

United States General Accounting Office Washington, D.C. 20548

October 31, 2002

The Honorable Stephen Horn Chairman, Subcommittee on Government Efficiency, Financial Management and Intergovernmental Relations Committee on Government Reform House of Representatives

Subject: Medicare Financial Management: Significant Progress Made to Enhance Financial Accountability

Dear Mr. Chairman:

Medicare provided health care coverage to 40 million people age 65 and over and to qualifying disabled persons at a cost of about \$240 billion in fiscal year 2001. In 1990, GAO designated the program as "high risk" for fraud and abuse because of its vast size, complex structure, and program management weaknesses.¹ In March and September 2000, we issued two reports, one on Medicare financial management and the other on Medicare improper payments.² These reports discussed weaknesses in the Centers for Medicare and Medicaid Services' (CMS) oversight of Medicare contractors in carrying out Medicare financial activities. We also cited CMS for deficiencies in its accounting procedures and improper payment measurement projects. We made eight recommendations for CMS to improve its performance in these areas and establish better financial control over the Medicare program.

At your request, we assessed CMS's progress in addressing these recommendations. This letter summarizes the information provided during our briefing to your staff on September 6, 2002. The enclosed briefing slides highlight the results of our work and the information provided at the briefing.

¹U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-01-263 (Washington, D.C: January 2001).

²U.S. General Accounting Office, *Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability*, GAO-AIMD-00-66 (Washington, D.C.: Mar. 15, 2000) and *Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse*, *Challenges Remain*, GAO-AIMD/OSI-00-281 (Washington, D.C.: Sept. 15, 2000).

Results in Brief	CMS has implemented corrective actions to substantially address four of the eight recommendations and has made good progress in addressing the remaining four. Actions taken by CMS include the implementation of more in-depth internal control reviews at Medicare contractors as well as the development of an accounting procedures manual to guide its financial management staff in consistent accounting and reporting for Medicare. CMS has also tested several innovative analysis techniques for identifying improper payments. These actions have helped CMS address some significant, long-standing financial management issues. Despite this progress, CMS needs to take further steps to fully address the remaining four recommendations. These steps include expanding its analysis of contractor financial data, ensuring resolution of audit findings, and enhancing detection of fraudulent and abusive Medicare payments. CMS is in the process of developing and implementing such actions.
Scope and Methodology	 To fulfill our objectives of assessing CMS's progress in addressing our prior recommendations, we reviewed CMS's audited financial statements for fiscal year 2000 and 2001, other financial reports, fiscal year 2001-2003 Annual Performance Plans, and the Comprehensive Plan for Financial Management to identify initiatives that address previously identified financial management weaknesses, determine if plans included actions to address our recommendations, and determine if the actions included were sufficient to address our recommendations;
	 obtained documentation on procedures implemented to address our recommendations and observed CMS Office of Financial Management staff while performing these procedures to determine if the procedures were in place and operating effectively; performed tests of audit resolution activities to confirm that procedures
	• performed tests of addit resolution activities to commit that procedures implemented to address our recommendations were in place and operating effectively;

- used the Comptroller General's *Standards for Internal Control in the Federal Government*³ to assess policies and procedures that CMS developed to address our recommendations;
- used our guide on *Strategies to Manage Improper Payments*⁴ to evaluate the three improper payment measurement projects and other initiatives that CMS had under way or planned; and
- held numerous interviews with the CMS Chief Financial Officer (CFO), Deputy CFO, program integrity officials, and staff members in the Department of Health and Human Services' Office of the Inspector General to obtain an understanding of the actions taken to address our recommendations.

We conducted our work from January 2002 through July 2002 in accordance with generally accepted government auditing standards. We requested comments on a draft of this report from the CMS CFO, Deputy CFO, and senior Medicare program integrity officials. These officials generally agreed with our findings as presented in the enclosed briefing slides, and the oral comments that they provided have been incorporated, as appropriate.

We are sending copies of this report to the Ranking Minority Member of your Subcommittee and the Chairmen and Ranking Minority Members of the Senate Committee on Governmental Affairs and House Committee on Government Reform. We are also sending copies of this report to the Secretary of Health and Human Services, Administrator of the Centers for Medicare and Medicaid Services, and other interested parties.

This report is available at no charge on our home page at http://www.gao.gov. If you have any questions about this report, please contact me at (202) 512-8341 or Kimberly Brooks, Assistant Director, at (202) 512-9038. You may also reach us by E-mail at calboml@gao.gov or

³U.S. General Accounting Office, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: November 1999).

⁴U.S. General Accounting Office, *Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations*, GAO-02-69G (Washington, D.C.: October 2001).

brooksk@gao.gov. Key contributors to this assignment were Johnny Clark, Lisa Crye, Suzanne Murphy, Cynthia Teddleton, and Lisa Willett.

