



February 2015

IMPROPER PAYMENTS

TRICARE Measurement and Reduction Efforts Could Benefit from Adopting Medical Record Reviews

GAO Highlights

Highlights of [GAO-15-269](#), a report to congressional committees

Why GAO Did This Study

Improper payments—payments that were made in an incorrect amount or should not have been made at all—are a contributor to excess health care costs. For programs identified as susceptible to significant improper payments, federal agencies are required to annually report estimates of improper payments, their root causes, and corrective actions to address them. In fiscal year 2013, DOD spent about \$21 billion for TRICARE and estimated improper payments of \$68 million, or an error rate of 0.3 percent. That year, HHS estimated that \$36 billion, or 10.1 percent, of the total \$357 billion in Medicare payments were improper.

GAO was mandated to examine improper payments in TRICARE and Medicare. This report addresses (1) TRICARE and Medicare improper payment measurement comparability; and (2) the extent to which each program identifies root causes of, and develops corrective actions to address, improper payments. GAO examined DHA and CMS documentation related to improper payment measurement and corrective actions, reviewed relevant laws and guidance, and interviewed agency officials and contractors.

What GAO Recommends

DOD should implement more comprehensive TRICARE improper payment measurement methods that include medical record reviews, and develop more robust corrective action plans. DOD concurred with GAO's recommendations and identified steps the department will need to take for implementation. HHS had no comments on the report.

View [GAO-15-269](#). For more information, contact Vijay D'Souza at (202) 512-7114 or dsouzav@gao.gov.

February 2015

IMPROPER PAYMENTS

TRICARE Measurement and Reduction Efforts Could Benefit from Adopting Medical Record Reviews

What GAO Found

The Defense Health Agency (DHA), the agency within the Department of Defense (DOD) responsible for administering the military health program known as TRICARE, uses a methodology for measuring TRICARE improper payments that is less comprehensive than the methodology used to measure improper payments in Medicare, the federal health care program for the elderly and certain disabled individuals. Both methodologies evaluate a sample of health care claims paid or denied by the contractors that process the programs' claims. However, DHA's methodology only examines the claims processing performance of the contractors that process TRICARE's purchased care claims. Unlike Medicare, DHA does not examine the underlying medical record documentation to discern whether each sampled payment was supported. Without examining the medical record, DHA does not verify the medical necessity of services provided. The agency also does not validate that the diagnostic and procedural information reported on the claim matches the care and services documented in the medical record. Comparatively, the Department of Health and Human Services' (HHS) Centers for Medicare & Medicaid Services' (CMS) approach to measuring Medicare improper payments examines medical records associated with a sample of claims to verify support for the payment. This methodology more completely identifies improper payments beyond those resulting from claim processing errors, such as those related to provider noncompliance with coding, billing, and payment rules. By not examining medical record documentation to discern if payments are proper, TRICARE's reported improper payment estimates are not comparable to Medicare's estimates, and likely understate the amount of improper payments relative to the estimates produced by Medicare's more comprehensive methodology.

The root causes of TRICARE improper payments and related corrective actions that DHA has identified are limited to addressing issues of contractor noncompliance with claims processing requirements, and are less comprehensive than the corrective actions identified by CMS. For example, DHA has identified the same single corrective action for each of the last three fiscal years to promote contractor compliance, but it only addresses improper payments caused by contractors' claims processing errors. CMS, by comparison, reports more comprehensive information about root causes of improper Medicare payments, develops corrective actions that more directly address root causes, and uses the information to address the agency's goal of reducing future improper payments. For example, for fiscal year 2013, CMS determined that some payments were improper because the services could have been provided in less intensive settings and CMS subsequently implemented two policies to address the problem. In contrast, DHA's less comprehensive approach limits its ability to address the causes of improper payments in the TRICARE program.

Contents

Letter		1
	Background	3
	TRICARE Improper Payment Measurement Methodology Was Less Comprehensive than Medicare's, Which Led to Improper Payment Rates That Were Not Comparable	10
	TRICARE's Root Cause Analysis and Corrective Action Plans for Improper Payments Only Addressed Contractor Compliance and Were Less Comprehensive Than Medicare's	18
	Conclusions	20
	Recommendations for Executive Action	21
	Agency Comments	21
Appendix I	Comments from the Department of Defense	24
Appendix II	GAO Contact and Staff Acknowledgments	26
Related GAO Products		27
Tables		
	Table 1: Characteristics of TRICARE and Medicare Improper Payment Measurement Methodologies	14
	Table 2: Examples of Information Verified by TRICARE and Medicare Improper Payment Measurement Methodologies	15
Figure		
	Figure 1: TRICARE and Medicare Outlays and Estimated Improper Payments, Fiscal Year 2013	5

Abbreviations

AFR	agency financial report
CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
DHA	Defense Health Agency
DME	durable medical equipment
DOD	Department of Defense
FFS	fee-for-service
HHS	Department of Health and Human Services
IPIA	Improper Payments Information Act of 2002
MAC	Medicare Administrative Contractor
MCSC	managed care support contracts
OIG	Office of Inspector General
OMB	Office of Management and Budget
TPCC	TRICARE purchased care contractors

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.



February 18, 2015

Congressional Committees

Improper payments—payments that were made in an incorrect amount or should not have been made at all—contribute to excess health care costs. In fiscal year 2013, the Department of Defense (DOD) spent about \$21 billion for the purchased care portion of the military health program known as TRICARE.¹ The Defense Health Agency (DHA), which administers TRICARE, reported improper payments of \$68 million, or an error rate of 0.3 percent in 2013. That same year, the Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that administers the Medicare fee-for-service (FFS) program, estimated that \$36 billion, or about 10.1 percent, of the total \$357 billion in Medicare FFS payments were improper.² Federal agencies annually report improper payment estimates and error rates for certain programs as a requirement of the Improper Payments Information Act of 2002 (IPIA), as amended.³ These laws also require agencies to report the root causes of improper payments and identify corrective actions to address them.

¹TRICARE includes several benefit options to provide health care to military service members, retirees, and their families. Medical care under TRICARE is provided by DOD personnel in military treatment facilities, or through civilian providers in civilian facilities, which is known as TRICARE's purchased care system.

²Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare consists of four parts. Parts A and B are known as Medicare FFS. Part A covers hospital and other inpatient stays; and Part B covers hospital outpatient, physician, and other services. Part C, also known as Medicare Advantage, is the private plan alternative to Medicare FFS under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit. Separate error rates are reported for Part C and Part D.

