IMPROPER PAYMENTS:

THE CASE OF MEDICAID

OCTOBER 21, 2015

BERYL H. "BERRI" DAVIS

CGFM, CPA, CIA, CGAP, CGMA, CCSA

DIRECTOR, FINANCIAL MANAGEMENT AND ASSURANCE

DAVISBH@GAO.GOV

U.S. GOVERNMENT ACCOUNTABILITY OFFICE

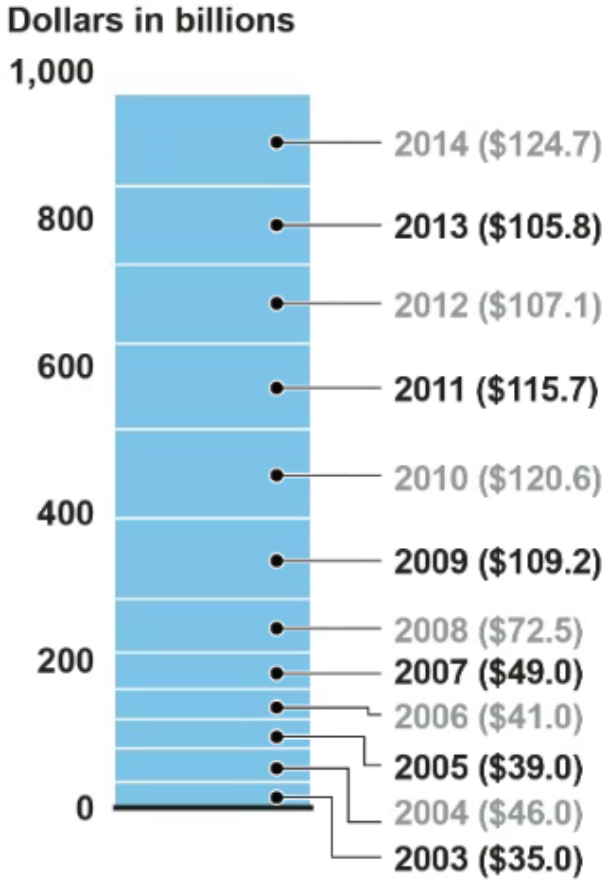
2015 National Intergovernmental Audit Forum

What Are Improper Payments?

- An improper payment is any payment that should not have been made or was made in an incorrect amount (including overpayments and underpayments).

- Improper payments remain a significant and pervasive government-wide issue. Since 2003, when certain agencies began reporting improper payments as required by the Improper Payments Information Act of 2002, cumulative improper payment estimates have totaled almost $1 trillion.

