



April 2016

MEDICARE

Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data

Accessible Version

Highlights of GAO-16-394, a report to the Chairman, Committee on Finance, U.S. Senate

Why GAO Did This Study

CMS uses several types of claim review contractors to help reduce improper payments and protect the integrity of the Medicare program. CMS pays its contractors differently—the agency is required by law to pay RAs contingency fees from recovered overpayments, while other contractors are paid based on cost. Questions have been raised about the focus of RA reviews because of the incentives associated with the contingency fees.

GAO was asked to examine the review activities of the different Medicare claim review contractors. This report examines (1) differences between prepayment and postpayment reviews and the extent to which contractors use them; (2) the extent to which the claim review contractors focus their reviews on different types of claims; and (3) CMS's cost per review and amount of improper payments identified by the claim review contractors per dollar paid by CMS. GAO reviewed CMS documents; analyzed CMS and contractor claim review and funding data for 2013 and 2014; interviewed CMS officials, claim review contractors, and health care provider organizations; and assessed CMS's oversight against federal internal control standards.

What GAO Recommends

GAO recommends that CMS (1) request legislation to allow the RAs to conduct prepayment claim reviews, and (2) provide written guidance on calculating savings from prepayment reviews. The Department of Health and Human Services disagreed with the first recommendation, but concurred with the second. GAO continues to believe the first recommendation is valid as discussed in the report.

View [GAO-16-394](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) uses different types of contractors to conduct prepayment and postpayment reviews of Medicare fee-for-service claims at high risk for improper payments. Medicare Administrative Contractors (MAC) conduct prepayment and postpayment reviews; Recovery Auditors (RA) generally conduct postpayment reviews; and the Supplemental Medical Review Contractor (SMRC) conducts postpayment reviews as part of studies directed by CMS. CMS, its contractors, and provider organizations identified few significant differences between conducting and responding to prepayment and postpayment reviews. Using prepayment reviews to deny improper claims and prevent overpayments is consistent with CMS's goal to pay claims correctly the first time and can better protect Medicare funds because not all overpayments can be collected. In 2013 and 2014, 98 percent of MAC claim reviews were prepayment, and 85 percent of RA claim reviews and 100 percent of SMRC reviews were postpayment. Because CMS is required by law to pay RAs contingency fees from recovered overpayments, the RAs can only conduct prepayment reviews under a demonstration. From 2012 through 2014, CMS conducted a demonstration in which the RAs conducted prepayment reviews and were paid contingency fees based on claim denial amounts. CMS officials considered the demonstration a success. However, CMS has not requested legislation that would allow for RA prepayment reviews by amending existing payment requirements and thus may be missing an opportunity to better protect Medicare funds.

The contractors focused their reviews on different types of claims. In 2013 and 2014, the RAs focused their reviews on inpatient claims, which represented about 30 percent of Medicare improper payments. In 2013 and 2014, inpatient claim reviews accounted for 78 and 47 percent, respectively, of all RA claim reviews. Inpatient claims had high average identified improper payment amounts, reflecting the costs of the services. The RAs' focus on inpatient claims was consistent with the financial incentives from their contingency fees, which are based on the amount of identified overpayments, but the focus was not consistent with CMS's expectations that RAs review all claim types. CMS has since taken steps to limit the RAs' focus on inpatient claims and broaden the types of claims being reviewed. The MACs focused their reviews on physician and durable medical equipment claims, the latter of which had the highest rate of improper payments. The focus of the SMRC's claim reviews varied.

In 2013 and 2014, the RAs had an average cost per review to CMS of \$158 and identified \$14 in improper payments per dollar paid by CMS to the RAs. The SMRC had an average cost per review of \$256 and identified \$7 in improper payments per dollar paid by CMS. GAO was unable to determine the cost per review and amount of improper payments identified by the MACs per dollar paid by CMS because of unreliable data on costs and claim review savings. Inconsistent with federal internal control standards, CMS has not provided written guidance on how the MACs should calculate savings from prepayment reviews. Without reliable savings data, CMS does not have the information it needs to evaluate the MACs' performance and cost effectiveness in preventing improper payments, and CMS cannot compare performance across contractors.

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Abbreviations

CERT	Comprehensive Error Rate Testing
CMS	Centers for Medicare & Medicaid Services
DME	durable medical equipment
FFS	fee-for-service
HHS	Department of Health and Human Services
HHS OIG	Department of Health and Human Services Office of Inspector General
MAC	Medicare Administrative Contractor
RA	Recovery Auditor
SMRC	Supplemental Medical Review Contractor

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U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

April 13, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

Dear Mr. Chairman:

In fiscal year 2014, Medicare fee-for-service (FFS) provided health insurance for approximately 38 million elderly and disabled beneficiaries at a cost of approximately \$364 billion.¹ Because of its size, complexity, and susceptibility to mismanagement and improper payments, we have designated Medicare a high-risk program.² Improper Medicare payments include payments made for treatments or services that are not covered by program rules, not medically necessary, or not provided to beneficiaries in the way that they were billed to Medicare. In fiscal year 2014, the Centers for Medicare & Medicaid Services (CMS)—the agency within the Department of Health and Human Services (HHS) that administers the Medicare program—made payments for 1.2 billion FFS claims. CMS later estimated that improper payments totaled nearly \$46 billion in the Medicare FFS program that year.

To reduce improper payments and ensure that payments to Medicare providers are made correctly, CMS conducts a number of program integrity activities.³ One such program integrity activity is the manual review of FFS claims and related medical records by trained clinicians and coders to ensure that the claims are consistent with Medicare

¹Medicare is the federally financed health insurance program for persons aged 65 and over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Part A covers inpatient hospital services, skilled nursing facility services, some home health services, and hospice services. Medicare Part B covers physician and hospital outpatient services, and durable medical equipment, prosthetics, orthotics, and supplies, among other things. Together, Parts A and B are known as traditional Medicare or Medicare FFS.

²See GAO, *High-Risk Series: An Update*, GAO-15-290 (Washington, D.C.: Feb. 2015).

³In this report, the term provider includes entities such as hospitals and physicians, entities that provide laboratory, ambulance, home health, hospice, therapy, and skilled nursing services, as well as entities that supply Medicare beneficiaries with durable medical equipment.

coverage, payment, and coding policies. Many improper claims can be identified only by manually reviewing associated medical records and a beneficiary's claim history, and exercising clinical judgment to determine whether a service is reasonable and necessary. Less than one percent of claims undergo manual reviews.⁴

Claim reviews can occur either before or after payments are made—known as prepayment and postpayment claim reviews, respectively—and CMS uses both to identify improper payments. When potential payment errors are identified during prepayment claim reviews, the claims are denied or partially denied and providers are not paid the denied amounts.⁵ With postpayment claim reviews, CMS attempts to identify and recover overpayments, or remediate underpayments, for claims that have already been paid. CMS has stated that one of its key strategies to reduce improper payments is to pay claims properly the first time to prevent the agency from having to recover overpayments.

CMS uses several different types of contractors to review claims at high risk for improper payment and claims that pose the greatest financial risk to Medicare. Medicare Administrative Contractors (MAC) process and pay claims and conduct prepayment and postpayment reviews. Recovery Auditors (RA) generally conduct postpayment claim reviews, though CMS conducted a demonstration from 2012 through 2014 during which RAs conducted prepayment reviews for certain services. The Supplemental Medical Review Contractor (SMRC) conducts postpayment claim reviews as part of CMS-directed studies on specific high-risk claims.

Compared to the other claim review contractors, RAs are paid differently for their reviews. Specifically, CMS is required by law to use a contingency fee structure under which the RAs are paid from recovered overpayments. In contrast, CMS pays other claim review contractors

⁴In this report we use the term “claim review” to refer to manual claim reviews. CMS and others sometimes refer to these claim reviews as “audits” or “medical reviews.” In addition to manual claim reviews, CMS also uses automated prepayment reviews—called prepayment “edits”—that use computer programming logic to ensure that payments are made correctly. Whereas manual claim reviews are conducted on very few claims, all claims are subject to automated edits. For additional information on prepayment edits, see GAO, *Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment*, GAO-13-102 (Washington, D.C.: Nov. 2012).

⁵Partially denied claims include claims in which certain billed services are denied, while other services are paid, and claims in which services are “downcoded” to services with lower reimbursement rates.

based on their costs to review claims. Some stakeholders have questioned whether the RAs focus their reviews on certain types of claims because of the financial incentives associated with the contingency fees.

You asked us to examine the activities of the Medicare claim review contractors. This report examines:

1. the differences, if any, between prepayment and postpayment reviews, and the extent to which the contractors utilize these types of reviews;
2. the extent to which the Medicare claim review contractors focus their reviews on different types of claims; and
3. CMS's cost per review and the amount of improper payments identified by the claim review contractors per dollar paid by CMS.

