



United States Government Accountability Office
Washington, DC 20548

July 20, 2009

The Honorable Thomas R. Carper
Chairman

The Honorable John McCain
Ranking Member

Subcommittee on Federal Financial Management, Government Information, Federal
Services, and International Security
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Tom Coburn, M.D.
United States Senate

*Subject: Improper Payments: Responses to Posthearing Questions Related to
Eliminating Waste and Fraud in Medicare and Medicaid*

On April 22, 2009, we testified¹ before your subcommittee at a hearing entitled, “Eliminating Waste and Fraud in Medicare and Medicaid.” At that hearing, we discussed federal agencies’ progress in estimating and reducing improper payments, as well as existing challenges for federal agencies to fully meet the requirements of the Improper Payments Information Act of 2002 (IPIA).² Further, our testimony provided an overview of implementation of IPIA with respect to the Medicare and Medicaid programs by the Centers for Medicare and Medicaid Services (CMS), a component of the Department of Health and Human Services (HHS).

This letter responds to a May 29, 2009, request for responses to questions for the record related to our April 22, 2009, testimony. Our responses are based on work associated with previously issued GAO reports (see Related GAO Products at the end of this correspondence), data included in HHS’s fiscal year 2008 annual financial report (AFR), and data reported for fiscal year 2008 by CMS. We conducted our work from May 2009 to July 2009 in accordance with all sections of GAO’s Quality Assurance Framework that are relevant to our objectives. The framework requires that we plan and perform the engagement to obtain sufficient and appropriate evidence to meet our stated objectives and to discuss any limitations in our work. We

¹GAO, *Improper Payments: Progress Made but Challenges Remain in Estimating and Reducing Improper Payments*, [GAO-09-628T](#) (Washington, D.C.: Apr. 22, 2009).

²Pub. L. No. 107-300, 116 Stat. 2350 (Nov. 26, 2002).

believe that the information and data obtained, and the analysis conducted, provide a reasonable basis for any findings and conclusions in this product. Your questions, along with our responses, follow.

1. What do you see as the biggest challenge for CMS to provide an estimate for improper payments under Medicare Part D?

With total outlays of about \$46 billion in fiscal year 2008, Medicare Part D is the last significant part of Medicare for which the department has yet to develop an estimate of improper payments. CMS testified in April 2009 that it is on track to develop that methodology, but a completion date was not provided. We have not yet evaluated CMS's current efforts to develop a methodology for estimating improper payments associated with Medicare Part D (Prescription Drug Benefit).

In developing its estimate, it will be important for CMS to determine where the vulnerabilities and risks exist in the Medicare Part D structure and operations that could impact CMS's ability to effectively detect, measure, and ultimately reduce improper payments. In HHS's fiscal year 2008 AFR, the department reported that it had calculated payment error rates for two components of Medicare Part D but also that its measurement was not fully implemented. Also, it will be important to consider HHS's Office of Inspector General (OIG)-identified concerns about CMS's implementation of internal controls to ensure payment accuracy as well as inadequate analysis of claims data.

2. Has GAO identified any problems with the current process for reviewing and paying Medicare claims that would make the program more vulnerable to fraudulent claims?

We have identified several weaknesses with the current process for reviewing Medicare claims. Limitations in the number of medical reviews conducted leave the home health benefit—within the Medicare program—vulnerable to improper payments, including payments resulting from fraud and abuse. We reported in February 2009 that in fiscal year 2007, only 0.5 percent of the more than 8.7 million home health agency (HHA) claims processed were subjected to prepayment review by Medicare's contractors.³ The contractors focused primarily on claims submitted by HHAs whose billing patterns differed from their peers on measures such as cost per episode. Of those claims that were reviewed, over 40 percent were denied in whole or in part. Furthermore, the contractors rarely performed postpayment medical reviews to recover funds previously paid in error, even when the HHA was identified as billing improperly through prepayment review. Thus, although the limited claims-review process that was performed was valuable in reducing potential improper payments, the extent of errors found would suggest that both prepayment

³GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, [GAO-09-185](#) (Washington, D.C.: Feb. 27, 2009).

and postpayment medical reviews should be increased to more effectively avoid or recoup overpayments.

