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MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE

Effective Implementation of Recent Laws and Agency Actions Could Help Reduce Improper Payments

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Highlights

Highlights of GAO-11-409T, a testimony before the Subcommittee on Federal Financial Management, Government Information, Federal Services, and International Security, Committee on Homeland Security and Governmental Affairs, U.S. Senate

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Why GAO Did This Study

GAO has designated Medicare and Medicaid as high-risk programs because they are particularly vulnerable to fraud, waste, abuse, and improper payments (payments that should not have been made or were made in an incorrect amount). Medicare is considered high-risk in part because of its complexity and susceptibility to improper payments, and Medicaid because of concerns about the adequacy of its fiscal oversight to prevent inappropriate spending.

In fiscal year 2010, the Centers for Medicare & Medicaid Services (CMS)—the agency that administers Medicare and Medicaid—estimated that these programs made a total of over $70 billion in improper payments.

This statement focuses on how implementing prior GAO recommendations and recent laws, as well as other agency actions, could help CMS carry out five key strategies GAO identified in previous reports to help reduce fraud, waste, and abuse and improper payments in Medicare and Medicaid. It is based on 16 GAO products issued from April 2004 through June 2010 using a variety of methodologies, such as analyses of Medicare or Medicaid claims, review of relevant policies and procedures, and interviews with officials. In February 2011, GAO also received updated information from CMS on agency actions.

View GAO-11-409T or key components. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov or Kay L. Daly at (202) 512-9095 or dalykl@gao.gov.

What GAO Found

The amount of improper payments creates urgency for CMS to effectively implement prior GAO recommendations, provisions in recently enacted laws, and recent guidance related to five key strategies to help reduce fraud, waste, abuse, and improper payments in Medicare and Medicaid.

1. **Strengthening provider enrollment standards and procedures.** Strengthening the standards and procedures for provider enrollment can help reduce the risk of enrolling entities intent on defrauding the program. The Patient Protection and Affordable Care Act as amended (PPACA) strengthens aspects of provider enrollment in Medicare and Medicaid. CMS is implementing these provisions, which include designating providers by levels of risk and providing more stringent review of high-risk providers.

2. **Improving prepayment review of claims.** Prepayment reviews of claims help ensure that Medicare pays correctly the first time. CMS is implementing a PPACA provision requiring states to add automated prepayment controls in their Medicaid programs. In addition, CMS is seeking contractors to apply predictive modeling analysis to claims as a way to develop new prepayment controls to add to Medicare; however, CMS has not implemented certain GAO recommendations related to prepayment review.

3. **Focusing postpayment claims review on most vulnerable areas.** Postpayment reviews are critical to identifying payment errors and recouping overpayments. CMS is instituting recovery audit contractor (RAC) programs in Medicare and Medicaid to increase postpayment review. However, CMS contractors generally choose their focus for claims review, and GAO continues to contend that CMS should make it a priority to focus claims administration contractors' postpayment review on the most vulnerable areas.

4. **Improving oversight of contractors.** CMS's oversight of contractors' activities to address fraud, waste, and abuse is critical. CMS has taken action to address GAO recommendations to improve oversight of prescription drug plan sponsors' fraud and abuse programs and to comply with other contractor oversight provisions in PPACA.

5. **Developing a robust process for addressing identified vulnerabilities.** Having mechanisms in place to resolve vulnerabilities that lead to improper payment is critical, but CMS has not developed a robust corrective action process for vulnerabilities identified by Medicare RACs, and has not fully implemented GAO recommendations to improve it. Further, CMS's guidance to states on Medicaid RAC programs did not include steps to address vulnerabilities through a corrective action process.

Effective implementation of these recommendations, provisions of law, and guidance will be a key factor in helping to reduce future improper payments.

Mr. Chairman, Ranking Member, and Members of the Subcommittee:

I am pleased to be here today to discuss provisions in recent laws and agency actions that may help reduce fraud, waste, and abuse[1] in the Medicare and Medicaid programs.[2] Fraud, waste, and abuse and improper payments put programs at risk. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.[3]

We have designated both Medicare and Medicaid as high-risk programs.[4] Medicare, a federally financed program, was designated as high risk because its complexity and susceptibility to improper payments, added to its size, have made it vulnerable to serious management challenges. The Centers for Medicare & Medicaid Services (CMS)—the agency in the Department of Health and Human Services (HHS) that administers Medicare and oversees Medicaid—has estimated improper payments for Medicare of almost $48 billion for fiscal year 2010.[5] This estimate does not include improper payments in Part D, the Medicare prescription drug

[1]Fraud represents intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

[2]Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicaid is the federal-state program that covers acute health care, long-term care, and other services for low-income people and consists of more than 50 distinct state-based programs. In fiscal year 2009, Medicaid covered about 65 million people. The federal government matches states' expenditures for most Medicaid services using a statutory formula based on each state's per capita income.

[3]This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note).

[4]In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). http://www.gao.gov/highrisk/risks/insurance/medicare_program.php.

[5]HHS, "Improper Payment Reduction Outlook FY 2009 through 2013," in *Fiscal Year 2010 Agency Financial Report* (Washington, D.C.: Nov. 15, 2010). The Secretary of HHS has delegated administration of the Medicare program to the Administrator of CMS. See Appendix I for abbreviations used in this statement.

benefit, for which the agency has not yet estimated a total amount. Medicaid, a federal-state program, was designated as high risk in part due to concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate spending. Medicaid also has significant improper payments. HHS estimated that the federal share of improper payments in the Medicaid program in fiscal year 2010 was $22.5 billion.[6] Since 2004, we have issued 16 products containing strategies we have identified for reducing fraud, waste, abuse, and improper payments in Medicare and Medicaid. My statement today updates our previous work in light of certain provisions affecting Medicare and Medicaid in PPACA;[7] the Small Business Jobs Act of 2010;[8] and pertinent agency actions.

