GAO
Accountability * Integrity * Reliability

United States General Accounting Office
Washington, D.C. 20548

October 31, 2002

The Honorable Stephen Horn
Chairman, Subcommittee on Government Efficiency,
Financial Management and Intergovernmental Relations
Committee on Government Reform
House of Representatives

Subject: *Medicare Financial Management: Significant Progress Made to Enhance Financial Accountability*

Dear Mr. Chairman:

Medicare provided health care coverage to 40 million people age 65 and over and to qualifying disabled persons at a cost of about $240 billion in fiscal year 2001. In 1990, GAO designated the program as "high risk" for fraud and abuse because of its vast size, complex structure, and program management weaknesses.[1] In March and September 2000, we issued two reports, one on Medicare financial management and the other on Medicare improper payments.[2] These reports discussed weaknesses in the Centers for Medicare and Medicaid Services' (CMS) oversight of Medicare contractors' financial operations and the guidance it provides contractors in carrying out Medicare financial activities. We also cited CMS for deficiencies in its accounting procedures and improper payment measurement projects. We made eight recommendations for CMS to improve its performance in these areas and establish better financial control over the Medicare program.

At your request, we assessed CMS's progress in addressing these recommendations. This letter summarizes the information provided during our briefing to your staff on September 6, 2002. The enclosed briefing slides highlight the results of our work and the information provided at the briefing.

[1]U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-01-263 (Washington, D.C: January 2001).

[2]U.S. General Accounting Office, *Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability*, GAO-AIMD-00-66 (Washington, D.C.: Mar. 15, 2000) and *Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain*, GAO-AIMD/OSI-00-281 (Washington, D.C.: Sept. 15, 2000).

Results in Brief

CMS has implemented corrective actions to substantially address four of the eight recommendations and has made good progress in addressing the remaining four. Actions taken by CMS include the implementation of more in-depth internal control reviews at Medicare contractors as well as the development of an accounting procedures manual to guide its financial management staff in consistent accounting and reporting for Medicare. CMS has also tested several innovative analysis techniques for identifying improper payments. These actions have helped CMS address some significant, long-standing financial management issues. Despite this progress, CMS needs to take further steps to fully address the remaining four recommendations. These steps include expanding its analysis of contractor financial data, ensuring resolution of audit findings, and enhancing detection of fraudulent and abusive Medicare payments. CMS is in the process of developing and implementing such actions.

Scope and Methodology

To fulfill our objectives of assessing CMS's progress in addressing our prior recommendations, we

- reviewed CMS's audited financial statements for fiscal year 2000 and 2001, other financial reports, fiscal year 2001-2003 Annual Performance Plans, and the Comprehensive Plan for Financial Management to identify initiatives that address previously identified financial management weaknesses, determine if plans included actions to address our recommendations, and determine if the actions included were sufficient to address our recommendations;

- obtained documentation on procedures implemented to address our recommendations and observed CMS Office of Financial Management staff while performing these procedures to determine if the procedures were in place and operating effectively;

- performed tests of audit resolution activities to confirm that procedures implemented to address our recommendations were in place and operating effectively;

- used the Comptroller General's *Standards for Internal Control in the Federal Government*[3] to assess policies and procedures that CMS developed to address our recommendations;

- used our guide on *Strategies to Manage Improper Payments*[4] to evaluate the three improper payment measurement projects and other initiatives that CMS had under way or planned; and

- held numerous interviews with the CMS Chief Financial Officer (CFO), Deputy CFO, program integrity officials, and staff members in the Department of Health and Human Services' Office of the Inspector General to obtain an understanding of the actions taken to address our recommendations.

We conducted our work from January 2002 through July 2002 in accordance with generally accepted government auditing standards. We requested comments on a draft of this report from the CMS CFO, Deputy CFO, and senior Medicare program integrity officials. These officials generally agreed with our findings as presented in the enclosed briefing slides, and the oral comments that they provided have been incorporated, as appropriate.

We are sending copies of this report to the Ranking Minority Member of your Subcommittee and the Chairmen and Ranking Minority Members of the Senate Committee on Governmental Affairs and House Committee on Government Reform. We are also sending copies of this report to the Secretary of Health and Human Services, Administrator of the Centers for Medicare and Medicaid Services, and other interested parties.