³Pub. L. No. 107-300, 116 Stat. 2350 (2002), as amended by the Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, 124 Stat. 2224 (2010) and the Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248, 126 Stat. 2390 (2013) (codified, as amended, at 31 U.S.C. § 3321 note). TRICARE and Medicare fiscal year improper payment estimates represent payments from the prior year. Fiscal year 2013 estimates were the most recently available at the time we did our work.

The National Defense Authorization Act for Fiscal Year 2014 required that we examine the similarities and differences between TRICARE and Medicare improper payments.⁴ While Medicare is a much larger program than the TRICARE purchased care system, the programs are served by many of the same health care providers, and TRICARE uses some of Medicare's coverage and payment policies.⁵ This report addresses (1) the extent to which TRICARE's and Medicare's measurement of improper payments are comparable; and (2) the extent to which TRICARE and Medicare identify root causes of improper payments, and develop effective corrective action plans to reduce them.

To examine the extent to which TRICARE's and Medicare's measurement of improper payments are comparable, we reviewed relevant laws related to federal improper payment reporting and related Office of Management and Budget (OMB) guidance to understand improper payment error rate requirements. We also reviewed DOD and HHS fiscal year 2013 improper payments and measurement methodologies, as reported in their agency financial reports (AFR). Further, we reviewed improper payment error rate methodological documentation that is internal to the DHA and the CMS, as well as policy manuals and other guidance in effect during fiscal year 2013. In addition, we conducted interviews with officials from DHA and its contractor responsible for conducting the TRICARE claims reviews used to produce the TRICARE improper payment estimates. We also interviewed CMS officials and two of the four contractors responsible for the Comprehensive Error Rate Testing (CERT) program, which calculates the Medicare improper payment estimates. In addition, to understand how TRICARE and Medicare measurement methodologies relate to other claims-based programs, we interviewed representatives and reviewed documentation from four organizations with knowledge of the claims review practices of private health insurance plans.⁶ We also reviewed the

⁴Pub. L. No. 113-66, § 725(a), 127 Stat. 672, 800-801 (2013). Our review focused on Medicare FFS because both Medicare FFS and TRICARE purchased care operate as fee-for-service. That is, they do not employ capitated payment arrangements. Throughout this report, we refer to Medicare FFS as Medicare and refer to TRICARE purchased care as TRICARE.

⁵Most providers that participate in the TRICARE purchased care system, including hospitals, must also be Medicare participating providers. In addition, many of TRICARE's covered benefits mirror Medicare's coverage.

⁶We interviewed representatives from the American Association of Medical Audit Specialists, the American Association of Professional Coders, the America's Health Insurance Plans, and the National Association of Insurance Commissioners.

improper payment measurement methodologies of eight other federal claims-based payment programs, as reported in their respective fiscal year 2013 AFRs,⁷ as well as improper payment reviews conducted by HHS's Office of Inspector General (OIG).

To examine the extent to which TRICARE and Medicare identify root causes of improper payments, and develop effective corrective action plans to reduce them, we reviewed DOD's and HHS's AFRs for fiscal years 2011, 2012, and 2013; reviewed internal control standards for the federal government, and findings from our prior reports; and interviewed officials from DHA and CMS about their roles and responsibilities.

We conducted this performance audit from July 2014 to February 2015 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.

Background

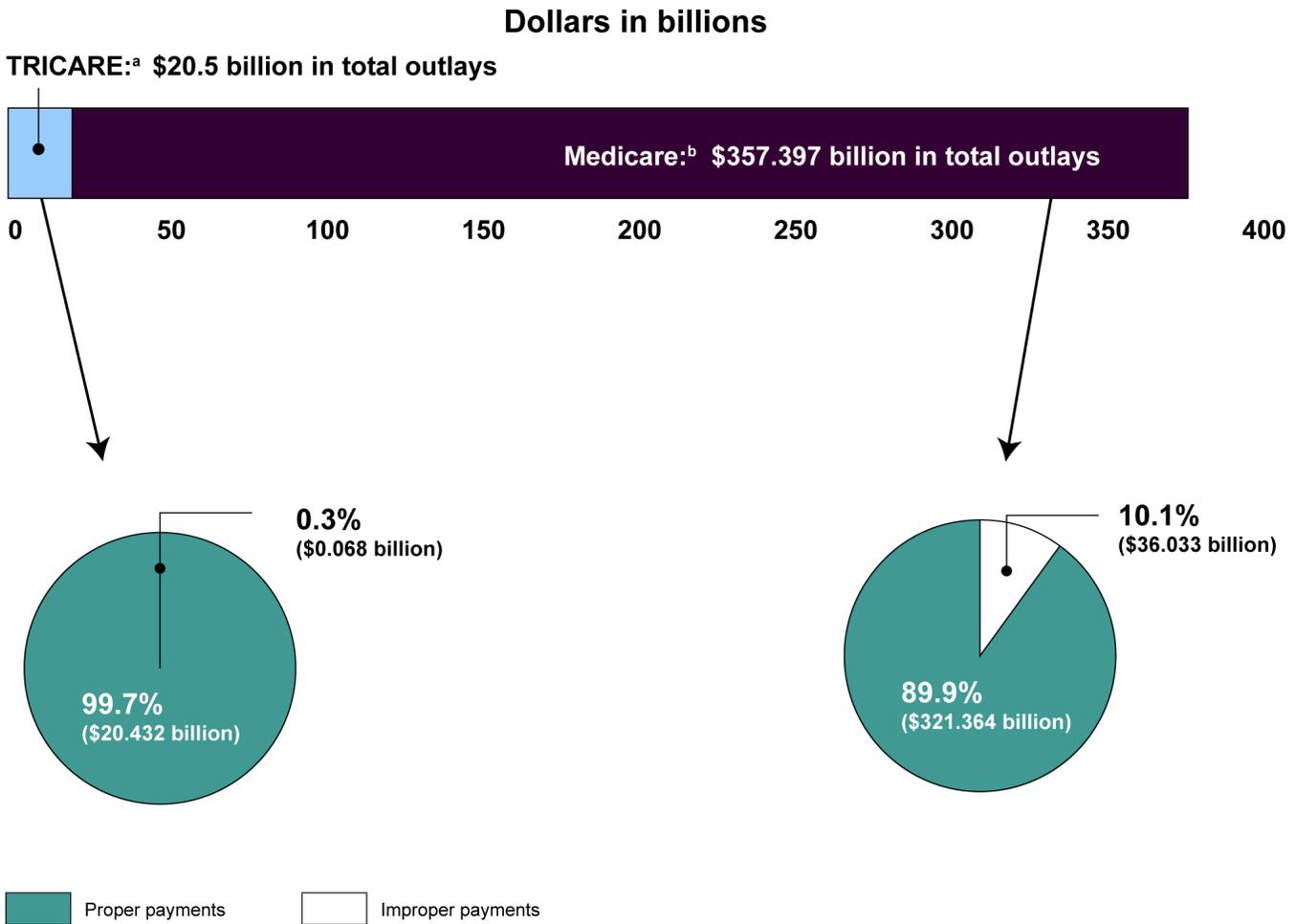
Fiscal year 2013 marked the 10th year of the implementation of IPIA, which, as amended, requires executive agencies to identify programs and activities susceptible to significant improper payments, estimate the amount of improper payments in susceptible programs and activities, and report these improper payment estimates, including root causes, and the actions taken to reduce them. In response to these requirements, executive agencies, including DOD and HHS, annually report improper