To examine the differences, if any, between prepayment and postpayment reviews, and the extent to which the contractors utilize these types of reviews, we interviewed key stakeholders—CMS, RA, and MAC officials—regarding any significant differences in conducting these reviews. We also reviewed relevant agency documents, including CMS reports to Congress on the RA program and each MAC's medical review strategy for 2013 and 2014.⁶ We reviewed the President's budget proposals for fiscal years 2015 through 2017 to identify any budget or legislative proposals relevant to the RA program.⁷ We also interviewed officials from 10 organizations representing a variety of different types of Medicare health care providers who have experienced claim reviews, including providers that had claims reviewed as part of the RA prepayment review demonstration, to obtain their perspectives on any differences between responding to prepayment and postpayment

⁶Each year the MACs submit medical review strategies to CMS that include a prioritized list of the specific improper payment vulnerabilities deemed most critical by each MAC to address and a description of plans to address them.

⁷Each year, the President submits a fiscal year budget request to Congress. In addition to providing detailed estimates of the financial operations of federal agencies and programs, the President's budget request typically includes legislative proposals.

reviews.⁸ To examine CMS's ability to collect overpayments, we reviewed Department of Health and Human Services Office of Inspector General (HHS OIG) reports on Medicare "currently not collectible" overpayments—overpayments for which a provider has not made a repayment for at least 6 months after the due date. We also obtained data from CMS on the number of prepayment and postpayment claim reviews conducted by the RAs. We obtained data from each of the 16 MACs on the number of prepayment and postpayment claim reviews they completed.⁹ We obtained study reports generated by the SMRC from CMS, which provided data on the number of claims reviewed by the contractor. We obtained data on the number of MAC and RA claim reviews conducted in calendar years 2013 and 2014, and SMRC claim reviews for completed studies initiated in fiscal years 2013 and 2014. At the time of our review, data for 2013 and 2014 were the most recent complete years of data available.

To examine the extent to which the Medicare claim review contractors focus their reviews on the different types of claims, we reviewed CMS documentation detailing RA, MAC, and SMRC claim review program requirements, including the Medicare Program Integrity Manual and contract statements of work.¹⁰ We obtained data from CMS on the number of claim reviews conducted by the RAs by the following types of Medicare claims: inpatient, outpatient, skilled nursing facility, hospice, home health, durable medical equipment (DME), and physician and other

⁸We interviewed officials from the following provider organizations: American Ambulance Association; American Association for Homecare; American Hospital Association; American Medical Association; American Medical Rehabilitation Providers Association; American Physical Therapy Association; Council for Quality Respiratory Care; National Association for Homecare & Hospice; National Association for the Support of Long Term Care; and Orthotic & Prosthetic Alliance.

⁹During the period of our review, CMS executed three MAC contracts that incorporated work associated with different, outgoing MAC contractors. Our data from these three MACs do not include claim reviews conducted under the outgoing contracts and, accordingly, our MAC data do not include all MAC claim reviews conducted during this time period.

¹⁰Our analysis included CMS claim review contractors that are responsible for reviewing claims at high risk for improper payment. We excluded several other CMS contractors that may review claims that have different responsibilities, such as Zone Program Integrity Contractors and Quality Improvement Organizations. Zone Program Integrity Contractors, who investigate potential Medicare fraud, may review provider claims as part of their investigations. Quality Improvement Organizations, who conduct activities to improve the quality of care for Medicare beneficiaries, review claims to ensure that care meets quality standards.

carrier.¹¹ We obtained data from each of the 16 MACs on the number of claim reviews that they completed by the same seven types of Medicare claims. We reviewed the study reports generated by the SMRC, and categorized the claim reviews conducted by the contractor according to the same seven types of Medicare claims. We examined the RA, MAC, and SMRC claim review data in light of published Medicare Comprehensive Error Rate Testing (CERT) data on the rates and amounts of improper payments by claim type for fiscal years 2012 and 2013.¹² Because claim review contractors use prior year CERT findings to focus their reviews on claims at high risk for improper payment, we compared the contractors' claim review data in 2013 and 2014 to fiscal year 2012 and 2013 CERT data. Additionally, we obtained data on CMS approvals of RA "audit issues"—the types of claims the RAs intend to review—from the inception of the program to May 2015.¹³

To examine the CMS cost per review and the amount of improper payments identified by the claim review contractors per dollar paid by CMS, we obtained data from CMS on agency funding of claim reviews for the MACs for calendar years 2013 and 2014. We also obtained CMS data on contingency fees paid to the RAs for reviews conducted in 2013 and 2014 as of July 2015.¹⁴ For SMRC studies, we obtained data on agency funding for studies initiated in fiscal years 2013 and 2014. We also obtained data on the amount of improper payments identified by each of

¹¹Inpatient and outpatient claims include claims for both hospitals and other institutional providers, such as inpatient and outpatient rehabilitation facilities. Physician and other carrier claims include claims for non-institutional providers, such as physicians, ambulances, and free-standing facilities, such as clinical laboratories. For the purposes of this report, we refer to this type of claim as "physician claims."

¹²The CERT rates and amounts we report may differ slightly from those in published CERT reports. We analyzed reported CERT data to generate improper payment rates and amounts for the seven types of Medicare claims, which did not necessarily align with the categories in the CERT reports. For example, the CERT reported the improper payment rate for inpatient hospital services, while we are reporting on the improper payment rates for inpatient claims broadly, which include inpatient rehabilitation services.

¹³We reviewed CMS's approval of RA audit issues for manual claim reviews. The RAs may also conduct automated postpayment reviews, and we did not review CMS approval of audit issues for those reviews.

¹⁴The amount RAs are paid for specific claim reviews can vary over time based on additional collections and claim review appeals. Medicare has a process that allows for the appeal of claim denials, and the RAs have to return contingency fees for claim denials that are overturned on appeal.

the contractors based on reviews conducted in the same time periods.¹⁵ For the amount of improper payments identified by the MACs, we obtained data from each of the 16 MACs. We obtained data on improper payments identified by the RAs from CMS. For the amount of improper payments identified by the SMRC, we obtained data from the contractor's study reports. We used the CMS cost per review and identified improper payment data to calculate the amount of improper payments identified by the claim review contractors per dollar paid by CMS, which allowed us to examine the value provided by each contractor.

For each of the three different types of contractors, we assessed the reliability of claim review data—including data on the number of prepayment and postpayment reviews, the number of reviews by claim type, and the amount of identified improper payments—and agency funding data. We also assessed the reliability of the RA audit issues data. We assessed these data by reviewing related documentation; comparing the data to published data; interviewing CMS, RA, and MAC officials; and testing the data for missing data, outliers, or obvious errors. Based on our assessment, we found the following:

- RA claim review, funding, and approved audit issues data were reliable for the purposes of our report.
- SMRC claim review and funding data were reliable for the purposes of our report.
- MAC data on the number of prepayment and postpayment reviews and the number of reviews by claim type were reliable for the purposes of our report. However, MAC data on the amount of identified improper payments and agency funding data for certain MACs were not reliable for the purposes of our report. As a result, we

¹⁵We obtained data on the amount of improper payments identified by each of the contractors, which may differ from the amount that is ultimately collected by CMS. Our data may differ from those published in CMS's reports to Congress on the RA program. The reports to Congress present data on the amount of overpayments collected each fiscal year, which may include collections from overpayments identified in reviews conducted in prior years.

reviewed CMS's oversight practices for these data and compared them against federal internal controls standards.¹⁶

We conducted this performance audit from June 2015 to February 2016 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

Contractors have a long-standing and essential role in administering the Medicare program, including conducting program integrity activities, such as claims reviews, which are integral to preventing improper payments.¹⁷ The contractors use the same general process for conducting claims reviews: they select claims for review; request medical documentation from providers to support Medicare coverage of those claims; apply Medicare coverage, payment, and coding requirements to determine if claims were paid properly; and communicate the results of their reviews to the providers.¹⁸ The three types of contractors we examined—the MACs, RAs, and the SMRC—are all responsible, to some extent, for reviewing claims at high risk for improper payment and claims that pose

¹⁶See GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999). Internal control is a process effected by an entity's oversight body, management, and other personnel that provides reasonable assurance that the objectives of an entity will be achieved.

¹⁷An 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. 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. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note). Office of Management and Budget guidance also instructs agencies to report as improper payments any payments for which insufficient or no documentation was found.