Over the years, the Congress has worked to address fraud, waste, and abuse, and improper payments in the Medicare and Medicaid programs. Beginning in 1997, the Congress provided funds specifically for activities to address fraud, waste, and abuse in federal health care programs. In addition, Congress created the Medicare Integrity Program to conduct activities designed to reduce fraud, waste, abuse, and improper payments in Medicare. The Deficit Reduction Act of 2005 created the Medicaid Integrity Program and included specific appropriations to reduce fraud, waste, and abuse in Medicaid. In 2010, PPACA provided further funding for such efforts and set new requirements specific to Medicare and Medicaid that are designed to address fraud, waste, and abuse. In the same year, the Improper Payments Elimination and Recovery Act of 2010 (IPERA) amended the Improper Payments Information Act of 2002 and established additional governmentwide requirements related to accountability, recovery auditing, compliance and noncompliance determinations, and reporting.[9] However, owing to the size and scope of

[6]In its *Fiscal Year 2010 Agency Financial Report*, HHS calculated and reported the 3-year (2008, 2009, and 2010) weighted average national payment error rate for Medicaid of 9.4 percent. See *Department of Health and Human Services FY 2010 Agency Financial Report* (Washington, D.C.: Nov. 15, 2010).

[7]Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA. The program integrity provisions discussed in this statement are generally located in sections 6401 through 6411 and 10603 and 10605 of PPACA as well as section 1304 of HCERA. For our previous work, see a list of related products at the end of this statement.

[8]Pub. L. No. 111-240, § 4241, 124 Stat. 2504, 2599.

[9]Implementing guidance has not been issued, and therefore it is too early to assess the implementation of these requirements.

Medicare and Medicaid, reducing improper payments and addressing fraud, waste, and abuse in these programs are continuing challenges for CMS—despite progress made by the agency that we have recognized since the programs were first designated as high risk.

CMS contractors play an important role in preventing improper payments in Medicare. Within Medicare Parts A and B—also known as Medicare fee-for-service (FFS)[10]—CMS contractors process and pay approximately 4.5 million claims per work day, enroll providers, respond to beneficiary questions, and investigate potential Medicare fraud. In addition, in Medicare Advantage (Part C) and the Medicare prescription drug benefit (Part D),[11] CMS contracts with private health plans and drug plan sponsors that administer Medicare benefits and in that capacity are responsible for helping to ensure Medicare program integrity.

With more than 50 distinct state-based programs that are partially federally financed, Medicaid creates complex challenges for CMS and states. CMS is responsible for overseeing the program at the federal level, while the states administer their respective programs' operations. Within broad federal requirements, each state operates its Medicaid program in accordance with a state plan. Differences in program design can lead to differences in state programs' vulnerabilities to improper payments and state approaches to protecting the program. States play a critical role in implementing strategies to reduce improper payments and address fraud, waste, and abuse. However, CMS also has a critical role in ensuring that adequate controls are in place and states' actions to help reduce improper payments are effective. Like Medicare, the state Medicaid programs also rely on contractors to help manage payments or services, but they vary in their use of contractors.

My testimony today focuses on how implementing recent laws and our prior recommendations, as well as other agency actions, could help CMS carry out five key strategies we identified in previous reports to help

[10]Medicare Parts A and B are known as original Medicare or Medicare FFS. Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services.

[11]Medicare beneficiaries have the option of obtaining coverage for Part A and B services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D.

reduce fraud, waste, and abuse and improper payments in Medicare[12] and Medicaid.[13] This statement discusses past agency actions, actions in progress, and actions that are still needed to implement certain recommendations that we continue to consider important. The five key strategies, and recommendations designed to facilitate them, are taken from the 16 products mentioned above. Twelve of these products, which we issued from April 2004 through June 2010, focused on fraud, waste, abuse, and improper payments in Medicare. Because Medicaid faces a similar challenge to reduce its improper payments, these Medicare strategies can also be helpful when tailored to Medicaid. The other 4 products, which we issued since July 2004, focused on reducing fraud, waste, abuse, and improper payments in Medicaid.[14]

The products on which this statement is based were developed by using a variety of methodologies, including analyses of Medicare and Medicaid claims, review of relevant policies and procedures, interviews with agency officials and other stakeholders, and site visits.[15] We also received updated information from CMS in February 2011 on its actions related to the laws, regulations, guidance, and open recommendations that we discuss in this statement. Our work was performed in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[12]These strategies were identified in our June 2010 testimony as critical to helping prevent fraud, waste, and abuse in Medicare. See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010).

[13]This statement deals with the challenge of reducing improper payments to providers and plans, but Medicaid has additional areas of concern, such as supplemental payments to providers that can lead to inappropriate federal payments to states. For a discussion of these areas, see GAO, *High Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

[14]A list of both sets of products appears at the end of this statement.

[15]For more detailed information on the methodologies used in our work, please consult the products listed at the end of this statement.

Implementation of Our Prior Recommendations and Recent Laws, as Well as Other Agency Actions, Could Help CMS Reduce Medicare and Medicaid Fraud, Waste, and Abuse

The implementation of specific recommendations made in our prior reports[16] and provisions in PPACA and the Small Business Jobs Act of 2010, as well as other agency actions, could help in reducing fraud, waste, and abuse in Medicare and Medicaid. In reports we have issued from 2004 through 2010, we have identified five key strategies as important to reducing Medicare and Medicaid fraud, waste, and abuse, and ultimately improper payments:[17]

- strengthening provider enrollment standards and procedures,
- improving prepayment review of claims,
- focusing postpayment claims review on the most vulnerable areas and adding new recovery audit contractors,
- improving oversight of contractors, and
- developing a robust process for addressing identified vulnerabilities.[18]

PPACA has a number of provisions that could also aid CMS in its efforts to minimize improper payments, and CMS has issued final rules implementing some of these provisions. Furthermore, the Small Business Jobs Act of 2010 and the Presidential Memorandum, "Enhancing Payment Accuracy through a Do Not Pay List," focus on preventing, reducing, and recovering improper payments, which could also help CMS in reducing improper payments in Medicare and Medicaid.

[16]For a list of recommendations that we made that CMS has not implemented, see appendix II.

[17]See GAO, *Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010). While the June 2010 statement specifically focused on the Medicare program, the strategies it presented are also applicable to the Medicaid program.

[18]Vulnerabilities are service-specific errors that result in improper overpayments and underpayments. An example of a vulnerability that leads to improper payments is providers billing for more than one blood transfusion in a hospital outpatient setting for a Medicare beneficiary in a day, which Medicare policy does not allow.

