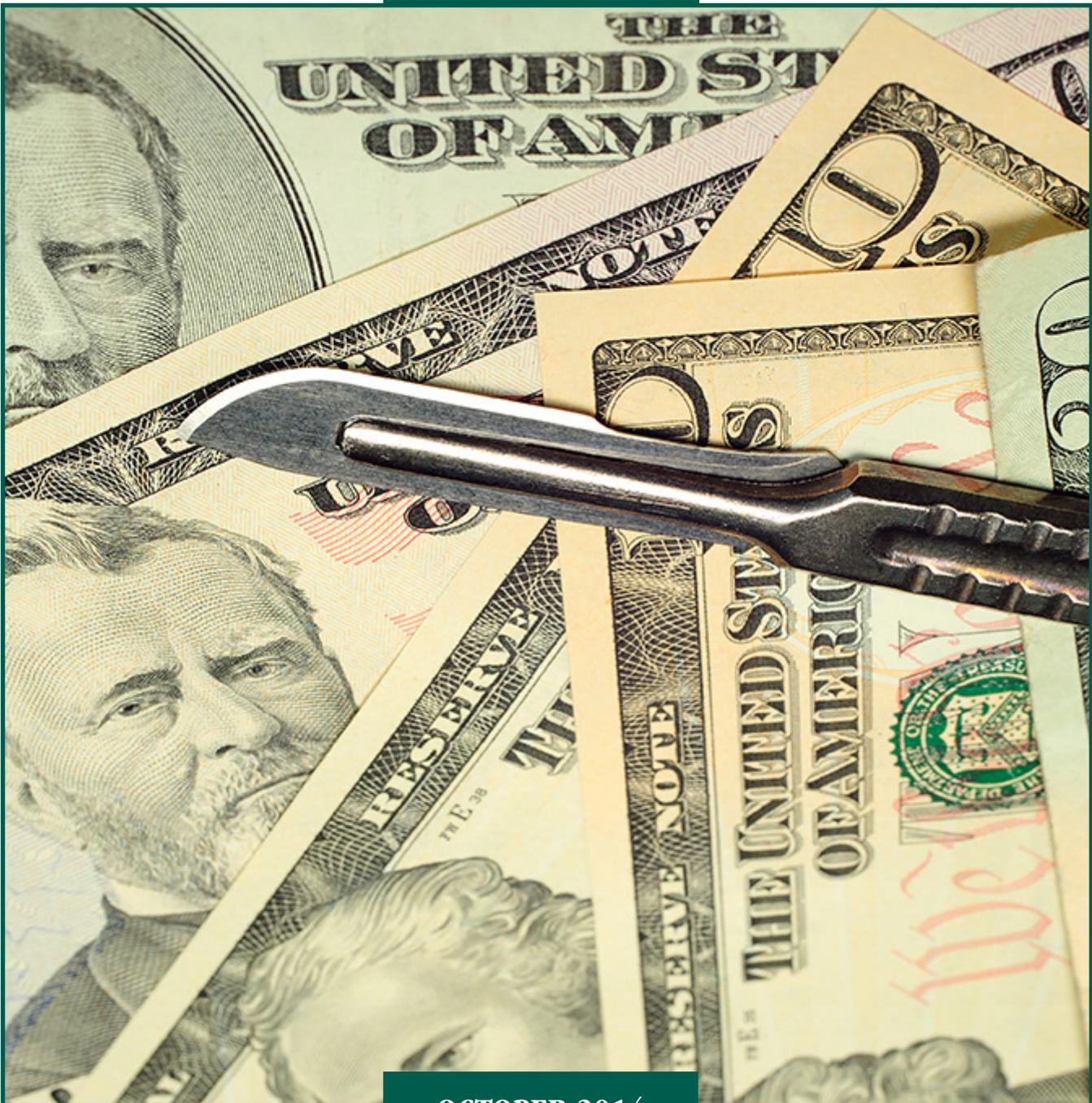


CBO

How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget



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Note

Unless otherwise indicated, all years referred to in this report are federal fiscal years (which run from October 1 to September 30).



Contents

Summary	1
What Is Fraud?	1
How Much Fraud Occurs in Federal Health Care Programs?	1
How Extensive Are Current Efforts to Combat Fraud in Health Care Programs?	2
What Factors Affect CBO's Estimates of the Budgetary Effects of Antifraud Legislation?	2
Fraud and Other Improper Payments	3
The Extent of Fraud and Other Improper Payments in Federal Health Care Programs	4
BOX 1. IMPROPER PAYMENTS	5
BOX 2. FRAUD IN PRIVATE HEALTH INSURANCE	6
Efforts to Combat Fraud	6
Factors Affecting CBO's Cost Estimates for Antifraud Legislation	7
Amount of Funds Provided	8
BOX 3. BUDGETARY SCOREKEEPING GUIDELINES	9
Extent of New Authority and New Rules	10
Effects on the Allocation of Resources Among Antifraud Activities	11
BOX 4. COST ESTIMATES FOR ANTIFRAUD PROVISIONS	12
Effects of Penalties on the Occurrence of Fraud	13
Appendix: Antifraud Laws and Regulations	17
About This Document	18
Tables	
1. CBO's Estimating Approach for Program Integrity Proposals	3
2. Sample Estimate of the Effect of Additional Funding for Program Integrity Activities	8



How Initiatives to Reduce Fraud in Federal Health Care Programs Affect the Budget

Summary

Observers often cite fraud as an important contributor to high health care spending, particularly in federal programs. This report describes how the Congressional Budget Office (CBO) estimates the budgetary effects of legislative proposals to reduce fraud in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), and how those estimates are used in the Congressional budget process.¹

What Is Fraud?

For the purposes of this report, fraud is considered to be any deliberate attempt to use deception to receive a service or payment from Medicare, Medicaid, or the Children's Health Insurance Program when the individual or entity in question has no right to that service or payment under the program's statutes and rules. Importantly, whether fraud has been committed is a legal determination and cannot be definitively known unless there has been some sort of adjudication (for example, a trial verdict or a settlement agreement).

Fraud falls within the broader category of improper payments, which are any payments in an incorrect amount (whether an overpayment or an underpayment) or to the wrong person. Not all improper payments are fraudulent,

however; some improper payments are the result of human error, mistakes in documentation, waste, or abuse.

How Much Fraud Occurs in Federal Health Care Programs?

Measuring fraud is not simple, in part because fraud can be determined with certainty only after the fact. Fraud also requires that someone act with intent to commit a crime, and determining intent can be challenging. Moreover, although fraud that has been successfully prosecuted can be quantified, there is no reliable method to estimate the amount of fraud that goes undetected, especially because at first glance successful fraud can look very much like appropriate payment for health care services.

The Government Accountability Office (GAO) has concluded that "there currently is no reliable baseline estimate of the amount of health care fraud in the United States," and CBO has not estimated the amount of fraud—either detected or undetected—in Medicare, Medicaid, and CHIP.² The Centers for Medicare & Medicaid Services (CMS), which has primary responsibility for federal oversight of all three programs, is developing an estimate of the incidence of fraud for some Medicare services; that estimate is expected to be available soon.

