



Testimony

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MEDICARE

Further Action Could Improve Improper Payment Prevention and Recoupment Efforts

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GAO Highlights

Highlights of [GAO-14-619T](#), a testimony before the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform, House of Representatives

Why GAO Did This Study

Due to its size, complexity, and susceptibility to mismanagement and improper payments, GAO has designated Medicare as a high-risk program. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about \$604 billion, and reported an estimated \$50 billion in improper payments—payments that either were made in an incorrect amount or should not have been made at all. Most of these improper payments were made through the Medicare FFS program, which pays providers based on claims and uses contractors to pay the claims and ensure program integrity.

This statement focuses on the progress made and steps still to be taken by CMS to improve improper payment prevention and recoupment efforts in the Medicare FFS program. This statement is based on relevant GAO products and recommendations issued from 2007 through 2014 using a variety of methodologies. GAO also updated information by examining public documents and, in April 2014, GAO received updated information from CMS on its actions related to laws and regulations discussed in this statement.

View [GAO-14-619T](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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What GAO Found

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has made progress improving improper payment prevention and recoupment efforts in the Medicare fee-for-service (FFS) program, but further actions are needed.

Provider enrollment. CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) that address past weaknesses identified by GAO and others. The agency has also put in place other measures intended to strengthen existing procedures, but could do more to improve provider enrollment screening and ultimately reduce improper payments. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses, meet certain Medicare standards, and are at legitimate locations. CMS also recently contracted for fingerprint-based criminal history checks of providers and suppliers it has identified as high-risk. However, CMS has not implemented other screening actions authorized by PPACA that could further strengthen provider enrollment.

Prepayment controls. In response to GAO's prior recommendations, CMS has taken steps to improve the development of certain prepayment edits—prepayment controls used to deny Medicare claims that should not be paid; however, important actions that could further prevent improper payments have not yet been implemented. For example, CMS has implemented an automated edit to identify services billed in medically unlikely amounts, but has not implemented a GAO recommendation to examine certain edits to determine whether they should be revised to reflect more restrictive payment limits. GAO has found that wider use of prepayment edits could help prevent improper payments and generate savings for Medicare.

Postpayment claims reviews. Postpayment claims reviews help CMS identify and recoup improper payments. Medicare uses a variety of contractors to conduct such reviews, which generally involve reviewing a provider's documentation to ensure that the service was billed properly and was covered, reasonable, and necessary. GAO has found that differing requirements for the various contractors may reduce the efficiency and effectiveness of such reviews. To improve these reviews, GAO has previously recommended CMS examine ways to make the contractor requirements more consistent. CMS reported that it has begun to address these recommendations. Although the percentage of Medicare claims that undergo postpayment review remains very small, GAO has found that the overall number of postpayment claims reviews has been increasing in recent years. HHS has reported that the increase in claims reviews is one factor causing backlogs in the Medicare appeals process.

GAO has ongoing work focused on how CMS could continue its efforts to reduce improper Medicare payments. For instance, GAO is examining the extent to which CMS's provider enrollment system can help prevent and detect the continued enrollment of ineligible providers in Medicare. GAO also has work underway to examine whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee:

I am pleased to be here today to discuss our work examining further action Medicare could take to improve its improper payment prevention and recoupment efforts.¹ In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about \$604 billion, and reported some of the largest estimates of improper payments among federal programs—payments that either were made in an incorrect amount or should not have been made at all.² Due to its size, complexity, and susceptibility to mismanagement and improper payments, we have designated Medicare as a high-risk program since 1990.³

The Centers for Medicare & Medicaid Services (CMS), the agency within the Department of Health and Human Services (HHS) that oversees Medicare, has estimated that improper payments in the Medicare program were almost \$50 billion in fiscal year 2013.⁴ CMS separately calculates error rates and performance targets for the Medicare fee-for-service (FFS) program, Medicare Advantage, and the Medicare Prescription Drug Benefit.⁵ Medicare FFS accounted for more than 70 percent of Medicare’s estimated improper payments in 2013. The Medicare FFS estimated improper payments were about \$36 billion or about 10.1 percent of total FFS payments. This is about \$6.5 billion

¹Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease.

