

GAO Highlights

Highlights of [GAO-14-712T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

Why GAO Did This Study

GAO has designated Medicare as a high-risk program, in part because the program's size and complexity make it vulnerable to fraud, waste, and abuse. In 2013, Medicare financed health care services for approximately 51 million individuals at a cost of about \$604 billion. The deceptive nature of fraud makes its extent in the Medicare program difficult to measure in a reliable way, but it is clear that fraud contributes to Medicare's fiscal problems. More broadly, in fiscal year 2013, CMS estimated that improper payments—some of which may be fraudulent—were almost \$50 billion.

This statement focuses on the progress made and important steps to be taken by CMS and its program integrity contractors to reduce fraud in Medicare. This statement is based on relevant GAO products and recommendations issued from 2004 through 2014 using a variety of methodologies. Additionally, in June 2014, GAO updated information based on new regulations regarding enrollment of certain providers in Medicare by examining public documents.

View [GAO-14-712T](#). For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

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MEDICARE FRAUD

Further Actions Needed to Address Fraud, Waste, and Abuse

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 in implementing several key strategies GAO identified or recommended in prior work as helpful in protecting Medicare from fraud; however, implementing other important actions that GAO recommended could help CMS and its program integrity contractors combat fraud. These strategies are:

Provider and Supplier Enrollment: The Patient Protection and Affordable Care Act (PPACA) authorized, and CMS has implemented, actions to strengthen provider and supplier enrollment that address past weaknesses identified by GAO and HHS's Office of Inspector General. For example, CMS has hired contractors to determine whether providers and suppliers have valid licenses and are at legitimate locations. CMS could further strengthen enrollment screening by issuing a rule to require additional provider and supplier disclosures of information, such as any suspension of payments from a federal health care program, and establishing core elements for provider and supplier compliance programs, as authorized by PPACA.

Prepayment and Postpayment Claims Review: Medicare uses prepayment review to deny claims that should not be paid and postpayment review to recover improperly paid claims. GAO has found that increased use of prepayment edits could help prevent improper Medicare payments. For example, prior GAO work identified millions of dollars of payments that appeared to be inconsistent with selected coverage and payment policies and therefore improper. Postpayment reviews are also critical to identifying and recouping overpayments. GAO recommended better oversight of both (1) the information systems analysts use to identify claims for postpayment review, in a 2011 report, and (2) the contractors responsible for these reviews, in a 2013 report. CMS has taken action or has actions under way to address these recommendations.

Addressing Identified Vulnerabilities: Having mechanisms in place to resolve vulnerabilities that could lead to improper payments is critical to effective program management and could help address fraud. However, prior GAO work has shown weaknesses in CMS's processes to address such vulnerabilities. For example, GAO has made multiple recommendations to CMS to remove Social Security numbers from beneficiaries' Medicare cards to help prevent identity theft. HHS agreed with these recommendations, but reported that CMS could not proceed with the changes for a variety of reasons, including funding limitations, and therefore has not taken action.

GAO work under way addressing these key strategies includes examining: (1) how well CMS's information system can prevent and detect the continued enrollment of ineligible or potentially fraudulent providers and suppliers in Medicare, (2) the potential use of electronic-card technologies to help reduce Medicare fraud, (3) CMS's oversight of program integrity efforts for prescription drugs, and (4) CMS's oversight of some of the contractors that conduct reviews of claims after payment. These studies could help CMS more systematically reduce potential fraud in the Medicare program.