1. Although not specifically mentioned in this report, similar issues arise with respect to the health care programs of the Department of Veterans Affairs and the military. Health insurance provided through the Federal Employees Health Benefits program or purchased through the health exchanges created by the Affordable Care Act is different in that the government pays some or all of the premiums rather than paying for the direct provision of care. Other than discussing certain components of the Medicare program—Part C (private managed care) and Part D (the outpatient prescription drug program)—this report does not address the issues arising from programs in which the government is solely subsidizing premiums.

2. Testimony of Kathleen M. King, Director, Health Care, and Kay L. Daly, Director, Financial Management and Assurance, Government Accountability Office, before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security of the Senate Committee on Homeland Security and Governmental Affairs, *Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, GAO-11-409T (March 9, 2011), www.gao.gov/products/GAO-11-409T.

How Extensive Are Current Efforts to Combat Fraud in Health Care Programs?

The federal government—primarily the Department of Health and Human Services (HHS), CMS (an agency within HHS), and the Department of Justice (DOJ)—has considerable flexibility in setting priorities and taking action to reduce fraud, but funding for antifraud activities is limited. In fiscal year 2014, spending on dedicated antifraud activities through the Health Care Fraud and Abuse Control (HCFAC) program was about \$1.4 billion, equal to about 0.2 percent of the federal government’s spending for the programs’ benefits.

In addition, HHS and DOJ have formed the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to make preventing fraud a cabinet-level priority. Task forces drawn from multiple federal agencies have focused on reducing fraud in cities where it has been prevalent, including Chicago, Dallas, and Miami. According to HHS, since 2009 the HEAT Medicare task force has filed criminal and civil charges against more than 1,700 defendants who falsely billed the Medicare program for more than \$5.5 billion.³

What Factors Affect CBO’s Estimates of the Budgetary Effects of Antifraud Legislation?

In general, CBO estimates that federal spending for the programs’ benefits would be reduced by legislation that would provide either additional funding or new authority to reduce fraud. Most proposals fall into one of four broad categories (see Table 1):

- Appropriating additional funds for antifraud activities;
- Making statutory changes that give federal agencies additional antifraud authorities or that redefine or clarify permissible practices, services, or behaviors in Medicare, Medicaid, and CHIP;
- Requiring agencies to undertake activities aimed at reducing fraud, some of which may already be authorized under current law, with or without additional funding; and
- Increasing penalties for violations of applicable law.

3. Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (February 2014), <http://go.usa.gov/5mvG> (PDF, 933 KB).

Legislation designed to reduce fraud can have spillover effects and also reduce waste and abuse. Antifraud proposals are often referred to as “program integrity” legislation, because they could reduce fraud, waste, and abuse, thus improving the accuracy of payments generally.

Appropriating Additional Funds. In its analyses of past proposals for providing additional funding for antifraud activities, CBO has estimated that such funding would yield savings that exceed the cost of carrying out those activities. For such estimates, CBO compares the proposed funding against its baseline (projected spending over the next 10 years) for HCFAC spending under current law and applies to the difference a return-on-investment factor of about 1.5:1 (that is, a dollar invested saves, on average, \$1.50). Under Congressional score-keeping guidelines, however, those estimated savings cannot be used to offset spending for purposes of overall budget enforcement—in other words, although the new investment would yield savings, the estimated savings do not “pay for” increased spending from those or other policies for the purpose of enforcing Congressional budget rules. Those rules were established in large part to avoid crediting uncertain potential savings as offsets against very certain up-front spending (in case the hoped-for savings did not materialize). Nevertheless, those savings, if realized, ultimately reduce federal budget deficits. Whenever possible, CBO provides information about such potential savings to lawmakers while legislation is under consideration.

Making Statutory Changes. CBO also analyzes legislative proposals to modify permissible practices and behaviors in Medicare, Medicaid, and CHIP. Because it is already illegal to defraud those programs, CBO looks at the scope of new authorities and requirements in proposed legislation and whether they would augment existing laws and regulations—for example, by expanding the universe of prohibited behaviors or by adding conditions for providers who wish to participate in the programs.

Mandating New or Additional Antifraud Activities. In analyzing proposals to mandate new or additional antifraud activities, CBO considers whether the federal government could undertake the activity under its current authority. Proposals might reduce spending for health care programs if they direct resources away from less effective antifraud activities or if they include funding for new activities that would save more than they cost.

Table 1.

CBO’s Estimating Approach for Program Integrity Proposals

Elements of Proposal	Could the Antifraud Proposal, By Itself, Result in Net Savings?	Would Any Net Savings Be Counted for Enforcing Budget Rules? ^a
Gives the government additional funding, whether mandatory or discretionary, for program integrity activities	Yes	No
Changes program policy to redefine permissible activities or expands the agency’s authority	Yes	Yes
Requires the government to undertake activities that are permitted under existing authority—		
With additional funding	Yes, depending on the amount of funding	Yes
Without additional funding	Depends on the proposal	Yes
Increases penalties for fraudulent behavior	Yes, increased revenues from monetary penalties, but savings from reduction in fraud less likely	Yes

Source: Congressional Budget Office.

a. A “no” entry means that the potential savings from the antifraud proposal cannot be counted for enforcing Congressional budget rules; a “yes” entry means that the savings can be counted for such purposes and thus can be used as an offset to an increase in spending from other provisions in the same legislation when enforcing budget rules.

Conversely, CBO might conclude that the newly required activity would displace other actions that are more effective at reducing fraud; if so, requiring new program integrity activities might increase, rather than decrease, federal spending.

Increasing Penalties. In assessing proposals to increase penalties, CBO considers how the proposed change in penalties would affect the expected costs (both monetary and nonmonetary) for individuals or businesses that commit fraud. In the past, CBO has estimated that the increase in expected costs from proposed changes in penalties for those inclined to commit fraud would have been too small to serve as a discernible deterrent to illegal behavior. Such policies, however, would probably yield increased revenues from the collection of larger financial penalties. With respect to nonmonetary penalties (such as jail time and prohibitions on serving Medicare beneficiaries), CBO evaluates, among other factors, the likelihood that the penalty would be enforced. In legislation CBO has analyzed, the monetary and nonmonetary penalties are often set at the discretion of legal authorities or

executive branch officials, reducing the likelihood that they would serve as an effective deterrent.

Fraud and Other Improper Payments

GAO has defined fraud as consisting of “intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain.”⁴ That definition includes two important concepts: intention—that is, willful action, not mistakes; and inappropriate gain, or a benefit to which one is not entitled.

In its assessment of health care fraud, the Federal Bureau of Investigation includes the following as examples of possible fraud: billing for services not rendered, “upcoding” services or items, making duplicate claims, unbundling packaged services or items, providing excessive or medically unnecessary services, and issuing

4. Testimony of King and Daly, *Medicare and Medicaid Fraud, Waste, and Abuse: Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments*, www.gao.gov/products/GAO-11-409T.

kickbacks.⁵ Because fraud generally requires intent, a provider or beneficiary must knowingly and deliberately commit those acts to be convicted of fraud.

It is unambiguously illegal to defraud Medicare, Medicaid, or CHIP. However, it can be difficult and time-consuming to recover payments stemming from fraud because whether fraud has been committed is a legal determination that requires proof of intent as well as evidence of inappropriate gain. Recovering all payments lost to fraud may not even be possible—providers can move or change the name of a business to avoid prosecution, for example, or be unable to make restitution even if successfully prosecuted. In some cases, the cost of pursuing and prosecuting fraud may exceed the losses from fraudulent claims.