Cumulative Improper Payment Estimates for Fiscal Years 2003 through 2014



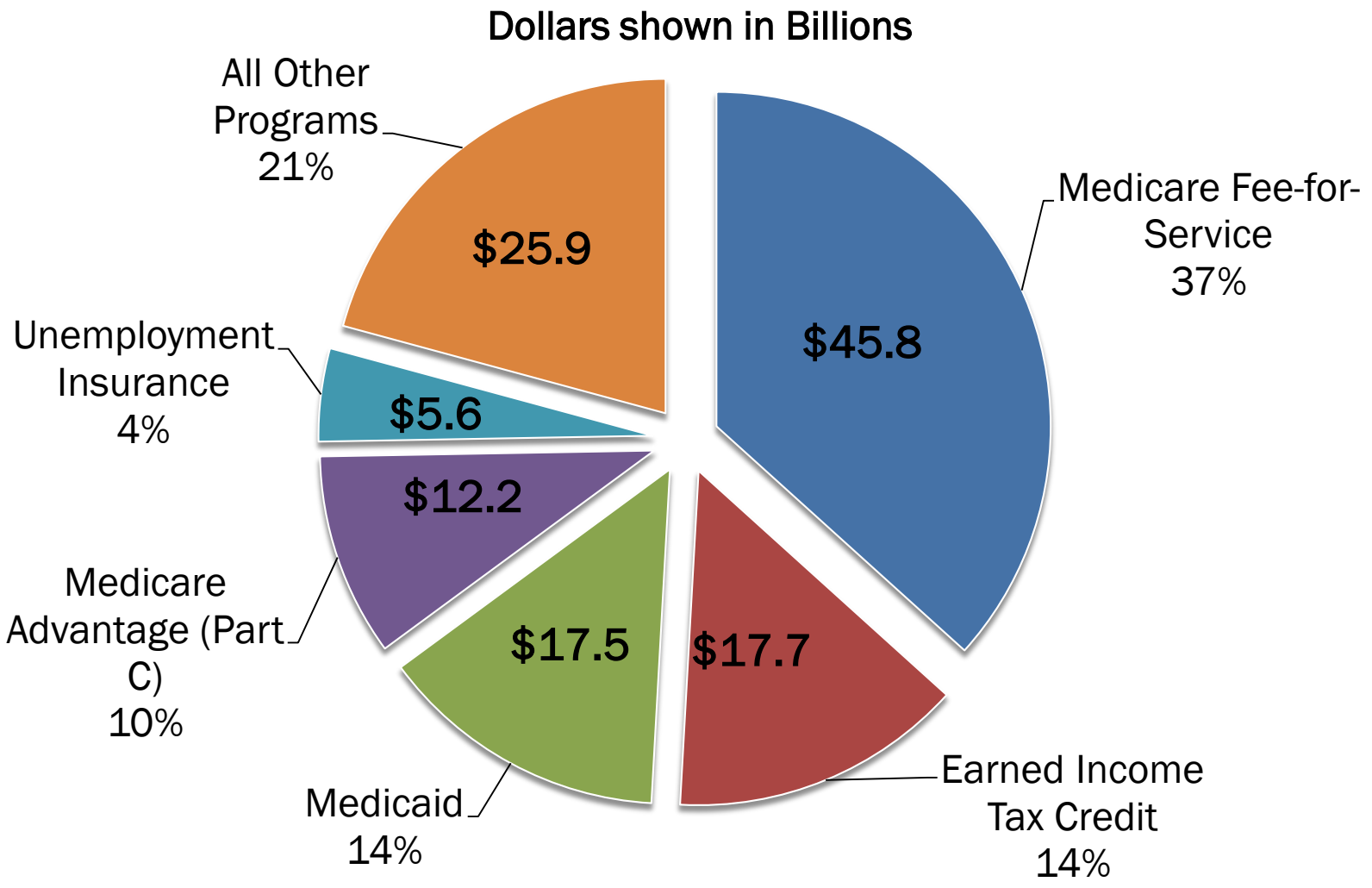
Source: GAO. | GAO-16-92T

Note: Generally, the specific programs and total number of programs that constitute the government-wide improper payment estimate vary from year to year. In earlier years, the number of programs included in the government-wide estimate generally increased as programs reported improper payment estimates for the first time.