Strengthening Provider Enrollment Procedures for Medicare and Medicaid Could Reduce the Risk of Enrolling Providers Intent on Defrauding or Abusing the Program

Our work on Medicare indicates that strengthening the standards and procedures for provider enrollment could help reduce the risk of enrolling providers intent on defrauding or abusing the program.[19] CMS has previously identified two types of providers whose services and items are especially vulnerable to improper payments—home health agencies (HHA) and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). In our 2009 report on HHAs, we found problems with the enrollment procedures—for example, CMS's contractors were not requiring HHAs to re-submit enrollment information (including information about key officials, operating capital, and practice location) for re-verification every 5 years as required by CMS.[20] In a 2005 report on DMEPOS suppliers, we found that CMS had not taken sufficient steps to prevent entities intent on defrauding Medicare from enrolling, and we reported that more effective screening and stronger enrollment standards were needed to ensure that new suppliers were legitimate businesses.[21] Partly in response to our recommendation to improve the provider enrollment process, CMS took steps to implement new supplier quality standards as part of an accreditation rule issued in August 2006 and proposed new supplier enrollment standards in January 2008. Suppliers were required to meet these new accreditation standards in 2009; however, the new supplier enrollment standards were not finalized until August 2010. Prior to the implementation of the new supplier enrollment standards, we exposed persisting weaknesses when we created two fictitious DMEPOS suppliers, which were subsequently enrolled by CMS's contractor and given permission to begin billing Medicare.[22] As an enrollment requirement, suppliers must, upon request, show that they have contracts for obtaining inventory if the suppliers do not produce their own inventory. Review would have shown that the contracts provided by our fictitious companies had been fabricated.

[19]Enrolling as a provider in Medicare and Medicaid allows a provider to provide services to beneficiaries and bill for those services.

[20]See GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, GAO-09-185 (Washington, D.C.: Feb. 27, 2009). CMS's contractors began to revalidate HHA enrollment during the course of our work on that engagement.

[21]See GAO, *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, GAO-05-656 (Washington, D.C.: Sept. 22, 2005).

[22]See GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, GAO-08-955 (Washington, D.C.: July 3, 2008).

For Medicaid, states have adopted requirements to check providers' backgrounds before enrollment or during re-enrollment; however, these enrollment procedures have not been sufficient to protect Medicaid. For example, in September 2009, we reported that in five states Medicaid paid over $2 million in controlled substance prescriptions during fiscal years 2006 and 2007 that were written or filled by 65 medical practitioners and pharmacies that were barred, excluded, or both from federal health care programs, including Medicaid, for such offenses as illegally selling controlled substances.[23] As a result, we recommended that CMS consider issuing guidance to state Medicaid programs to provide assurance that their program requirements and systems prevent the processing of claims from providers and pharmacies that were barred from federal contracts or excluded from Medicare and Medicaid. We also recommended that CMS periodically identify deaths of Medicaid providers and prevent the approval of claims associated with providers who had died.

Implementation of PPACA provisions related to provider enrollment could protect Medicare and Medicaid from making improper payments and address some of our previous concerns and recommendations. PPACA requires the Secretary, in consultation with the HHS Office of Inspector General (OIG), to establish procedures for screening providers enrolling in Medicare and Medicaid,[24] including assessing the risk levels of fraud, waste, and abuse by categories of providers. At a minimum, PPACA requires all providers to be subject to licensure checks, which may include checks across state lines. Depending on the risks presented by the type of provider, CMS may require additional screening procedures, such as criminal history checks.[25] Further, PPACA provides for enhanced oversight for specific periods for new providers and of initial claims of DMEPOS suppliers. In addition, PPACA directs HHS to promulgate a regulation requiring providers to include their National Provider Identifier on all Medicare and Medicaid enrollment applications and claims for payment.

[23]See GAO, *Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States*, GAO-09-957 (Washington, D.C.: Sept. 9, 2009). The five states whose claims we reviewed for this report were California, Illinois, New York, North Carolina, and Texas.

[24]This law also applies to certain provisions related to Medicaid or to the state Children's Health Insurance Program (CHIP), which is the joint federal-state program that provides health coverage to children whose families have incomes that are low, but not low enough to qualify for Medicaid. This statement does not address how PPACA will affect CHIP.

[25]The enhanced screening procedures that PPACA provided for will apply to new providers beginning 1 year after the date of enactment and to currently enrolled providers 2 years after that date.

On February 2, 2011, CMS and the HHS OIG published a final rule to implement these new screening procedures.[26] The rule is designed to institute a consistent set of enrollment procedures for Medicare and Medicaid, but not to abridge CMS's established screening authority or diminish the screening that providers currently undergo. Therefore, if states have additional Medicaid screening procedures, they will be able to maintain them.[27]

For Medicare, CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for providers at each level. Based in part on our work and that of the HHS OIG and its own experience, CMS designated newly enrolling HHAs and DMEPOS suppliers as high risk and designated other providers at the lower levels.[28] Providers in all risk levels are to be screened to verify that they meet specific requirements established by Medicare. This includes checking providers' licenses, including checks across state lines; and checking certain databases, to verify items such as Social Security numbers, on a pre- and post-enrollment basis to ensure that they continue to meet enrollment criteria.[29] Moderate- and high-risk providers are also subject to unannounced site visits. All individuals who own a 5 percent or greater interest in high-risk providers are subject to fingerprinting and criminal

[26]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011).

[27]In discussing the final rule, CMS noted that Medicare already employs a number of the screening practices described in PPACA to determine if a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

[28]CMS considered issues such as past levels of improper payments and occurrences of fraud among different provider types to determine risk levels. The moderate level comprises re-enrolling HHAs and re-enrollng DMEPOS suppliers; ambulance suppliers; community mental health centers; comprehensive outpatient rehabilitation facilities; hospice organizations; independent diagnostic testing facilities; independent clinical laboratories; and physical therapists, including physical therapy groups and portable X-ray suppliers. Other providers, such as physicians and ambulatory surgical centers, are in the limited risk level.

[29]The database checks may include verification of the following: Social Security number; National Provider Identifier; National Practitioner Databank licensure; whether the provider has been excluded from federal health care programs by the OIG; taxpayer identification number; and death of an individual practitioner, owner, authorized official, delegated official, or supervising physician.

background checks.[30] CMS's implementation of fingerprinting and criminal history checks would address our 2009 recommendation for CMS to assess the feasibility of verifying the criminal history of all key HHA officials named on the provider enrollment applications.

