June 15, 2010

MEDICARE FRAUD, WASTE, AND ABUSE

Challenges and Strategies for Preventing Improper Payments

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Highlights

Highlights of GAO-10-844T, a testimony before the Subcommittees on Health and Oversight, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

GAO has designated Medicare as a high-risk program since 1990, in part because the program's size and complexity make it vulnerable to fraud, waste, and abuse. Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain, while abuse represents actions inconsistent with acceptable business or medical practices. Waste, which includes inaccurate payments for services, also occurs in the Medicare program.

Fraud, waste, and abuse all can lead to improper payments, overpayments and underpayments that should not have been made, or that were made in an incorrect amount. In 2009, the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare—estimated billions of dollars in improper payments in the Medicare program.

This statement will focus on challenges facing CMS and selected key strategies that are particularly important to helping prevent fraud, waste, and abuse, and ultimately to reducing improper payments. It is based on nine GAO products issued from September 2005 through March 2010 using a variety of methodologies, including analysis of claims, review of relevant policies and procedures, stakeholder interviews, and site visits. GAO received updated information from CMS in June 2010.

View GAO-10-844T or key components.
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What GAO Found

GAO has identified challenges and strategies in five key areas important in preventing fraud, waste, and abuse, and ultimately to reducing improper payments. GAO has made recommendations in these areas. CMS has made progress in some of these areas, and recent legislation may provide the agency with enhanced authority. However, CMS faces continuing challenges.

1. **Strengthening provider enrollment process and standards.** Checking the background of providers at the time they apply to become Medicare providers is a crucial step to reduce the risk of enrolling providers intent on defrauding or abusing the program. In particular, GAO has recommended stricter scrutiny of providers identified as particularly vulnerable to improper payments to ensure they are legitimate businesses.

2. **Improving pre-payment review of claims.** Pre-payment reviews of claims are essential to helping ensure that Medicare pays correctly the first time. GAO has recommended that CMS further enhance its ability to identify improper claims through additional automated pre-payment claim review before they are paid.

3. **Focusing post-payment claims review on most vulnerable areas.** Post-payment reviews are critical to identifying payment errors and recouping overpayments. GAO has recommended that CMS better target claims for post payment review on the most vulnerable areas.

4. **Improving oversight of contractors.** Because Medicare is administered by contractors, overseeing their activities to address fraud, waste, and abuse is critical. GAO found that CMS's oversight of prescription drug plan sponsors' compliance programs has been limited. However, partly in response to GAO's recommendation, CMS oversight of these programs is expanding.

5. **Developing a robust process for addressing identified vulnerabilities.** Having mechanisms in place to resolve vulnerabilities that lead to improper payment is vital to program management, but CMS has not developed a robust process to specifically address these. GAO has recommended that CMS establish an adequate process to ensure prompt resolution of identified improper payment vulnerabilities.