²An improper payment is defined as any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. It includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (codified at 31 U.S.C. § 3321 note).

³GAO, *High-Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013)

⁴A list of abbreviations used in this statement is provided in appendix I.

⁵Medicare consists of four parts. Parts A and B are known as Medicare FFS. Part A covers hospital and other inpatient stays and Part B covers hospital outpatient, physician, and other services. Part C, also known as Medicare Advantage, is the private plan alternative to Medicare FFS under which beneficiaries receive benefits through private health plans. Part D is the outpatient prescription drug benefit.

higher than in 2012 and did not meet the fiscal year 2013 target error rate of 8.3 percent that the agency set for itself to reduce improper payments.⁶ Improper payments may be a result of fraud, waste, or abuse, but it is important to distinguish that the \$50 billion in estimated improper payments reported by CMS in fiscal year 2013 is not an estimate of fraud in Medicare.⁷ Reported improper payment estimates include many types of payments that should not have been made or were made in an incorrect amount such as overpayments, underpayments, and payments that were not adequately documented.

According to HHS, the primary cause of improper payments in Medicare FFS was administrative and documentation errors in large part due to insufficient documentation, meaning the medical records submitted by the provider or supplier were inadequate to support payment for the services billed.⁸ HHS has reported that physicians and suppliers substantially contributed to insufficient documentation errors. HHS also cited the provision of services that were found not to be medically necessary and incorrect diagnosis coding as causes for FFS improper payments. Medical necessity errors occur, for example, when a claim is paid for a service that should have been provided in a less intensive setting. This error type has accounted for the majority of Part A inpatient hospital improper payments. For Medicare Advantage, HHS reported that the majority of the improper payment estimate resulted from insufficient documentation to support the diagnoses submitted by private health plans for payment. HHS cited administrative and documentation errors as the cause for all improper payments in the prescription drug benefit. Despite

⁶See Department of Health and Human Services, *Fiscal Year 2012 Agency Financial Report* (Washington D.C.: Nov 15, 2012).

⁷Fraud consists of intentional acts of deception with knowledge that the action or representation could result in an inappropriate gain. Waste includes inaccurate payments for services, such as unintentional duplicate payments. Abuse represents actions inconsistent with acceptable business or medical practices.

⁸Department of Health and Human Services, *Fiscal Year 2013 Agency Financial Report* (Washington D.C.: Dec 16, 2013). Medicare FFS uses the Comprehensive Error Rate Testing (CERT) program to calculate improper payment estimates. The CERT program categorized five types of errors—no documentation, insufficient documentation, medical necessity, incorrect coding, and other errors (such as duplicate payments). In this statement, the term provider includes entities such as hospitals or physicians, and supplier means an entity that supplies Medicare beneficiaries with durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) such as walkers and wheelchairs.

CMS efforts to address these causes, reducing Medicare improper payments continues to be a challenge.

Today, my testimony will focus on the progress made and steps still needed by CMS to reduce improper payments in the Medicare FFS program. I will focus on CMS's progress with respect to three key strategies we have identified in prior work that can help prevent improper payments and recoup overpayments:

- Strengthening provider enrollment standards and procedures to help reduce the risk of enrolling entities intent on defrauding the program;
- Improving prepayment controls, to ensure that claims are paid correctly the first time; and
- Improving postpayment claims review and recovery of improper payments to reduce the likelihood of improper payments and recoup overpayments.

My statement today is based primarily on previous GAO reports related to Medicare program integrity efforts issued between January 2007 and April 2014. A list of related GAO products is included at the end of this statement.⁹ We supplemented prior work with additional information on Medicare improper payments reported by HHS in its fiscal year 2013 agency financial report and with other publicly available information from HHS's website on Medicare appeals, and we received updated information from CMS in April 2014 on its actions related to relevant laws, regulations, and recommendations that had not yet been implemented discussed in this statement. Our work for this statement and the products on which it was based was conducted 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.

⁹The products listed at the end of this statement contain detailed information on the various methodologies used in our work.