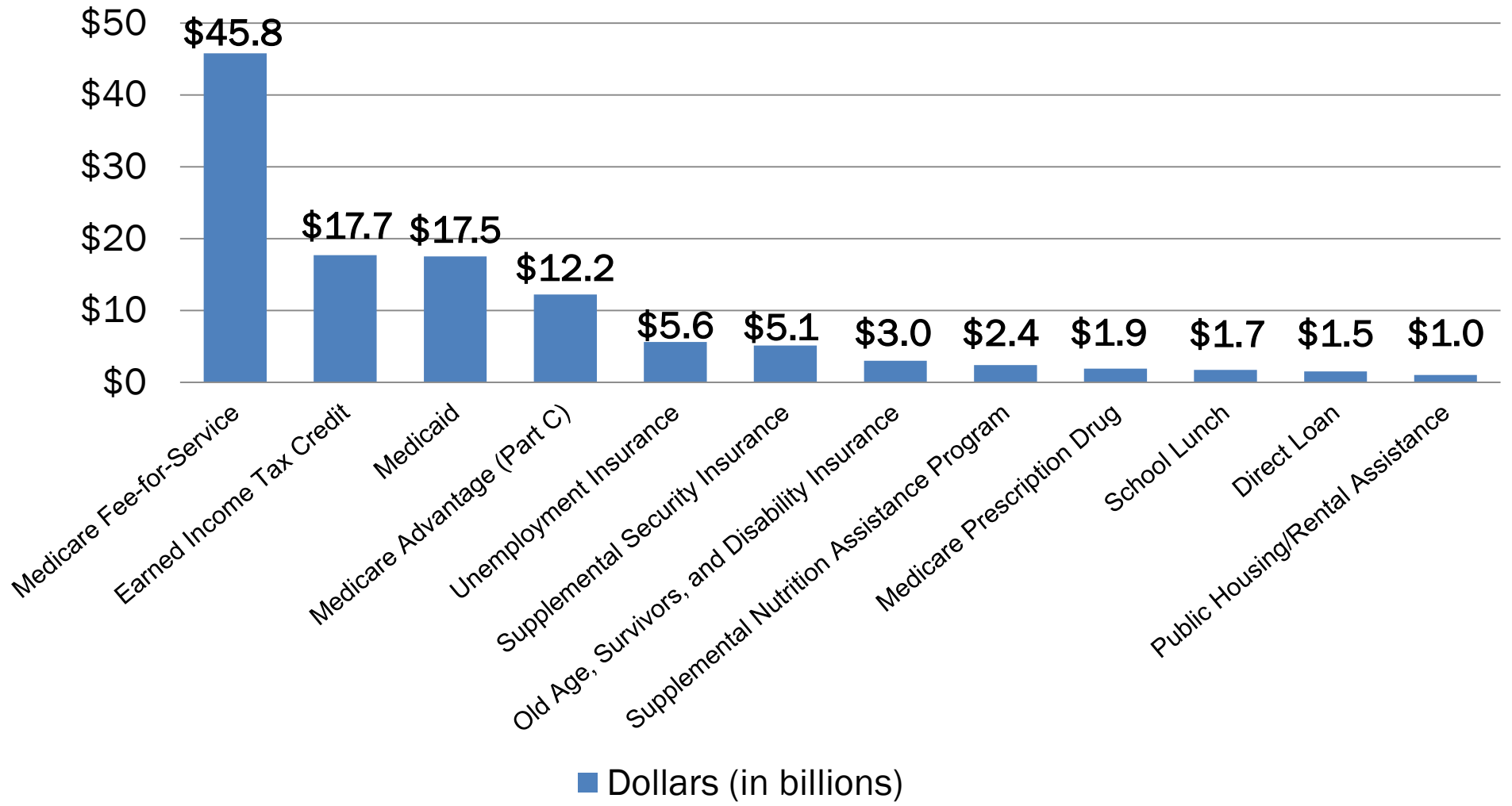
Fiscal Year 2014 Improper Payment Estimates

- OMB and federal agencies reported improper payment estimates totaling **$124.7 billion** in fiscal year 2014, an increase of approximately **$19 billion** from the prior year revised estimate of $105.8 billion.
  - $16 billion of the increase in fiscal year 2014 is attributed primarily to increased error rates in three major programs:
    - HHS's Medicare Fee-for-Service (10.1% to 12.7%)
    - HHS's Medicaid (5.8% to 6.7%)
    - Treasury's Earned Income Tax Credit (24.0% to 27.2%)