A payment resulting from fraud is a type of improper payment, which also encompasses payments in incorrect amounts or to the wrong person, duplicate payments, and those that do not include credit for applicable discounts or are used by the recipient for an improper purpose.⁶ The universe of improper payments is broad. Improper payments can result from fraud, waste, or abuse, but they also can arise from simple human error, such as a typographical error in paperwork. GAO describes waste and abuse this way: “Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business practices or medical practices.”

It may not be clear whether a given payment is improper, and if it is, whether it is the result of fraud, waste, or abuse. For example, it may be difficult to distinguish between a provider making an honest mistake and a provider acting with intent to bill the government fraudulently, especially because whether fraud has been committed can be established absolutely only after resolution of a criminal or civil case. Improper payments also can result from a lack of appropriate paperwork or documentation (for example, neglecting to include a patient’s Medicare identification number on a claim), in which

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5. “Upcoding” is billing for a more complicated diagnosis than the patient actually has or for a more costly procedure than is actually performed. A kickback is an inducement, usually financial, given to a provider or beneficiary for choosing a specific service or item.
 6. As defined in the Improper Payments Information Act of 2002 (Public Law 107-300). That law was amended by the Improper Payments Elimination and Recovery Act of 2010, P.L. 111-204, Stat. 2227. The statutory definition of fraud is at 31 U.S.C §3321 note.

case the criteria for payment have not been met even if the underlying medical service was both reasonable and necessary. (See Box 1 for further discussion of the different types of improper payments and Box 2 for a discussion of fraud in private health insurance.)

Some waste does not represent improper payments. That kind of waste may arise from a lack of knowledge about the best way to treat a given condition in a specific person (perhaps leading to tests or procedures that are not absolutely necessary but do not cause harm), either because the state of medical knowledge is imperfect or because some particular consideration makes evaluating alternative treatment options difficult.⁷

The Extent of Fraud and Other Improper Payments in Federal Health Care Programs

GAO has assessed the Administration’s efforts to prevent fraud in the Medicare program (as well as in other government programs). It concluded the following:

Although there have been convictions for multimillion-dollar schemes that defrauded the Medicare program, the extent of the problem is unknown. There are no reliable estimates of the extent of fraud in the Medicare program or for the health care industry as a whole. By its very nature, fraud is difficult to detect, as those involved are engaged in intentional deception. Although the full extent of the problem is unknown, it is clear that, as one of the largest programs in the federal government, the Medicare program is vulnerable to fraud, contributing to its fiscal problems.⁸

The amount of fraudulent payments *recovered* in Medicare, Medicaid, and CHIP *can* be measured. According to a report from HHS and DOJ, individuals

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7. For a longer discussion of that sort of waste, see Nicole Cafarella Lallemand, *Reducing Waste in Health Care*, Health Affairs Health Policy Brief (December 13, 2012), <http://tinyurl.com/am2wtxu>.
 8. Testimony of Kathleen M. King, Director, Health Care, Government Accountability Office, before the Subcommittee on Health of the House Committee on Ways and Means, *Medicare: Progress Made, but More Action Needed to Address Medicare Waste, Fraud, and Abuse*, GAO-14-560T (April 30, 2014), www.gao.gov/products/GAO-14-560T. Other analysts and organizations have estimated that fraud accounts for between 3 percent and 10 percent of spending on health care, but the methodology underlying those estimates is not known.

Box 1.**Improper Payments**

Several types of improper payments are possible in government health care programs. For example, in the Medicare program, there are different payment codes for mammography services, depending on the circumstances and the extent of testing. Screening mammograms are for people who do not have any symptoms; they are recommended for women between the ages of 50 and 74 every other year to look for evidence of disease. Diagnostic mammograms are for men and women who have signs of disease. There are separate codes for each type of mammogram and payments differ.

If a Medicare beneficiary receives a diagnostic mammogram of one breast, the radiologist should put code 77055 on the Medicare claim form. If, instead, the provider makes a mistake and writes 77056 (which indicates a diagnostic mammogram of two breasts), and then receives payment based on code 77056, that would be an *improper payment*. It would not be fraudulent and could be corrected by adjusting future payments to the provider (in this case,

downward). Under the Government Accountability Office's definition, such a mistake would be considered waste, but not fraud or abuse.

However, if the radiologist submitted a claim but never provided a mammogram at all, that would probably be *fraud* and thus subject to civil or criminal penalties. It also would be fraud if the radiologist deliberately wrote the code 77056 when he or she should have written 77055. *Abuse* could occur if the physician ordered significantly more frequent mammograms—for example, four a year—without symptoms or other reasons for more frequent testing (for example, if there was no family history of disease and all tests to date were normal), contradicting screening recommendations. It would be *waste* if that same patient received two mammograms because two different doctors ordered one, each not knowing of the other's order. (This scenario of two mammograms would probably not be considered an improper payment according to the statutory definition because there is no duplicate payment to a single individual.)

and businesses repaid just over \$4 billion to the government during 2013 in restitution and penalties for fraud, much of which represents recoupment from past activities. Since 1997, the government has recouped about \$26 billion in such payments (or 0.3 percent of the approximately \$9 trillion spent for those programs over the 1997–2013 period).⁹ The return to the federal government and states should be considered only a partial measure of the effectiveness of the investment in anti-fraud activities, however, because it represents only the money repaid, not fraud that has been deterred.

CBO has not estimated the amount of fraud that has occurred in Medicare, Medicaid, or CHIP, nor has the agency found a reliable method for projecting the amount of future spending on fraudulent services (in other words, establishing a “baseline” of fraudulent

spending). The amount recovered is not a good indicator of the prevalence of fraud because the amount of a settlement or recovery may be only a fraction of the prosecuted wrongdoing and because recoveries do not account for fraud that goes undetected. (See below for further discussion of CBO's approach to estimating the effects of additional antifraud spending.)

In the broader category of improper payments, HHS estimates the amount of such payments for Medicare, Medicaid, and CHIP.¹⁰ In 2013, improper payments, including underpayments and overpayments, were estimated to account for the following percentages of the federal government's payments:¹¹

9. Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (February 2014), <http://go.usa.gov/5mvG> (PDF, 933 KB).

10. The Office of Management and Budget provides specific guidance to federal agencies on appropriate methodologies for estimating their rates of improper payments. See Office of Management and Budget, “Issuance of Appendix C to OMB Circular A-123” (August 10, 2006), <http://go.usa.gov/5mvz> (PDF, 237 KB).

11. Medicaid and CHIP are funded jointly by the states; the error rate is for federal payments only.

Box 2.**Fraud in Private Health Insurance**

Private health insurance also is vulnerable to fraud. The type of fraud may differ from that which occurs in government health care programs (such as Medicare, Medicaid, and the Children's Health Insurance Program), however, because of differences in the way that private health insurance operates. For example, private payers tend to rely much more on prior authorization and prepayment review of covered services, giving them an opportunity to prevent fraud that is generally less available in government health care programs. Private payers are also more likely to contract with specific providers—unlike the

Medicare fee-for-service program, which generally accepts all providers that wish to participate.

Private health plans may themselves engage in fraudulent activities, perpetrating fraud against those who purchase the insurance. In one case, for example, a major health insurance company was found to have manipulated prices so that plan members paid more than their contracted cost-sharing amount.¹

1. *AMA v. United Healthcare Corporation*, 2009 U.S. Dist. LEXIS 45610 (S.D.N.Y., May 7, 2009).