CMS Has Improved Key Strategies for Preventing and Recouping Improper Payment, but More Can Be Done

CMS has made progress strengthening provider enrollment procedures and prepayment controls in the Medicare program to help ensure that payments are made correctly the first time, but the agency could further improve upon its efforts by implementing additional enrollment procedures and prepayment strategies. Likewise, additional improvements to CMS's postpayment claims review activities could improve their efficiency and effectiveness.

CMS Has Implemented Certain Enrollment Procedures to Better Screen Providers, but Has Not Completed Others

CMS has implemented certain provider enrollment screening procedures authorized by the Patient Protection and Affordable Care Act (PPACA) and put in place other measures intended to strengthen existing procedures.¹⁰ The changes to provider screening procedures are intended to address past weaknesses identified by GAO and the HHS's Office of Inspector General (OIG) that allowed entities intent on committing fraud to enroll in Medicare. Blocking the enrollment of such providers helps to prevent Medicare from making improper payments. Specifically, CMS added screenings of categories of provider enrollment applications by risk level and contracted with new national enrollment screening and site visit contractors.

- *Screening Provider Enrollment Applications by Risk Level:* CMS and the OIG issued a final rule in February 2011 to implement many of the new screening procedures required by PPACA.¹¹ CMS designated three levels of risk—high, moderate, and limited—with different screening procedures for categories of Medicare providers at each level. Providers in the high-risk level are subject to the most rigorous screening. Based in part on our work and that of the OIG, CMS designated newly enrolling home health agencies and suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) as high risk, and designated other providers as lower risk.

¹⁰Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

¹¹*Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers*, 76 Fed. Reg. 5862 (Feb. 2, 2011). In discussing the final rule, CMS noted that Medicare had already employed a number of the screening practices described in PPACA to determine whether a provider is in compliance with federal and state requirements to enroll or to maintain enrollment in the Medicare program.

Providers at all risk levels are screened to verify that they meet specific requirements established by Medicare, such as having current licenses or accreditation and valid Social Security numbers. High- and moderate-risk providers are also subject to unannounced site visits.

Further, PPACA authorizes CMS to require fingerprint-based criminal background checks of providers and suppliers depending on the risks presented. In March 2014, CMS awarded a contract to a Federal Bureau of Investigation-approved contractor that will enable the agency to access criminal history information to help conduct those checks of high-risk providers and suppliers. CMS has indicated that the agency will continue to review the criteria for its screening levels and will publish changes if the agency decides to update the assignment of screening levels for categories of Medicare providers. Doing so could become important because the Department of Justice and HHS reported multiple convictions, judgments, settlements, or exclusions against types of providers not currently at the high-risk level, including community mental health centers and ambulance providers.¹²

- *National Enrollment Screening and Site Visit Contractors:* CMS contracted with two new contractors at the end of 2011 to assume centralized responsibility for two functions that had been the responsibility of multiple contractors. One of the new contractors is conducting automated screenings to check that existing and newly enrolling providers and suppliers have valid licensure, accreditation, and a National Provider Identifier, and are not on the OIG list of providers and suppliers excluded from participating in federal health care programs. The second contractor conducts site visits of providers to determine whether sites are legitimate and the providers meet certain Medicare standards. A CMS official reported that, since the implementation of the PPACA screening requirements, the agency

¹²Department of Health and Human Services and the Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2013* (Washington, D.C.: February 2014).

had revoked over 17,000 suspect providers' privileges to bill the Medicare program.¹³

Although CMS has taken actions to strengthen the provider enrollment process, we and the OIG have found that CMS has not taken other actions authorized by PPACA and that could improve screening and ultimately reduce improper payments.¹⁴ They include issuing a rule to require surety bonds for certain providers and suppliers as well as a rule on provider and supplier disclosure requirements.