⁷We reviewed the methodologies of the Social Security Administration's Supplemental Security Income, Disability Insurance, and Old-Age and Survivors Insurance; HHS's Child Care Development Fund, Medicaid, and the Children's Health Insurance Program; the Office of Personnel Management's Federal Employee Health Benefit Program; and the Veterans Health Administration's Non-VA Care Fee program.

payment estimates and improper payment rates for certain programs in their AFRs.⁸ (See fig.1.)

⁸In November 2014, after we completed the majority of the work for this review, DOD published its fiscal year 2014 AFR, which included an estimated TRICARE improper payment rate of 0.87 percent. For fiscal year 2014, DHA modified its TRICARE improper payment calculation formula in response to our prior findings and those of the DOD-OIG, which we do not consider material for this review. HHS also published its fiscal year 2014 AFR in November 2014, including an estimated Medicare improper payment rate of 12.7 percent. CMS attributed some of the improper payment increase to documentation requirement changes for certain services. Although fiscal year 2014 improper payment reporting is outside the scope of this review, the fiscal year 2014 rates reported did not change the key findings of our review.

Figure 1: TRICARE and Medicare Outlays and Estimated Improper Payments, Fiscal Year 2013



Source: GAO analysis of Department of Defense and Department of Health and Human Services' fiscal year 2013 agency financial reports. | GAO-15-269

Notes:

The TRICARE and Medicare improper payment estimates represent payments from the prior fiscal year. Fiscal year 2013 estimates were the most recently available at the time we did our work.

^aTRICARE outlays and improper payment estimates include payments made through the TRICARE purchased care system. DOD refers to TRICARE purchased care payments as military health benefits in its agency financial report.

^bMedicare outlays and improper payment estimates are for the Medicare fee-for-service program.

TRICARE Purchased Care Payment Process

DHA uses private sector contractors—referred to as TRICARE purchased care contractors (TPCC)—to develop and maintain the private health care provider networks that make up the purchased care system, as well as process and pay claims. The TPCCs include three Managed Care Support Contractors (MCSC) that manage health care networks for most TRICARE benefits in the United States, one contractor to manage overseas claims, one contractor to manage TRICARE’s supplemental Medicare coverage program, one contractor to manage the pharmacy benefit, and three contractors to manage dental benefits.

Under TRICARE, private providers or TRICARE enrollees submit claims to TPCCs who, on behalf of TRICARE, are responsible for adjudicating and paying the claims according to established policies and procedures.⁹ TPCCs subject claims to automatic edits to ensure accuracy and determine how the claims will be adjudicated—either paid or denied. For example, automated edits compare claim information to TRICARE requirements in order to approve or deny claims or to flag them for additional review. TPCCs also conduct more in-depth reviews of certain claims prior to payment.¹⁰ The TPCCs processed about 200 million claims in fiscal year 2013.

Medicare Payment Process

Medicare providers submit claims to Medicare Administrative Contractors (MAC), which are responsible for processing and paying these claims, among other activities.¹¹ MACs subject claims to automatic prepayment edits to ensure accuracy, much like the automated edits in the TRICARE purchased care program.¹² For example, some prepayment edits are related to service coverage and payment, while others verify that the claim submissions contain needed information, that providers are enrolled

⁹TRICARE benefits managed by TPCCs are not paid through capitation arrangements—fixed amounts per member per time period—as may be used for other managed care programs. The MCSCs, a subset of the TPCCs, are held liable for payment errors for certain claims.

¹⁰TPCCs are required to conduct medical reviews for certain services, such as for experimental services. Medical reviews verify the medical necessity of services and involve interpretation of medical records by a registered nurse.

¹¹There were 12 MACs responsible for Medicare Parts A and B claims and 4 MACs responsible for durable medical equipment (DME) claims in fiscal year 2014.

¹²MACs review medical record documentation of certain claims prior to payment, such as those submitted by providers with identified problems submitting correct claims.

in Medicare, and that patients are eligible Medicare beneficiaries. The MACs processed 1.2 billion Medicare claims in 2013.

Postpayment Claims Reviews

DHA and CMS also subject a portion of TRICARE and Medicare claims to postpayment review by contractors to identify and recoup improperly paid claims. Most private health insurers also conduct postpayment reviews to identify improper payments, according to organizations we spoke to with knowledge of claims review practices. Multiple review methodologies exist depending on the objective of the review, but many require examination of the underlying medical record. For example, reviews examine the underlying patient medical record to validate that accurate codes were used,¹³ that services were rendered as the physician directed, were medically necessary,¹⁴ and were properly documented. The HHS-OIG, which carries out Medicare program integrity activities, uses medical record reviews to determine the scope of improper payments in targeted reviews of specific service types. HHS-OIG officials have stated that by reviewing medical records and other documentation associated with a claim, they can identify services that are undocumented, medically unnecessary, or incorrectly coded, as well as duplicate payments and payments for services that were not provided. For example, the HHS-OIG found that 61 percent of power wheelchairs provided to Medicare beneficiaries in the first half of 2007 were medically unnecessary or had claims that lacked sufficient documentation to determine medical necessity, which accounted for \$95 million in improper Medicare payments.¹⁵

¹³Claim reimbursement is based on the procedure codes and diagnosis codes included on each claim. Procedure codes describe what service, or bundle of services, were provided to the patient. Diagnosis codes establish why the visit and services provided during the visit were needed. Some portion of coding verification can be automated, but validation that the accurate diagnosis code was used requires medical record review by trained coders.

¹⁴Medical necessity means the health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms meet accepted standards of medicine. Both TRICARE and Medicare, as well as private health plans, define the medical necessity requirements in which they will pay for claims.

¹⁵See for example, HHS-OIG, *Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines*, OEI-04-09-00260, July 2011.

