • Beneficiary not receiving the low-income benefit approved by CMS.
Unauthorized services or provider	0	3	• Out of service area. • Failure to follow authorization rules.
Suspect billing	0	1	• Questionable or suspicious billing practices. • Overutilization.
Unspecified	0	61	• For these incidents, MA organizations either did not specify the type of fraud, reported the type as miscellaneous, or provided a description that was too vague to categorize.
Total	**147,840**	**12,311**	

Source: OIG analysis of MA organizations' survey responses.

APPENDIX D

Table D-1: Types of Corrective Actions Initiated by Medicare Advantage Organizations in 2009

Type of Corrective Action	Number of Part C Corrective Actions		Number of Part D Corrective Actions	
	Top Three MA[1] Organizations	Remaining MA Organizations	Top Three MA Organizations	Remaining MA Organizations
Prepayment review	997,977	2,005	100,906	71
Collection of overpayment	11,626	2,228	2,798	3,104
Provider education	578	7,608	0	434
Disciplinary action	42	1,267	0	61
Postpayment review	1	909	65	594
Utilization monitoring	0	504	0	144
Counseling/coaching	0	288	0	3
Termination from network	11	80	0	132
Employee training	0	64	0	17
Administrative actions	0	51	0	7
Member education	0	32	0	1
Policy or procedure change	0	30	0	112
Agent termination	0	30	0	1
Agent/broker training	0	11	0	0
Monitoring	0	10	0	0
Referral for corrective action or corrective action plan	0	4	0	6
Case management	0	1	0	21
Exclusion from network participation	0	0	0	44
Other education efforts	0	0	0	37
Claim correction/reversal	0	0	0	6
Internal referrals	0	0	0	3
Unspecified	0	126	0	13
Total	**1,010,235**	**15,248**	**103,769**	**4,811**

[1] Medicare Advantage.
Source: Office of Inspector General analysis of MA organizations' survey responses.

APPENDIX E

Table E-1: Referrals to Other Entities for Further Investigation by Medicare Advantage Organizations in 2009

Entity That Received Referrals of Potential Fraud and Abuse Incidents	Number of Part C Referrals		Number of Part D Referrals		Total Number of Referrals
	Top Three MA[1] Organizations	Remaining MA Organizations	Top Three MA Organizations	Remaining MA Organizations	
Medicare drug integrity contractors	39	275	0	469	784
State insurance commissioners	0	403	0	67	470
Office of Inspector General (OIG)	0	371	0	47	418
Department of Justice	0	187	0	158	345
State agency	0	218	0	24	242
State or local law enforcement	0	74	0	137	211
Centers for Medicare & Medicaid Services	0	49	0	4	53
Licensing board	0	40	0	8	48
National Health Care Anti-Fraud Association	0	19	0	0	19
Insurance fraud bureau	0	8	0	3	11
Medicaid agency	0	10	0	0	10
State Board of Pharmacy	0	0	0	4	4
National Association of Insurance Commissioners	0	1	0	0	1
Other entities	0	34	1	6	40
Total	**39**	**1,689**	**1**	**927**	**2,656**

[1] Medicare Advantage.
Source: OIG analysis of MA organizations' survey responses.

APPENDIX F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: DEC 0 8 2011

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicare Advantage Organizations' Identification of Potential Fraud and Abuse" (OEI-03-10-00310)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled, "Medicare Advantage Organizations' Identification of Potential Fraud and Abuse." This report has multiple objectives. First, it seeks to determine the extent to which Medicare Advantage (MA) organizations identify potential fraud and abuse related to their Part C and, if applicable, Part D plans. Secondly, it determined the extent to which MA organizations conduct inquiries, initiate corrective actions, and make referrals for further investigation in response to potential fraud and abuse incidents.

MA organizations' efforts to identify and address potential fraud and abuse are crucial to protecting the integrity of the MA program. These organizations are required to have compliance plans in place that include programs to detect, correct and prevent fraudulent and abusive activity.

We appreciate the OIG's efforts in working with CMS to help ensure that vulnerabilities are addressed. CMS response to each of the OIG recommendations and other comments follow.

OIG Recommendation

Ensure that MA organizations are implementing programs to detect, correct, and prevent fraud, waste, and abuse, as required in their compliance plans, so that all potential Part C and Part D fraud and abuse incidents may be identified.