- *Surety Bonds*: PPACA authorized CMS to require a surety bond for certain types of at-risk providers and suppliers.¹⁵ Surety bonds may serve as a source for recoupment of erroneous payments. DMEPOS suppliers are currently required to post a surety bond at the time of enrollment.¹⁶ CMS told us in April 2014 that the agency collected about \$1.6 million in DMEPOS supplier overpayments between February 2012 and March 2013. However, also in April 2014, CMS reported that it had not scheduled for publication a proposed rule to impose a surety bond requirement as authorized by PPACA for other types of at-risk providers and suppliers—such as home health agencies and independent diagnostic testing facilities.
- *Providers and Suppliers Disclosure*: CMS has not yet scheduled the publication of a proposed rule for increased disclosures of prior actions taken against providers and suppliers enrolling or revalidating enrollment in Medicare, such as whether the provider or supplier has been subject to a payment suspension from a federal health care

¹³S. Agrawal, Deputy Administrator and Director, Center for Program Integrity, Centers for Medicare & Medicaid Services, *Preventing Medicare Fraud: How Can We Best Protect Seniors and Taxpayers?*, testimony before the Senate Special Aging Committee, March 26, 2014.

¹⁴GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*, [GAO-12-351](#) (Washington, D.C.: Apr. 10, 2012).

¹⁵A surety bond guarantees that if a provider or supplier does not fulfill its obligation to Medicare, CMS can recover its losses via the surety bond.

¹⁶42 U.S.C. § 1395m(a)(16)(B). A DMEPOS surety bond is a bond issued by an entity guaranteeing that a DMEPOS supplier will fulfill its obligation to Medicare. If the obligation is not met, the surety bond is paid to Medicare. *Medicare Program; Surety Bond Requirement for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*, 74 Fed. Reg. 166 (Jan. 2, 2009).

program.¹⁷ As we reported in April 2012, agency officials indicated that developing the additional disclosure requirements has been complicated by provider and supplier concerns about what types of information will be collected, what CMS will do with it, and how the privacy and security of this information will be maintained.¹⁸

We are currently examining the ability of CMS's provider enrollment system to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Specifically, we are assessing the process used to enroll and verify the eligibility of Medicare providers in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) and the extent to which CMS's controls are designed to prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in PECOS.¹⁹

CMS Has Improved Prepayment Controls, but More Could Be Done to Prevent Improper Payments

CMS has enhanced its efforts to reduce improper payments by improving prepayment controls, particularly prepayment edits to deny claims that should not be paid. CMS has stated that one of its key goals is to pay claims properly the first time—that is, to ensure that payments go to legitimate providers in the right amount for reasonable and necessary services covered by the program for eligible beneficiaries. To do so, among other things, CMS uses prepayment controls such as prepayment edits—instructions that CMS's contractors, including Medicare Administrative Contractors (MAC), program into claims processing systems that compare claim information to Medicare requirements in

¹⁷At the time of initial enrollment or revalidation of enrollment, PPACA requires providers and suppliers to disclose, in a form and manner and at such time as determined by the Secretary, any current or previous affiliation with another provider or supplier that has uncollected debt; has been or is subject to a payment suspension under a federal health care program; has been excluded from participation under Medicare, Medicaid, or State Children's Health Insurance Program; or has had its billing privileges denied or revoked. Pub. L. No. 111-148, § 6401(a), 124 Stat. 119, 750 (2010).

¹⁸[GAO-12-351](#).

¹⁹PECOS is CMS's centralized database for Medicare enrollment information. To bill Medicare, providers and suppliers must first enroll in PECOS and as part of the enrollment process CMS contractors validate certain provider information.

order to approve or deny claims or to flag them for additional review.²⁰ For example, some prepayment edits are related to service coverage and payment, while others are implemented to verify that the claim is properly filled out, that providers are enrolled in Medicare, or that patients are eligible Medicare beneficiaries.²¹ Most of the edits implemented by CMS and its contractors are automated and applied to all claims; if a claim does not meet the criteria of the edits, it is automatically denied. Other prepayment edits are manual; they flag a claim for individual review by trained staff to determine whether it should be paid.

We previously evaluated CMS's implementation of prepayment edits and found that while use of prepayment edits saved Medicare at least \$1.76 billion in fiscal year 2010, the savings could have been greater had prepayment edits been used more widely.²² For example, based on our analysis of a limited number of national policies and local coverage determinations in 2012,²³ we identified \$14.7 million and \$100 million in payments, respectively, that were inconsistent with policies and determinations and were therefore improper. Such inconsistencies could have been identified using automated edits.