Improper Payment Reporting Requirements

IPIA, as amended, requires federal executive branch agencies to (1) review all programs and activities, (2) identify those that may be susceptible to significant improper payments, (3) estimate the annual amount of improper payments for those programs and activities, (4) implement actions to reduce the root causes of improper payments and set reduction targets, and (5) report on the results of addressing the foregoing requirements. In response to these requirements and OMB implementing guidance, agencies generally publicly report their improper payment estimates each November in their AFRs.¹⁶

An improper payment is defined by statute as 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. It includes duplicate payments, and any payment made for an ineligible recipient, an ineligible good or service, a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts.¹⁷ OMB guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation is found.¹⁸

The extent of agencies' reported improper payments depends, in part, on how they test program components for errors. While OMB's implementation guidance provides parameters for developing statistically valid estimates, it does not specifically dictate how agencies should test

¹⁶For programs with improper payment estimates greater than \$10 million, agencies must report the gross estimates of the annual amount of improper payments (i.e., overpayments plus underpayments) made in the program and a description of the methodology used to derive those estimates in their AFRs.

¹⁷IPIA, § 2(g)(2) (codified, as amended, at 31 U.S.C. § 3321 note).

¹⁸OMB, Memorandum M-11-16, *Issuance of Revised Parts I and II to Appendix C of OMB Circular A-123* (Apr. 14, 2011); OMB, Memorandum M-15-02, *Appendix C of OMB Circular A-123, Requirements for Effective Estimation and Remediation of Improper Payments* (Oct. 20, 2014).

for improper payments.¹⁹ According to OMB officials, the latitude in the guidance is because of the variation in how federal programs operate.

Although OMB's implementation guidance allows such variation, several federal programs which pay for services based on claims submitted by beneficiaries or providers, including Medicare, examined the underlying documentation for each of a sample of claims to determine the validity of payments as part of their efforts to estimate improper payments in fiscal year 2013.²⁰ For example, CMS's method for testing payments for errors in Medicaid fee-for-service and Children's Health Insurance Program fee-for-service includes both a claims processing review and medical record review.²¹ Most Medicaid and Children's Health Insurance Program improper payments were identified through the medical record reviews in fiscal year 2013.

With respect to IPIA's required root cause analysis and corrective action reporting,²² the corrective actions agencies develop depend, in part, on the improper payments identified by their measurement methodology. OMB guidance on corrective actions states that agencies should continuously use their improper payment measurement results to identify new and innovative corrective actions to prevent and reduce improper payments. Internal control standards for the federal government also state that federal agencies should establish policies and procedures to

¹⁹For the purposes of this review, we examined improper payment testing methodology, which refers to how the agency reviews payments to identify whether they were improper. By comparison, the agency's sampling methodology—how it determines which payments to sample to provide a statistically significant error rate—and the statistical methods used to calculate improper payment rates are outside the scope of this review. Additionally, DOD-OIG recently issued a review of DHA's sampling and estimating methodologies. See DOD-OIG, *DoD Methodologies to Identify Improper Payments in the Military Health Benefits and Commercial Pay Programs Need Improvement*, DODIG-2015-068, January 15, 2015.

²⁰In addition to Medicare, the following six federal programs reviewed the underlying documentation from providers or beneficiaries: Medicaid, Children's Health Insurance Program, Child Care Development Fund, Disability Insurance, Old-Age and Survivor's Insurance, and Supplemental Security Income.

²¹Medicaid and the Children's Health Insurance Program are the joint federal-state programs administered by the states that provide health insurance to certain low-income individuals and children. CMS also reports separate beneficiary eligibility improper payment rates for Medicaid and the Children's Health Insurance Program.

²²IPIA, § 2(d) (codified, as amended, at 31 U.S.C. § 3321 note).

ensure that the findings of audits and other reviews—including the improper payment measurement results—are promptly addressed and corrected.²³

TRICARE Improper Payment Measurement Methodology Was Less Comprehensive than Medicare's, Which Led to Improper Payment Rates That Were Not Comparable

DHA's approach to measuring improper payments in TRICARE was less comprehensive than that used by CMS for Medicare. Both methodologies evaluate a sample of health care claims paid or denied by the contractors that process program claims. However, while CMS's methodology examined underlying patient medical records supporting each of the sampled claims, DHA did not evaluate comparable medical record documentation to discern whether each payment was supported. Consequently, TRICARE's reported improper payment estimates were not comparable to Medicare's estimates, and likely understated the amount of improper payments in the TRICARE program relative to the estimates produced by Medicare's more comprehensive measurement methodology.

TRICARE's Improper Payment Measurement Methodology Was Less Comprehensive than Medicare's Methodology

The improper payment measurement methodology that DHA used to estimate the TRICARE improper payments reported in DOD's fiscal year 2013 AFR was less comprehensive than the measurement methodology CMS used to estimate Medicare improper payments. Specifically, the supporting documentation that DHA's methodology examined to test whether sampled health care claims were paid properly was less comprehensive than Medicare's methodology, which examined medical record documentation for each sampled claim. According to DHA and CMS guidance, the agencies also developed their measurement methodologies for different purposes.

TRICARE: DHA's approach to measuring TRICARE improper payments examined whether the TPCCs processed and paid submitted claims according to TRICARE policies. Since 1994, DHA has employed a contractor to conduct postpayment claims reviews for the primary purpose of determining the accuracy of TPCCs' claims processing and

²³GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999).

compliance with TRICARE policy, according to DHA's claims review contractor guidance, and contractor and DHA officials.²⁴ DHA officials reported that DHA has also aggregated these TPCC-specific compliance reviews to report the national TRICARE improper payment rate, as required by IPIA since 2003. While DHA has changed aspects of the compliance review methodology to meet reporting requirements for statistically significant estimates,²⁵ and, according to DHA, to reflect legal and contractual changes impacting TRICARE, the basic process of reviewing claims has not changed in 20 years. As a result, DHA continues to only identify improper payments due to contractor compliance problems.

To determine the TPCCs' claims processing performance, the TRICARE claims review contractor examines a sample of paid and denied claim records, including any documentation used by the TPCC to adjudicate the claim. For each of the claims the DHA samples, the TPCC is required to send to the TRICARE claims review contractor copies of the processed claim, the beneficiary's claim history, and any documentation it used to process the claim. According to DHA and claims review contractor officials, the documentation varies by claim and can include information from the DHA eligibility database or prior authorization and referral forms. DHA and claims review contractor officials reported that medical record documentation is only included in the improper payment claims review if the TPCC conducted a medical review as part of its original claim processing.²⁶ According to the TRICARE claims review contractor, DHA officials, and the agency's claims review guidance, the contractor conducts automated and manual reviews of the claim and supporting documentation to verify that the TPCC processed the claim according to

²⁴In this report, we refer to this contractor as the TRICARE claims review contractor.