In its discussion of the February 2, 2011 final rule, CMS indicated that the agency intended to review the criteria for its screening levels on a consistent and ongoing basis and would publish changes if the agency decided to update the assignment of screening levels for Medicare providers. This may become necessary, because fraud is not confined to newly enrolling HHAs and DMEPOS. As more scrutiny is given to these two types of providers, the types of providers that CMS is classifying as moderate risk, such as physical therapy practices, may begin to attract more individuals who are intent on defrauding Medicare or Medicaid. In their 2010 annual report on the Health Care Fraud and Abuse Control Program, DOJ and HHS reported convictions or other legal actions, such as exclusions or civil monetary penalties, against several types of Medicare providers other than DMEPOS suppliers and HHAs, such as medical clinics and physical therapy practices.[31] CMS has also established triggers for adjustments to an individual provider's risk level. For example, if an individual limited- or moderate-risk provider has been excluded from Medicare by the HHS OIG, that individual provider would move to the high-risk level.

For Medicaid, one requirement in CMS's February 2011 rule is that state Medicaid agencies are to establish categorical levels of risk for their providers. For the moderate- and high-risk providers, a state Medicaid agency must conduct site visits, and for high-risk providers, it must conduct fingerprinting and criminal background checks.

[30]In February 2011, CMS told us that the agency had requested additional comments on how best to implement the fingerprinting and criminal history record check requirements and might adopt some of the comments in implementing this provision. CMS will not implement fingerprinting and criminal history record checks until after subregulatory guidance is published that explains how the agency plans to ensure that privacy rights are respected and that addresses other operational concerns.

[31]*The Department of Health and Human Services and the Department of Justice Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2010* (Washington, D.C.: January 2011).

In addition to enhancing screening procedures, PPACA includes two provisions that strengthen other aspects of provider enrollment for Medicare and Medicaid. CMS implemented these provisions in its February 2011 final rule. First, PPACA allows CMS to declare a moratorium on enrollment of new Medicare and Medicaid providers when the agency determines such a moratorium to be necessary to prevent or combat fraud, waste, and abuse. State Medicaid agencies may also authorize such a moratorium. Second, PPACA also requires state Medicaid programs to terminate providers that have been terminated from Medicare or other state Medicaid programs.

PPACA also imposes new requirements on Medicare and Medicaid providers, including a requirement for establishing compliance programs that adhere to standards established by the Secretary in consultation with the OIG.[32] CMS sought public comment on establishing such compliance programs in a proposed rule on September 23, 2010.[33] The agency indicated in explaining its February 2011 final rule that it intended to conduct further rulemaking on compliance program requirements and would advance specific proposals in the future. In addition, PPACA imposes specific requirements for providers to disclose any current or previous affiliation with a provider that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or CHIP; or has had its billing privileges denied or revoked. The law allows CMS to deny enrollment to any such provider whose previous affiliations pose an undue risk. In February 2011, CMS told us that it was drafting a proposed rule to implement this authority. Further, providers that order home health services must have a face-to-face encounter with the beneficiary before the services can be ordered. CMS issued a final rule regarding this requirement in November 2010.[34] Finally, providers that order DMEPOS or

[32]In general, a compliance program is the internal set of policies, processes, and procedures that a provider organization implements to help it act ethically and lawfully. In this context, compliance plans help provider organizations prevent and detect violations of Medicare laws and regulations.

[33]*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*. 75 Fed. Reg. 58204 (Sept. 23, 2010).

[34]*Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2011; Changes in Certification Requirements for Home Health Agencies and Hospices*. 75 Fed. Reg. 70,372 (Nov. 17, 2010).

home health services for beneficiaries will have to be enrolled in Medicare or Medicaid and maintain documentation on the services or items ordered, and the claims for these services and items must contain their National Provider Identifier number.

Before PPACA, CMS had taken other steps over the past 3 years regarding the legitimacy of providers, and PPACA has provisions that are consistent with some of these steps. First, the agency implemented a statutory requirement for DMEPOS suppliers to post a surety bond to help Medicare recoup erroneous payments that result from fraudulent or abusive billing practices.[35] PPACA extended CMS's authority to impose surety bonds consistent with billing volume to all Medicare providers.[36] Second, as directed by law, CMS required that all DMEPOS suppliers be accredited by a CMS-approved accrediting organization to ensure that they meet minimum standards. In June 2010, CMS told us that approximately 9,000 DMEPOS suppliers were dis-enrolled as result of these surety bond and accreditation requirements. Third, CMS began to implement a Medicare competitive bidding program for durable medical equipment and supplies with prices that took effect in January 2011 from the first round of bidding. This program could also help reduce fraud, waste, and abuse because it requires CMS to select DMEPOS suppliers based in part on new scrutiny of their financial documents and other application materials, among other things. The program took effect initially in nine metropolitan areas. PPACA built upon some of these efforts. It required CMS to speed up implementation of the competitive bidding program, expanding the number of areas to be included in the second round of bidding from 70 to 91 by the end of 2011.

[35]Social Security Act §1834(a)(16)(B). As of October 2009, DMEPOS suppliers were required to obtain and submit a surety bond in the amount of at least $50,000. A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, Medicare will recover its losses via the surety bond. Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), 74 Fed. Reg. 166 (Jan. 2, 2009).

[36]Before PPACA, the Social Security Act also required CMS to impose surety bonds on HHAs and permitted the imposition of surety bonds on certain other Medicare providers. PPACA requires any surety bond imposed to be commensurate with the provider's billing volume. CMS officials stated that the agency is drafting a rule to implement this authority, in which the agency will propose imposing surety bonds on additional providers.

Improving Prepayment Review of Claims Could Prevent Improper Payments from Being Made

Our work on Medicare has shown that prepayment reviews of claims are essential to help ensure that Medicare pays correctly the first time. Conducting these reviews is challenging due to the volume of claims. Overall, less than 1 percent of Medicare's claims are subject to a medical record review by trained contractor personnel. Therefore, having robust automated payment controls—called edits—in place that can deny inappropriate claims or flag them for further review is critical. However, we have found weaknesses in these prepayment controls. For example, in 2007, we found that contractors responsible for reviewing DMEPOS claims did not have automated prepayment controls in place to identify questionable claims, such as those associated with atypically rapid increases in billing or for items unlikely to be prescribed in the normal course of medical care.[37] Lack of such prepayment controls has resulted in losses to Medicare.[38] As a result, we recommended in 2007 that CMS require its contractors to develop thresholds for unexplained increases in billing and use them to develop automated prepayment controls. Although CMS has not implemented that recommendation specifically, it has added edits to flag claims for services unlikely to be provided in the normal course of medical care. Additional prepayment controls, such as those based on thresholds for unexplained increases in billing, could further enhance CMS's ability to identify improper claims before they are paid.