As we recommended, CMS has taken steps to improve the development of certain prepayment edits that are implemented nationwide. For example, the agency has centralized the development and

²⁰Some edits use provider enrollment information, while others use information on coverage or payment policies, to determine whether claims should be paid. MACs process and pay FFS claims. In addition to MACs, CMS has other types of contractors to help identify and recover improper payments, address fraud and abuse, or develop specific types of edits.

²¹For more information on the scope of prepayment coverage, payment and coding 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. 13, 2012).

²²[GAO-13-102](#).

²³CMS typically develops national coverage determination policies for services that have the potential to affect a large number of beneficiaries and that have the greatest effect on the Medicare program. Development of national coverage determinations is a lengthy process, which requires review of clinical evidence and allows for public comment. In addition, each MAC has the authority to develop local coverage determinations (LCDs) that delineate the circumstances under which services are considered reasonable and necessary and are therefore covered in the geographic area where that MAC processes claims.

implementation of automated edits based on a type of national policy called national coverage determinations.²⁴ In addition, CMS has modified its processes for identifying provider billing of services that are medically unlikely, in order to prevent circumvention of automated edits designed to identify an unusually large quantity of services provided to the same patient.²⁵ However, as of April 2014, CMS had not fully implemented several of the recommendations we made in 2013 that we believe would promote greater use of prepayment edits and better ensure proper payment.²⁶ For example, the agency did not include, in its written guidance to agency staff on procedures for ensuring consideration of automated edits, time frames for making decisions on whether an edit would be developed nor did it include requirements for assessing the effects of corrective actions taken. In addition, although CMS has taken initial steps to improve the data it collects about local prepayment edits implemented by its contractors, it had not yet determined a final process for how it would obtain and disseminate information about these edits across contractors.²⁷ Nor does CMS require contractors to share information with each other about the underlying policies and savings related to their most effective edits, as the agency currently lacks a database to collect such information. Having information about the most effective local edits would enable contractors to determine the most appropriate approach for implementing Medicare payment policy effectively, which could help reduce improper payments.

To help prevent improper payments, CMS also implemented a specific type of national edit, called a Medical Unlikely Edit (MUE), which limits the amount of a service that is paid when billed by a provider for a beneficiary on the same day. The limits for certain services that have been fraudulently or abusively billed are unpublished to deter providers from billing up to the maximum allowable limit. In 2013, we reported that CMS may be missing opportunities to prevent improper payments because it

²⁴GAO, *Medicare Fraud: Progress Made, but More Action Is Needed to Address Medicare Fraud, Waste and Abuse*, [GAO-14-560T](#) (Washington, D.C.: Apr. 30, 2014).

²⁵CMS refers to these automated edits as Medically Unlikely Edits (MUE).

²⁶See [GAO-13-102](#) for our recommendations related to our evaluation of CMS's implementation of prepayment edits.

²⁷MACs may create prepayment edits to implement their LCDs. CMS has responsibility for providing information and oversight to MACs with respect to their use of prepayment edits to promote effective stewardship of Medicare funds.

has not systematically evaluated MUE limits to determine whether national edits should be revised to reflect more restrictive local limits.²⁸ In addition, we found that CMS and its contractors did not have a system in place for examining claims to determine the extent to which providers may be exceeding unpublished MUE limits and whether payments for such services were proper. As a result, we recommended that CMS examine contractor edits to determine whether any national unpublished MUE limits should be revised, consider reviewing claims to identify providers that exceed the unpublished MUE limits, and determine whether the provider's billing was proper. HHS agreed with these recommendations, but as of April 2014, CMS had not implemented them.

Postpayment Claims Reviews Have Increased in Recent Years, but More Could Be Done to Increase Consistency across Contractors

Medicare uses four types of contractors to conduct postpayment claims reviews to identify and recoup overpayments.²⁹ The contractors all use the same Medicare coverage and payment guidelines.

- MACs, in addition to conducting prepayment claims reviews, conduct postpayment claims reviews to help ensure accurate payment and specifically to identify payment errors. This includes identifying ways to address future payment errors—for example, through automated controls that can be added on a prepayment basis and by educating providers with a history of a sustained or high level of billing errors to ensure that they comply with Medicare billing requirements.
- Zone Program Integrity Contractors (ZPIC), the CMS contractors responsible for detecting and investigating fraud, perform postpayment claims reviews as a part of their investigations.³⁰

²⁸GAO, *Medicare Program Integrity: Few Payments in 2011 Exceed Limits Under One Type of Prepayment Control, but Reassessing Limits Could Be Helpful*, [GAO-13-430](#) (Washington, D.C.: May 9, 2013).