CMS Response

The CMS concurs with this recommendation. As noted in OIG's findings, CMS already conducted 33 compliance plan audits in 2010. These compliance program audits include an evaluation of an MA organizations' implementation and effectiveness of its programs to detect, correct, and prevent fraud, waste, and abuse.

Agency Comments (Continued)

The annual audit evaluation process uses various data sources to identify MAOs that present the greatest risk to Medicare Beneficiaries and the Part C and Part D programs. In addition, the CMS will continue to provide resources to MA organizations' through education and outreach to aid in the identification of fraud and abuse. Education and outreach will include publication of an updated manual chapter that will include instructions and guidance on how to implement a program to detect, correct, identify and prevent fraud, waste, and abuse.

OIG Recommendation

Review MA organizations to determine why certain organizations reported especially high or low volumes of potential Part C and Part D fraud and abuse incidents and inquiries.

CMS Response

The CMS does not concur with this recommendation. In light of the enhancements to compliance plan audits and the fact that this report is based on data from 2009, the CMS does not believe contacting the MA organizations' identified in this study is necessary. The CMS analyzes fraud, waste, and abuse incidents and inquiries to inform its current processes.

OIG Recommendation

Develop specific guidance for MA organizations on defining potential Part C and Part D fraud and abuse incidents and inquiries.

CMS Response

The CMS concurs with this recommendation. Currently, CMS hosts quarterly fraud work groups for MAOs, the National Benefit Integrity MEDIC and CMS to share information about emerging fraud schemes. In addition, CMS conducts various types of outreach and education activities to increase Part C and Part D fraud and abuse awareness. The CMS is in the process of developing a Part C and Part D Fraud Handbook by the fall of 2012. The purpose of the handbook is to inform sponsoring organizations about detecting and preventing fraud in the Part C and Part D programs. Also, CMS updated the compliance plan requirements in 422 C.F.R. 503(b)(4)(vi) and 423 C.F.R. 504(b)(4)(vi) to add more detailed regulatory requirements on each of the 7 compliance program elements and specifically require that MA organizations' have an "effective" compliance program. These changes became effective January 1, 2011.

OIG Recommendation

Require MA organizations to report to CMS aggregate data related to their Part C and Part D antifraud, waste, and abuse activities.

CMS Response

The CMS concurs in part with this recommendation within the scope of CMS' existing data collection authority. The CMS does require MA organizations' to have effective compliance

Agency Comments (Continued)

programs that include measures to detect, correct, and prevent fraud, waste, and abuse. During compliance program audits, the CMS reviews cases of reported fraud, waste, and abuse. Audit results may provide an indication of MA organizations' industry performance overall and allows the CMS to target guidance and education. In considering the implementation of this recommendation, the CMS will explore the option of placing additional burden on MA organizations' vs. the value of the information to be gained in collecting such data.

OIG Recommendation

Ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents.

CMS Response

The CMS concurs with this recommendation. CMS will explore developing additional methods to ensure that all MA organizations are responding appropriately to potential fraud and abuse incidents. In addition to publishing the updated manual chapter, the CMS will also consider developing education and outreach based on lessons learned from completed audits to improve industry performance in this area.

OIG Recommendation

Require MA organizations to refer potential fraud and abuse incidents that may warrant further investigation to CMS or other appropriate entities.

CMS Response

The CMS concurs in part with this recommendation. CMS does not currently have regulatory authority to require mandatory self-reporting. The CMS will explore the option of placing additional burden on MA organizations' vs. the value of the information to be gained in collecting such data. Through guidance and education, CMS will continue to encourage MA organizations' to voluntarily self report fraud and abuse incidents.

The CMS has continuously strived to establish and enhance its relationship with MA organizations. This relationship is founded in part on a mutual interest in combating waste, fraud, and abuse, which victimize the public and private sectors alike. To that end, the CMS is committed to collaborating with MA organizations to implement programs to detect, correct, and prevent fraud, waste, and abuse. In addition, on a wider scale, the CMS, in conjunction with our law enforcement partners such as OIG and FBI, is currently actively pursuing a variety of avenues to partner with the private sector, including private payers such as MA organizations, in areas such as data sharing and other mutually beneficial anti-fraud activities.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

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