¹⁸We have previously reported on claim review contractor requirements and CMS's contract oversight. See GAO, *Medicare Program Integrity: Increased Oversight and Guidance Could Improve Effectiveness and Efficiency of Postpayment Claims Reviews*, GAO-14-474 (Washington, D.C.: July 2014) and GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*, GAO-13-522 (Washington, D.C.: July 2013).

the greatest financial risk to Medicare (see Table 1). However, the contractors have varying roles and levels of CMS direction and oversight in identifying claims for review.

Table 1: Centers for Medicare & Medicaid Services (CMS) Contractors That Conduct Medicare Fee-for-Service Claim Reviews

	Medicare Administrative Contractors	Recovery Auditors	Supplemental Medical Review Contractor
Number of contractors	16 ^a	4	1
Primary purpose of contractor claims reviews	To better ensure payment accuracy in their geographic regions and ensure provider compliance with Medicare requirements	To identify improper payments through postpayment claim reviews	To conduct nationwide postpayment claim reviews as part of CMS-directed studies
Type of claim reviews conducted	Prepayment and postpayment	Postpayment ^b	Postpayment
Identification of claims for review	Contractors develop a claim review strategy for targeting high-risk claims	Contractors identify claims for review among CMS-approved audit issues	CMS directs studies on claims at high risk for improper payments

Source: GAO analysis of CMS information. | GAO-16-394

Notes: Our report examines CMS claim review contractors that are responsible for reviewing claims at high risk for improper payment. We excluded several other CMS contractors that may review claims that have different responsibilities, such as Zone Program Integrity Contractors and Quality Improvement Organizations.

^aThere are 12 Part A/B Medicare Administrative Contractors and 4 Durable Medical Equipment Medicare Administrative Contractors. Four of the 12 A/B Medicare Administrative Contractors process all home health and hospice claims.

^bFrom 2012 through 2014, CMS conducted a demonstration in which the Recovery Auditors conducted prepayment claim reviews for certain types of claims.

MACs

MACs process and pay claims and conduct prepayment and postpayment reviews for their established geographic regions. As of January, 2016, 12 MACs—referred to as A/B MACs—processed and reviewed Medicare Part A and Part B claims, and 4 MACs—referred to as DME MACs—processed and reviewed DME claims.¹⁹ MACs are responsible for identifying both high-risk providers and services for claim reviews, and CMS has generally given the MACs broad discretion to identify claims for

¹⁹Four of the 12 A/B MACs process all home health and hospice claims.

review. Each individual MAC is responsible for developing a claim review strategy to target high-risk claims.²⁰

In their role of processing and paying claims, the MACs also take action based on claim review findings. The MACs deny payment on claims when they or other contractors identify payment errors during prepayment claim reviews. When MACs or other claim review contractors identify overpayments using postpayment reviews, the MACs seek to recover the overpayment by sending providers what is referred to as a demand letter. In the event of underpayments, the MACs return the balance to the provider in a future reimbursement.

RAs

The RA program has four regional RAs that generally conduct postpayment claim reviews based on CMS-approved audit issues. For each audit issue, the RAs submit to CMS for review and approval a description of the types of claims that they propose to review and the basis for assessing whether the claims and related payments are proper. For example, one RA received approval in 2013 to review DME supplier claims for knee braces to ensure that beneficiaries met Medicare coverage requirements for the equipment. Each RA is responsible for developing their own audit issues, and CMS generally gives the RAs discretion to identify claims for review among the approved issues. According to the RAs' statement of work, CMS expects them to review all types of claims and to select those claims that are at high risk of improper payments for review. In limited circumstances, CMS has directed the RAs to review specific claims. For example, beginning in April 2013, CMS directed the RAs to review claims for therapy services that exceeded an annual per beneficiary limit.²¹

²⁰For additional information on the MAC roles and responsibilities, see GAO, *Medicare Administrative Contractors: CMS Should Consider Whether Alternative Approaches Could Enhance Contractor Performance*, GAO-15-372 (Washington, D.C.: Apr. 2015).

²¹Congress established per beneficiary Medicare limits for therapy services, which took effect in 1999. However, Congress imposed temporary moratoria on the limits several times until 2006, when it required CMS to implement an exceptions process in which exceptions to the limits are allowed for reasonable and necessary therapy services. Starting in 2012, the exceptions process has applied a claim review requirement on claims after a beneficiary's annual incurred expenses reach certain thresholds. For additional information on the therapy service limits, see GAO, *Medicare Outpatient Therapy: Implementation of the 2012 Manual Medical Review Process*, GAO-13-613 (Washington, D.C.: July, 2013).

As required by law, the RAs are paid on a contingent basis from recovered overpayments.²² The contingency fees generally range from 9.0 percent to 17.5 percent, and vary by RA region, the type of service reviewed, and the way in which the provider remits the overpayment. Because the RAs are paid from recovered funds rather than appropriated funds, the use of RAs expands CMS's capacity for claim reviews without placing additional demands on the agency's budget. The RAs are allowed to target high-dollar claims that they believe have a high risk of improper payments, though they are not allowed to identify claims for review solely because they are high-dollar claims. The RAs are also subject to limits that only allow them to review a certain percentage or number of a given provider's claims.

The RAs initially identified high rates of error for short inpatient hospital stays and targeted those claims for review. Certain hospital services, particularly services that require short hospital stays, can be provided in both an inpatient and outpatient setting, though inpatient services generally have higher Medicare reimbursement amounts. The RAs found that many inpatient services should have been provided on an outpatient basis and denied many claims for having been rendered in a medically unnecessary setting.²³ Medicare has a process that allows for the appeal of claim denials, and hospitals appealed many of the short inpatient stay claims denied by RAs. Hospital appeals of RA claim denials helped contribute to a significant backlog in the Medicare appeals system.²⁴

The requirement that RAs be paid on a contingent basis from recovered overpayments generally precludes them from conducting prepayment reviews. However, according to CMS officials, the Secretary waived this requirement under HHS's demonstration authority for the purpose of

²²42 U.S.C. § 1395ddd(h)(1).

²³For additional information on Medicare coverage of short hospital stays, see Medicare Payment Advisory Commission, *June 2015 Report to the Congress: Medicare and the Health Care Delivery System* (Washington, D.C.: June 2015).
<http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf>

²⁴The number of appeals for Part A claims increased substantially in recent years in part because of appeals of RA denials of inpatient hospital claims. To reduce the number of short inpatient hospital stay claims in the appeals process, from August through October 2014, CMS offered an administrative agreement to any hospital willing to withdraw their pending appeals of short inpatient hospital stay claims in exchange for partial payment of 68 percent of the claim amount.

determining whether RA prepayment reviews could prevent fraud and the resulting improper payments and, in turn, lower the FFS improper payment rate. From 2012 through 2014, operating under this waiver authority, CMS conducted the RA Prepayment Review Demonstration in 11 states. In these states, CMS directed the RAs to conduct prepayment claim reviews for specific inpatient hospital services. Additionally, the RAs conducted prepayment reviews of therapy claims that exceeded the annual per beneficiary limit in the 11 demonstration states. Under the demonstration, instead of being paid a contingency fee based on recovered overpayments, the RAs were paid contingency fees based on claim denial amounts.

In anticipation of awarding new RA contracts, CMS began limiting the number of RA claim reviews and discontinued the RA Prepayment Review Demonstration in 2014. CMS required the RAs to stop sending requests for medical documentation to providers in February 2014, so that the RAs could complete all outstanding claim reviews by the end of their contracts. However, in June 2015, CMS cancelled the procurement for the next round of RA contracts, which had been delayed because of bid protests. Instead, CMS modified the existing RA contracts to allow the RAs to continue claim review activities through July 31, 2016. In November 2015, CMS issued new requests for proposals for the next round of RA contracts and, according to CMS officials, plans to award them in 2016.

SMRC

The SMRC conducts nationwide postpayment claim reviews as part of CMS-directed studies aimed at lowering improper payment rates. The SMRC studies often focus on issues related to specific services at high risk for improper payments, and provide CMS with information on the prevalence of the issues and recommendations on how to address them. Although CMS directs the types of services and improper payment issues that the SMRC examines, the SMRC identifies the specific claims that are reviewed as part of the studies.

Medicare CERT Program

CMS's CERT program annually estimates the amount and rate of improper payments in the Medicare FFS program, and CMS uses the CERT results, in part, to direct and oversee the work of claim review contractors, including the MACs, RAs, and SMRC. CMS's CERT program develops its estimates by using a contractor to conduct postpayment claim reviews on a statistically valid random sample of claims. The CERT program develops the estimates as part of CMS's efforts to comply with the Improper Payments Information Act, which requires agencies to

annually identify programs susceptible to significant improper payments, estimate amounts improperly paid, and report these estimates and actions taken to reduce them.²⁵ In addition, the CERT program estimates improper payment rates specific to Medicare service and provider types and identifies services that may be particularly at risk for improper payments.