- Medicare, 9.3 percent (or about \$50 billion),
- Medicaid, 5.8 percent (or about \$14 billion), and
- CHIP, 7.1 percent (or about \$0.6 billion).¹²

Almost all of those improper payments are overpayments, which account for roughly 92 percent of known improper payments in Medicare, almost 98 percent of such payments in Medicaid, and approximately 96 percent of such payments in CHIP.¹³

Those percentages and dollar amounts are *not* HHS's (or CBO's) estimates of how much fraud occurs in Medicare, Medicaid, or CHIP. In fact, with respect to Medicare, HHS specifically cautions against citing the improper payment rate as a measure of fraud, noting that the methodology used to calculate that rate is not designed to measure the amount of fraud.¹⁴ Improper payments include many payments that are not fraudulent—for example, some for which the paperwork was incorrect, although the service itself was proper—and does not include undetected fraud.

12. Data are from Payment Accuracy, "High-Error Programs," www.paymentaccuracy.gov/high-priority-programs. The Medicare error rate used above is the sum of the dollar amount of improper payments for three programs—fee-for-service Medicare, Medicare Advantage, and Medicare Part D (the outpatient drug benefit)—divided by total payments.

13. For more information on the error rates for specific health care programs and how they are calculated, see Department of Health and Human Services, *FY 2013 Agency Financial Report* (December 2013), <http://go.usa.gov/5mwC> (PDF, 3.9 MB).

Efforts to Combat Fraud

The task of preventing and addressing fraud in Medicare, Medicaid, and CHIP rests primarily with the Centers for Medicare & Medicaid Services, the agency responsible for administering the programs. CMS's efforts range from screening providers that want to participate in Medicare and suspending payments when there is evidence of fraud to revoking providers' billing privileges and referring cases to law enforcement authorities. Other agencies involved in preventing fraud in Medicare, Medicaid, and CHIP are the Department of Health and Human Services (of which CMS is a part), the HHS Office of Inspector General (OIG), and the Department of Justice. Because Medicaid and CHIP are jointly funded by the federal government and the states, the federal government usually realizes only a portion of recoveries from fraud settlements pertaining to those programs.

An important component of the federal government's antifraud efforts in Medicare, Medicaid, and CHIP is the Health Care Fraud and Abuse Control program. Through HCFAC, dedicated federal funding is available

14. If CMS finds a questionable payment in its sample of claims when calculating the improper payment rate, it does not review other claims from the same provider to look for additional improper payments or for patterns that might indicate fraud. Instead, certain CMS contractors, particularly Zone Program Integrity Contractors, are responsible for detecting possible fraud. For more information on the calculation of the improper payment rate, see Centers for Medicare & Medicaid Services, *Medicare Fee-for-Service 2012 Improper Payments Report* (September 2013), <http://go.usa.gov/wSKP> (PDF, 991 KB).

to prevent health care fraud (as well as the related issues of waste and abuse); approximately \$1.4 billion was spent in fiscal year 2014 to support activities of HHS, DOJ, and other agencies that reduce fraud and other improper payments. Part of HCFAC's annual funding is mandatory (that is, not subject to annual appropriation); it rises automatically with inflation. Over the past several years, lawmakers have provided an average of \$300 million per year in additional funding through annual appropriations for the program. HCFAC funding supports a broad range of activities, such as reviewing claims before and after payment to verify medical necessity, integrating data and analysis within CMS, and pursuing criminal investigations.¹⁵

In 2009, HHS and DOJ formed the Health Care Fraud Prevention and Enforcement Action Team to make preventing fraud a cabinet-level priority. Part of the HEAT initiative is to assemble task forces drawn from multiple federal agencies that focus on reducing fraud in cities where it has been prevalent, including Chicago, Dallas, and Miami. According to HHS, since 2009 the HEAT Medicare task force has filed criminal and civil charges against more than 1,700 defendants that have falsely billed the Medicare program for more than \$5.5 billion.¹⁶ HHS and CMS also have begun working with private payers and other entities to share information and best practices. Among the participants are health insurers, state Medicaid programs, and trade associations.¹⁷

In addition, since 2010, CMS has increased its use of data analytics to facilitate more prepayment review of claims to prevent fraud before payment occurs. According to CMS, its Fraud Prevention System analyzes all Medicare fee-for-service claims before payment, allowing CMS to promptly address suspected fraud. CMS targets resources to specific types of claims and providers, and the Fraud Prevention System prioritizes

the most troubling or problematic claims and billing activities.¹⁸

Factors Affecting CBO's Cost Estimates for Antifraud Legislation

Legislative proposals to reduce fraud may take a number of different approaches. Proposals might aim to reduce the occurrence of fraud by changing the scope of permissible and impermissible activities (for example, by tightening the conditions under which Medicaid will pay for a service) or by increasing the probability that fraud will be detected (for example, by dedicating additional resources to antifraud activities). Proposals designed to prevent fraud might also do so by changing the associated penalties—both monetary and nonmonetary—for those who commit it.

In CBO's estimation, prohibiting certain activities or increasing the probability of detection are approaches that are generally more effective than are policies that seek to prevent fraud through increased penalties. Nevertheless, monetary penalties will generally result in additional revenues and thus contribute to deficit reduction.

When estimating the budgetary effects of legislation to combat fraud, CBO considers several factors:

- The amount of additional antifraud funds,
- The extent of the new authority provided to agencies or new policies designed to lessen fraud,
- The effect on agencies' ability to allocate resources to antifraud activities with a high rate of return and whether additional funding would be made available to support new activities as well as ongoing initiatives, and
- The effect of penalties on the incidence of fraud and the amount of any new penalties that might be collected.

15. HCFAC funds are allocated among DOJ, CMS, and several agencies within HHS (including OIG).

16. Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (February 2014), <http://go.usa.gov/5mvG> (PDF, 933 KB).

17. For more on HHS's antifraud activities, see Department of Health and Human Services and Department of Justice, "Stop Medicare Fraud," www.stopmedicarefraud.gov; Department of Health and Human Services, Office of Inspector General, "Fraud," <http://oig.hhs.gov/fraud/>; and Centers for Medicare & Medicaid Services, Center for Program Integrity, <http://go.usa.gov/5mwW>.

18. Testimony of Peter Budetti, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, before the Subcommittee on Health of the House Committee on Energy and Commerce, *Fostering Innovation to Fight Waste, Fraud, and Abuse in Health Care* (February 27, 2013), <http://go.usa.gov/5mwR> (PDF, 231 KB).

Table 2.**Sample Estimate of the Effect of Additional Funding for Program Integrity Activities**

Millions of Dollars, by Fiscal Year

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Total, 2015- 2024
Change in Budget Authority	100	0	0	0	0	0	0	0	0	0	100
Change in Outlays	80	10	10	0	0	0	0	0	0	0	100
Memorandum:											
Nonscorable Change in Outlays ^a	-30	-34	-37	-37	-8	-4	0	0	0	0	-150

Source: Congressional Budget Office.

Note: Budget authority is authority provided by law to enter into obligations that will result in outlays of federal funds. Outlays are payments made to liquidate obligations. The table reflects the assumption that funding will be spent over three years and that the return on investment is \$1.50 for every dollar spent, with savings accruing over four years.

a. Change in the deficit; not counted for budget enforcement purposes.

