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MEDICARE AND MEDICAID

CMS Should Assess Documentation Necessary to Identify Improper Payments

GAO Highlights

Highlights of GAO-19-277, a report to congressional addressees

Why GAO Did This Study

In fiscal year 2017, Medicare FFS had an estimated $23.2 billion in improper payments due to insufficient documentation, while Medicaid FFS had $4.3 billion—accounting for most of the programs' estimated FFS medical review improper payments. Medicare FFS coverage policies are generally national, and the program directly pays providers, while Medicaid provides states flexibility to design coverage policies, and the federal government and states share in program financing.

Among other things, GAO examined: (1) Medicare and Medicaid documentation requirements and factors that contribute to improper payments due to insufficient documentation; and (2) the extent to which Medicaid reviews provide states with actionable information. GAO reviewed Medicare and Medicaid documentation requirements and improper payment data for fiscal years 2005 through 2017, and interviewed officials from CMS, CMS contractors, and six state Medicaid programs. GAO selected the states based on, among other criteria, variation in estimated state improper payment rates, and FFS spending and enrollment.

What GAO Recommends

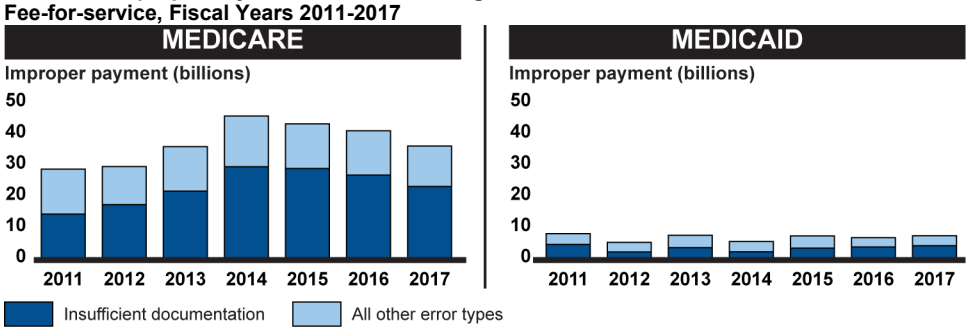
GAO is making four recommendations to CMS, including that CMS assess and ensure the effectiveness of Medicare and Medicaid documentation requirements, and that CMS take steps to ensure Medicaid's medical reviews effectively address causes of improper payments and result in appropriate corrective actions. CMS concurred with three recommendations, but did not concur with the recommendation on Medicaid medical reviews. GAO maintains that this recommendation is valid as discussed in this report.

View GAO-19-277. For more information, contact James Cosgrove at (202) 512-7144, or cosgrovej@gao.gov, or Carolyn L. Yocom at yocomc@gao.gov

What GAO Found

The Centers for Medicare & Medicaid Services (CMS) uses estimates of improper payments to help identify the causes and extent of Medicare and Medicaid program risks and develop strategies to protect the integrity of the programs. CMS estimates Medicare and Medicaid fee-for-service (FFS) improper payments, in part, by conducting medical reviews—reviews of provider-submitted medical record documentation to determine whether the services were medically necessary and complied with coverage policies. Payments for services not sufficiently documented are considered improper payments. In recent years, CMS estimated substantially more improper payments in Medicare, relative to Medicaid, primarily due to insufficient documentation (see figure).

Estimated Improper Payments Identified through Medical Review in Medicare and Medicaid Fee-for-service, Fiscal Years 2011-2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' data. | GAO-19-277

For certain services, Medicare generally has more extensive documentation requirements than Medicaid. For example, Medicare requires additional documentation for services that involve physician referrals, while Medicaid requirements vary by state and may rely on other mechanisms—such as requiring approval before services are provided—to ensure compliance with coverage policies. Although Medicare and Medicaid pay for similar services, the same documentation for the same service can be sufficient in one program but not the other. The substantial variation in the programs' improper payments raises questions about how well the programs' documentation requirements help identify causes of program risks. As a result, CMS may not have the information it needs to effectively address program risks and direct program integrity efforts.

CMS's Medicaid medical reviews may not provide the robust state-specific information needed to identify causes of improper payments and address program risks. In fiscal year 2017, CMS medical reviews identified fewer than 10 improper payments in more than half of all states. CMS directs states to develop corrective actions specific to each identified improper payment. However, because individual improper payments may not be representative of the causes of improper payments in a state, the resulting corrective actions may not effectively address program risks and may misdirect state program integrity efforts. Augmenting medical reviews with other sources of information, such as state auditor findings, is one option to better ensure that corrective actions address program risks.