This report is available at no charge on our home page at http://www.gao.gov. If you have any questions about this report, please contact me at (202) 512-8341 or Kimberly Brooks, Assistant Director, at (202) 512-9038. You may also reach us by E-mail at calboml@gao.gov or

[3]U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

[4]U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations*, GAO-02-69G (Washington, D.C.: October 2001).

brooksk@gao.gov. Key contributors to this assignment were Johnny Clark, Lisa Crye, Suzanne Murphy, Cynthia Teddleton, and Lisa Willett.

Sincerely yours,

Linda M. Calbom
Director
Financial Management and Assurance

Enclosure

Enclosure: September 2002 Briefing on Progress Made to Enhance Financial Accountability

Medicare Financial Management

Significant Progress Made to Enhance Financial Accountability

Briefing to the staff of the
Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations
House Committee on Government Reform

September 2002

10/31/2002 1

GAO
Accountability * Integrity * Reliability

Briefing Purpose

This briefing provides the results of our review based on your request that we assess the Centers for Medicare and Medicaid Services' (CMS) progress in establishing accountability for the Medicare program, including progress in addressing our prior recommendations to

- correct internal control weaknesses and other financial management issues, and
- enhance efforts for identifying and measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse.

Results in Brief

- In March and September 2000, we reported on Medicare financial management and improper payments, finding weaknesses in oversight of contractor financial activities, accounting procedures, and improper payment measurement projects. We made eight recommendations for CMS to improve its performance in these areas. CMS has implemented corrective actions to substantially address four of the eight recommendations and has made good progress in addressing the remaining four recommendations. These actions have helped CMS correct some significant, long-standing financial management issues. Additional actions are needed to fully address the remaining recommendations and CMS has either developed or partially implemented such actions. Our report recommendations and the specific results of our review are included in table 1.

10/31/2002 3

GAO
Accountability * Integrity * Reliability

Results in Brief—Status of Recommendations

Table 1 – Status of Recommendations

	Recommendations	Substantial progress made	Additional actions needed
Medicare financial management	GAO/AIMD-00-66—*Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (March 2000)		
	Improve guidance to contractors for executing financial activities.	*	
	Refine and expand review procedures to improve oversight of contractor financial activities.		*
	Develop, document, and implement procedures for evaluating and resolving audit findings and coordinate implementation between central and regional staff.		*
	Develop analysis and risk assessment procedures.		*
	Develop comprehensive accounting policies and procedures.	*	
	Develop a comprehensive strategy for Medicare financial management.	*	

10/31/2002 4

GAO
Accountability * Integrity * Reliability

Results in Brief—Status of Recommendations

	Recommendations	Substantial progress made	Additional actions needed
Medicare improper payments	GAO/AIMD/OSI-00-281—*Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain (*September 2000)		
	Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify improper payments and evaluate their effectiveness.	*	
	Include sufficient scope and evaluation in the design of measurement methodologies to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective actions.		*

Scope and Methodology

For this review we did the following:

- Reviewed CMS's audited FY 2000 and FY 2001 financial statements; Department of Health and Human Services (HHS) accountability reports; and GAO, HHS's Office of Inspector General (OIG), and other financial reports to determine the status of previously identified financial management weaknesses.
- Reviewed CMS's FY 2001 through FY 2003 Annual Performance Plans and the Comprehensive Plan for Financial Management to determine if the plans included actions addressing our recommendations.
- Performed tests of CMS's database of financial management procedures to assess its effectiveness in providing guidance to contractors.

10/31/2002 6

GAO
Accountability * Integrity * Reliability

Scope and Methodology (cont'd)

- Performed walk-throughs to observe Office of Financial Management activities and tests of audit resolution activities to confirm that procedures related to our recommendations were in place and operating effectively.

- Used the Comptroller General's *Standards for Internal Control in the Federal Government*[1] to assess policies and procedures that CMS developed to address our recommendations.

- Used our guide on *Strategies to Manage Improper Payments*[2] to evaluate the three improper payment measurement projects and other initiatives that CMS had under way or planned.

