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GAO Highlights

Highlights of GAO-14-619T, a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

MEDICARE

Further Action Could Improve Improper Payment Prevention and Recoupment Efforts

Why GAO Did This Study

Due to its size, complexity, and susceptibility to mismanagement and improper payments, GAO has designated Medicare as a high-risk program. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about $604 billion, and reported an estimated $50 billion in improper payments—payments that either were made in an incorrect amount or should not have been made at all. Most of these improper payments were made through the Medicare FFS program, which pays providers based on claims and uses contractors to pay the claims and ensure program integrity.

This statement focuses on the progress made and steps still to be taken by CMS to improve improper payment prevention and recoupment efforts in the Medicare FFS program. This statement is based on relevant GAO products and recommendations issued from 2007 through 2014 using a variety of methodologies. GAO also updated information by examining public documents and, in April 2014, GAO received updated information from CMS on its actions related to laws and regulations discussed in this statement.

View GAO-14-619T. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has made progress improving improper payment prevention and recoupment efforts in the Medicare fee-for-service (FFS) program, but further actions are needed.

Provider enrollment. CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) that address past weaknesses identified by GAO and others. The agency has also put in place other measures intended to strengthen existing procedures, but could do more to improve provider enrollment screening and ultimately reduce improper payments. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses, meet certain Medicare standards, and are at legitimate locations. CMS also recently contracted for fingerprint-based criminal history checks of providers and suppliers it has identified as high-risk. However, CMS has not implemented other screening actions authorized by PPACA that could further strengthen provider enrollment.

Prepayment controls. In response to GAO's prior recommendations, CMS has taken steps to improve the development of certain prepayment edits—prepayment controls used to deny Medicare claims that should not be paid; however, important actions that could further prevent improper payments have not yet been implemented. For example, CMS has implemented an automated edit to identify services billed in medically unlikely amounts, but has not implemented a GAO recommendation to examine certain edits to determine whether they should be revised to reflect more restrictive payment limits. GAO has found that wider use of prepayment edits could help prevent improper payments and generate savings for Medicare.

Postpayment claims reviews. Postpayment claims reviews help CMS identify and recoup improper payments. Medicare uses a variety of contractors to conduct such reviews, which generally involve reviewing a provider's documentation to ensure that the service was billed properly and was covered, reasonable, and necessary. GAO has found that differing requirements for the various contractors may reduce the efficiency and effectiveness of such reviews. To improve these reviews, GAO has previously recommended CMS examine ways to make the contractor requirements more consistent. CMS reported that it has begun to address these recommendations. Although the percentage of Medicare claims that undergo postpayment review remains very small, GAO has found that the overall number of postpayment claims reviews has been increasing in recent years. HHS has reported that the increase in claims reviews is one factor causing backlogs in the Medicare appeals process.

GAO has ongoing work focused on how CMS could continue its efforts to reduce improper Medicare payments. For instance, GAO is examining the extent to which CMS's provider enrollment system can help prevent and detect the continued enrollment of ineligible providers in Medicare. GAO also has work underway to examine whether CMS has strategies for coordinating postpayment review contractors' claims review activities.