



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

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.

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MEDICARE AND MEDICAID FRAUD, WASTE, AND ABUSE

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

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.