PPACA requires state Medicaid agencies to add some specific prepayment edits. Beginning with claims submitted on October 1, 2010, PPACA requires states to incorporate into their Medicaid Management Information System compatible National Correct Coding Initiative (NCCI) methodologies in order to promote correct coding and to control improper coding leading to inappropriate payment.[39] These methodologies are in use

[37]See GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Suppliers*, GAO-07-59 (Washington, D.C.: Jan. 31, 2007).

[38]For example, we found that from the first quarter of 2003 through the first quarter of 2005, due to an absence of such prepayment controls, 225 suppliers increased their billing to Medicare both by at least 500,000 and by at least 50 percent from at least one 3-month period to the next. In November 2004, the U.S. government won a default civil judgment against 16 of these suppliers for filing false claims against Medicare for services not rendered—after they were paid almost $40 million from January 2003 through September 2004.

[39]NCCI, a CMS program that consists of coding policies and edits, was initiated for Medicare in 1996 to help ensure correct payment for Medicare Part B for physician, laboratory, and radiology services claims. Under NCCI, CMS's contractors screen Medicare Part B claims with automated prepayment edits designed to detect anomalies that indicate a claim has incorrect information.

in the Medicare program for edits related to certain practitioner services, ambulatory surgical center services, outpatient hospital services, and supplier claims for durable medical equipment. For example, NCCI edits can detect claims with duplicate services delivered to the same beneficiary on the same date of service, such as more than one excision of a gallbladder for the same beneficiary. CMS provided guidance on how to implement this requirement through a state Medicaid directors' letter issued on September 1, 2010.

The Small Business Jobs Act of 2010 also has a provision regarding claims review to prevent improper payments. It requires CMS to use predictive modeling and other analytic techniques—known as predictive analytic technologies—both to identify and to prevent improper payments under the Medicare FFS program.[40] The law requires these predictive analytic technologies to be used to analyze and identify Medicare provider networks, billing patterns, and beneficiary utilization patterns and detect those that represent a high risk of fraudulent activity. Through such analysis, unusual or suspicious patterns or abnormalities could be identified that could be used to prioritize additional review of suspicious transactions before payment is made. CMS published a solicitation in December 2010 for these technologies and a case management system to track findings. The law requires that the solicitation require contractors that are selected to begin using these technologies on July 1, 2011, in the 10 states identified by CMS as having the highest risk of waste, fraud, or abuse in Medicare FFS payments. After the initial year, based on the results of the predictive analytic technologies, their use will be expanded to other states. Based on the results after year 3, the technologies are to be expanded to Medicaid. In September 2010, CMS indicated that it was conducting pilots to test the ability of the technologies to identify potential fraud in paid claims. Agency officials told us that the experience from the pilot projects helped them develop the solicitation. CMS reported that it planned to incorporate the technologies for prepayment review after testing them through postpayment review to ensure that the new technologies work as intended and do not disrupt claims from legitimate providers or diminish access to care for legitimate beneficiaries.

[40]The law requires these predictive analytic technologies to be integrated into the Medicare FFS claims flow and prevent the payment of claims identified as potentially fraudulent, wasteful, or abusive until the claims can be verified as valid.

In addition, a June 2010 Presidential Memorandum directed agencies to check certain databases—known as the "Do Not Pay List"—before making payments, to ensure that payments did not go to individuals who were dead or excluded from receiving federal payments or to entities that had been excluded from receiving federal payments. CMS officials stated that, in response to the Presidential Memorandum, the agency reviewed the databases that it and its Medicare contractors were using to determine payment eligibility for providers and took action to ensure that the agency's method of ensuring payment eligibility was consistent with the intent of the "Do Not Pay List". Specifically, CMS told us that it is currently reviewing the following databases: (1) the Social Security Administration's (SSA) Death Master File, (2) HHS OIG's Exclusions Database, (3) the Federal Payment Levy Program (FPLP), (4) the Treasury Offset Program, and (5) General Services Administration's Excluded Parties List System (EPLS).[41] CMS reported that it uses information from these databases to update its provider enrollment system. Specifically, provider enrollment information is checked monthly against the Medicare Exclusion Database, which contains information from the HHS OIG's Exclusions Database, the GSA's EPLS, and the SSA's Death Master File to update providers' enrollment status. Agency officials told us that CMS's contractors integrate updated provider enrollment information into CMS's payment system. Specifically, changes in CMS's provider enrollment system are downloaded nightly to the CMS contractors that pay claims.[42] Claims are then run through prepayment edits to check that providers are active and eligible for payment. With regard to Medicaid, CMS officials said that the state programs use some of these data sets, such as SSA's Death Master File, but that the states' abilities to complete checks consistent with the Presidential Memorandum would depend on whether they could obtain access to other databases, such as the FPLP, which has information on federal tax debt. The CMS officials added that they have encouraged states to review the databases available to them prior to making payments.

[41]See http://www.ntis.gov/products/ssa-dmf.aspx [SSA death master]; http://oig.hhs.gov/fraud/exclusions.asp [HHS OIG Exclusions] http://www.irs.gov/individuals/article/0,,id=100551,00.html [FPLP]; and http://fms.treas.gov/debt/top.html.

[42]These contractors include Medicare Administrative Contractors (MAC) and any fiscal intermediaries or carriers still administering claims. These MACs, carriers, and fiscal intermediaries are responsible for ensuring that they only pay claims to eligible providers.

Focusing Postpayment Claims Review on the Most Vulnerable Areas and Adding New Recovery Audit Contractors Could Increase Identification of Improper Payments

We have found that postpayment reviews are critical to identifying payment errors to recoup overpayments in Medicare and that there are steps that could strengthen postpayment review. These steps involve focusing postpayment claims review on the most vulnerable areas and increasing the amount of postpayment review by using recovery audit contractors (RAC) for the Medicare and Medicaid programs.

CMS's claims administration contractors conduct limited postpayment reviews; therefore, it is important that they target their postpayment review resources on providers with a demonstrated high risk of improper payments.[43] For example, in 2009 we recommended that postpayment reviews be conducted on claims submitted by HHAs with high rates of improper billing identified through prepayment review.[44] To date, CMS has not implemented this recommendation; however, in February 2011 CMS told us that its contractors are developing medical review strategies that may include postpayment reviews on HHAs. We continue to believe that focusing postpayment claims review on the most vulnerable areas should be a priority.