[1]U.S. General Accounting Office, *Standards for Internal Control in the Federal Government,* GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 2001)

[2]U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations,* GAO-02 69G (Washington, D.C.: Oct. 2001)

Scope and Methodology (cont'd)

- Held numerous interviews with CMS officials, including the Chief Financial Officer (CFO), Deputy CFO, staff in the Office of Financial Management's Accounting Management Group and the Program Integrity Group, CMS regional financial management staff, and the HHS/OIG staff to obtain an understanding of the actions taken by CMS to address our recommendations.

- Conducted our work from January 2002 through July 2002 in accordance with generally accepted government auditing standards. We requested comments on a draft of this briefing from the CMS Chief Financial Officer (CFO), Deputy CFO, and senior Medicare program integrity officials. These officials generally agreed with our findings and the oral comments that they provided have been incorporated.

10/31/2002 8

GAO
Accountability * Integrity * Reliability

Background

Medicare

- Annually, provides health care coverage to about 40 million people 65 and over and to qualifying disabled persons. Medicare costs were about $240 billion in FY 2001.

- Is a program designated by GAO as "high risk" for fraud and abuse because of its vast size, complex structure, and program management weaknesses.[3]

CMS

- Has primary responsibility for administering the Medicare program.

- Employs about 50 Medicare claims contractors[4] that are responsible for processing fee-for-service claims, managing the billions of dollars used to pay those claims, and protecting Medicare from fraud and abuse.

[3]U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-01-263 (Washington, D.C: Jan. 2001).
[4]There are 37 companies that CMS contracts with to process claims. CMS counts them as 50 contractors because some have two contracts toprocess both Part A and Part B Medicare claims.

GAO
Accountability * Integrity * Reliability

Background (cont'd)

Medicare Financial Management

- CMS received a "clean" opinion on its FY 2001 financial statements. This was the third consecutive unqualified opinion. However, the audit of CMS's financial statements cited material internal control weaknesses including ineffective financial systems and processes, specifically the lack of an integrated accounting system and inadequacies in CMS oversight of contractors' financial data

- CMS oversees contractors financial operations annually through four types of reviews:

    - Annual financial statement audits - which test expenditures and internal controls for a sample of Medicare contractors.

10/31/2002 10

Background (cont'd)

Medicare Financial Management (cont'd)

- Accounts receivable reviews - which validate completeness and accuracy of contractors' accounts receivable for the CFO audit.
- Statement of Auditing Standards (SAS) #70 reviews - which assess contractors' internal control environments and determine if stated controls are in place and operating effectively.
- Internal control certification reviews - which validate contractors' processes for annually assessing internal control and reporting results to CMS.

10/31/2002 11

Background (cont'd)

Medicare Financial Management (cont'd)

- In March 2000, we reported on CMS's financial management, finding that CMS had not addressed long-standing weaknesses. Specifically, CMS had not improved its oversight of contractor financial activities, documented its accounting policies and procedures, resolved audit findings in a timely manner, or developed a financial management strategy.

Background (cont'd)

Medicare Improper Payments

- Since 1996, the OIG has estimated the level of improper Medicare payments. In fiscal year 2001, the OIG reported an estimated $12.1 billion of improper payments, which is 6.3 percent of total fee-for-service payments.
- In 2000, CMS had three improper payment measurement projects designed to enhance its ability to measure and reduce the rate of improper payments in various stages of development.
    - The Comprehensive Error Rate Testing (CERT) project and the Payment Error Prevention Program (PEPP) were designed to provide improper payment estimates by provider, contractor, type of service, and geographic location.
    - The Model Fraud Rate Project was designed to test the use of a variety of investigative techniques and develop a methodology for measuring fraud and abuse.

10/31/2002 13

Background (cont'd)

Medicare Improper Payments (cont'd)

- In September 2000, we reported on the three measurement projects, finding that CMS could improve its ability to determine underlying causes of improper payments, including fraud and abuse, by incorporating certain techniques such as data analysis that focuses on provider and beneficiary billing histories, third party confirmations to validate claims data with independent sources, and beneficiary and provider contacts.