There are also weaknesses with respect to selecting claims to review in Medicare Fee-for-Service. In January 2007, we reported on shortfalls in the automated prepayment controls that are used to deny durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims that should not be paid or to identify claims that should be reviewed.⁴ For example, CMS's contractors responsible for the medical review of these claims did not have edits with predesigned thresholds in place to identify claims for review that were part of an atypical increase in billing.⁵ Further, there are weaknesses in monitoring home health agencies' claims. We found that CMS did not routinely send verification of services billed by the HHAs to the authorizing physicians, to determine whether the type and frequency of home health visits were consistent with what physicians had authorized.⁶

In addition to the weaknesses with the current Medicare claims review process, we found that failure to effectively screen health providers before granting them billing privileges also increases the program's vulnerability to fraudulent claims. In September 2005, we reported on weaknesses in standards, procedures, and oversight of the screening process for DMEPOS suppliers,⁷ which could leave the program vulnerable to fraudulent claims activities. Despite some improvements, in July 2008, we reported on deficiencies in CMS's enrollment and inspection process for DMEPOS suppliers that would allow them to fraudulently bill Medicare for unnecessary supplies or supplies from nonexistent suppliers.⁸ As part of our investigation, we created fictitious DMEPOS companies to which CMS granted billing privileges despite having no clients and no inventory. Those billing privileges could have allowed the fictitious companies to bill Medicare for potentially millions of dollars for nonexistent supplies. We also reported that criminals who create similar fictitious DMEPOS companies typically steal or illegally buy Medicare beneficiary numbers and physician identification numbers and use them to repeatedly submit bogus claims. HHS acknowledged that CMS's oversight of DMEPOS suppliers contains gaps in oversight that still require improvements. In addition, we identified issues with screening potential and current home health agencies that may enable problem providers to enter and remain in the Medicare program. For example, we reported

⁴GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, [GAO-07-59](#) (Washington, D.C.: Jan. 31, 2007).

⁵Due to the absence of the threshold edits, we found that from the first quarter of 2003 through the first quarter of 2005, 225 suppliers increased their billing to Medicare by \$500,000 and 50 percent from at least one 3-month period to the next.

⁶[GAO-09-185](#).

⁷GAO, *Medicare: More Effective Screening and Stronger Enrollment Standards Needed for Medical Equipment Suppliers*, [GAO-05-656](#) (Washington, D.C.: Sept. 22, 2005).

⁸GAO, *Medicare: Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process*, [GAO-08-955](#) (Washington, D.C.: July 3, 2008).

that CMS does not require its home health contractors responsible for screening applications to verify the criminal history of persons named on the application.

Health care fraud is a serious financial drain on our health care system. HHS reported in its fiscal year 2008 AFR that an estimated \$17.2 billion of Medicare Fee-for-Service and Medicare Advantage claims were improperly paid for reasons such as medically unnecessary services and insufficient documentation. It is unclear how much of this estimate resulted from fraudulent claims. Our work to uncover vulnerabilities to fraud in the Medicare program focused on specific areas as discussed above; consequently, opportunities for fraud may also exist in other areas of the Medicare program.

3. Is there any reason CMS cannot include penalties in its Medicare Administrative Contractor contracts for paying improper or fraudulent claims that you are aware of?

Consistent with the Social Security Act⁹ and applicable federal procurement regulations, CMS may include provisions in Medicare Administrative Contractor (MAC) contracts to: (1) prescribe the costs incurred by MACs in processing and paying Medicare claims that CMS may reimburse; (2) provide incentives or disincentives related to payment accuracy; and (3) hold MACs and their employees liable for improper or fraudulent claims payments under limited circumstances.¹⁰ Otherwise, neither the Social Security Act nor applicable federal procurement regulations expressly provides for CMS to reduce amounts owed to MACs under their contracts or to assess charges against MACs for improper or fraudulent claims payments.

The MAC contracts contain requirements for MACs to take certain actions and implement certain plans to manage Medicare trust fund finances and achieve

⁹Act of Aug. 14, 1935, ch. 531, 49 Stat. 620, as amended, 42 U.S.C. secs. 301 et seq.

¹⁰As required by section 911 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), CMS is replacing its Medicare Part A and Part B claims payment contractors (fiscal intermediaries and carriers) with MACs. This process must be completed by October 1, 2011. On behalf of CMS, MACs provide Medicare Part A and Part B claims processing and benefit payment services for providers and suppliers, among other functions. CMS awards cost-plus-award-fee type contracts to MACs, meaning that MACs are reimbursed for their allowable, allocable, and reasonable costs plus an award fee, up to amounts prescribed in the contracts, calculated using criteria in an award fee plan, in addition to a base fee amount. These contracts generally are subject to the Federal Acquisition Regulation (FAR), which includes rules, standards, and requirements for the awarding, administration, and termination of government contracts.

payment accuracy.¹¹ Under the MAC contracts, CMS reimburses MACs for the allowable, allocable, and reasonable costs of these efforts. While not considered a penalty, CMS may disallow any costs claimed by a MAC related to claims and payment processing, including finance and payment management, that fail to meet these standards.¹²

The Secretary of HHS is authorized to develop MAC-specific performance requirements and provide incentives to MACs to provide quality service and promote efficiency.¹³ This is consistent with provisions in the Federal Acquisition Regulation, subpart 16.4, that authorize the use of positive and negative incentives in incentive-type, cost-reimbursement contracts. These provisions appear to authorize performance standards in the MAC contracts related to making proper payments that would be considered in determining the amount of the fee earned by the contractor under a cost-plus-award-fee type contract or other incentive-type contract, as mutually agreed to by both the government and the contractor.