Amount of Funds Provided

The Budget Control Act of 2011 (Public Law 112-25), which imposed caps on discretionary funding in 2013 and subsequent years, allows for adjustments to those caps for purposes of increasing discretionary spending on program integrity activities. (In other words, legislation can provide a certain amount of additional appropriated funds in excess of the caps if the additional funding is for program integrity activities.) That provision applies to the HCFAC program and to continuing disability reviews in the Social Security Disability Insurance program. Additional funding also could be provided in the form of direct spending authority enacted in authorizing legislation, which would not be subject to the caps.

CBO expects that increased funding for antifraud activities through the HCFAC program would result in reductions in direct spending for health care that exceed the amount invested; that return on investment would generally be realized over several years.¹⁹ (Direct spending occurs without action by the appropriations committees.) Because of budgetary guidelines used by the Congress, however, those reductions cannot be counted as decreases in direct spending for budget enforcement purposes. In other words, the reductions cannot be counted as an

offset to other spending for the purpose of enforcing budget rules and thus are referred to as nonscorable (see Box 3). (Those rules were adopted largely to avoid using uncertain potential savings as an offset to up-front spending.) Even though the reduction in spending does not count for budget enforcement purposes, to the extent that it was realized, it would contribute to overall deficit reduction.

CBO's approach to estimating such nonscorable effects involves comparing the proposed funding for program integrity activities against CBO's baseline for HCFAC spending under current law and applying to the difference a return-on-investment factor of about 1.5:1. CBO's estimate of that return on additional investments is similar to previous estimates by the Office of the Actuary at CMS for funding increases proposed in the President's budget, and it reflects CBO's judgment about the average expected return on additional investments, accounting for variation among the antifraud activities supported by HCFAC funding.

As an illustration, consider the effect of legislation that would increase funding for the HCFAC program by \$100 million relative to CBO's baseline (see Table 2).²⁰

19. To the extent that federal funds for program integrity activities are used in ways that reduce spending on health care benefits that are jointly financed by the federal government and the states, the return on investment realized by the federal government would be lower, and it might not exceed the amount invested in program management activities.

20. In this illustrative example, legislation would provide additional funding in the form of new direct spending authority. If legislation instead *authorized* future additional appropriations, CBO would estimate the effect in the same way but would note that the estimate reflects the assumption that the authorized amount would be appropriated.

Box 3.**Budgetary Scorekeeping Guidelines**

Congressional scorekeeping guidelines govern which changes in direct spending can be counted in determining the extent to which—for enforcement of budget rules—provisions in a bill would increase or reduce deficits. Those guidelines apply to all programs in the federal budget, and two are particularly relevant to the Congressional Budget Office’s (CBO’s) cost estimates for program integrity legislation.¹ First, scorekeeping rule 3 states the following:

Entitlements and other mandatory programs (including offsetting receipts) will be scored at current law levels ... unless Congressional action modifies the authorizing legislation.

In other words, even though additional discretionary appropriations for antifraud activities in a mandatory program might lead to budgetary savings (from reduced spending in the program), such savings are not counted as reductions in spending for the purpose of enforcing budget rules.

Scorekeeping rule 14 states this:

No increase in receipts or decrease in direct spending will be scored as a result of provisions of a law that provides direct spending for

administrative or program management activities.

Rule 14 prohibits the counting of budgetary savings as a result of providing funding in authorizing legislation for administrative or program management activities, including antifraud efforts.

Under those scorekeeping guidelines, additional funding for program integrity activities, whether mandatory or discretionary, does not yield “scorable” savings that can be used to offset other spending for budget enforcement purposes. Those rules were established in large part to avoid crediting uncertain potential savings as an offset against very certain up-front spending (in case the hoped-for savings did not materialize). It should be noted that rule 14 is asymmetric: Offsetting *savings* from an *increase* in program integrity funding are not scorable, but *costs* from a *reduction* in program integrity funding are scorable.

In its cost estimates, CBO provides estimates of overall deficit reduction—scorable and nonscorable savings—from increased funding for program integrity activities. In those estimates, nonscorable effects are usually shown as a memorandum item at the bottom of the table (see Table 2 for an illustration).²

1. Those budget scorekeeping guidelines were published in the *Conference Report to the Balanced Budget Act of 1997* (pp. 1007–1014 of H. Rept. 105-217, which became Public Law 105-33). They are used by the House and Senate Budget Committees, CBO, and the Office of Management and Budget to ensure that the budgetary effects of legislation are measured using specified and consistent scorekeeping conventions.

2. See, for example, Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010), Table 5, p. 11, www.cbo.gov/publication/21351.

In this example, CBO estimates that it would take CMS three years to spend the added funds, with most (\$80 million) spent in the first year. The additional funding would yield estimated savings of \$150 million, which would accrue over six years. Those savings would be identified in CBO’s cost estimate but would not count for the purpose of enforcing budget rules.

The Administration has published estimates of returns from the HCFAC program that differ from the factor that CBO uses. In the *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013*, HHS and DOJ estimate a return on investment of 5.40:1 (that is, \$5.40 returned for every dollar invested) since 1997 for the HCFAC program’s activities aimed at preventing fraud and abuse. The report also includes a three-year

average (2011–2013) return on investment of \$8.10 per dollar invested.²¹

The difference between the returns estimated by HHS and included in the HCFAC report and CBO’s estimated returns stems from the fact that CBO is estimating the *marginal* return on *new* investment—that is, the savings from each *additional* dollar, not the savings returned from all HCFAC spending in a given year or over time. In contrast, the Administration’s estimated return on investment is the result of dividing fraud recoveries in specific years (which will include recoveries resulting from activities in prior years) by the HCFAC appropriation for those years.²² The estimated return on additional funding is smaller than the average return over time because most of the initial funding is presumably directed to the activities believed to have the highest return on investment, and thus additional funding is probably directed toward activities of lower or less certain value.

CBO expects that a significant increase in funding might lead to savings of less than \$1.50 per dollar of added funding, for several reasons. First, CBO projects that the marginal return on each additional dollar diminishes as total funding increases. In fact, the marginal return on a very large amount of additional funding might fall below \$1 per dollar invested, in which case the spending could exceed the savings from the investment. Second, CMS could have difficulty spending a great deal of additional funding in a short time, in part because there are restrictions on how HCFAC funding may be used (for example, CMS is required to allocate some funding to DOJ and the Federal Bureau of Investigation in addition to supporting its own initiatives and tasks).²³ If HCFAC funding was increased significantly, CBO would probably reduce its estimate of the rate at which CMS would spend

the money, at least in the near term, and might even determine that some funding would not be used during the period for which it was available. If some money went unspent, the savings would be proportionately less than CBO currently estimates for additional HCFAC funding. Over time, CMS might be able to increase the rate at which it could spend additional HCFAC funds, particularly if some of the existing restrictions on the use of funds were lifted.