Cross-checking claims for home health services with the physicians who prescribed them can be a further safeguard against fraud, waste, and abuse, but, as we reported in 2009, this is not routinely done.[45] For example, a physician must certify that a beneficiary needs home health services before services can be provided, but CMS does not routinely provide physicians with information that would enable a physician to determine whether an HHA was billing for services that the physician had not authorized or services that the physician would not consider necessary for the beneficiary's care. We recommended that CMS require that physicians receive a statement of services beneficiaries received based on the physicians' certification, but to date, the agency has not taken action. Taking such action also could be beneficial for other services and items susceptible to fraud and abuse that are not billed directly by physicians, such as DMEPOS. In February 2011, CMS indicated that it did not plan to implement this recommendation because agency officials thought that it would involve extensive resources to do so.

[43]We reported in 2009 that two contractors paying home health services claims conducted postpayment reviews on fewer than 700 of the 8.7 million claims they paid in fiscal year 2007. See GAO-09-185.

[44]See GAO-09-185.

[45]See GAO-09-185.

Prior to PPACA, CMS had efforts focusing on postpayment review of claims, most recently its new national RAC program, which began in March 2009, after completion of a 3-year demonstration program in 2008.[46] The national program is designed to help the agency supplement the postpayment reviews conducted by contractors other than RACs. The RACs review Part A and B claims after payment, but because RACs are paid a contingent fee based on the dollar value of the improper payments identified, they have focused on claims from inpatient hospital stays, which are generally more costly services. We pointed out to CMS in our previous work that other contractors' postpayment review activities could be more valuable if CMS directed these contractors to focus on items and services where RACs are not expected to focus their reviews, and where improper payments are known to be high, such as home health services claims.[47]

PPACA expands Medicare's RAC program to Parts C and D. CMS published a request for comments on the development of Parts C and D RACs in December 2010. CMS awarded a Part D RAC task order for a 1-year base period that began January 2011 and 4 option years.

PPACA also requires state Medicaid programs to establish contracts, consistent with state law and similar to the contracts established for the Medicare RAC program, with one or more RACs. These state RACs are to identify underpayments and identify and recoup overpayments made for services provided by state Medicaid programs. In November 2010, CMS issued a proposed rule and guidance to states on establishing a Medicaid Recovery Audit Contractor program. CMS's proposed rule covered issues such as contingency fees and establishing a process for provider appeals of RAC determinations. States can ask CMS for an exception to the Medicaid RAC requirements. CMS officials told us that as of February 2011, 55 state Medicaid agencies have submitted their plans for addressing the Medicaid RAC PPACA provision, and 14 states have asked for

[46]The Medicare Prescription Drug, Improvement and Modernization Act of 2003 directed CMS to conduct a project to demonstrate how effective the use of RACs would be in identifying underpayments and overpayments, and in recouping overpayments in Medicare. Pub. L. No. 108-173, § 306, 117 Stat. 2066, 2256. Subsequently, in December 2006 the Tax Relief and Health Care Act of 2006 required CMS to implement a national RAC program by January 1, 2010. Pub. L. No. 109-342, div. B, title III, § 302, 120 Stat. 2924, 2991 (codified at 42 U.S.C. § 1395ddd(h)).

[47]See GAO, *Medicare Fraud, Waste and Abuse: Challenges and Strategies for Preventing Improper Payments*, GAO-10-844T (Washington, D.C.: June 15, 2010).

exceptions in part or in whole. CMS plans to make public its decisions on any exceptions granted.

Improving Oversight of Contractors Could Help Ensure That Safeguard Activities Are Conducted

Overseeing the activities of contractors that provide services to Medicare beneficiaries is critical to addressing fraud, waste, and abuse and preventing improper payments. Over the years, we found areas where CMS's oversight had been insufficient to ensure that required program control activities were conducted and working well. For example, all Part D drug plan sponsors are required to have programs to detect, correct, and prevent fraud, waste, and abuse—also referred to as fraud and abuse programs. CMS is responsible for ensuring that sponsors are in compliance with this requirement; however, in 2008 we found that CMS's oversight of these programs had been limited.[48] We recommended that CMS conduct timely audits of sponsors' fraud and abuse programs. CMS agreed with this recommendation, and in March 2010 we reported that CMS had completed desk audits of selected sponsors' programs and was beginning to implement an expanded oversight strategy, including on-site audits to assess the effectiveness of these programs more thoroughly.[49] In November 2010, CMS officials reported that the agency had conducted on-site audits of 33 of the 290 sponsors in 2010, which covered 62 percent of the enrolled beneficiaries in 2010. As a result of the on-site audits, CMS had taken formal enforcement actions against several sponsors. In addition, CMS published a final rule in April 2010 to increase its oversight efforts and ensure that sponsors have effective programs in place.[50]

PPACA included new requirements for CMS to evaluate contractors receiving Medicare Integrity Program and Medicaid Integrity Program funding every 3 years. In addition, PPACA requires these contractors to provide performance statistics to HHS and OIG upon request. These statistics may include the number and amount of overpayments recovered, the number of fraud referrals, and the return on investment of such

[48]GAO, *Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited*, GAO-08-760 (Washington, D.C.: July 21, 2008).

[49]See *Medicare Part D: CMS Oversight of Part D Sponsors' Fraud and Abuse Programs Has Been Limited, but CMS Plans Oversight Expansion*. GAO-10-481T (Washington, D.C.: March 3, 2010). A desk audit includes reviews of requested documents only, in contrast to site visits, which include other tasks, such as interviews with sponsor officials.

[50]*Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs*, 75 Fed. Reg. 19,678 (Apr. 15, 2010).

activities. In February 2011, CMS officials told us that they are taking action to implement these requirements for Medicare and Medicaid. For Medicare, CMS reported that it is currently tracking performance statistics and is adding to and refining these statistics. CMS is also currently developing the specific performance statistics for its Part D integrity contractors and expects to finalize these statistics this year. For Medicaid, CMS also reported that it is requiring states to track performance statistics and anticipates finalizing the specific performance statistics to be tracked by March 2011.