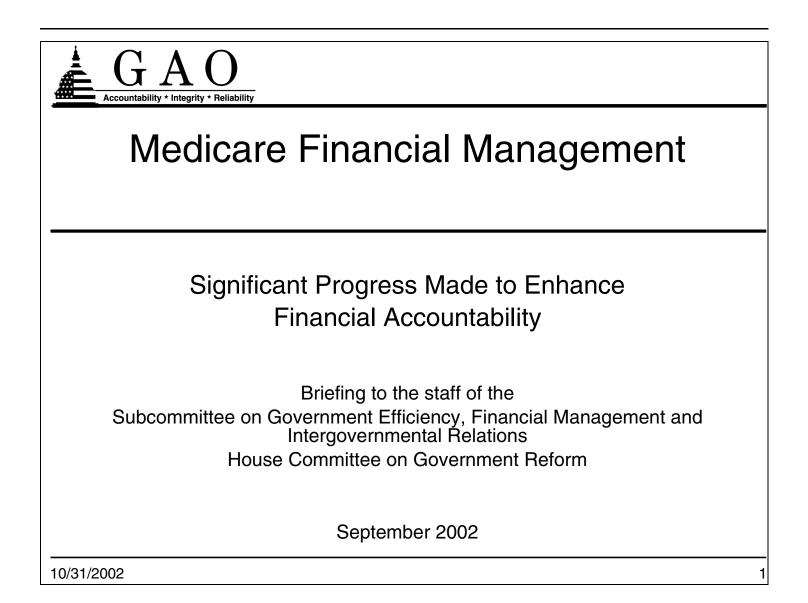
Sincerely yours,

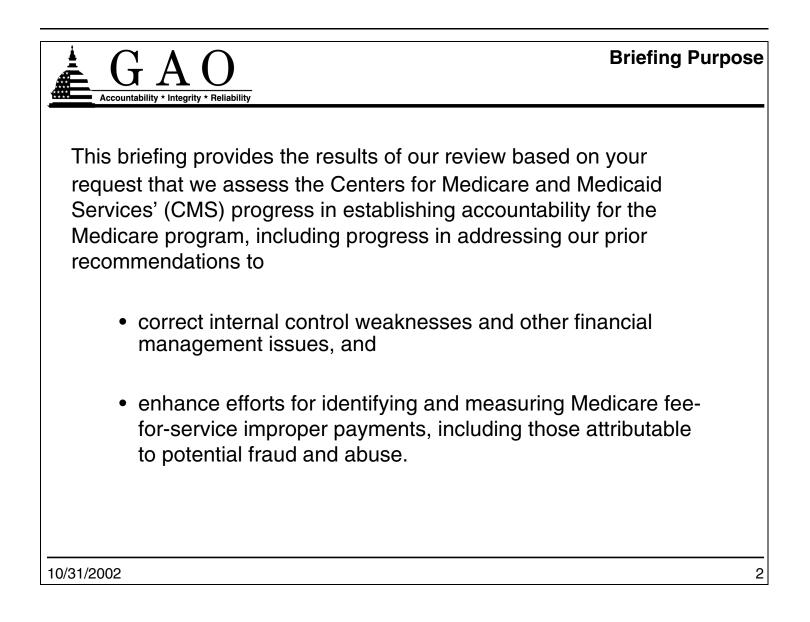
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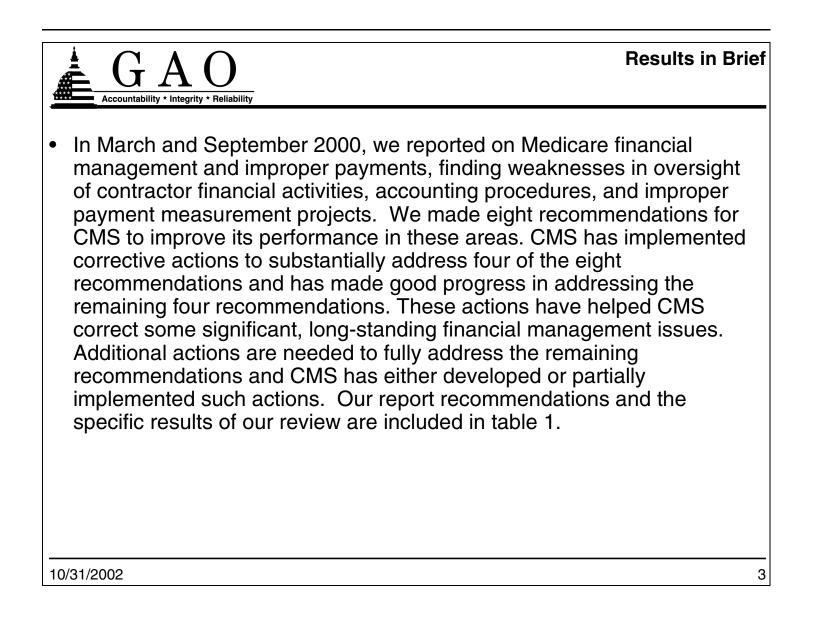
Linda M. Calbom Director Financial Management and Assurance

Enclosure

Enclosure: September 2002 Briefing on Progress Made to Enhance Financial Accountability