²⁹In this statement, we discuss the four types of primary contractors that perform claims reviews. In addition to these four, in 2012 CMS established the Supplemental Medicare Review Contractor type to perform national claims reviews of Medicare Part A, Part B, and durable medical equipment providers and suppliers. This type of contractor conducts large-volume medical reviews nationwide for specific services, such as Inpatient Psychiatric Facility Interrupted Stays, Epidural Injections, and Place-of-Service coding. We are not discussing this type of contractor because it was too new to examine during our most recent work on Medicare postpayment contractors.

³⁰Program safeguard contractors conducted activities to investigate fraud prior to the establishment of ZPICs, and are still doing so in one of seven geographic zones.

Therefore, ZPIC reviews generally focus on providers whose billing patterns are unusual or aberrant in relation to those of similar providers in order to identify potential fraud.

- The Comprehensive Error Rate Testing (CERT) contractor estimates the Medicare FFS improper payment rate by using the results of postpayment claims reviews conducted on a sample of claims processed by the MACs. CERT reviews may also help identify program vulnerabilities by measuring the payment accuracy of each MAC, and the Medicare FFS improper payment rate by type of claim and service.
- Recovery audit contractors (RAC) conduct postpayment claims reviews to identify improper payments. Use of RACs was designed to be in addition to MACs' existing claims review processes, since the number of postpayment reviews conducted by MACs and other contractors was small relative to the number of claims paid and the amount of improper payments. Whereas RACs are paid on a contingency fee basis based on the amount of improper payments they recoup, the other three contractors are paid under the terms of their contract using appropriated funds.³¹ In February 2014, CMS announced a "pause" in the RAC program as the agency makes changes to the program and starts a new procurement process for the next round of recovery audit contracts. CMS said it anticipates awarding all five of these new Medicare FFS recovery audit contracts by the end of summer 2014.³²

All four types of contractors conduct complex reviews of claims. Complex reviews involve manual examinations of each claim and any related documentation requested and received from the provider, including paper files, to determine whether the service was billed properly, and was covered, reasonable, and necessary. Licensed clinical professionals, such as licensed practical nurses, and certified coders typically perform

³¹Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about 40 years. Typically, contractors that perform recovery audits are paid a contingency fee based on a percentage of the overpayments collected. In Medicare, the RACs are paid a contingency fee based on both the percentage of overpayments collected and underpayments identified.

³²PPACA required the expansion of Medicare RACs to Parts C and D. See Pub. L. No. 111-148, § 6411(b) 124 Stat. 119, 775 (2010) (codified at 42 U.S.C. § 1395ddd(h)). CMS has implemented a RAC for Part D, and CMS said it plans to award a contract for a Part C RAC by the end of 2014.

the reviews. Contractors have physician medical directors on staff who provide guidance about making payment determinations on the basis of medical records and other documentation and who may discuss such determinations with providers.

In addition to conducting complex reviews, RACs also conduct automated and semiautomated postpayment claims reviews. Automated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Automated postpayment reviews analyze paid claims and identify those that can be determined to be improper without examining any additional documentation, such as when a durable medical equipment supplier bills for items that should have been included as part of a bundled payment for a skilled nursing facility stay.³³ Semiautomated reviews use computer programming logic to check for possible improper payments, but allow providers to send in information to rebut the claim denial before it is implemented. If providers send in information, RAC staff review it before making a final determination.

Our prior work has found that the overall number of postpayment claims reviews has been increasing in recent years, but remains a very small percentage of total Medicare claims submitted.³⁴ In 2012, the most recent year for which we have data, the four types of Medicare postpayment review contractors conducted about 2.3 million claims reviews, which is a 55 percent increase from 2011. RACs conducted about 2.1 million, or 90 percent, of these reviews in 2012. All four types of contractors listed except the CERT contractor increased the number of claims they reviewed in 2012, as shown in table 1.