Few Differences Exist between Prepayment and Postpayment Reviews and Use Varies by Contractor, but Prepayment Reviews Better Protect Medicare Funds

Prepayment Reviews Better Protect Medicare Funds, and Stakeholders Report Few Differences between Prepayment and Postpayment Reviews

Prepayment reviews, which occur before payments are made, can better protect Medicare funds compared to postpayment reviews. One of CMS's key strategies to reduce improper payments is to pay claims properly the first time, and prepayment reviews prevent CMS from having to recover overpayments—often referred to as the “pay and chase” process—identified through postpayment reviews.²⁶ Prepayment reviews can better protect agency funds because

²⁵See Improper Payments Information Act of 2002 (IPIA), Pub. L. No. 107-300, 116 Stat. 2350 (2002) (codified, as amended, at 31 U.S.C. § 3321 note). The IPIA was subsequently 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).

²⁶We have also reported that prepayment controls are generally more cost-effective than postpayment controls and help avoid costs associated with the “pay and chase” process. See GAO, *A Framework for Managing Fraud Risks in Federal Programs*, GAO-15-593SP (Washington, D.C.: July 28, 2015).

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- CMS is not always able to collect overpayments identified through postpayment reviews. A 2013 HHS OIG study found that each year over the period from fiscal year 2007 to fiscal year 2010, approximately 6 to 9 percent of all overpayments identified by claim review contractors were deemed not collectible.²⁷
 - Postpayment reviews require more administrative resources compared to prepayment reviews. Once overpayments are identified on a postpayment basis, CMS requires contractors to take timely efforts to collect the overpayments. HHS OIG reported that the process for recovering overpayments can involve creating and managing accounts receivables for the overpayments, tracking provider invoices and payments, and managing extended repayment plans for certain providers.²⁸ In contrast, contractors do not need to take these steps, and expend the associated resources, for prepayment reviews, which deny claims before overpayments are made.

Key stakeholders we interviewed identified few significant differences in conducting and responding to prepayment and postpayment reviews. Specifically, CMS, MAC, and RA officials stated that prepayment and postpayment review activities are generally conducted by claim review contractors in similar ways. Officials we interviewed from health care provider organizations told us that providers generally respond to prepayment and postpayment reviews similarly, as both types of review occur after a service has been rendered, and involve similar medical documentation requirements and appeal rights.

Though provider organizations generally reported responding to prepayment and postpayment reviews similarly, they did identify two issues specific to prepayment reviews. First, providers have the option to

²⁷These statistics are based on CMS summary financial data, and the currently not collectable classification for overpayments can vary based on when overpayments are identified and demanded, and if overpayments are under appeal. See Department of Health and Human Services, Office of Inspector General, *Medicare's Currently Not Collectible Overpayments*, OEI-03-11-00670 (Washington, D.C.: June 2013).

²⁸HHS OIG, OEI-03-11-00670.

hold discussions with the RAs for postpayment review findings, and CMS recently implemented the option for SMRC findings as well. The discussions offer providers the opportunity to give additional information before payment determinations are made and before providers potentially enter the Medicare claims appeals process. Several of the provider organizations we interviewed found the RA discussions helpful, stating that some providers have been able to get RA overpayment determinations reversed. Such discussions are not available for RA prepayment claim reviews or for MAC reviews. CMS officials stated that the discussions are not feasible for prepayment claim reviews due to timing difficulties, as the MACs and RAs are required to make payment determinations within 30 days after receiving providers' medical records.

Second, providers stated that they may face certain cash flow burdens with prepayment claim reviews that they do not face with postpayment reviews due to how the claims are treated in the Medicare appeals process.²⁹ When appealing postpayment review overpayment determinations, providers keep their Medicare payment through the first two levels of appeal before CMS recovers the identified overpayment. If the overpayment determinations are overturned at a higher appeal level, CMS must pay back the recovered amount with interest accrued for the period in which the amount was recouped. In contrast, providers do not receive payment for claims denied on a prepayment basis and, if prepayment denials are overturned on appeal, providers do not receive interest on the payments for the duration the payments were held by CMS.

MACs Generally Use Prepayment Reviews, while RAs and the SMRC Use Postpayment Reviews

The MACs, SMRC, and RAs varied in the extent to which they conducted prepayment and postpayment reviews from 2013 through 2014. Nearly all of the MAC claim reviews were conducted on a prepayment basis. From 2013 through 2014, the MACs conducted approximately 3 million prepayment reviews, which accounted for 98 percent of their total claim reviews (see Table 2). The MACs generally use prepayment reviews to focus on high-risk services, including billing issues identified by CMS's CERT program, CMS, or the HHS OIG and issues identified through the MACs' own analyses. Each year the MACs are required to submit medical review strategies to CMS that include a prioritized list of high-risk

²⁹The Medicare FFS appeals process consists of five levels of review that include CMS contractors, staff divisions within HHS, and ultimately, the federal judicial system, allowing appellants who are dissatisfied with the decision at one level to appeal to the next level.

claims deemed most critical by each MAC to address and a description of plans to address them.

Table 2: Prepayment and Postpayment Claim Reviews by Medicare Contractors, 2013-2014

Medicare Administrative Contractors (MAC)	Supplemental Medical Review Contractor		Recovery Auditors		
	Number of reviews ^a	Percentage of total reviews (%)	Number of reviews	Percentage of total reviews (%)	Number of reviews
Prepayment claim reviews	2,978,945	98	0	0	303,090 ^b
Postpayment claim reviews	75,916	2	178,167	100	1,677,023
Total claim reviews	3,054,861	100	178,167	100	1,980,113

Source: GAO analysis of the Centers for Medicare & Medicaid Studies (CMS) and MAC data. | GAO-16-394

^aDuring 2013 and 2014, CMS executed three MAC contracts, which incorporated work associated with different outgoing MAC contractors. Our data from these three MACs do not include claim reviews conducted under the outgoing contracts and, accordingly, our MAC data do not include all MAC claim reviews conducted during this time period.

^bRecovery Auditors generally conduct postpayment claim reviews. However, from 2012 through 2014, CMS conducted a demonstration in which the Recovery Auditors conducted prepayment claim reviews for certain types of claims.

During the same time period, the MACs conducted approximately 76,000 postpayment claim reviews, though some MACs did not conduct any postpayment claims reviews. Prior to the establishment of the national RA program, the MACs conducted a greater proportion of postpayment reviews. However, the MACs have shifted nearly all of their focus to conducting prepayment reviews, as responsibility for conducting postpayment reviews has generally shifted to the RAs. According to CMS officials, the MACs currently use postpayment reviews to analyze billing patterns to inform other review activities, including future prepayment reviews, and to help determine where to conduct educational outreach for specific providers. CMS has also encouraged the MACs to use postpayment reviews to perform extrapolation, a process in which the MACs estimate an overpayment amount for a large number of claims based on a sample of claim reviews. According to CMS officials, extrapolation is not used often but is an effective strategy for providers that submit large volumes of low-dollar claims with high improper payment rates.

The SMRC is focused on examining Medicare billing and payment issues at the direction of CMS, and all of its approximately 178,000 reviews in 2013 and 2014 were postpayment reviews. The SMRC uses postpayment

reviews because its studies involve developing sampling methodologies to examine issues with specific services or specific providers. For example, in 2013, CMS directed the SMRC to complete a national review of home health agencies, which involved reviewing five claims from every home health agency in the country. CMS had the SMRC conduct this study to examine issues arising from a new coverage requirement that raised the improper payment rate for home health services.³⁰ Additionally, a number of SMRC studies used postpayment sampling to perform extrapolation to determine overpayment amounts for certain providers.

The RAs generally conducted postpayment reviews, though they conducted prepayment reviews under the Prepayment Review Demonstration. The RAs conducted approximately 85 percent of their claim reviews on a postpayment basis in 2013 and 2014—accounting for approximately 1.7 million postpayment claim reviews—with the other 15 percent being prepayment reviews conducted under the demonstration. CMS is no longer using the RAs to conduct prepayment reviews because the demonstration ended. Outside of a demonstration, CMS must pay the RAs from recovered overpayments, which effectively limits the RAs to postpayment reviews. CMS and RA officials who we interviewed generally considered the demonstration a success, and CMS officials told us that they included prepayment reviews as a potential work activity in the requests for proposals for the next round of RA contracts, in the event that the agency is given the authority to pay RAs on a different basis. However, the President's fiscal year budget proposals for 2015 through 2017 did not contain any legislative proposals that CMS be provided such authority. Obtaining the authority to allow the RAs to conduct prepayment reviews would align with CMS's strategy to pay claims properly the first time. In not seeking the authority, CMS may be missing an opportunity to reduce the amount of uncollectable overpayments from RA reviews and save administrative resources associated with recovering overpayments.