Extent of New Authority and New Rules

Legislation could grant the federal government or state governments specific new authority to reduce fraud or establish new policies to minimize fraud in Medicare, Medicaid, and CHIP. If proposed legislation would give an agency additional authority or would mandate policy changes to reduce the occurrence of fraud, CBO would analyze such legislation and its effects on spending by considering several elements: whether any new authority would be implemented, and if so, how and when; the effects of any prior, similar legislation; and findings from GAO and HHS that indicated the extent of the particular type of fraudulent activity the legislation was addressing. Such an analysis would consider, for example, the current amount of spending on a type of provider or service, the prevalence of the activity that would be prohibited or restricted, and how quickly and effectively CMS could implement the changed policy. (For an example of the estimated budgetary effects of a new rule enacted in recent legislation, see the discussion about the Affordable Care Act in Box 4.)

CBO analyzes proposed legislation in the context of the existing statutory and regulatory framework, which is supported by dedicated federal funding and already explicitly prohibits fraud. (For a more detailed description of the existing framework, see the appendix to this report.) Thus, savings would not result from legislation that merely restated current prohibitions against fraud. Potential savings also may be limited because the barriers to significant further reductions in fraud are probably not primarily statutory or regulatory but rather stem from the difficulty in detecting and prosecuting fraud and from the challenge of using finite resources efficiently while also fulfilling other duties. Moreover, intensive fraud detection efforts might result in false allegations or create administrative burdens, which could make the programs less efficient for (and less attractive to) providers and beneficiaries.

21. The \$5.40 figure reflects HHS’s and DOJ’s statement that the 2011–2013 estimated return on investment of \$8.10 for every dollar invested is \$2.70 higher than the return on investment since the program’s inception in 1997. See Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (February 2014), <http://go.usa.gov/5mvG> (PDF, 933 KB).

22. *Ibid.*, “Appendix.”

23. On the basis of spending patterns over the past few years, CBO has tapered its estimate of the rate at which HCFAC funding is spent, anticipating that it now takes three years, rather than two years, to spend each year’s funding. CBO’s revision of the rate of spending coincided with a marked increase in HCFAC funding.

Effects on the Allocation of Resources Among Antifraud Activities

Through HCFAC and the agency's program management funding, CMS has relatively broad authority but finite resources for antifraud activities. The amount of resources that CMS can allocate to antifraud efforts is limited because laws and regulations already mandate numerous activities for the agency—from paying claims and educating providers to writing regulations and negotiating contracts with third parties, such as insurers—so that Medicare, Medicaid, and CHIP can operate. Because CMS's resources are finite, the agency cannot undertake every possible antifraud activity; limited funding requires the agency to make choices and set priorities. For example, CMS has chosen to develop an estimate of the amount of fraud among providers of home health care, rather than other types of providers. Recent studies and reports suggest that home health care has been particularly vulnerable to fraud in recent years. Because the agency must make choices, an important part of CBO's analysis of antifraud proposals is a comparison of the proposed new efforts with the antifraud activities anticipated under current law based on the antifraud authorities and resources already available.

CBO's analysis, which depends on the specifics of each proposal, starts from the general presumption that, all else being equal, CMS allocates its limited antifraud resources (that is, those resources that are not already required for other activities) to activities allowed under its current legal authority that, on average, have a better return on investment than would be realized if the agency spent those resources on other program integrity activities permitted, but not used, under current law. This does *not* mean that CBO assumes that every dollar is spent optimally, only that, across the range of its activities, CMS uses its limited resources in the ways that will result in a better average return than would be realized from other permitted, but not used, program integrity activities.

Beyond that starting point, CBO's analysis considers several other factors:

- *The authority already available to CMS.* CBO reviews the relevant laws and regulations to understand how significantly a bill would change CMS's authority. In particular, CBO analyzes the flexibility available to the agency, under both current law and the proposed legislation, and how prescriptive a bill might be in defining the new activity.
- *The strength of the evidence with respect to current program vulnerabilities and how CMS has addressed them thus far.* In this regard, reports from GAO and the HHS Office of Inspector General, among other sources, are often useful for identifying the scope of a given problem and the effect of any previous actions taken by the agency.
- *The technical feasibility of an activity.* CBO's analysis considers CMS's current data and management infrastructure and whether a proposal would require any sort of technology or process that the agency does not yet use and, if so, what resources would be required to develop the necessary capacity. CBO also takes into account the possibility that a proposal could initially increase costs but then reduce them as a given technology matures or as CMS's internal systems adapt to technological or structural changes.
- *The expected costs and benefits.* Some activities might have a high potential reward—by eliminating a significant amount of fraud—but also a high potential cost. If CMS's resources are insufficient for the investment, then pursuing it might be ineffective. In addition, if stakeholders can easily avoid compliance with a new policy, the benefits might be difficult to achieve and CBO would probably reduce its estimate of any savings.

Although each analysis is different and unique to the specific proposal, CBO has previously drawn one of two basic conclusions about proposals that focus on expanding CMS's required antifraud activities:

- CBO would probably ascribe savings to proposals that would direct CMS to *replace* an activity of low value with one that clearly seemed to have higher value. For example, in June 2012, the Office of Inspector General at HHS testified that two current audit programs designed to reduce Medicaid fraud are not efficient and actually entail costs that exceed the savings.²⁴ If legislation directed CMS to conduct those audits differently, CBO might conclude that the

24. See the testimony of Ann Maxwell, Regional Inspector General for Evaluation and Inspections, Office of the Inspector General, Department of Health and Human Services, before the Subcommittee on Federal Financial Management of the Senate Committee on Homeland Security and Governmental Affairs (June 14, 2012).

Box 4.**Cost Estimates for Antifraud Provisions**

In recent years, the Congressional Budget Office (CBO) has published estimates of the costs of program integrity provisions in the Affordable Care Act and the Budget Control Act of 2011.

The Affordable Care Act

The Affordable Care Act includes several provisions designed to reduce fraud, waste, and abuse in Medicare, Medicaid, and the Children's Health Insurance Program.¹ In total, CBO estimated that those provisions would result in about \$6 billion of "scorable" savings (that is, they would offset other spending for budget enforcement purposes) over 10 years. In addition, CBO estimated that the legislation would generate just over \$2 billion of "non-scorable" savings (which would not offset other spending for budget enforcement purposes) from increased funding for program integrity activities.²

One provision to which CBO attributed savings imposes new requirements on facilities that participate in Medicare and Medicaid as community mental health centers (CMHCs), which are freestanding facilities that offer a range of services (generally known as partial hospitalization) to people with serious mental illnesses. Those services are meant to substitute for more costly inpatient hospitalization. In a 2009 report, the Office of Inspector General (OIG) of the Department of Health and Human Services estimated that as much as 92 percent of payments for partial hospitalization in CMHCs was improper—that is, about 92 percent of the government's spending on CMHCs should not have occurred—although not all of those payments were the result of fraud.³ The Affordable Care Act mandated that facilities wishing to participate in Medicare as CMHCs must meet a new

1. As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions. The sections referred to in this paragraph are subtitles E and F of the Patient Protection and Affordable Care Act and sections 1301–1305 of the Health Care and Education Reconciliation Act.

2. See Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (March 20, 2010), www.cbo.gov/publication/21351.

3. Department of Health and Human Services, *Compendium of Unimplemented Office of Inspector General Recommendations* (May 2009), <http://go.usa.gov/5mGY> (PDF, 3.3 MB). According to one report on CMHCs, the reasons that expenditures were "unallowable or otherwise highly questionable" included ineligible beneficiaries and services that were neither reasonable nor necessary.

Continued

modifications would save money by substituting an activity with a higher average value for one with a lower average value.²⁵ Such savings would be counted for budget enforcement purposes.