Review Results – Financial Management

The Following Are Actions CMS Has Taken to Address Recommendations in our March 2000 Report *Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability* (GAO/AIMD-00-66)

10/31/2002 15

Review Results – Financial Management

Recommendation

To improve financial management and accountability in the Medicare program, we recommended that the CMS Administrator:

- Improve guidance to contractors for executing Medicare financial activities by ensuring that financial management policies are updated and issued.

CMS Actions

- Updated and issued 19 program memorandums since we last reported that provide contractors with policy guidance on several long-standing financial reporting problems.
    - FY 2001 financial statement audit findings, as compared to those of FY 2000, showed a reduction in findings related to untimely cost reporting, untimely debt transfers, and inappropriate allocation of funds between Medicare trust funds since guidance was issued.

Review Results – Financial Management

CMS Actions (cont'd)

- Developed an Internet-accessible database that consolidates all financial management guidance, including recently issued program memorandums.
    - The database provides contractors with easier access to key financial management regulations that were previously contained in several different manuals.
- Held conferences to issue and discuss new policies on financial issues. Contractors reported that the conferences helped clarify existing and proposed guidance and allowed them to provide comments before policies were finalized.

10/31/2002 17

GAO
Accountability * Integrity * Reliability

Review Results – Financial Management

Progress Assessment

- Substantial progress made. Recommendation closed.

Review Results – Financial Management

Recommendation

- Refine and expand review procedures to improve oversight of contractor financial activities.

CMS Actions

- Expanded the internal control objectives used in evaluating contractors' financial operations.
    - The revised internal control objectives provide CMS with more detailed criteria for evaluating whether contractors properly record and document financial transactions and clarify internal control requirements for contractors.

10/31/2002 19

GAO
Accountability * Integrity * Reliability

Review Results – Financial Management

CMS Actions (cont'd)

- Refined the types of internal control reviews conducted annually.
  - Performed reviews at 13 of the 50 contractors that tested if internal controls designed for Medicare activities were in place and operating effectively as compared to previous reviews that only assessed the design of internal controls.
  - Instituted a review to verify the process contractors follow in their annual assessments of internal control. The number of internal control weaknesses self-reported by contractors significantly increased after this process was implemented.
    - Medicare contractors reported 42 material weaknesses and 308 reportable conditions in their financial operations in FY 2000. After the validation process, contractors reported 300 material weaknesses and 1,300 reportable conditions in FY 2001.

10/31/2002 20

Review Results – Financial Management

Progress Assessment

- Additional action is needed. Recommendation remains open.
  - While CMS has made significant improvements, its efforts to refine and expand review of contractors' financial activities have not included ongoing review at all contractors of monthly expenditure reports that are an important control for monitoring contractor financial operations.
  - The monthly expenditure report includes a reconciliation of funds expended by each contractor that helps ensure that amounts reported to CMS by contractors are accurate, supported, complete, and properly classified.
  - CMS has developed procedures for reviewing the monthly expenditure reports and recently applied the procedures in reviews at six Medicare contractors. CMS expects to expand reviews to more contractors in FY 2003.

10/31/2002 21

Review Results – Financial Management

Recommendation

- Develop, document, and implement procedures for evaluating and resolving audit findings and coordinate with central and regional staff to ensure that corrective actions are implemented in a timely manner.

CMS Actions

- Developed and issued written procedures that provide staff with guidance for evaluating audit findings from all financial-related reviews and steps to follow in resolving the weaknesses identified.
    - The procedures clarify requirements that contractors must adhere to in submitting corrective action plans that address identified weaknesses. They also provide CMS staff with instructions on how to evaluate the adequacy of the contractors' plans.

Review Results – Financial Management

CMS Actions (cont'd)

- Developed and implemented systems to track findings from the four types of contractor financial oversight reviews conducted annually. These systems have helped ensure that all findings reported to CMS are being tracked.

- Established a work group of central and regional staff to develop a strategy for ensuring that contractors take action to address weaknesses identified from audits. This work group is responsible for developing procedures for monitoring contractors' actions and designating the central and regional staff to carry out the procedures.