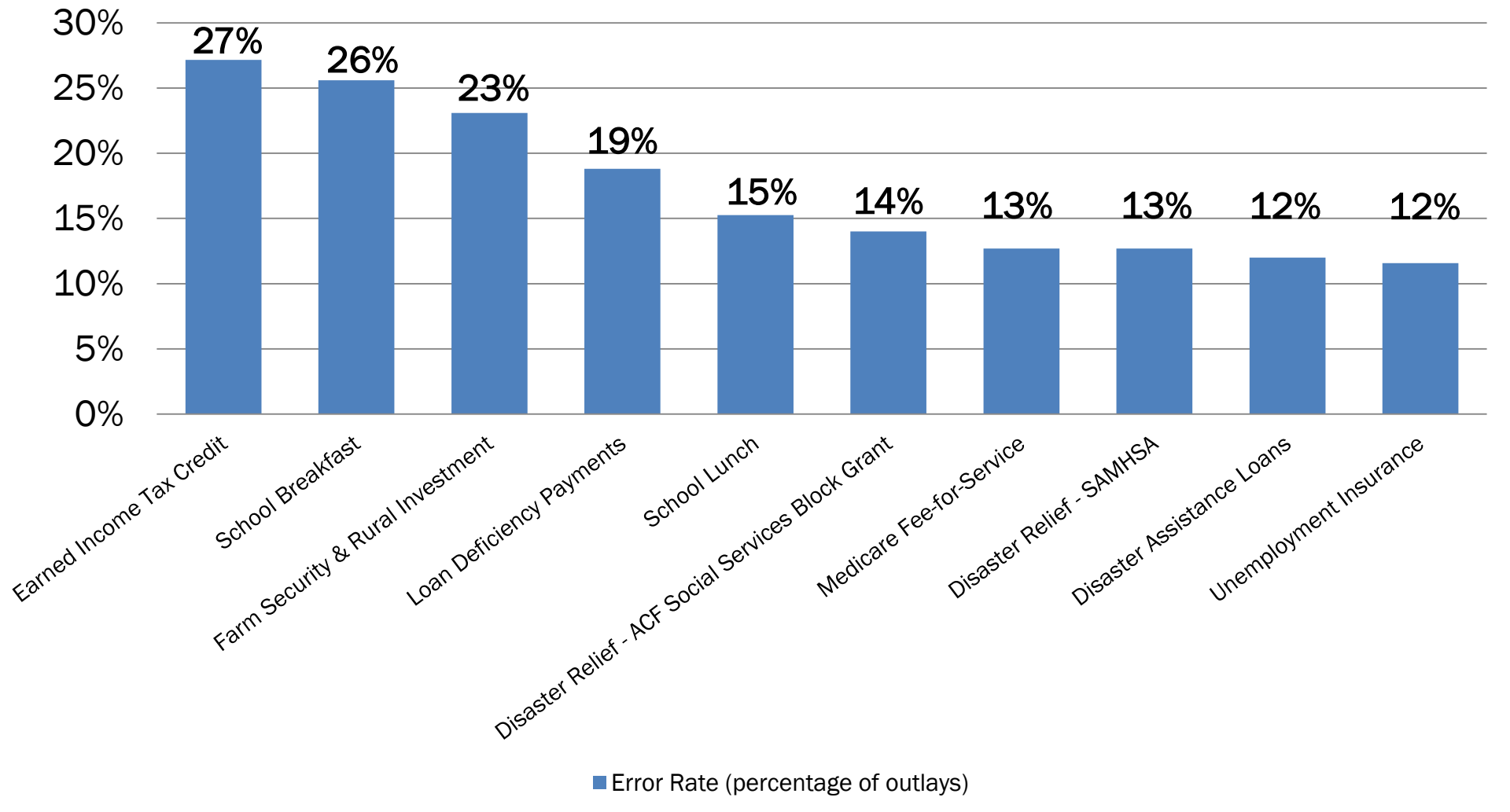
Fiscal Year 2014 Improper Payment Estimates – Program Distribution of $124.7 billion



Programs with Improper Payment Estimates Exceeding $1 Billion in Fiscal Year 2014



Programs with Error Rates Greater than 10% in Fiscal Year 2014



Medicaid Improper Payments

- In fiscal year 2014, CMS reported approximately **$17.5 billion** in Medicaid improper payments, a **$3.1 billion** increase from the prior year estimate.