³⁰The rate of improper payments for home health services rose from 6.1 percent in fiscal year 2012 to 17.3 percent in fiscal year 2013 and to 51.4 percent in fiscal year 2014. According to CMS, the increase in improper payments occurred primarily because of CMS's implementation of a requirement that home health agencies have documentation showing that referring providers conducted a face-to-face examination of beneficiaries before certifying them as eligible for home health services.

Contractors Focused on Different Types of Claims in 2013 and 2014

RAs Focused on Inpatient Claim Reviews, Though CMS Has Taken Steps to Ensure RAs Review All Claim Types

Our analysis of RA claim review data shows that the RAs focused on reviewing inpatient claims in 2013 and 2014, though this focus was not consistent with the degree to which inpatient services constituted improper payments, or with CMS's expectation that the RAs review all claim types. In 2013, a significant majority—78 percent—of all RA claim reviews were for inpatient claims, and in 2014, nearly half—47 percent—of all RA claim reviews were for inpatient claims (see Table 3). For RA postpayment reviews specifically, which excludes reviews conducted as part of the RA Prepayment Review Demonstration, 87 percent of RA reviews were for inpatient claims in 2013, and 64 percent were for inpatient claims in 2014.³¹ Inpatient services had high amounts of improper payments relative to other types of services—with over \$8 billion in improper payments in fiscal year 2012 and over \$10 billion in fiscal year 2013—which reflect the costs of providing these services. However, inpatient services did not have a high improper payment rate relative to other services and constituted about 30 percent of overall Medicare FFS improper payments in both years.³²

³¹All of the prepayment reviews conducted by the RAs were CMS-directed reviews, either for specific inpatient hospital services or therapy services. With the exception of CMS-directed reviews for therapy services in the states outside of the Prepayment Review Demonstration, claims for postpayment review are generally selected by the RAs, based on audit issues approved by CMS.

³²CMS officials noted that RA reviews of inpatient claims focused on claims for short inpatient hospital stays, which had high improper payment rates. For example, in fiscal year 2012, short inpatient hospital stays of one day or less had an improper payment rate of 36 percent. For our analysis, we obtained data by claim type, and we were unable to analyze the specific type of inpatient claims reviewed by the RAs.

Table 3: Percentage of Recovery Auditor (RA) Claim Reviews by Claim Type, 2013 and 2014

Claim type	2013 Total RA reviews (%) ^a	2013 RA postpayment reviews (%)	FY 2012 improper payment rate (%) ^b	FY 2012 percentage of estimated improper payments (%) ^b
Inpatient	78	87	7	28
Outpatient	8	4	5	10
Skilled nursing facility	2	1	5	6
Hospice	0	0	2	1
Home health agency	2	2	6	4
Durable medical equipment	3	3	66	22
Physician	8	2	10	30
Number of RA reviews	1,463,978	1,300,379	—	—
Claim type	2014 Total RA reviews (%) ^a	2014 RA postpayment reviews (%)	FY 2013 improper payment rate (%) ^b	FY 2013 percentage of estimated improper payments (%) ^b
Inpatient	47	64	8	29
Outpatient	22	14	6	11
Skilled nursing facility	7	5	7	7
Hospice	0	0	8	3
Home health agency	4	5	17	9
Durable medical equipment	3	4	58	16
Physician	18	9	11	26
Number of RA reviews	516,135	376,644	—	—

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-394

Note: Percentages may not add to 100 percent due to rounding.

^aTotal RA reviews in 2013 and 2014 include postpayment reviews as well as prepayment reviews for certain types of claims conducted as part of the RA Prepayment Review Demonstration.

^bThe improper payment rate represents the percentage of Medicare fee-for-service payments that CMS's Comprehensive Error Rate Testing (CERT) program estimates to be improper in a given fiscal year. The CERT program estimated that the total amount of improper payments in fiscal year 2012 was \$29.6 billion, and \$36.0 billion in fiscal year 2013. Since the claim review contractors often base their reviews on prior year CERT findings on claims at high risk for improper payment, we compared 2013 and 2014 RA claim review data to fiscal year 2012 and 2013 CERT data.

As will be discussed, the proportion of inpatient reviews in 2014 would likely have been higher if CMS—first under its own authority and then as required by law—had not prohibited the RAs from conducting reviews of claims for short inpatient hospital stays at the beginning of fiscal year 2014. The RAs conducted about 1 million fewer claim reviews in 2014 compared to 2013, and nearly all of the decrease can be attributed to fewer reviews of inpatient claims.

In general, the RAs have discretion to select the claims they review, and their focus on reviewing inpatient claims is consistent with the financial incentives associated with the contingency fees they receive, as inpatient claims generally have higher payment amounts compared to other claim types. By law, RAs receive a portion of the recovered overpayments they identify, and RA officials told us that they generally focus their claim reviews on audit issues that have the greatest potential returns. Our analysis found that RA claim reviews for inpatient services had higher average identified improper payment amounts per postpayment claim review relative to other claim types in 2013 and 2014 (see Table 4). For example, in 2013, the RAs identified about 10 times the amount per postpayment claim review for inpatient claims compared to claim reviews for physicians.

Table 4: Recovery Auditor Average Identified Improper Payment Amount per Postpayment Claim Review by Claim Type, 2013 and 2014

Claim type	Recovery Auditor 2013 reviews	Recovery Auditor 2014 reviews
Inpatient	\$3,085	\$2,431
Outpatient	\$1,116	\$1,103
Skilled nursing facility	\$2,303	\$2,731
Hospice	—	—
Home health agency	\$775	\$1,380
Durable medical equipment	\$826	\$458
Physician	\$308	\$304

Source: GAO analysis of the Centers for Medicare & Medicaid Services data. | GAO-16-394

Although CMS expects the RAs to review all claim types, CMS's oversight of the RAs did not ensure that the RAs distributed their reviews across claim types in 2013 and 2014. According to CMS officials, the agency's approval of RA audit issues is the primary way in which CMS controls the type of claims that the RAs review. However, the officials said they generally focus on the appropriateness of the review methodology when

determining whether to approve the audit issues, instead of on whether the RA's claim review strategy encompasses all claim types. The RAs generally determine the types of audit issues that they present to CMS for approval, and based on our analysis of RA audit issues data, we found that from the inception of the RA program to May 2015, 80 percent of the audit issues approved by CMS were for inpatient claims. Additionally, CMS generally gives RAs discretion regarding the claims that they select for review among approved audit issues.

However, CMS has taken steps to limit the RAs' focus on inpatient claims through changes to the RA program, and the agency has included additional oversight mechanisms in the statements of work for the next round of RA contracts. As a result of CMS implementing new coverage policies for inpatient admissions, the RAs were prohibited from conducting reviews related to the appropriateness of inpatient admissions for claims with dates of admission between October 1, 2013 and December 31, 2015.³³ The RAs are currently only allowed to review the appropriateness of inpatient admissions for claims with dates of admission on or after January 1, 2016, for providers identified as high-risk for noncompliance with Medicare coverage policies.³⁴ Further, starting January 1, 2016, CMS implemented claim type-specific RA review limits for institutional providers, rather than a single limit for all of the provider's claims. For example, a hospital that bills for inpatient and outpatient services will have separate inpatient and outpatient RA review limits that reflect the proportion of claims paid to the hospital in the previous year.

³³Effective October 1, 2013, CMS changed the coverage requirements for short inpatient hospital stays. As a result, CMS prohibited RA claim reviews related to the appropriateness of inpatient admissions for claims with dates of admission between October 1, 2013 and September 30, 2014. In April 2014 and April 2015, Congress enacted legislation directing CMS to continue the prohibition of RA claim reviews related to the appropriateness of inpatient admissions for claims with dates of admission through September 30, 2015, unless there was evidence of fraud and abuse. Protecting Access to Medicare Act of 2014, Pub. L. No. 113-93, § 111, 128 Stat. 1040, 1044 (2014); Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 521, 129 Stat. 87, 176 (2015). In July 2015, CMS announced that it would not allow such RA claim reviews for claims with dates of admission of October 1, 2015 through December 31, 2015. The RAs were allowed to continue reviews of short stay inpatient claims for reasons other than reviewing inpatient status, such as reviews related to coding requirements.

³⁴Beginning on October 1, 2015, Quality Improvement Organizations assumed responsibility for conducting initial claim reviews related to the appropriateness of inpatient hospital admissions. Starting January 1, 2016, the Quality Improvement Organizations will refer providers exhibiting persistent noncompliance with Medicare policies to the RAs for potential further review.