10/31/2002 23

GAO
Accountability * Integrity * Reliability

Review Results – Financial Management

Progress Assessment

- Additional action is needed. Recommendation remains open.
  - While improvements have been made, the current process for tracking audit findings is inefficient. Staff must manually enter audit findings from different audits into s ability to obtain a comprehensive summary of contractor problems and ensure resolution of all issues.
  - CMS recently began developing a combined system for tracking audit findings and contractor corrective action plans that will address current inefficiencies. Implementation is expected in 2003.
  - CMS continues to formulate an agreement between central and regional staff on responsibility for overseeing contractors' implementation of corrective action plans. The work group that CMS formed to address this issue has not yet implemented a strategy.

10/31/2002 24

Review Results – Financial Management

Recommendation

- Develop analysis and risk assessment procedures to improve CMS's ability to detect irregular financial activities and identify high-risk contractors.

CMS Actions

- Developed analytical tools to perform trend analysis of critical financial data,including Medicare accounts receivable. Identified several overstatements that would have significantly affected the accuracy of the financial statements, including a $198 million overstatement in one contractor's accounts receivable balance.

- Developed risk assessment factors to use in identifying high-risk contractors. The risk factors include dollar value of expenditures, dollar value of accounts receivable, and the number of outstanding audit findings. These procedures helped CMS target limited resources to test internal controls of high-risk contractors.

10/31/2002 25

Review Results – Financial Management

Progress Assessment

- Additional action is needed. Recommendation remains open.
    - The risk assessment procedures that CMS developed have been effective in identifying certain high-risk contractors. However, deficiencies in CMS's financial/trending analysis procedures have been cited. For example, the HHS-OIG noted in the FY 2001 Financial Statement Audit Report that CMS did not document its trending analysis results and has not yet established mechanisms to archive results and historical data for future analysis. CMS has already begun taking action intended to improve it financial analysis by issuing detailed instructions to Medicare contractors and regional office staff for performing financial/trend analysis procedures. The instructions were effective June 30, 2002.

Review Results – Financial Management

Recommendation

- Develop comprehensive accounting policies and procedures to improve internal financial reporting.

CMS Actions

- Developed a comprehensive accounting and financial reporting procedures manual.

- Completed chapters of the manual related to accounting and reporting for the Medicare program. These chapters are written in accordance with federal accounting standards. As such, they help ensure that accounting transactions are treated consistently and increase reliability in CMS financial reporting. The procedures also help promote a uniform understanding of accounting policy among CMS financial management staff.

10/31/2002 27

Review Results – Financial Management

CMS Actions (cont'd)

- Drafted chapters of the manual related to accounting and reporting for the Medicaid program. These chapters are being written in accordance with federal accounting standards and should also improve the reliability of CMS financial data. Final issuance is expected by September 30, 2002.

Progress Assessment

- Substantial progress made. Recommendation closed.

10/31/2002 28

Review Results – Financial Management

Recommendation

- Develop a comprehensive strategy for Medicare financial management that clearly defines goals and objectives, requirements for an integrated financial management system, and human capital needs.

CMS Actions

- Developed a Comprehensive Plan and Strategy for Financial Management and issued its second update of the plan in 2002.
  - The plan defines financial management goals, objectives, and specific corrective actions to address financial management weaknesses.
  - The plan is supported by annual project plans that identify milestones for achieving goals and initiatives in the overall plan.

10/31/2002 29

GAO
Accountability * Integrity * Reliability

Review Results – Financial Management

CMS Actions (cont'd)

- Initiated a human capital needs assessment project that is scheduled to be completed in 2003. This effort is supposed to determine the required skills and competencies needed for Medicare financial management and assist managers in developing a strategy for addressing deficiencies.

- Developed a detailed systems architecture and project plans for the Healthcare Integrated General Ledger Accounting System (HIGLAS), which is designed to eliminate the ad hoc spreadsheet applications used to record and report financial information and fully integrate Medicare contractor and CMS accounting systems. Implementation is expected by 2007.

    - The HIGLAS project plans are being developed in accordance with Joint Financial Management Improvement Program's Federal Financial Management Systems Requirements. This should help ensure that the system is properly designed and implemented to promote consistency and reliability in Medicare financial information.

Review Results – Financial Management

Progress Assessment

- Substantial progress Made. Recommendation closed.

Review Results – Improper Payments

The Following Are Actions CMS Has Taken to Address Recommendations in our September 2000 Report *Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain* (GAO/AIMD/OSI-00-281)

10/31/2002 32

Review Results – Improper Payments

Recommendation

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse, we recommended that the CMS Administrator:

- Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify improper payments and evaluate their effectiveness.