- In contrast, if legislation mandated—without sufficient additional funding—a new enforcement activity of uncertain value that CMS could undertake within its authority under current law, CBO might

estimate that the legislation would have no budgetary effect or could increase costs because CMS might have to give up an activity of demonstrated value in favor of a new approach of uncertain value. Although CBO does not usually have any basis for determining which activities CMS might forgo to meet the new requirements, it would expect CMS to forgo some high-value activities and some activities of lesser value, possibly resulting in a lower average return on investment, leading to a net increase in costs.

25. CBO's analysis would be similar for legislation that involved an antifraud activity to be undertaken by states for Medicaid and CHIP.

Under Congressional scorekeeping rules governing the consideration of legislation that would affect the federal

Box 4.**Continued****Cost Estimates for Antifraud Provisions**

requirement that only 60 percent of their patient population could comprise Medicare beneficiaries.¹ In CBO's judgment, that provision reduces the likelihood of fraud in those facilities because they will be required to serve a broader pool of clients than just Medicare beneficiaries—and bill a more diverse group of payers—and thus cannot rely solely on Medicare for their revenues.

Some existing CMHCs will be unable to meet the new requirement and thus will cease to participate in Medicare, CBO expects. The new requirement will also prevent some new CMHCs from opening and thus from billing Medicare and Medicaid. Some of those providers who withdraw from Medicare or never open may be fraudulent and others may be legitimate; CBO has no basis for distinguishing between the two. Because of the high estimated error rate in CMHC payments, CBO estimated that the savings from this provision will outweigh any cost from the use of more expensive services, such as inpatient care.² All told, CBO estimated that this

1. See section 1301 of the Health Care and Education Reconciliation Act.

2. On December 18, 2013, OIG released a report on CMHCs. The agency noted that, because of increased enforcement, Medicare payments to CMHCs have fallen from \$273 million in 2008 to \$31 million in 2012. See Office of Inspector General, "Spotlight on . . . Fighting Fraud at Community Mental Health Centers" (accessed October 14, 2014), <http://go.usa.gov/5mGB>.

new requirement will reduce spending for Medicare and Medicaid by more than \$500 million between 2010 and 2019.

The Budget Control Act of 2011

The Budget Control Act, which set caps on discretionary funding for the 2013–2021 period, did not appropriate funding for antifraud activities. It did, however, authorize funding above those caps for antifraud activities of the Health Care Fraud and Abuse Control (HCFAC) program.

Under the assumption that the authorized amounts in excess of the caps would be appropriated, CBO estimated that the additional HCFAC funding would result in outlays that were \$3.0 billion more than the amounts in CBO's baseline between 2013 and 2021, thereby yielding nonscorable savings of \$3.7 billion over that period.³ (If the \$3.7 billion in estimated savings was compared with the \$3.0 billion invested, it would seem to imply a return-on-investment factor lower than the 1.5:1 that CBO typically estimates. The reason for that discrepancy is that some savings from the investment would accrue after the 10-year period covered by CBO's cost estimate.)

3. See Congressional Budget Office, letter to the Honorable John A. Boehner and the Honorable Harry Reid, concerning CBO's analysis of the August 1 Budget Control Act (August 1, 2011), pp. 3–4, www.cbo.gov/publication/41626.

budget (see Box 3 on page 9), program savings from simply increasing funding for antifraud activities in general are not scorable, but savings or added costs that would result from a change in the nature of those activities are (even if additional funding is provided to pay for that change). Increased program costs that might result from cutting spending on antifraud activities or from replacing high-value antifraud activities with lower-value ones are scorable. Requiring a new antifraud activity without providing funding to pay for it could result in scorable savings or costs, depending on how effective the new

activity was judged to be, compared with those it would displace.

Effects of Penalties on the Occurrence of Fraud

Committing fraud in Medicare, Medicaid, or CHIP entails the possibility of incarceration, fines, and temporary or permanent exclusion from the programs. Despite those risks, individuals and businesses still choose to engage in illegal behavior. In 2011 testimony before the Congress, the Chief Counsel to HHS's Inspector General stated:

The perpetrators of these [health care fraud] schemes range from street criminals, who believe it is safer and more profitable to steal from Medicare than to traffic in illegal drugs, to Fortune 500 companies that pay kickbacks to physicians in return for referrals. . . . We are concerned that providers that engage in health care fraud may consider civil penalties and criminal fines a cost of doing business.²⁶

Individuals and businesses committing fraud in Medicare, Medicaid, and CHIP may have concluded that the size of possible penalties (potentially large), in light of the probability of being caught (potentially low, given the breadth of the programs and the number of participants), is still less than the gains to be realized from deliberately engaging in fraud. For example, in July 2012, one pharmaceutical company agreed to pay \$3 billion in fines to resolve charges about its marketing and pricing practices; the amount paid was just under 11 percent of the company's revenue from three drugs covered by the settlement.²⁷

Moreover, in some cases the penalties seem to be insufficient to prevent repeated misbehavior. In September 2010, a pharmaceutical company settled with the Justice Department over violations of the antikickback statute. As part of the settlement, the company agreed to implement a corporate compliance program and to pay more than \$400 million in fines. In April 2013, DOJ charged the same company with paying kickbacks to doctors in exchange for prescribing the company's products.²⁸

26. Testimony of Lewis Morris, Chief Counsel to the Inspector General, Department of Health and Human Services, before the Subcommittee on Oversight of the House Committee on Ways and Means (March 2, 2011), <http://go.usa.gov/5mf3> (PDF, 80 KB).

27. "Fine and Punishment: The Economics of Crime Suggests That Corporate Fines Should Be Even Higher," *Economist* (July 21, 2012), www.economist.com/node/21559315.

28. Department of Justice, "United States Files Complaint Against Novartis Pharmaceuticals Corp. for Allegedly Paying Kickbacks to Doctors in Exchange for Prescribing Its Drugs" (press release, April 26, 2013), <http://go.usa.gov/5mfT>, and "Novartis Pharmaceuticals Corp. to Pay More Than \$420 Million to Resolve Off-Label Promotion and Kickback Allegations" (press release, September 30, 2010), <http://go.usa.gov/wSEJ>.

For providers who submit fraudulent claims for durable medical equipment or home health care services, the returns may not be billions of dollars but may still exceed those available through legitimate business or other, riskier types of criminal activities. The returns may also be available more quickly: In general, CMS must pay Medicare claims within 30 days of receipt, so a provider of fraudulent services or items can realize gains, cease the illegal activity, and disappear before CMS or its contractors have any reason to suspect fraud. Discovering and prosecuting such fly-by-night providers may be especially challenging, and such individuals and entities may be especially untroubled by the prospect of penalties because they perceive that the risk of being caught is low.

The findings underlying recent CBO estimates of the effects of legislation that would increase the dollar amount of civil or criminal penalties for violations of antifraud provisions have been twofold: The agency has projected an increase in the size of monetary penalties (which are recorded in the budget as revenues and offset other spending) but has estimated that deterrent effects would not be discernible given the ranges of penalty increases in those proposals and the lack of any changes likely to increase the probability of detection. Most companies or individuals would probably see such penalties as a manageable cost of doing business and would decide that the certain benefit (that is, receiving federal payments or services) outweighs the uncertain and unlikely costs.