²⁵DHA has developed sample sizes to comply with OMB precision standards and has added active duty dental claims and pharmacy claims, in addition to medical claims, to its improper payment estimates. For fiscal year 2014, DHA also changed its improper payment calculation so that it is based on the paid amount, rather than billed amount, in response to past GAO and DOD-OIG findings. Though these changes improve the accuracy of estimates related to TPCC claims processing errors—the sampling methodology and statistical methods, they do not address the underlying method of testing claims—the testing methodology.

²⁶TPCCs are required to conduct prepayment medical reviews for certain services, such as for experimental services. Medical reviews verify the medical necessity of services and involve interpretation of medical records by a registered nurse. DHA could not provide the percentage of claims that TPCCs review for medical necessity prior to payment.

TRICARE policy and contract requirements. For example, the claims review contractor uses automated auditing tools to verify the clinical accuracy of procedure codes listed on the claim. It also verifies that the beneficiary and provider were eligible, the claimed services were covered TRICARE benefits, the TPCC calculated correct pricing and cost sharing, and prior authorization and medical necessity were documented when necessary, among other things. If a medical review was conducted by the TPCC, DHA and the TRICARE claims review contractor told us that the contractor does not typically re-evaluate the TPCC's decision, but only ensures that the documentation exists.²⁷ Based on a review of DHA's claims review guidance and statements from DHA and claims review contractor officials, DHA's improper payment measurement methodology also does not independently validate that the medical records support the diagnosis or procedure codes submitted on the claim.

According to DHA guidance, if the TPCC did not provide a copy of the claim or processed the claim incorrectly based on the documentation provided, the claims review contractor will consider some or all of the payment as an error and action is taken to adjust the payments accordingly. DHA guidance provides TPCCs the opportunity to submit additional documentation to support their processing decisions and remove certain errors. After the audit results are finalized, DHA uses the information to calculate improper payment rates for each TPCC and to estimate its national improper payment rate.

Medicare: CMS developed the Comprehensive Error Rate Testing (CERT) program to estimate the national Medicare improper payment rate to comply with IPIA, and to monitor payment decisions made by the MACs, according to CMS's CERT guidance.²⁸ CMS's CERT program

²⁷The TRICARE claims review contractor is required to have clinical staff (e.g. registered nurse and physician) accessible to conduct a medical review. Although the claims review contractor has such staff available, DHA and review contractor officials we spoke to said the review contractor had not completed an independent medical review for any claims in at least the last four years.

²⁸CMS originally established two programs to monitor the payment accuracy of the Medicare FFS program: the Hospital Payment Monitoring Program and the CERT program. The Hospital Payment Monitoring Program measured the improper payment rate only for Part A inpatient hospital claims, while the CERT program measured the improper payment rate for all other Part A and Part B Medicare FFS claim types. Beginning with the 2009 reporting period, the Hospital Payment Monitoring Program was dissolved and the CERT program became fully responsible for sampling and reviewing all Medicare claim types for improper payments.

methodology focuses on compliance with conditions of Medicare's payment policies by both the provider and MAC.²⁹ The CERT program targets high-risk aspects of the Medicare program. Specifically, CMS officials told us that because Medicare maintains common shared systems that determine for all MACs whether a provider is enrolled in Medicare, and what the payment rate should be, CMS has deemed these aspects of the claims payment process to be at low risk of improper payments, and they are not examined through CERT.³⁰ Instead, the CERT program focuses on problems that MACs cannot otherwise identify using automated means, according to CMS officials. CMS has employed contractors to carry out the CERT program since 2003.³¹ CMS has reported that the agency has modified the CERT measurement methodology to address identified trends and improve accuracy.

CMS's approach to measuring improper payments involves examining the medical record associated with a stratified random sample of processed Medicare claims to determine whether there is support for the payment, and to assess whether the payment followed Medicare's coverage, coding, and billing rules. CMS's CERT guidance specifies that, for each sampled claim, the CERT documentation contractor obtain the medical record and other pertinent documentation from the provider that submitted the claim.³² If the provider does not provide the medical record and other requested information, the CERT review contractor identifies the payment amount as an error. According to CMS's CERT guidance and contractor officials, when medical records are received, the contractor's clinical and coding specialists review the claim and the supporting medical records to assess whether the claim followed

²⁹For the purposes of this report we refer to providers and suppliers—those that provide DME supplies—collectively as providers.

³⁰According to CMS officials, the agency has other checks in place to ensure the correct functionality of the Medicare provider enrollment and shared claims processing systems.

³¹There are four CERT contractors—statistical, claims review, documentation, and electronic support—that work together to carry out the CERT program. This report focuses on the work of the CERT documentation and claims review contractors.

³²Other pertinent documentation varies by type of claim, but in nearly all circumstances includes the medical record. For example, for DME claims, the contractor could request a certificate of medical necessity or model device number in addition to the medical records that support the medical necessity of the device. If the MAC fully denied the sampled claim for a reason other than medical review, then the CERT reviewer would only validate proper processing of the claim and not review the medical record.

Medicare’s payment rules. Claims that do not follow Medicare’s payment rules or claims for which the provider submitted insufficient documentation to determine that the services were provided or medically necessary are classified as an error by the CERT reviewer and action is taken to adjust the payments accordingly. Medicare allows providers whose claims were denied by the CERT review contractor to appeal those claims, and if the error determination for a claim is overturned through the appeals process, the CERT review contractor adjusts the error accordingly.³³ Once all the errors are finalized, the CERT statistical contractor calculates the national error rates. Table 1 compares the purpose of and documentation reviewed by the TRICARE and Medicare improper payment measurement methodologies.

Table 1: Characteristics of TRICARE and Medicare Improper Payment Measurement Methodologies

	TRICARE	Medicare
Claims review program used to measure improper payments	TRICARE claims review	Comprehensive Error Rate Testing
Primary purpose of claims review program	To determine the accuracy of TRICARE purchased care contractors’ (TPCC) claims processing procedures and compliance with TRICARE policies	To estimate the national Medicare fee-for-service improper payment rate and a rate for each Medicare Administrative Contractor
Documentation examined	Varies by claim, support for claim processing decisions obtained from TPCC. Processing documentation reviewed for claim processing accuracy. Medical record obtained for certain claims, but not reviewed by clinical staff for validity of claimed information.	Medical record and other pertinent information obtained from provider or supplier that submitted claim. Medical record reviewed by clinical staff and certified medical coders for validity of claimed information.