³³If the durable medical equipment claim is submitted prior to the bundled skilled nursing facility claim, the durable medical equipment claim may not appear to be improper when made.

³⁴GAO, *Medicare Program Integrity: Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency*. [GAO-13-522](#) (Washington, D.C.: July 23, 2013).

Table 1: Volume of Contractors' Postpayment Claims Reviews, by Type of Contractor 2011-2012

| Type of contractor | Type of review | 2011 | 2012 | Percent change |
|--|------------------------|------------------|------------------|----------------|
| Medicare Administrative Contractors (MAC) ^a | Complex ^b | 10,518 | 84,070 | 699% |
| Zone Program Integrity Contractors (ZPIC) ^c | Complex | 92,655 | 107,621 | 16 |
| Comprehensive Error Rate Testing (CERT) contractor | Complex | 47,877 | 41,396 | -14 |
| Recovery Audit Contractors (RAC) ^d | Automated ^e | 723,484 | 985,946 | 36 |
| | Complex ^f | 634,613 | 1,121,509 | 77 |
| | Total | 1,358,097 | 2,107,455 | 55 |
| Total | | 1,509,147 | 2,340,542 | 55% |

Source: GAO analysis of CMS data.

^aReviews completed by MACs do not include the reviews performed by the three legacy contractors that were continuing to provide claims administration services as of June 2013.

^bComplex reviews are manual examinations of claims documentation including paper files, to determine whether the service was billed properly and was covered, reasonable, and necessary. They typically are performed by licensed clinical professionals or certified coders.

^cReviews completed by ZPICs include those performed by the program safeguard contractors (PSC) and reflect PSCs' reviews of potentially abusive physical therapy claims in one geographic area.

^dRAC data are reported for fiscal years 2011 and 2012, rather than calendar year.

^eAutomated reviews use computer programming logic to check claims for evidence of improper coding or other mistakes. Only the RACs conducted automated postpayment reviews.

^fRAC complex reviews are based on the number of additional documentation requests received and also include semiautomated reviews.

While the number of postpayment reviews has increased significantly, the percentage of Medicare claims reviewed after payment remains small. The 2.3 million reviews performed by these four types of contractors accounted for less than 1 percent of the more than 1 billion FFS claims paid annually. About 1.4 million of the reviews were complex reviews which required the submission of documentation for review.

As a systematic matter, the increase in postpayment claims reviews is one factor causing backlogs and delays at the third level of the Medicare appeals process. Medicare providers and suppliers can appeal prepayment and postpayment claims determinations through the Medicare appeals process, which offers four levels of administrative review followed by judicial review. The first two levels of appeals for FFS claims are managed by two CMS contractors—the MAC that processed the original claim and a Qualified Independent Contractor, in that order.³⁵

³⁵There are five Qualified Independent Contractors that serve different areas of the country and focus on specific parts of the Medicare FFS program.

The third level of appeal is to an Administrative Law Judge (ALJ) at the Office of Medicare Hearings and Appeals (OMHA), a separate staff division within HHS. A Part A or Part B appeal filed with OMHA should generally be decided within 90 days of the appeal being filed.³⁶ However, due to a backlog of cases, OMHA currently reports that the average time for appeals to be decided in fiscal year 2014 is 346 days.³⁷ The number of appeals filed at the ALJ level increased from 59,601 in fiscal year 2011 to 384,651 in fiscal year 2013, according to OMHA. OMHA's website currently says that new appeals will take about 28 months before they are put on an ALJ's hearing docket. OMHA has reported that part of the reason for the backlog in Medicare appeals is the increase in postpayment contractor activities. We have been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and what HHS is doing to address it.

We have made recommendations to CMS in the past to improve the postpayment claims review process, and we continue to do work in this area. In October 2012, we reported on CMS's Fraud Prevention System (FPS), which uses predictive analytics to analyze Medicare FFS claims.³⁸ FPS is intended to detect aberrant billing practices as quickly as possible so they can be investigated to determine whether the payments are proper. At the time, we recommended that CMS integrate FPS with Medicare's payment-processing system to allow for the prevention of payments until suspect claims could be investigated by ZPICs. Although CMS reported in April 2014 that it had integrated the systems, the system still does not have the ability to suspend payment until suspect claims can be investigated. CMS has begun to implement prepayment edits in FPS that automatically deny claims based on attributes of the FPS edit which reviews the claim against historical claims across all lines of business.³⁹

³⁶OMHA also adjudicates other Medicare appeals, including those related to Part D prescription drug coverage. However, Part A and Part B appeals make up the vast majority of appeals made to OMHA.