- The **$17.5 billion** estimate represents an error rate of **6.7%** of federal Medicaid program outlays.

- CMS uses its Payment Error Rate Measurement (PERM) program to develop its Medicaid improper payment estimate.

Payment Error Rate Measurement (PERM)

- The PERM program measures improper payments in Medicaid based on reviews of the (1) fee-for-service, (2) managed care, and (3) eligibility components of Medicaid.
- Under the PERM methodology, CMS places states in one of three cycles, and each year one of the cycles reports new state-level data based on the previous year's samples.
  - CMS then calculates the national Medicaid program improper payment estimate using these new data for one-third of the states and older data for the other two-thirds of the states.
- Because of Affordable Care Act changes to the way states adjudicate eligibility for Medicaid, the states are directed to implement Medicaid Eligibility Review Pilots in place of PERM eligibility reviews for fiscal years 2014-2016.
  - The PERM eligibility measurement component for improper payment estimates will resume in fiscal year 2017.

Types of Medicaid Improper Payments

- **FY 2014 root causes** reported in HHS's Annual Financial Report
  - **80% Verification errors** – most related to state claims processing systems not being compliant with new requirements
  - **11% Authentication and Medical Necessity errors** – most related to provider billing errors
  - **10% Administrative and Documentation errors** – most related to insufficient documentation
- **GAO has issued recommendations** that could help reduce Medicaid improper payments.

Reducing Medicaid Improper Payments GAO-15-208 and GAO-16-92T

- **Improving third-party liability efforts**
  - Medicaid is the health care payer of last resort.
    - If enrollees have another source of health care coverage, that source should pay, to the extent of its liability, before Medicaid.
    - States have reported challenges working with private insurers, including issues in obtaining out-of-state coverage data.
  - **GAO recommended** actions that could help improve cost-saving efforts in this area, such as monitoring and sharing information on third-party liability challenges across all states and providing guidance to states on oversight of third-party liability efforts related to Medicaid managed care plans.
    - In May 2015, HHS reported that CMS has begun developing a work plan to implement the recommendation.

Reducing Medicaid Improper Payments GAO-13-50 and GAO-16-92T

- **Strengthening program integrity**
  - CMS has taken positive steps to oversee program integrity efforts in Medicaid, including:
    - reconfiguring its approach in 2013 to reduce duplicate reviewing and auditing of states' claims,
    - redesigning its comprehensive reviews of states' program integrity activities toward a more targeted risk assessment approach, and
    - increasing its efforts to hold states accountable for reliably reporting program integrity recoveries.
  - CMS has not strengthened its efforts to calculate a return on investment (ROI) for its program integrity efforts, as GAO has recommended.
  - In January 2015, CMS officials confirmed that the agency is developing a methodology for calculating a single ROI that reflects the Center for Program Integrity's initiatives for both Medicare and Medicaid, and they expect to have their methodology finalized later this year.

Reducing Medicaid Improper Payments GAO-14-341 and GAO-16-92T

- **Increasing oversight of managed care**
  - Most Medicaid beneficiaries receive services through a managed care system (as opposed to a fee-for-service system), and managed care expenditures have been growing at a faster rate than fee-for-service.
  - In May 2014, GAO reported that most state and federal program integrity officials interviewed did not closely examine managed care payments, focusing on fee-for-service claims instead.
  - **GAO recommended** that CMS require states to (1) conduct audits of payments to and by managed care organizations, (2) update managed care guidance on program integrity practices, and (3) provide states with further support in overseeing managed care program integrity.
    - In June 2015, the agency issued a proposed rule to revise program integrity policies. If finalized, the rule would require states to conduct audits of managed care organizations' service utilization and financial data every 3 years.