Of particular importance in CBO's estimates for anti-fraud proposals is whether the imposition of higher penalties is *required* or *authorized*. Under section 1128 of the Social Security Act, exclusion from federal health care programs (that is, prohibiting a person, people, or an entire company from providing services under Medicare, Medicaid, or CHIP) is mandatory for certain actions, including felony conviction for health care fraud. Exclusion is permitted, but not required, for other actions, including a misdemeanor fraud conviction, obstruction of an investigation, or failure to disclose required information.

CBO has analyzed proposals in which the penalty itself is enforced at the discretion of executive branch officials or legal authorities or the dollar amount is "not more than" or "up to" some amount. When legislation would grant the Secretary of HHS flexibility in assessing a penalty,

CBO's estimates consider the probability that some penalties will be less than the maximum.²⁹

For example, under the law, the Secretary could exclude the drug company cited above from participating in federal health care programs as a result of the actions that led to its \$3 billion settlement with DOJ. Doing so, however, would require that none of that company's products be available to any of the millions of people covered by Medicare, Medicaid, or CHIP. The disruption to patient care, with potentially serious consequences, makes the likelihood of such a penalty quite small.³⁰

The government can exclude, and has excluded, individuals from its programs as a consequence of a company's behavior, but that action has been relatively rare.³¹ Given the possibly serious effects on people's health and health care, the government may prefer to enter into an agreement with the company or individual under which the government monitors the entity's activities and ensures

29. The Administration's 2014 budget included a proposal to allow the assessment of civil monetary penalties against providers that failed to update enrollment records. There was no legislative language associated with that proposal; nevertheless, based on the brief description and CBO's judgment that the fines were not required, CBO estimated that the proposal would result in a small increase in collected penalties but would have no deterrent effect. For example, see Congressional Budget Office, "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2014 Budget" (May 17, 2013), <http://go.usa.gov/5mf9> (PDF, 118 KB).

For an estimate of the effects of legislation to exclude providers from participating in Medicare, see Congressional Budget Office, cost estimate for H.R. 6130, the Strengthening Medicare Anti-Fraud Measures Act of 2010, as introduced on September 15, 2010 (September 22, 2010), www.cbo.gov/publication/21844.

30. In one recent case, the federal government excluded a company from participating in Medicare and Medicaid. Shortly thereafter, the firm sold itself to its corporate parent company. The government agreed not to prosecute the parent company.

compliance with the law while preserving access to needed services or products.³² In addition, exclusion from Medicare, Medicaid, or CHIP is probably not a deterrent for a provider or supplier with no interest in legitimate long-term participation in the programs. It also may be easier for the government to exclude single providers or small groups of providers because the size and structure of a large corporation may make it difficult to identify precisely who has engaged in prohibited behavior and who should be held responsible. For example, if the government finds that a drug company's salesperson has paid kickbacks to a physician, the Office of Inspector General could implement a range of possible exclusions, from the individual salesperson to a manager or the chief executive. OIG would not face such complexities when penalizing fraud by a one- or two-person enterprise.

Legislation could impose financial penalties of such magnitude that CBO would conclude that the fines would deter a significant amount of fraud; in that case, CBO would estimate a reduction in outlays for the programs involved.³³ CBO would probably anticipate that penalties that were mandatory and specific would be more effective in deterring fraud than any that were not.

31. See Ruskin Moscou Faltischek, White Collar Crime & Investigations: Law Update, "Good Works Overcome OIG's Exclusion Presumption for Forest Labs' CEO" (September 2011), <http://tinyurl.com/pdlxpnv> (PDF, 104 KB). For an instance in which individuals were excluded, see Ropes & Gray, "Alert: D.C. Circuit Holds That Former Purdue Pharma Executives Who Pleaded Guilty to Misdemeanor Misbranding May Be Excluded From Participation in Federal Health Care Programs" (August 1, 2012), <http://tinyurl.com/pxy2qoc>.

32. Ed Silverman, "Will Ranbaxy Labs Be Excluded From Medicare and Medicaid?" *Forbes* (May 22, 2013), <http://tinyurl.com/nhx37us>.

33. For a fuller discussion, see Gary S. Becker, "Crime and Punishment: An Economic Approach," *Journal of Political Economy*, vol. 76, no. 2 (March–April 1968), pp. 169–217.



Appendix: Antifraud Laws and Regulations

Numerous statutes pertain to fraud in Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP).¹ The Medicare program has rules and requirements, such as mandating professional licensure for physicians, for individuals and institutions that want to furnish services to beneficiaries. Title XI of the Social Security Act includes several provisions specific to prohibited behaviors in Medicare, Medicaid, and CHIP, and it delineates the punishment for violations of the law.² In the latter two programs, states play an important role in preventing fraud. For all three programs, the Centers for Medicare & Medicaid Services works with other federal and state agencies to combat fraud; at the federal level, the Health Care Fraud and Abuse Control program plays a particularly prominent part in that work.

Other, broader federal statutes also apply to Medicare, Medicaid, and CHIP. In particular, the False Claims Act, or FCA (31 U.S.C. §§ 3729–3733), imposes liability on individuals and companies that defraud the federal government.³ The whistleblower (or qui tam) section of the FCA allows an individual (known as a relator) to bring

suit on behalf of the federal government if the individual has knowledge of fraud committed against the government. The relator is entitled to a share of any settlement that results from litigation stemming from his or her information. On the basis of the number of prosecutions and settlements in recent years, the whistleblower provisions of the FCA seem to be particularly successful in uncovering health care fraud and returning significant amounts of money to the U.S. Treasury and state governments.⁴

In Medicaid and CHIP, which are largely administered by the states, rules about providers’ eligibility, program management, and claims processing are primarily left to states’ discretion under federal guidelines. Therefore, the federal government may play a more indirect role in reducing fraud in those programs. For example, the federal government requires states to operate Medicaid Fraud Control Units (which investigate and prosecute Medicaid fraud), and 2005 legislation encouraged states that did not already have a false claims act to enact one.⁵

1. This is a brief summary of the relevant laws. For additional details, see Jennifer Staman, *Health Care Fraud and Abuse Laws Affecting Medicare and Medicaid: An Overview*, Report for Congress RS22743 (Congressional Research Service, September 8, 2014); and Cliff Binder, *Medicare Program Integrity: Activities to Protect Medicare From Payment Errors, Fraud, and Abuse*, Report for Congress RL34217 (Congressional Research Service, August 3, 2011).

2. 42 U.S.C. §§1301–1320e2.

3. Many states have their own versions of the FCA, and states often benefit from actions under the federal FCA by sharing in financial settlements.

4. For example, see Scott Becker and Molly Gamble, “The Growth of Healthcare Fraud Qui Tam Suits,” *Becker’s Hospital Review* (November 26, 2013), <http://tinyurl.com/k42ebwp>.

5. See the Deficit Reduction Act of 2005, Public Law 109-171. The Affordable Care Act also mandates that states undertake antifraud activities for Medicaid and CHIP.

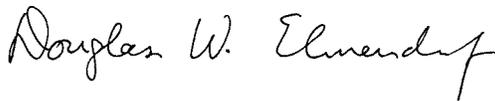
About This Document

This document provides background information on fraud within federal health care programs and on the methods the Congressional Budget Office (CBO) uses to estimate costs of proposed legislation designed to reduce fraud. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

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