Additionally, in the statements of work for the next round of RA contracts, CMS stated that it will monitor the extent to which the RAs are reviewing all claim types, may impose a minimum percentage of reviews by claim type, and may take corrective action against RAs that do not review all claim types.

CMS has also taken steps to provide incentives for the RAs to review other types of claims. To encourage the RAs to review DME claims—which had the highest rates of improper payments in fiscal years 2012 and 2013—CMS officials stated that they increased the contingency fee percentage paid to the RAs for DME claims.³⁵ Further, in the requests for proposals for the next round of RA contracts, CMS included a request for a national RA that will specifically review DME, home health agency, and hospice claims. CMS officials told us that they are procuring this new RA because the existing four regional RAs reviewed a relatively small number of these types of claims. Although DME, home health agency, and hospice claims combined represented more than 25 percent of improper payments in both 2013 and 2014, they constituted 5 percent of RA reviews in 2013 and 6 percent of reviews in 2014.

**MAC Claim Reviews
Focused on Physician and
DME Claims**

In 2013 and 2014, the MACs focused their claim reviews on physician and DME claims. Physician claims accounted for 49 percent of MAC claim reviews in 2013 and 55 percent of reviews in 2014, while representing 30 percent of improper payments in fiscal year 2012 and 26 percent in fiscal year 2013 (see Table 5). DME claims accounted for 29 percent of their reviews in 2013 and 26 percent in 2014, while representing 22 percent of total improper payments in fiscal year 2013 and 16 percent of improper payments in fiscal year 2014. DME claims also had the highest rates of improper payments in both years.

³⁵DME claims have the highest contingency fee percentages relative to other claim types in each RA region, with the fees generally ranging from 14.0 percent to 17.5 percent.

Table 5: Percentage of Medicare Administrative Contractor (MAC) Claim Reviews by Claim Type, 2013 and 2014

Claim type	2013 MAC reviews (%) ^a	FY 2012 improper payment rate (%) ^b	FY 2012 percentage of estimated improper payments (%) ^b
Inpatient	7	7	28
Outpatient	8	5	10
Skilled nursing facility	2	5	6
Hospice	1	2	1
Home health agency	3	6	4
Durable medical equipment	29	66	22
Physician	49	10	30
Number of MAC reviews	1,439,954	—	—

Claim type	2014 MAC reviews (%) ^a	FY 2013 improper payment rate (%) ^b	FY 2013 percentage of estimated improper payments (%) ^b
Inpatient	4	8	29
Outpatient	9	6	11
Skilled nursing facility	1	7	7
Hospice	1	8	3
Home health agency	4	17	9
Durable medical equipment	26	58	16
Physician	55	11	26
Number of MAC reviews	1,614,907	—	—

Source: GAO analysis of MAC and the Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-394

Note: Percentages may not add to 100 percent due to rounding.

^aDuring 2013 and 2014, CMS executed three MAC contracts which incorporated work associated with different, outgoing MAC contractors. Our data from these three MACs do not include claim reviews conducted under the outgoing contracts and, accordingly, our MAC data do not include all MAC claim reviews conducted during this time period.

^bThe improper payment rate represents the percentage of Medicare fee-for-service payments that CMS's Comprehensive Error Rate Testing (CERT) program estimates to be improper in a given fiscal year. The CERT program estimated that the total amount of improper payments in fiscal year 2012 was \$29.6 billion, and \$36.0 billion in fiscal year 2013. Since the claim review contractors often base their reviews on prior year CERT findings on claims at high risk for improper payment, we compared 2013 and 2014 MAC claim review data to fiscal year 2012 and 2013 CERT data.

According to CMS officials, the MACs focused their claim reviews on physician claims—a category which encompasses a large variety of provider types, including labs, ambulances, and individual physician offices—because they constitute a significant majority of all Medicare

claims.³⁶ CMS officials also told us that they direct MAC claim review resources to DME claims in particular because of their high improper payment rate. Further CMS officials told us that the MACs' focus on reviewing physician and DME claims was in part due to how CMS structures the MAC claim review workload. CMS official noted that each A/B MAC is responsible for addressing improper payments for both Medicare Part A and Part B, and MAC Part B claim reviews largely focus on physician claims. Additionally, 4 of the 16 MACs are DME MACs that focus their reviews solely on DME claims. CMS officials also noted that MAC reviews of inpatient claims were likely lowered during this period because of CMS's implementation of new coverage policies for inpatient admissions. Similar to the RAs, the MACs were limited in conducting reviews for short inpatient hospital stays after October 1, 2013.³⁷

The Focus of SMRC Claim Reviews Varied between 2013 and 2014 Based on CMS's Direction

The focus of the SMRC's claim reviews depended on the studies that CMS directed the contractor to conduct in 2013 and 2014. In 2013, the SMRC focused its claim reviews on outpatient and physician claims, with physician claims accounting for half of all SMRC reviews (see Table 6). Physician claims accounted for 30 percent—the largest percentage—of the total amount of estimated improper payments in fiscal year 2012. In 2014, the SMRC focused 46 percent of its reviews on home health agency claims and 44 percent of its claim reviews on DME claims, which had the two highest improper payment rates in fiscal year 2013.

³⁶Physician claims constituted more than 75 percent of all Medicare claims in 2013.

³⁷In changing coverage requirements for short inpatient hospital stays, CMS directed the MACs to conduct "probe and educate" reviews on a set number of claims for most hospitals to assess their understanding and compliance with the new requirements and to conduct individualized educational efforts.

Table 6: Percentage of Supplemental Medical Review Contractor (SMRC) Claim Reviews by Claim Type, Fiscal Year (FY) 2013 and 2014

Claim type	FY 2013 SMRC reviews (%)	FY 2012 improper payment rate (%) ^a	FY 2012 percentage of estimated improper payments (%) ^a
Inpatient	8	7	28
Outpatient	36	5	10
Skilled nursing facility	0	5	6
Hospice	0	2	1
Home health agency	0	6	4
Durable medical equipment	7	66	22
Physician	50	10	30
Number of SMRC reviews	67,697	—	—
Claim type	FY 2014 SMRC reviews (%)	FY 2013 improper payment rate (%) ^a	FY 2013 percentage of estimated improper payments (%) ^a
Inpatient	0	8	29
Outpatient	5	6	11
Skilled nursing facility	1	7	7
Hospice	0	8	3
Home health agency	46	17	9
Durable medical equipment	44	58	16
Physician	4	11	26
Number of SMRC reviews	110,470	—	—

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) data. | GAO-16-394

Note: Percentages may not add to 100 percent due to rounding.

^aThe improper payment rate represents the percentage of Medicare fee-for-service payments that CMS's Comprehensive Error Rate Testing (CERT) program estimates to be improper in a given fiscal year. The CERT program estimated that the total amount of improper payments in fiscal year 2012 was \$29.6 billion, and \$36.0 billion in fiscal year 2013. Since the claim review contractors often base their reviews on prior year CERT findings on claims at high risk for improper payment, we compared 2013 and 2014 SMRC claim review data to fiscal year 2012 and 2013 CERT data.

CMS generally directs the SMRC to conduct studies examining specific services, and the number of claims reviewed by claim type is highly dependent on the methodologies of the studies. For example, one SMRC study involved reviewing nearly 50,000 DME claims for suppliers deemed high risk for having improperly billed for diabetic test strips. In 2014, the claim reviews for this study accounted for all of the SMRC's DME claim reviews and nearly half of all the SMRC claim reviews. Additionally, in 2014, the SMRC reviewed more than 50,000 claims as part of its study that examined five claims from every home health agency. The study followed a significant increase in the improper payment rate for home

health agencies from 2012 to 2013, from 6 percent to 17 percent. In some cases, SMRC studies focused on specific providers. For example, a 2013 SMRC study reviewed claims for a single hospital to follow up on billing issues previously identified by the HHS OIG.

Both RAs and the SMRC Generated Savings for CMS, but Unreliable Data Prevent Comparison to MACs

CMS Paid the RAs an Average of \$158 per Review, and the RAs Averaged \$14 in Identified Improper Payments per Dollar Paid by CMS in 2013 and 2014

The RAs were paid an average of \$158 per claim review conducted in 2013 and 2014 and identified \$14 in improper payments, on average, per dollar paid by CMS in contingency fees (see Table 7). The cost to CMS in RA contingency fees per review decreased from \$178 in 2013 to \$101 in 2014 because the average identified improper payment amount per review decreased from \$2,549 to \$1,509. The decrease in the average identified improper payment amount per review likely resulted from the RAs conducting proportionately fewer reviews of inpatient claims in 2014 compared to 2013.