Source: GAO analysis of Defense Health Agency and Centers for Medicare & Medicaid Services information. | GAO-15-269

TRICARE’s Methodology Is Likely to Understate Its Improper Payment Rate Compared to Medicare’s Methodology

Compared to DHA’s methodology, CMS’s CERT methodology of examining underlying medical records to independently verify Medicare claims and payments more completely identifies potential improper payments, such as those caused by provider noncompliance with coding, billing, and payment rules. While DHA’s methodology is designed to identify improper payments resulting from TPCC claims processing compliance errors, it does not comprehensively capture errors that occur

³³The Medicare appeals process provides beneficiaries, providers, and suppliers the ability to dispute Medicare coverage and payment decisions.

at the provider level or errors that can only be identified through an examination of underlying medical record documentation. Table 2 compares examples of the information verified by the TRICARE and Medicare improper payment measurement methodologies.

Table 2: Examples of Information Verified by TRICARE and Medicare Improper Payment Measurement Methodologies

Type of information reviewed	Verified by measurement methodology	
	TRICARE	Medicare
Contractor claims processing review		
Beneficiary eligibility for services	●	●
Claim was properly executed (e.g., appropriate provider or beneficiary signatures on the claim)	●	●
Services indicated on claim were an appropriate program benefit	●	●
Procedure code reflects diagnosis and information on claim	●	●
Other insurance liability reflected in payment	●	●
No duplicate payments in claim history	●	●
Correct pricing and cost sharing used to calculate payment	●	○
Medical record review		
Evidence of medical necessity—medical record supports that services paid were medically necessary	○	●
Verification of correct coding—medical record supports that correct procedure and diagnosis codes were used	○	●
Documentation of provider services—provider has documentation to support the services claimed	○	●

Legend: ● = Measurement methodology verifies, ○ = Measurement methodology does not verify

Source: GAO analysis of Defense Health Agency and Centers for Medicare & Medicaid Services information. | GAO-15-269

CMS’s CERT methodology identifies certain improper payments that DHA’s TRICARE claims review methodology would not fully identify. Such improper payments accounted for nearly all of the 10.1 percent improper payment rate that CMS reported in fiscal year 2013. For example, differences include:

- **Evidence of medical necessity:** As noted, the TRICARE claims review contractor’s medical necessity review is limited to confirming that the TPCC completed a medical review when required and the claim passed certain edits. Consequently, the review contractor may not identify payments for medically unnecessary services for the claims that a TPCC did not previously review. The claims review contractor would also fail to identify if the TPCC made an improper medical necessity determination for those claims that it was required to review because the claims review contractor does not re-review the TPCC’s determination. Conversely, CMS’s CERT methodology identifies such

errors. Through the CERT program's independent medical record review for each sampled claim, CMS has estimated that improper payments related to medically unnecessary services accounted for 2.8 percent of total Medicare payments and 26.6 percent of total improper payments in fiscal year 2013.

- Verification of correct coding: The TRICARE claims review contractor confirms that the codes used for reimbursement matches the diagnosis claimed and passed coding edits,³⁴ but does not verify that the medical documentation validates the codes that were billed or diagnosis claimed. As a result, the TRICARE claims review methodology could fail to identify if a provider used, and the TPCC paid for, services based on an incorrect code. CMS's CERT program identifies such errors and estimated that 1.5 percent of Medicare payments in fiscal year 2013 were improper because of incorrect coding. Such errors accounted for 13.7 percent of total estimated improper payments that year.
- Documentation of provider services: Since DHA's claims review methodology does not request documentation from providers, it is unclear whether TRICARE providers maintain the required documentation to support the services they claim.³⁵ In contrast, CMS estimated that 6.1 percent of Medicare payments were improper in fiscal year 2013 because of insufficient documentation, which accounted for 56.8 percent of total estimated improper payments.³⁶ That is, the provider submitted some documentation, but the CERT reviewer could not conclude that some of the allowed services were actually provided at the level billed or were medically necessary. In addition, "no documentation" errors—where the provider submitted none of the requested medical records—accounted for 0.2 percent of

³⁴Automated edits are programmed to verify the accuracy of procedure code billing on claims. For example, edits identify situations in which the beneficiary's age or gender does not correlate with the procedure code.

³⁵If the TPCC did not provide required documentation to the review contractor to support its adjudication decision, then the TRICARE claims review contractor will consider the payment improper. While this verifies that the TPCC reviewed documentation when needed, it does not verify that the provider maintained the required documentation for every sampled claim.

³⁶CERT categorizes errors into five types—(1) medical necessity, (2) incorrect coding, (3) insufficient documentation, (4) no documentation, and (5) other. Other errors, such as duplicate payments, accounted for 0.2 percent of total Medicare payments and 1.4 percent of total improper payments that year.

Medicare payments or 1.4 percent of total improper payments in fiscal year 2013.

DHA officials reported that TRICARE has other postpayment mechanisms in place to examine medical records and thus identify the types of improper payments that the TRICARE claims review program does not. However, the results of the other mechanisms are not reflected in the estimated improper payment rates that DHA reports. For example, DHA conducts quality monitoring reviews that analyze medical record documentation and identify problems such as paid services that were not medically necessary. DHA policy also requires the TPCCs to conduct quarterly internal reviews of a sample of medical records to determine the medical necessity of care provided, and determine if the diagnostic and procedural information of the patient—as reported on the claim—matches the physician’s description of care and services documented in the medical record. However, the potential problems identified by these reviews are not considered or publicly reported as improper payments in the DOD’s AFR.

Due to the fundamental differences in DHA’s and CMS’s approaches to measuring improper payments, reported improper payment rates for TRICARE and Medicare are not comparable. By not examining underlying medical record documentation to discern if payments for claims are proper, DHA is likely not identifying all types of improper payments in TRICARE, and thus understating the rate of improper payments. OMB’s IPIA implementation guidance does not specifically dictate how agencies should test for improper payments. However, Medicare and certain other federal claims-based programs conduct more comprehensive reviews that include examination of the underlying documentation for each sampled claim to determine the validity of payment as part of their efforts to estimate improper payments under IPIA. The HHS-OIG and most of the organizations with knowledge of health care claims review practices that we spoke with also acknowledge that reviewing the underlying medical records is needed to verify appropriate payment.

TRICARE's Root Cause Analysis and Corrective Action Plans for Improper Payments Only Addressed Contractor Compliance and Were Less Comprehensive Than Medicare's

The root causes and related corrective actions that DHA reported in DOD's fiscal year 2013 AFR are limited to addressing issues of contractor noncompliance with claims processing requirements. For example, DHA reported the following root causes for the 0.3 percent errors it found to be improper: incorrect pricing for medical procedures and equipment (47 percent), missing authorization or pre-authorization (14 percent), and cost sharing or deductible miscalculations (11 percent).³⁷ These categories are largely processing errors that reflect DHA's approach to identifying errors, and do not address underlying causes of improper payments not related to contractor compliance, such as errors made by providers who may not fully understand or comply with DHA policies. DHA cannot fully identify provider-level improper payment errors without reviews of the paperwork submitted by providers, including reviews of underlying medical records.