Developing a Robust Process for Addressing Identified Vulnerabilities Could Help Reduce Improper Payments

Having mechanisms in place to resolve vulnerabilities that lead to improper payment is critical to effective program management, but our work has shown that CMS has not developed a robust process to specifically address identified vulnerabilities that lead to improper payments in Medicare. We have reported that an agency should have policies and procedures to ensure that (1) the findings of all audits and reviews are promptly evaluated, (2) decisions are made about the appropriate response to these findings, and (3) actions are taken to correct or resolve the issues promptly.[51] We have also stressed the importance of holding individuals accountable for achieving agency objectives.

As we reported in March 2010, CMS did not establish an adequate process during its recovery audit contracting demonstration or in planning for the national program to ensure prompt resolution of identified improper payment vulnerabilities in Medicare.[52] During the demonstration, CMS did not assign responsibility to agency officials or contractors for taking corrective action. According to CMS officials, the agency took corrective action only for vulnerabilities with national implications, and let the contractors that processed and paid claims decide whether to take action

[51]These are all aspects of internal control, which is the component of an organization's management that provides reasonable assurance that the organization achieves effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations. Internal control standards provide a framework for identifying and addressing major performance challenges and areas at greatest risk for mismanagement. GAO, *Internal Control Standards: Internal Control Management and Evaluation Tool* GAO-01-1008G (Washington, D.C.: August 2001).

[52]GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight,* GAO-10-143 (Washington, D.C.: March 31, 2010).

for vulnerabilities that might occur only in certain geographic areas. Additionally, during the demonstration CMS did not specify in a plan what type of corrective action was required or establish a time frame for corrective action. The documented lack of assigned responsibilities impeded CMS's efforts to promptly resolve the vulnerabilities identified during the demonstration.

For the national Medicare RAC program, although CMS established a corrective action team to compile, review, and categorize identified vulnerabilities and discuss corrective action recommendations, the corrective action process is still incomplete. CMS appointed the Director of the Office of Financial Management to be responsible for the day-to-day operations of the program, and the CMS Administrator to be responsible for vulnerabilities that span agency components. However, the corrective action process still does not include any steps to either assess the effectiveness of the corrective actions taken or adjust them as necessary based on the results of the assessments. Further, the agency has not developed time frames for implementing corrective actions.

Because of these weaknesses, we recommended that CMS develop and implement a corrective action process that includes policies and procedures to ensure that the agency promptly (1) evaluates findings of RAC audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.[53] CMS concurred with this recommendation. Agency officials said they intended to review vulnerabilities on a case-by-case basis and were considering assigning them to risk categories to help prioritize their actions. However, to date, this recommendation has not been implemented. In February 2011, CMS reported that the agency is still working to address the vulnerabilities identified during the demonstration program. Specific to corrective actions, CMS told us that it now requires its contractors to consider and evaluate vulnerabilities identified by various entities, including the RACs.

For the Medicaid RAC program, CMS's proposed rule for state Medicaid programs does not include any steps to collect information on vulnerabilities to improper payment and develop a corrective action process to address them. Lessons learned from the Medicare RAC program indicate that collecting information on vulnerabilities and having an

[53]GAO-10-143.

adequate corrective action process are important to address vulnerabilities. In turn, this suggests that having Medicaid RACs report to state Medicaid agencies and CMS on the vulnerabilities they identify and having a corrective action process to address those vulnerabilities would be important to reduce Medicaid improper payments. State Medicaid agencies are required to have a corrective action process as part of their activities to reduce their Medicaid error rates. Information from the Medicaid RAC program could be incorporated into these processes. Although its guidance was silent on this issue, in February 2011, CMS told us that state Medicaid programs will be responsible for addressing RAC-identified vulnerabilities and that it will monitor and assist states in implementing corrective actions.

Concluding Observations

The amount of improper payments in the Medicare and Medicaid programs creates urgency for CMS to act decisively to reduce them. Identifying the nature, extent, and underlying causes of improper payments is an essential prerequisite to reducing them, as is implementing our prior recommendation to develop an adequate corrective action process to address vulnerabilities. CMS could also take other actions to help better address the issue of fraud, waste, abuse, and improper payments in the Medicare and Medicaid programs. For Medicare, these include (1) developing thresholds for unexplained increases in billing and using them to develop automated prepayment controls, (2) conducting postpayment reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review, (3) cross-checking claims for home health services with the physicians who prescribed them, and (4) focusing claims administration contractors' postpayment reviews on items and services where RACs are not expected to focus their reviews, and where improper payments are known to be high. For Medicaid, other actions include ensuring that states develop adequate corrective action processes to address vulnerabilities to improper Medicaid payments to providers and issuing guidance to states to better prevent payment of improper claims for controlled substances.

As it implements PPACA provisions concerning Medicare and Medicaid, CMS has an opportunity to address fraud, waste, abuse, and improper payments in the two programs. CMS has made progress in rulemaking and issuing guidance to implement this law, the Small Business Jobs Act, and the "Do Not Pay List" memorandum. CMS's implementation efforts are in process, so it is too early to gauge their effects. As these requirements become part of Medicare and Medicaid operations, additional evaluation and oversight will help determine whether they are implemented as

intended and have the desired effect on better ensuring proper payment. As the implementation process proceeds, we are continuing to monitor these issues. Notably, we are beginning new work to assess CMS's efforts to strengthen the standards and procedures for Medicare provider enrollment to reduce the risk of enrolling providers that are intent on defrauding or abusing the program. We also plan to examine the effectiveness of different types of prepayment edits in Medicare and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. The level of importance placed on effectively implementing our recommendations and the requirements established by recent laws and guidance will be a key factor in reducing improper payments in the Medicare and Medicaid programs and ensuring that federal funds are used efficiently and for their intended purposes.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

Contacts and Acknowledgments

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Appendix I: Abbreviations

CHIP	Children's Health Insurance Plan
CMS	Centers for Medicare & Medicaid Services
DMEPOS	durable medical equipment, prosthetics, orthotics, and supplies
EPLS	General Services Administration's Excluded Parties List System
FFS	Medicare fee-for-service
FPLP	Federal Payment Levy Program
HCERA	Health Care and Education Reconciliation Act of 2010
HHA	home health agencies
HHS	Department of Health and Human Services
NCCI	National Correct Coding Initiative
OIG	Office of the Inspector General
PPACA	Patient Protection and Affordable Care Act
RAC	Recovery Audit Contractor
SSA	Social Security Administration