Table 7: Recovery Auditor Funding and Identified Improper Payments, 2013-2014

	2013	2014	2013 and 2014 combined
Number of claim reviews	1,463,978	516,135	1,980,113
Payments in contingency fees ^a	\$260,270,105	\$51,888,213	\$312,158,318
Average cost to CMS per review	\$178	\$101	\$158
Identified improper payments	\$3,731,142,616	\$778,942,350	\$4,510,084,966
Average identified improper payments per review	\$2,549	\$1,509	\$2,278
Identified improper payments per dollar paid by the Centers for Medicare & Medicaid Services (CMS)	\$14	\$15	\$14

Source: GAO analysis of CMS data. | GAO-16-394

Note: ^aContingency fee data for RA claim reviews in 2013 and 2014 represent costs as of July 2015. The amount RAs are paid for specific claim reviews can vary over time based on additional collections and claim reviews that are overturned on appeal.

CMS Paid the SMRC an Average of \$256 per Review, and the SMRC Averaged \$7 in Identified Improper Payments per Dollar Paid in 2013 and 2014

The SMRC was paid an average of \$256 per claim review conducted in studies initiated in fiscal years 2013 and 2014, though the amount paid per claim review varied by study and varied between years (see Table 8). In particular, the amount paid to the SMRC is significantly higher for studies that involve extrapolation for providers who had their claims reviewed as part of the studies and were found to have a high error rate. Based on our analysis, the higher average amount paid per review in 2014—\$346 compared to \$110 in 2013—can in part be attributed to the SMRC conducting proportionally more studies involving extrapolation in 2014. As well as increasing study costs, the use of extrapolation can significantly increase the associated amounts of identified improper payments per study. For example, the SMRC study on diabetic test strips involved extrapolation and included reviews of nearly 50,000 claims from 500 providers. It cost CMS more than \$23 million to complete, but the SMRC identified more than \$63 million in extrapolated improper payments. According to CMS officials, the agency has the SMRC perform extrapolation as part of its studies when it is cost effective—that is, when anticipated extrapolated overpayment amounts are greater than the costs associated with having the SMRC conduct the extrapolations.

Table 8: Supplemental Medical Review Contractor Funding and Identified Improper Payments, 2013-2014

	2013	2014	2013 and 2014 combined
Number of claim reviews	67,697	110,470	178,167
CMS funding	\$7,462,133	\$38,193,029	\$45,655,162
Average cost to CMS per review	\$110	\$346	\$256
Identified improper payments	\$183,499,208	\$145,224,361	\$328,723,569
Average identified improper payments per review	\$2,711	\$1,315	\$1,845
Identified improper payments per dollar paid by the Centers for Medicare & Medicaid Services (CMS)	\$25	\$4	\$7

Source: GAO analysis of CMS data. | GAO-16-394

The amount the SMRC was paid per review also varied based on the type of service being reviewed and the number of reviews conducted. CMS pays the SMRC more for claim reviews for Part A services, such as inpatient and home health claims, than for claim reviews for Part B services, such as physician and DME claims, because CMS officials said that claim reviews of Part A services are generally more resource-intensive. Additionally, CMS gets a volume discount on SMRC claim reviews, with the cost per review decreasing once the SMRC reaches certain thresholds for the number of claim reviews in a given year.

The SMRC identified \$7 in improper payments per dollar paid by the agency, on average, in 2013 and 2014, though the average amount varied considerably by study and varied for 2013 and 2014. In 2013, the SMRC averaged \$25 in improper payments per dollar paid, while in 2014, it averaged \$4. The larger figure for 2013 is primarily attributed to two SMRC studies that involved claim reviews of inpatient claims that identified more than \$160 million in improper payments but cost CMS less than \$1 million in total to conduct.

CMS's Lack of Reliable MAC Cost and Savings Data Precludes Analysis of the Cost per Review and the Amount of Improper Payments Identified per Dollar Paid by CMS

We were unable to determine the cost per review and the amount of improper payments identified by the MACs per dollar paid by CMS because the agency does not have reliable data on funding of MAC claim reviews for 2013 and 2014, and the agency collects inconsistent data on the savings from prepayment claim denials. For an agency to achieve its objectives, federal internal control standards provide that an agency must obtain relevant data to evaluate performance towards achieving agency goals.³⁸ By not collecting reliable data on claim review funding and by not having consistent data on identified improper payments, CMS does not have the information it needs to evaluate MAC cost effectiveness and performance in protecting Medicare funds.

We found that CMS's data on MAC funding for claim reviews were not reliable because in 2013 and 2014 not all MACs reported funding data specific to prepayment and postpayment reviews. We previously reported in 2011 that CMS did not have reliable information to determine the amount of funds spent by each MAC on individual program integrity activities, and we recommended that CMS complete planned data system changes to accurately capture such funding data.³⁹ Despite CMS having made the needed data system changes, we found that in 2013 and 2014 at least three MACs were still not reporting data that provided information on the specific funds spent to conduct prepayment and postpayment claim reviews. Instead, the MACs were reporting their costs in terms of

³⁸[GAO/AIMD-00-21.3.1](#).

³⁹MACs are involved with multiple aspects of Medicare operations, and therefore, they receive funds to conduct several different types of program integrity activities. Our 2011 report found that the lack of reliable data on funds spent by each MAC limited CMS's ability to assess the cost effectiveness of its program integrity activities. For more information, see GAO, *Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*, [GAO-11-592](#) (Washington, D.C.: July, 2011).

higher-level, broader contractual work activities. CMS officials told us that they have not required the MACs to report data on specific funds spent to conduct prepayment and postpayment claim reviews. However, as of February 2016, CMS officials told us that all MACs are either currently reporting specific data on prepayment and postpayment claim review costs or planning to do so soon.

We also found that data on savings from MAC prepayment reviews were not consistent across the MACs. In particular, the MACs use different methods to calculate and report savings associated with prepayment claim denials, which represented about 98 percent of MAC claim review activity in 2013 and 2014. According to CMS and MAC officials, claims that are denied on a prepayment basis are never fully processed, and the Medicare payment amounts associated with the claims are never calculated. In the absence of processed payment amounts, the MACs use different methods for calculating prepayment savings. According to the MACs:

- Two MACs use the amount that providers bill to Medicare to calculate savings from prepayment claim denials. However, the amount that providers bill to Medicare is often significantly higher than and not necessarily related to how much Medicare pays for particular services. One MAC estimated that billed amounts can be, on average, three to four times higher than allowable amounts. Accordingly, calculated savings based on provider billed amounts can greatly inflate the estimated amount that Medicare saves from claim denials.

Nine MACs calculate prepayment savings by using the Medicare “allowed amount.” The allowed amount is the total amount that providers are paid for claims for particular services, though it is generally marginally higher than the amount that Medicare pays, as it includes the amount Medicare pays, cost sharing that beneficiaries are responsible for paying, and amounts that third parties are responsible for paying.⁴⁰ Additionally, the allowed amounts may not account for Medicare payment policies that may reduce provider payments, such as bundled payments.⁴¹

⁴⁰Many Medicare FFS beneficiaries have some form of additional health care coverage provided by third parties that helps cover the beneficiaries’ Medicare cost sharing.

⁴¹Medicare may reimburse providers a single “bundled” payment for multiple services provided as part of a single episode of care.

-
- Five MACs compare denied claims with similar claims that were paid to estimate what Medicare would have paid.⁴²

CMS has not provided the MACs with documented guidance or other instructions for how to calculate savings from prepayment reviews. Federal internal controls standards provide that an agency must document guidance that has a significant impact on the agency's ability to achieve its goals.⁴³ In reviewing MAC claim review program documentation, including the Medicare Program Integrity Manual and MAC contract statements of work, we were unable to identify any instructions on how the MACs should calculate savings from prepayment claim denials. Further, several MACs we interviewed indicated that they have not been provided guidance for calculating savings from prepayment denials. CMS officials told us that they were under the impression that all of the MACs were reporting prepayment savings data based on the amount that providers bill to Medicare, which can significantly overestimate the amount that Medicare saves from prepayment claim denials. Because CMS has not provided documented guidance on how to calculate savings from prepayment claim review, the agency lacks consistent and reliable information on the performance of MAC claim reviews. In particular, CMS does not have reliable information on the extent to which MAC claim reviews protect Medicare funds or on how the MACs' performance compares to other contractors conducting similar activities.⁴⁴

Conclusions

CMS contracts with claim review contractors that use varying degrees of prepayment and postpayment reviews to identify improper payments and protect the integrity of the Medicare program. Though we found few differences in how contractors conduct and how providers respond to the two review types, prepayment reviews are generally more cost-effective

⁴²Two of the MACs that compare denied claims to similar paid claims to calculate prepayment savings use this method only for Part A claims, and for Part B claims they use allowed amounts. Additionally, according to CMS officials, the RAs also compared denied claims to similar paid claims to calculate the savings associated with their reviews for the Prepayment Review Demonstration.

