July 28, 2011

IMPROPER PAYMENTS

Reported Medicare Estimates and Key Remediation Strategies

GAO Highlights

Accountability * Integrity * Reliability

Highlights of GAO-11-842T, a testimony before the Subcommittee on Government Organization, Efficiency and Financial Management, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

GAO has designated Medicare as a high-risk program because of its size, complexity, and susceptibility to improper payments. In 2010, Medicare covered 47 million elderly and disabled beneficiaries and had estimated outlays of $516 billion. The Centers for Medicare & Medicaid Services (CMS) is the agency in the Department of Health and Human Services (HHS) responsible for administering the Medicare program and leading efforts to reduce Medicare improper payments.

This testimony focuses on estimated improper payments in the Medicare program for fiscal year 2010 and the status of CMS's efforts to implement key strategies to help reduce improper payments. This testimony is primarily based on previous GAO reporting related to governmentwide improper payments, Medicare high-risk challenges and program integrity efforts, and CMS's information technology systems intended to identify improper payments. GAO supplemented that prior work with additional information on the nature and extent of Medicare improper payments reported by HHS in its fiscal year 2010 agency financial report. GAO also received updated information from CMS in February 2011 and, in select cases, as of July 2011, on its actions related to relevant laws, regulations, guidance, and open recommendations pertaining to key remediation strategies.

View GAO-11-842T or key components. For more information, contact Kay L. Daly at (202) 512-9312 or dalykl@gao.gov or Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

For fiscal year 2010, HHS reported an estimate of almost $48 billion in Medicare improper payments, representing about 38 percent of the total $125.4 billion estimate for the federal government. However, this Medicare improper payment estimate is incomplete because HHS has yet to develop a comprehensive estimate for the Medicare prescription drug benefit. The improper payment estimate includes both overpayments and underpayments. Causes cited include inadequate documentation, medically unnecessary services, coding errors, and payment calculation errors. It is important to recognize that the $48 billion is not an estimate of fraud in Medicare. Because the improper payment estimation process is not designed to detect or measure the amount of fraud that may exist, there may be fraud that is not reflected in HHS's reported estimate.

CMS faces challenges in designing and implementing internal controls to effectively prevent or detect and recoup improper payments. In 2010, CMS established the Center for Program Integrity to serve as its focal point for all national Medicare program integrity issues. Based on past work, GAO identified five key strategies to help reduce fraud, waste, and abuse and improper payments in Medicare, which CMS has reported initiating actions to address. GAO has made recommendations to strengthen CMS's implementation of these strategies, some of which the agency has not implemented.

Strengthen provider enrollment standards and procedures. Strong standards and procedures can help reduce the risk of enrolling providers intent on defrauding the program. CMS has taken action to implement provisions of the Patient Protection and Affordable Care Act by screening providers by levels of risk and providing more stringent review of high-risk providers, but has yet to implement certain GAO recommendations in this area.

Improve prepayment reviews. Prepayment reviews of claims help ensure that Medicare pays correctly the first time. According to CMS, as of July 1, 2011, CMS has begun applying predictive modeling analysis to claims and plans to expand Medicare prepayment controls. CMS has not implemented GAO's recommendation to improve prepayment reviews.

Focus postpayment reviews on vulnerable areas. Postpayment reviews are critical to identifying payment errors and recouping overpayments. In March 2009, CMS began instituting a national recovery audit contractor (RAC) program to help the agency supplement its postpayment reviews. CMS has also developed information technology to help it better identify claims paid in error, but GAO recently reported that the systems are not being used to the extent originally planned and made several recommendations to address the issues.

Improve oversight of contractors. CMS has taken action to improve oversight of prescription drug plan sponsors' fraud and abuse programs, which addresses GAO's recommendation, but is still developing specific performance statistics.

Develop a robust process to address identified vulnerabilities. Having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical. While CMS has begun actions in this area, it has not developed a robust corrective action process for vulnerabilities identified by Medicare RACs as GAO recommended.