Appendix II: Open Recommendations

GAO report title and number		GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)			
Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies, GAO-07-59	1.	The Administrator of CMS should require the Program Safeguard Contractors to develop thresholds for unexplained increases in billing—and use them to develop automated prepayment controls as one component of their manual medical review strategies.	CMS has not implemented our recommendation specifically, but has added edits to flag claims for services that were unlikely to be provided in the normal course of medical care. CMS told us they are in the process of awarding contracts to implement advanced fraud detection and some contract awardees may have the ability to include increases in billing as part of those fraud detection efforts.
Home Health Agencies (HHA)			
Medicare: Improvements Needed to Address Improper Payments in Home Health, GAO-09-185	2.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should assess the feasibility of verifying the criminal history of all key officials named on an HHA enrollment application.	The Patient Protection and Affordable Care Act requires CMS to establish additional screening procedures for providers enrolling in Medicare and Medicaid. CMS has published a final rule that subjects high-risk providers in Medicare to fingerprinting and criminal background checks. Implementation of these efforts would address our recommendation.
	3.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should give physicians whose identification number was used to certify or recertify a plan of care a statement of services the HHA provided to that beneficiary based on the physician's certification.	CMS has no plans to implement this recommendation. The agency indicated that doing so would require extensive resources and funding.
	4.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should direct CMS contractors to conduct postpayment medical reviews on claims submitted by HHAs with high rates of improper billing identified through prepayment review.	CMS has not implemented this recommendation, but CMS reported that its contractors are developing medical review strategies that may include postpayment reviews on HHA claims. We believe there is an opportunity to further strengthen controls on improper payments if CMS were to direct its contractors to specifically conduct postpayment medical reviews on claims submitted with high rates of billing identified through prepayment review.

GAO report title and number		GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
	5.	To strengthen the controls on improper payments in the Medicare home health benefit, the Administrator of CMS should amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. Grounds for revocation could include a pattern of submitting claims that are falsified, for persons who do not meet Medicare's coverage criteria, or are for services that are not medically necessary.	CMS has not implemented this recommendation.
Controlled Substances			
Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States, GAO-09-957	6.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that claims processing systems prevent the processing of claims from providers and pharmacies debarred from federal contracts (i.e., on the Excluded Parties List System (EPLS)), excluded from the Medicare and Medicaid programs (i.e., on the List of Excluded Individuals/Entities (LEIE)), or both.	CMS told us it has taken various steps to implement this recommendation. It issued guidance to state Medicaid directors regarding the frequency with which states should check for excluded parties and directing them to provide guidance to enrolled providers and managed care organizations regarding checking for excluded employers, contractors, agents, etc. CMS also conducts triennial comprehensive program integrity reviews of states, in which they examine a sample of providers to determine if they contained excluded individuals.
	7.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that Drug Utilization Review and restricted recipient program requirements adequately identify and prevent doctor shopping and other abuses of controlled substances.	CMS has taken some steps to address this recommendation. Beginning in fiscal year 2011, as part of the triennial comprehensive program integrity reviews, CMS staff reviewed states' recipient restriction programs. CMS also made efforts to educate providers, beneficiaries, and others on related payment integrity and quality assurance issues.
	8.	To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that effective claims processing systems are in place to periodically identify both duplicate enrollments and deaths of Medicaid beneficiaries and to prevent the approval of claims when appropriate.	CMS has begun to take steps to address aspects of this recommendation. The agency is in the process of working with states to validate their processes to prevent the approval of claims for deceased Medicaid beneficiaries.

GAO report title and number	GAO recommendation	Centers for Medicare & Medicaid Services (CMS) implementation status
	9. To establish an effective fraud prevention system for the Medicaid program, the Administrator of CMS should evaluate our findings and consider issuing guidance to the state programs to provide assurance that effective claims processing systems are in place to periodically identify deaths of Medicaid providers and prevent the approval of claims when appropriate.	CMS has taken some steps to improve how deceased provider information is incorporated into claims processing in the Medicaid program. Specifically, CMS told us that it is currently implementing steps to access Medicare's provider enrollment system, which is updated monthly to reflect excluded and deceased providers, in order to inform Medicaid's provider data.
Recovery Audit Contracting		
Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight, GAO-10-143	10. To help reduce future improper payments, the Administrator of CMS should develop and implement a process that includes policies and procedures to ensure that the agency promptly: (1) evaluates findings of recovery audit contractors (RAC) audits, (2) decides on the appropriate response and a time frame for taking action based on established criteria, and (3) acts to correct the vulnerabilities identified.	Although CMS has not implemented our recommendation specifically, it has taken some steps to address vulnerabilities identified by the RAC demonstration program. For example, CMS has developed provider-specific reports related to the demonstration program and established a team to facilitate the corrective action process. In addition, CMS told us that it now requires its contractors to consider and evaluate vulnerabilities identified by various entities, including the RACs.

Source: GAO and GAO analysis of CMS information.

Related GAO Products

Medicare Fraud, Waste, and Abuse: Challenges and Strategies for Preventing Improper Payments. GAO-10-844T. Washington, D.C.: June 15, 2010.

Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight. GAO-10-143. Washington, D.C.: March 31, 2010.

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Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program. GAO-10-27. Washington, D.C.: November 6, 2009.

Medicaid: Fraud and Abuse Related to Controlled Substances Identified in Selected States. GAO-09-957. Washington, D.C.: September 9, 2009.

Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments. GAO-09-628T. Washington, D.C.: April 22, 2009.

Medicare: Improvements Needed to Address Improper Payments in Home Health. GAO-09-185. Washington, D.C.: February 27, 2009.

Medicare Part D: Some Plan Sponsors Have Not Completely Implemented Fraud and Abuse Programs, and CMS Oversight Has Been Limited. GAO-08-760. Washington, D.C.: July 21, 2008.

Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process. GAO-08-955. Washington, D.C.: July 3, 2008.

Medicare: Competitive Bidding for Medical Equipment and Supplies Could Reduce Program Payments, but Adequate Oversight Is Critical. GAO-08-767T. Washington, D.C.: May 6, 2008.

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Medicaid Program Integrity: State and Federal Efforts to Prevent and Detect Improper Payments. GAO-04-707. Washington, D.C.: July 16, 2004.

Medicare: CMS Did Not Control Rising Power Wheelchair Spending. GAO-04-716T. Washington, D.C.: April 28, 2004.

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