⁴³GAO/AIMD-00-21.3.1.

⁴⁴In addition, CMS has reported data on MAC claim review savings to Congress. For example, see HHS, *Fiscal Year 2016 Centers for Medicare & Medicaid Services Justification of Estimates for Appropriations Committees*.

because they prevent improper payments and limit the need to recover overpayments through the “pay and chase” process, which requires administrative resources and is not always successful. Although CMS considered the Prepayment Review Demonstration a success, and having the RAs conduct prepayment reviews would align with CMS’s strategy to pay claims properly the first time, the agency has not requested legislative authority to allow the RAs to do so. Accordingly, CMS may be missing an opportunity to better protect Medicare funds and agency resources.

Inconsistent with federal internal control standards, CMS has not provided the MACs with documented guidance or other instructions for how to calculate savings from prepayment reviews. As a result, CMS does not have reliable data on the amount of improper payments identified by the MACs, which limits CMS’s ability to evaluate MAC performance in preventing improper payments. CMS uses claim review contractors that have different roles and take different approaches to preventing improper payments. However, the essential task of reviewing claims is similar across the different contractors and, without better data, CMS is not in a position to evaluate the performance and cost effectiveness of these different approaches.

Recommendations for Executive Action

We recommend that the Secretary of HHS direct the Acting Administrator of CMS to take the following two actions:

- In order to better ensure proper Medicare payments and protect Medicare funds, CMS should seek legislative authority to allow the RAs to conduct prepayment claim reviews.
- In order to ensure that CMS has the information it needs to evaluate MAC effectiveness in preventing improper payments and to evaluate and compare contractor performance across its Medicare claim review program, CMS should provide the MACs with written guidance on how to accurately calculate and report savings from prepayment claim reviews.

Agency Comments and Our Evaluation

We provided a copy of a draft of this report to HHS for review and comment. HHS provided written comments, which are reprinted in appendix I. In its comments, HHS disagreed with our first recommendation, but it concurred with our second recommendation. HHS also provided us with technical comments, which we incorporated in the report as appropriate.

HHS disagreed with our first recommendation that CMS seek legislative authority to allow the RAs to conduct prepayment claim reviews. HHS noted that other claim review contractors conduct prepayment reviews and CMS has implemented other programs as part of its strategy to move away from the “pay and chase” process of recovering overpayments, such as prior authorization initiatives and enhanced provider enrollment screening. However, we found that prepayment reviews better protect agency funds compared with postpayment reviews, and believe that seeking the authority to allow the RAs to conduct prepayment reviews is consistent with CMS’s strategy.

HHS concurred with our second recommendation that CMS provide the MACs with written guidance on how to accurately calculate and report savings from prepayment claim reviews. HHS stated that it will develop a uniform method to calculate savings from prepayment claim reviews and issue guidance to the MACs.

As agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretary of Health and Human Services, the Acting Administrator of CMS, appropriate congressional requesters, and other interested parties. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staff members have any questions about this report, please contact me at (202) 512-7114 or at kingk@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 that made key contributions to this report are listed in appendix II.

Sincerely,



Kathleen M. King
Director, Health Care

Appendix I: Comments from the Department of Health and Human Services



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20548

MAR 31 2016

Kathleen King
Director, Health Care
U.S. Government Accountability Office
441 G Street NW
Washington, DC 20548

Dear Ms. King:

Attached are comments on the U.S. Government Accountability Office's (GAO) report entitled, "Medicare: Claim Review Programs Could Be Improved with Additional Prepayment Reviews and Better Data" (GAO-16-394).

The Department appreciates the opportunity to review this report prior to publication.

Sincerely,

Jim R. Esquea
Assistant Secretary for Legislation

Attachment

GENERAL COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS) ON THE GOVERNMENT ACCOUNTABILITY OFFICE'S DRAFT REPORT ENTITLED: MEDICARE: CLAIM REVIEW PROGRAMS COULD BE IMPROVED WITH ADDITIONAL PREPAYMENT REVIEWS AND BETTER DATA (GAO-16-394)

The Department of Health and Human Services (HHS) appreciates the opportunity to review and comment on this draft report. HHS is strongly committed to program integrity in the Medicare program and takes seriously our responsibility to protect taxpayer dollars by identifying and correcting improper payments.

HHS partners with multiple types of contractors to conduct claim reviews to identify and correct improper payments. Recovery Auditors (RAs) identify and correct improper payments through the efficient detection and collection of overpayments made on claims for health care services provided to beneficiaries and through the identification of underpayments to providers. They are also responsible for highlighting common billing errors, trends, and other Medicare payment issues for CMS. In Fiscal Year 2014, RAs collectively identified and corrected more than 1.1 million claims for improper payments, which resulted in \$2.57 billion dollars in improper payments being corrected. The Supplemental Medical Review Contractor (SMRC) performs a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare program. One of the primary tasks of the SMRC is conducting nationwide medical review as directed by CMS. Medicare Administrative Contractors (MACs) process medical claims for Medicare fee-for-service providers and beneficiaries. MACs are also responsible for identifying high-risk providers, suppliers, and services for claim reviews. Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs) investigate instances of suspected fraud, waste, and abuse.

As noted in the GAO report, HHS is working to move beyond “pay and chase” operations in which the agency has to recover overpayments and is using innovative prevention and detection activities to pay claims properly the first time. As part of this process, CMS has implemented the Fraud Prevention System (FPS), which applies predictive analytics technology on claims prior to payment to identify aberrant and suspicious billing patterns. The FPS runs predictive algorithms and other sophisticated analytics nationwide against all Medicare fee-for-service claims. CMS uses the FPS to target investigative resources to suspicious claims and providers and swiftly impose administrative action if warranted. Since CMS implemented the technology in June 2011, the FPS has identified or prevented \$820 million in inappropriate payments.

HHS also has multiple prior authorization models to help make sure services are provided in compliance with Medicare coverage, coding, and payment rules before services are rendered and claims are paid. Through prior authorization, a request for provisional affirmation of coverage is submitted for review before a service is furnished to a beneficiary and before a claim is submitted for payment. Prior authorization does not create additional documentation requirements or delay medical service. It requires the same information that is currently necessary to support Medicare payment, but earlier in the process. HHS believes prior authorization is an effective way to promote compliance with Medicare rules for some items and services.

In addition, HHS has implemented categorical risk-based screening of newly enrolling Medicare providers and suppliers and revalidates Medicare providers and suppliers under these new requirements every three or five years based on the new requirements established by the Affordable Care Act. Since these regulations were issued, more than one million providers and

suppliers have been subject to the new screening requirements. Over 500,000 provider and supplier practice locations had their billing privileges deactivated as a result of revalidation and other screening efforts, and more than 34,000 provider and supplier enrollments were revoked.

GAO's recommendations and HHS' responses are below.

GAO Recommendation

In order to better ensure proper Medicare payments and protect Medicare funds, CMS should seek legislative authority to allow the RAs to conduct prepayment claims reviews.

HHS Response

HHS does not concur with this recommendation. Currently, MACs, ZPICs, and PSCs conduct prepayment claim reviews. In addition, HHS has implemented programs, including FPS, prior authorizations models, and categorical risk-based screening of Medicare providers and suppliers, to move beyond “pay and chase” operations and pay claims properly the first time. The Fiscal Year 2017 President’s budget does not include a legislative proposal to allow RAs to conduct prepayment claims reviews.

GAO Recommendation

In order to ensure that CMS has the information it needs to evaluate MAC effectiveness in preventing improper payments and to evaluate and compare contractor performance across its Medicare claim review program, CMS should provide the MACs with written guidance on how to accurately calculate and report savings from prepayment claim reviews.

HHS Response

HHS concurs with this recommendation. HHS will work to develop a method for MACs to calculate savings from prepayment claim reviews. HHS will issue guidance to instruct the MACs to report savings from prepayment claim reviews in a uniform way.

HHS thanks GAO for their efforts on this issue and looks forward to working with GAO on this and other issues in the future.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

Kathleen M. King, (202) 512-7114, kingk@gao.gov.

Staff Acknowledgments

In addition to the contact named above, Lori Achman, Assistant Director; Michael Erhardt; Krister Friday; Richard Lipinski; Kate Tussey; and Jennifer Whitworth made key contributions to this report.

Appendix III: Accessible Data

Agency Comment Letter

Text of Appendix I: Comments from the Department of Health and Human Services

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