CMS Actions

- Implemented the Statistical Analysis Center (SAC) pilot project that employed experts in statistical analysis to identify suspicious Medicare claims resulting from potentially fraudulent and abusive activities.

GAO
Accountability * Integrity * Reliability

Review Results – Improper Payments

CMS Actions (cont'd)

- Evaluated the effectiveness of techniques used in the SAC project and determined that they would yield substantial findings when applied to other claims data in the future.
- Accomplished the following through the SAC Project:
  - Gained experience aggregating Medicare claims for doctor visits, hospital services, and medical equipment into one database–claims are usually maintained in separate databases by different claims contractors across states.
  - Gained experience applying data mining techniques to the database to identify questionable payments. Identified unusual billing patterns of providers, claims that contain illogical data or conflicting identifying information, and beneficiary claims for duplicate or similar services.

Review Results – Improper Payments

CMS Actions (cont'd)

- Gained experience using techniques such as data sharing to cross-reference claims data with independent sources, including Social Security Administration records. Identified claims for services provided after beneficiary date of death.
- Identified about $38.26 million in potentially fraudulent payments from the data mining and data sharing techniques applied, and referred the results of the analysis to claims contractors for further investigation and collection.
- Collected about $490,000 of the improper payment amounts identified by the end of our field work.
- Demonstrated the benefit of applying statistical analysis to rapidly assess whether a potential pattern of abuse exists, according to program integrity officials.

Review Results – Improper Payments

CMS Actions (cont'd)

- Added to CMS's experiences with employing companies that have expertise in data mining, statistical analysis, and antifraud efforts.

- In addition,
  - CMS plans to continue the type of analysis performed in the SAC with Program Safeguard Contractors (PSC)[4] that it plans to hire over the next 2 years. PSCs are expected to have the data tools and capabilities necessary to identify new program risks and expertise to conduct fraud case development, follow up on tips, support law enforcement, and perform innovative data analysis to combat fraud.

[5]The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized CMS to contract with entities to perform certain program safeguard functions.

10/31/2002 36

Review Results – Improper Payments

Progress Assessment

Substantial progress made. Recommendation closed.

- Through the SAC pilot, CMS successfully experimented with various analysis techniques that we recommended for identifying claims resulting from potentially fraudulent and abusive activities.
- The knowledge and experience gained from the SAC pilot provides CMS with proven techniques that can be incorporated into its measurement methodologies to further analyze claims data and enhance future fraud and abuse detection.
- In addition, PSCs are to help ensure that the latest techniques are used to identify potential fraud and that improper payments are investigated and amounts inappropriately paid are collected.

10/31/2002 37

Review Results – Improper Payments

Recommendation

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to fraud and abuse, we recommended that the CMS Administrator:

- Include sufficient scope and evaluation in the design of the measurement methodologies to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective actions.

CMS Actions

- Revised the scope of the Model Fraud Rate Project to include fraud detection techniques that we recommended, such as provider and beneficiary contacts and third party confirmations. Project implementation is planned for FY 2003 pending approval of CMS's budget request.

10/31/2002 38

Review Results – Improper Payments

CMS Actions (cont'd)

- Created databases of sampled claims through the Comprehensive Error Rate Testing (CERT) project and the Payment Error Prevention Program (PEPP). These databases include over 120,000 beneficiary claims for physician services and medical equipment and over 60,000 claims for inpatient hospital services that CMS can use to expand evaluation of underlying causes.

GAO
Accountability * Integrity * Reliability

Review Results – Improper Payments

Progress Assessment

- Additional action is needed. Recommendation remains open.
  - While the Model Fraud Rate Project will include in its scope techniques such as provider and beneficiary contacts and third party confirmations to evaluate claims, this project has not been implemented.
  - The CERT and PEPP projects provide CMS with valuable databases for applying data mining, data sharing, and statistical analysis techniques similar to those proven effective by the SAC project. However, CMS has not implemented procedures to perform additional evaluation and analysis of the CERT and PEPP claims to enhance future fraud and abuse detection.

(190079)

10/31/2002 40