CMS has developed mechanisms—within the framework established by the statute—to encourage MACs to perform effectively and efficiently such as establishing an award fee program.¹⁴ Currently, we have ongoing work to examine how CMS has assessed the performance of the MACs. During our preliminary work, we noted that CMS has developed specific performance metrics as part of the award fee program to provide an incentive for MACs to achieve desired results. One of those metrics includes measuring a MAC's payment accuracy and ability to reduce improper claims payments. Because the MAC contracts have been awarded relatively recently, it is too soon to evaluate the effectiveness of providing an award fee for meeting a payment-accuracy metric.

With respect to improper or fraudulent benefit payments made by a MAC, section 1874A(d)(3) of the Social Security Act provides that a MAC shall not be held liable to the United States for payments made by its certifying or disbursing officers unless the MAC acts with reckless disregard of its contractual obligations or with intent to defraud the United States. It also provides that this exemption from liability does not

¹¹Under section 1874A of the Social Security Act, as amended by section 911 of MMA (42 U.S.C. § 1395kk-1), and the terms of their contracts with CMS, MACs receive and review Medicare Part A and Part B claims and approve those that comply with applicable laws, regulations, and CMS policies. To cover claims paid, the MACs draw on funds from a benefits account held by the commercial bank. CMS issues a letter of credit to authorize the funds into the benefits account. Payments may be made only by disbursing officers designated in writing by the MAC, based on the authorization of a separate certifying officer designated in writing by the MAC. (MACs are required by their contracts to account for benefit payments separately from their administrative costs.)

¹²Agencies may assess penalties for indirect costs submitted for payment that contain indirect costs expressly unallowable or determined unallowable pursuant to FAR §§ 42.709 through 42.709-6.

¹³42 U.S.C. § 1395kk-1(b).

¹⁴CMS also employs other tools to detect improper payments and fraud in the Medicare payment system, such as engaging Program Safeguard Contractors under the Medicare Integrity Program and Recovery Audit Contractors.

extend to violations of the False Claims Act.¹⁵ The False Claims Act authorizes a court to impose a civil penalty on a person for certain acts, including knowingly presenting or causing to be presented to an officer or employee of the United States a false or fraudulent claim for payment or approval.

We are providing copies of this correspondence to interested parties. This correspondence is also available on GAO's home page at <http://www.gao.gov>. Should you have any questions on matters discussed in this correspondence or need additional information, please contact me at (202) 512-9095 or by e-mail at dalykl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this correspondence. Key contributors to this correspondence are listed in enclosure I.



Kay L. Daly
Director
Financial Management and Assurance

Enclosures

¹⁵31 U.S.C. §§ 3729-3731. Individual certifying and disbursing officers are afforded the same exemption from liability.

Enclosure I: GAO Contact and Staff Acknowledgments

GAO Contact:

Kay L. Daly, (202) 512-9095 or dalykl@gao.gov

Staff Acknowledgments:

In addition to the contact named above Sabrina Springfield, Assistant Director; Sheila Avruch; LaSherri Bush; Richard Cambosos; F. Abe Dymond; Joy Kraybill; Crystal Lazcano; Sarah-Lynn McGrath; Olivia Smith; and David Yoder.

Related GAO Products

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.

High-Risk Series: An Update. [GAO-09-271](#). Washington, D.C.: January 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: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies. [GAO-07-59](#). Washington, D.C.: January 31, 2007.

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

Health Care Fraud: Schemes to Defraud Medicare, Medicaid, and Private Health Care Insurers. [GAO/T-OSI-00-15](#). Washington, D.C.: July 25, 2000.

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.

GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's Web site (www.gao.gov). Each weekday afternoon, GAO posts on its Web site newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to www.gao.gov and select "E-mail Updates."

Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's Web site, <http://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Web site: www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

Automated answering system: (800) 424-5454 or (202) 512-7470

Congressional Relations

Ralph Dawn, Managing Director, dawnr@gao.gov, (202) 512-4400
U.S. Government Accountability Office, 441 G Street NW, Room 7125
Washington, DC 20548

Public Affairs

Chuck Young, Managing Director, youngc1@gao.gov, (202) 512-4800
U.S. Government Accountability Office, 441 G Street NW, Room 7149
Washington, DC 20548