³⁷OMHA prioritizes beneficiary appeals and expedited appeals of Part D drug denials.

³⁸GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*, [GAO-13-104](#) (Washington, D.C.: Oct. 15, 2012).

³⁹CMS told us that it implemented the first FPS edit in January 2014 and that two additional FPS edits are planned for implementation in June 2014 and two more in September 2014.

In July 2013, we reported that the differences in CMS's postpayment claims review requirements for the four types of contractors may reduce the efficiency and effectiveness of claims reviews by complicating providers' compliance with the requirements.⁴⁰ For instance, while RACs have to obtain approval from CMS for the billing issues they choose to review on a widespread basis and notify providers and suppliers of those issues on their websites, the other contractors do not. In addition, the minimum number of days that CMS requires a contractor to give a provider to submit additional documentation for a complex review before the claim can be found improper for lack of documentation varies among the contractors from 30 days for ZPICs to 75 days for the CERT contractor. Staffing requirements and quality assurance requirements also vary among the four types of contractors. We recommended that CMS examine all postpayment review requirements for contractors to determine whether they could be made more consistent without negative effects on program integrity. We also recommended that CMS reduce differences in those requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. In commenting on that report, CMS agreed with our recommendations and stated that the agency was beginning to review its requirements for postpayment claims reviews. We are following up on this work with a study reviewing, among other things, whether CMS has strategies for coordinating postpayment review contractors' claims review activities.

In conclusion, given the amount of estimated improper payments in the Medicare program, the imperative for CMS to use all available authorities to prevent and recoup improper payments is clear. Although CMS has taken important steps to strengthen key strategies for identifying and preventing improper payments, the agency must continue to improve upon these efforts. Identifying the nature, extent, and underlying causes of improper payments and developing adequate corrective action processes to address vulnerabilities are essential prerequisites to reducing them. As CMS continues its implementation of PPACA, additional evaluation and oversight will help determine whether implementation of relevant provisions has been effective in reducing improper payments. We are continuing to conduct a body of work that assesses CMS's efforts to refine and improve its ability to prevent, identify, and recoup improper payments. Notably, we are currently

⁴⁰[GAO-13-522](#).

assessing the extent to which CMS's information system can help prevent and detect the continued enrollment of ineligible or potentially fraudulent providers in Medicare. Additionally, we are examining CMS's oversight of some of the contractors that conduct postpayment reviews of claims including whether CMS has a strategy for coordinating these contractors' claims review activities. Separately, we have also been asked to examine the Medicare appeals process, including the reasons for the appeals backlog and how it is being addressed. Through this work, we hope to develop further recommendations for CMS to help the agency continue to refine its efforts to reduce improper Medicare payments.

Chairman Lankford, Ranking Member Speier, and Members of the Subcommittee, this concludes my prepared remarks. I would be pleased to respond to any questions you may have at this time.

GAO Contact and Staff Acknowledgments

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Appendix I: Abbreviations

| | |
|--------|---|
| ALJ | Administrative Law Judge |
| CERT | Comprehensive Error Rate Testing |
| CMS | Centers for Medicare & Medicaid Services |
| DMEPOS | durable medical equipment, prosthetics, orthotics, and supplies |
| FFS | fee-for-service |
| FPS | Fraud Prevention System |
| HHS | Department of Health and Human Services |
| LCD | local coverage determination |
| MAC | Medicare Administrative Contractor |
| MUE | Medically Unlikely Edit |
| OIG | Office of Inspector General |
| OMHA | Office of Medicare Hearings and Appeals |
| PECOS | Provider Enrollment, Chain, and Ownership System |
| PPACA | Patient Protection and Affordable Care Act |
| PSC | program safeguard contractor |
| RAC | recovery audit contractor |
| ZPIC | Zone Program Integrity Contractor |

Related GAO Products

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