MIAMI (AP) — Health care companies say they're losing millions of dollars that are tied up in appeals because of increasing numbers of Medicare audits. But the rise in the often duplicative audits has failed to reduce Medicare fraud, according to a report released Wednesday.

In recent years, the Obama administration has added manpower to investigate cases, increase audits and analyze more data to fight fraud in the taxpayer-funded Medicare program. Yet a report from the U.S. Senate Special Committee on Aging criticized the government for not targeting its resources more effectively. Improper payments within Medicare's largest sector increased for the first time in five years, jumping from $30 billion to $36 billion, despite the Obama administration's all-out campaign to prevent fraud. Medicare fraud in the fee-for-service program had steadily declined since 2009, but improper payments rose between 2011 and 2012, according to the report that cites the most recent data available. During that same time, federal health officials launched a $77 million technology screening system designed to proactively prevent fraudulent providers from joining the system and prevent bogus claims from being paid in the first place.

But the committee expressed concern that the government's "strategy to reduce improper payments is actually a strategy aimed more at identifying and recovering improper payments that have already occurred," according to the report.

Federal health officials said in the report that new policy changes confused providers. They also noted the new screening technology prevented $210 million in fraudulent payments in its second year of operation.

The Medical Equipment Suppliers Association said some providers experienced between 24 and 228 audits in one year, according to a letter to federal health officials included in the report.

Ascension Health had 66,613 claims audited and about half were alleged to be improper payments. The company says the government withheld about $200 million in payments while it appealed. Less than one-fourth of appealed recoveries were upheld, according to the report. Catholic Health Initiatives said it's appealed 87 percent of cases and won the vast majority, but complained significant funds were withheld during the process.

"What has been created is an overly complicated system with duplication where virtually any (durable medical equipment) claim payment can be recouped," according to prepared testimony from Walter Gorski, head of Gorski Healthcare Group LLC, during a round table Wednesday with Sen. Nelson and health care stakeholders, including the American Hospital

Association.

The report also blamed the federal government for lax oversight of its confusing maze of private fraud prevention contractors, noting a fundamental flaw in the way certain contractors are paid because they are paid based on the dollar amount of fraud they identify. Experts say a more effective system would incentivize contractors by paying them based on their ability to reduce fraudulent payment instead of merely identifying large amounts.

Medicare has been a highly sensitive political issue for the Obama administration partly due to a backlash from seniors over program cuts to help finance the president's health care overhaul. Top officials have since emphasized the administration's stewardship of Medicare, touting better benefits and oversight.

"Despite doing more audits than ever before, Medicare just isn't getting the job done when it comes to preventing payment errors," said committee Chairman Bill Nelson (D-FL).