DHA's one corrective action for TRICARE for the past three fiscal years—to incentivize payment accuracy through contract bonuses and penalties based on audit results—may be a good method to promote contractor compliance, but it will not address providers' noncompliance with billing rules. DHA officials said that they have not changed or added to the corrective action plan in at least three fiscal years because contract requirements are still in place to financially incentivize contractors to process health care claims correctly. Although DHA could include other corrective actions, the current approach only addresses improper payments caused by contractors' claims processing errors.

Under the IPIA, as amended, and implementing guidance, agencies are to identify program weaknesses, make improvements, and reduce future improper payments. Our prior work has found that DHA missed opportunities to prevent future improper payments; for example, in a May 2013 report examining IPIA compliance throughout DOD, we found that DOD did not adequately implement key IPIA provisions and OMB requirements for fiscal year 2011. We recommended that DOD's corrective action plans be developed using best practices to ensure that root causes are addressed, improper payments reduced, and federal dollars protected.³⁸ A senior DOD official told us that the agency planned

³⁷The remaining 28 percent of TRICARE errors were not categorized in DOD's fiscal year 2013 AFR root cause analysis.

³⁸GAO, *DOD Financial Management: Significant Improvements Needed in Efforts to Address Improper Payment Requirements*, [GAO-13-227](#) (Washington, D.C.: May 2013).

to implement this recommendation by November 15, 2014; however, DHA cannot address these recommendations with respect to TRICARE until it has identified improper payments using a measurement methodology that goes beyond contractor compliance issues.

CMS, by comparison, reported more detailed and constructive information about the 10.1 percent of Medicare payments it reported as improper in HHS's fiscal year 2013 AFR. In addition to describing the types of errors that most frequently led to improper payments, CMS also provided contextual information about specific factors that contributed to the errors. For example, CMS reported that some improper payments were made for services that, while clinically appropriate, could be provided in less intensive settings and therefore did not meet Medicare's medical necessity requirements. CMS also identified the provider types that contributed most substantially to each type of improper payment. For example, hospitals contributed substantially to medical necessity errors.

CMS's multiple corrective actions are more detailed and clearly tied to reported root causes of Medicare improper payments than TRICARE's. For example, CMS is

- expanding the Medicare Recovery Audit Contractor program to allow prepayment reviews of certain types of claims with historically high amounts of improper payments, therefore preventing improper payments from being made in the first place;³⁹ and
- implementing two policies pertaining to inpatient hospital claims that will specifically address the identified root cause of care being provided in inappropriately intensive settings.

CMS provides MACs with contract-specific root causes of improper payment data on a quarterly basis. These data are used by MACs to update their corrective actions quarterly.⁴⁰ Quarterly updates to corrective actions allow CMS and its contractors to tailor efforts to address specific root causes of errors, and review its plans for reducing errors using

³⁹Medicare Recovery Audit Contractors identify underpayments and overpayments, and recoup overpayments in the Medicare program.

⁴⁰In their plans, contractors must describe the corrective actions (that is, medical review and provider outreach and education actions) that they plan to take to lower their error rates.

measurable targets, which help the agency know when it has made progress in addressing program weaknesses.

In addition to reporting root causes and corrective actions in the AFR, CMS uses its Medicare improper payment results to address the agency's stated goal of reducing Medicare improper payments due to programmatic weaknesses. For example, CMS

- annually develops and reports a more detailed analysis of improper payment findings than is provided in the AFR by providing specific examples of areas identified as particularly vulnerable to improper payments, analysis of root causes of those errors, and detailed error information by service and provider;⁴¹ and
- undertakes program-wide action to address improper payment findings. For example, after finding that durable medical equipment suppliers contributed substantially to insufficient documentation errors, CMS began a prior authorization demonstration in seven states to reduce improper payments for power mobility devices.

In comparison with DHA, CMS has a more comprehensive approach to identifying Medicare improper payments and root causes, and addresses those weaknesses through its corrective actions. Without a more comprehensive approach, DHA will be limited in its ability to address the causes of improper payments in the TRICARE program.

Conclusions

The extent of improper payments identified by agencies depends, in part, on how they test their program components for errors. TRICARE and Medicare are at similar risk for improper payments because both health care programs pay providers on a fee-for-service basis, the programs' providers overlap, both programs depend on contractors to process and pay claims, and TRICARE uses some of Medicare's coverage and payment policies. However, DHA does not have as robust an approach to measuring improper payments in the TRICARE program as CMS has for the Medicare program. Specifically, DHA does not routinely examine medical record documentation in its approach to measuring TRICARE improper payments. While DHA has other reviews in place that analyze

⁴¹HHS, *The Supplementary Appendices for the Medicare Fee-for-Service 2013 Improper Payments Report* (January 2014); HHS, *Medicare Fee-for-Service 2013 Improper Payments Report* (July 2014).

medical record documentation and could be leveraged to more comprehensively identify improper payments, the results of those reviews are not considered or reported as improper payments. This may account for why the reported improper payment rate for TRICARE is less than 1 percent while the reported rate for Medicare is 10 percent. Although TRICARE is a smaller program compared to Medicare, it still costs the government a significant amount of money—about \$21 billion in fiscal year 2013 for the purchased care portion of TRICARE—and DOD has determined TRICARE to be susceptible to significant improper payments under IPIA, as amended. Without a robust measure of improper payment rates in the TRICARE program, DHA cannot effectively identify root causes and take steps to address practices that contribute to improper payments and excess spending.

Recommendations for Executive Action

To better assess and address the full extent of improper payments in the TRICARE program, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following two actions:

1. implement a more comprehensive TRICARE improper payment measurement methodology that includes medical record reviews, as done in other parts of its existing postpayment claims review programs; and
2. once a more comprehensive improper payment methodology is implemented, develop more robust corrective action plans that address underlying causes of improper payments, as determined by the medical record reviews.

Agency Comments

We provided a draft of this report to DOD and HHS for comment. In its written comments, reproduced in appendix I, DOD concurred with our recommendations. DOD also outlined the steps the department will take prior to implementation, including conducting discussions within the department; developing implementation plans; and hiring or contracting for the needed workforce to begin implementing the recommendations. DOD noted that taking these steps would take time. Given the potentially high cost of improper payments, we believe DOD should move expeditiously. HHS had no comments on the report.

We are sending copies of this report to appropriate congressional committees, the Secretary of Defense, the Assistant Secretary of Defense (Health Affairs), the Secretary of Health and Human Services, the Administrator of CMS, and other interested parties. The report also will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or dsouzav@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix II.



Vijay A. D'Souza
Director, Health Care

List of Committees

The Honorable John McCain
Chairman
The Honorable Jack Reed
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Thad Cochran
Chairman
The Honorable Richard J. Durbin
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Mac Thornberry
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable Rodney Frelinghuysen
Chairman
The Honorable Pete Visclosky
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: Comments from the Department of Defense



DEFENSE
HEALTH AGENCY

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS**

7700 ARLINGTON BOULEVARD, SUITE 5101
FALLS CHURCH, VIRGINIA 22042-5101

JAN 22 2015

Mr. Vijay D'Souza
Director, Health Care
U.S. Government Accountability Office
441 G Street, NW
Washington DC 20548

Dear Mr. D'Souza:

This is the Department of Defense response to the Government Accountability Office (GAO) Draft Report GAO-15-269, "IMPROPER PAYMENTS: TRICARE Measurement and Reduction Efforts Could Benefit from Adopting Medical Record Reviews," dated December 23, 2014 (GAO Code 291216).

Thank you for the opportunity to review and provide comments on the Draft Report. Overall, I concur with the report's findings and conclusions and provide responses to the two recommendations.

My specific comments to Recommendations 1 and 2 are enclosed for your consideration to incorporate into the Final Report. The Defense Health Agency continues to strive for achieving appropriateness in the identification and reporting of improper payments under the TRICARE Program. The Agency welcomes the findings as a method for identifying areas of potential weakness and a means for improving operational procedures.

My points of contact for this issue is Ms. Karla Johnson-Griffith (Functional) who may be reached at (303) 676-3726, or Karla.Johnson-Griffith@dha.mil and Mr. Gunther Zimmerman (Audit Liaison) who may be reached at (703) 681-4360, or Gunther.Zimmerman@dha.mil.

Sincerely,


Joseph B. Marshall, Jr.
Director, Business Support Directorate

Enclosures:
As stated

GAO DRAFT REPORT DATED DECEMBER 23, 2014
GAO-15-269 (GAO CODE 291216)

“IMPROPER PAYMENTS: TRICARE MEASUREMENT AND REDUCTION
EFFORTS COULD BENEFIT FROM ADOPTING MEDICLA RECORD REVIEWS”

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATION

To better assess and address the full extent of improper payments in the TRICARE program, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to take the following two actions:

RECOMMENDATION 1: Implement a more comprehensive TRICARE improper payment measurement methodology that includes medical record reviews, as done in other parts of its existing post payment claims review programs; and

DEPARTMENT OF DEFENSE RESPONSE: Concur. Defense Health Agency’s policy, procedures and contractual requirements for identifying improper payments include the review of TRICARE purchased care contractors’ claims processing procedures by an independent contractor, and the statistically valid sampling of medical, pharmacy, and active duty dental claims. As noted, reviews have been performed to ensure that purchased care contractors’ claims are processed in accordance with TRICARE policy and contract requirements.

Implementing a more comprehensive improper payment measurement methodology that includes medical record reviews is possible, but will require time to:

1. Conduct in-depth discussions with agency components;
2. Develop an enterprise-wide implementation plans; and
3. Hire or contract for the workforce required to achieve the proposed recommendation.

RECOMMENDATION 2: Once a more comprehensive improper payment methodology is implemented, develop more robust corrective action plans that address underlying causes of improper payments, as determined by the medical record reviews.

DEPARTMENT OF DEFENSE RESPONSE: Concur with no comment.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Vijay D'Souza, (202) 512-7114 or dsouzav@gao.gov

Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Rebecca Abela; Drew Long; Dawn Nelson; and Jennifer Whitworth made key contributions to this work.

Related GAO Products

Improper Payments: Government-Wide Estimates and Reduction Strategies. [GAO-14-737T](#). Washington, D.C.: July 9, 2014.

Medicare: Further Action Could Improve Improper Payment Prevention and Recoupment Efforts. [GAO-14-619T](#). Washington, D.C.: May 20, 2014.

Medicare Program Integrity: Contractors Reported Generating Savings, but CMS Could Improve Its Oversight. [GAO-14-111](#). Washington, D.C.: October 25, 2013.

Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency. [GAO-13-522](#). Washington, D.C.: July 23, 2013.

DOD Financial Management: Significant Improvements Needed in Efforts to Address Improper Payment Requirements. [GAO-13-227](#). Washington, D.C.: May 13, 2013.

Medicare Program Integrity: Few Payments in 2011 Exceeded Limits under One Kind of Prepayment Control, but Reassessing Limits Could Be Helpful. [GAO-13-430](#). Washington, D.C.: May 9, 2013.

Medicaid: Enhancements Needed for Improper Payments Reporting and Related Corrective Action Monitoring. [GAO-13-229](#). Washington, D.C.: March 29, 2013.

Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment. [GAO-13-102](#). Washington, D.C.: November 13, 2012.

Program Integrity: Further Action Needed to Address Vulnerabilities in Medicaid and Medicare Programs. [GAO-12-803T](#). Washington, D.C.: June 7, 2012.

Improper Payments: Remaining Challenges and Strategies for Governmentwide Reduction Efforts. [GAO-12-573T](#). Washington, D.C.: March 28, 2012.

Improper Payments: Moving Forward with Governmentwide Reduction Strategies. [GAO-12-405T](#). Washington, D.C.: February 7, 2012.

Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness. [GAO-11-592](#). Washington, D.C.: July 29, 2011.

Improper Payments: Reported Medicare Estimates and Key Remediation Strategies. [GAO-11-842T](#). Washington, D.C.: July 28, 2011.

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

Improper Payments: Status of Agencies' Efforts to Address Improper Payment and Recovery Auditing Requirements. [GAO-08-438T](#). Washington, D.C.: January 31, 2008.

Improper Payments: Federal Executive Branch Agencies' Fiscal Year 2007 Improper Payment Estimate Reporting. [GAO-08-377R](#). Washington, D.C.: January 23, 2008.

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

Strategies to Manage Improper Payments: Learning From Public and Private Sector Organizations. [GAO-02-69G](#). Washington, D.C.: October 2001.

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 website (<http://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <http://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 website, <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.

Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#). Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#). Visit GAO on the web at www.gao.gov.

To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <http://www.gao.gov/fraudnet/fraudnet.htm>

E-mail: fraudnet@gao.gov

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

Congressional Relations

Katherine Siggerud, Managing Director, siggerudk@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