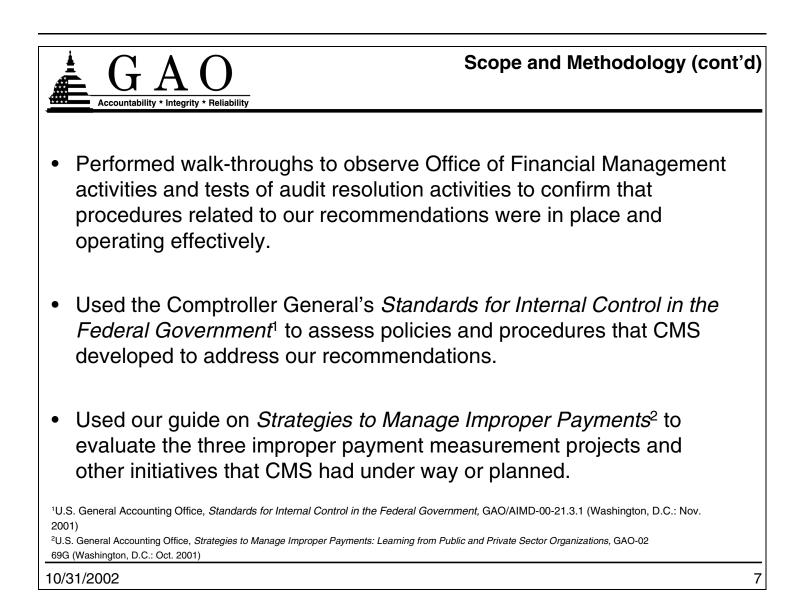




G Accountability * Ir	A O		n Brief—Status ecommendatio
	tus of Recommendations		
	Recommendations	Substantial progress made	Additional actions needed
Medicare financial management	GAO/AIMD-00-66—Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability (March 2000)		
	Improve guidance to contractors for executing financial activities.	*	
	Refine and expand review procedures to improve oversight of contractor financial activities.		*
	Develop, document, and implement procedures for evaluating and resolving audit findings and coordinate implementation between central and regional staff.		*
	Develop analysis and risk assessment procedures.		*
	Develop comprehensive accounting policies and procedures.	*	
	Develop a comprehensive strategy for Medicare financial management.	*	
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- A O bility * Integrity * Reliability		n Brief—Status ecommendatio
Recommendations	Substantial progress made	Additional actions needed
GAO/AIMD/OSI-00-281—Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain (September 2000)		
Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify improper payments and evaluate their effectiveness.	*	
Include sufficient scope and evaluation in the design of measurement methodologies to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective actions.		*
	GAO/AIMD/OSI-00-281—Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain (September 2000) Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify improper payments and evaluate their effectiveness. Include sufficient scope and evaluation in the design of measurement methodologies to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective	AO Recommendations Substantial progress made Recommendations Substantial progress made GAO/AIMD/OSI-00-281—Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain (September 2000) Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify improper payments and evaluate their effectiveness. * Include sufficient scope and evaluation in the design of measurement methodologies to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective *

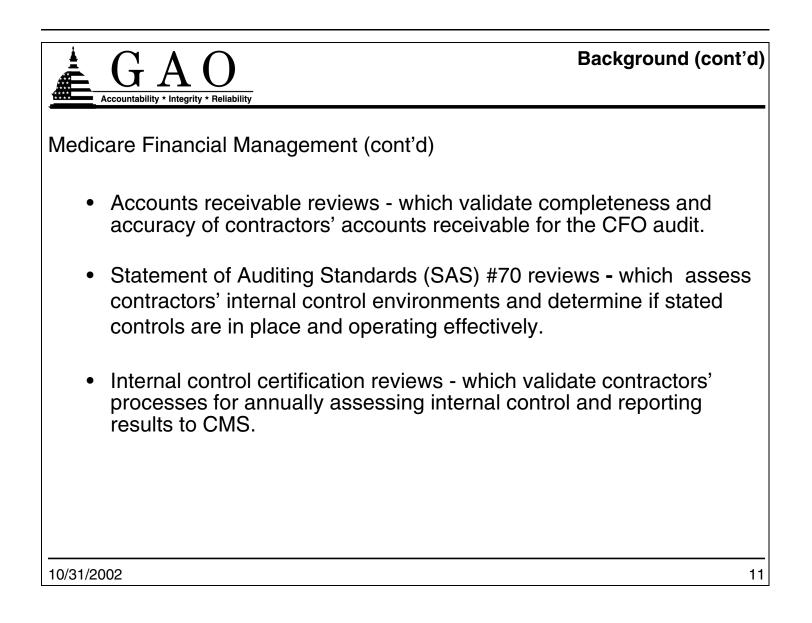
	GAO Countability * Integrity * Reliability Scope and Methodology
For thi	s review we did the following:
Dep and repo	iewed CMS's audited FY 2000 and FY 2001 financial statements; artment of Health and Human Services (HHS) accountability reports; GAO, HHS's Office of Inspector General (OIG), and other financial orts to determine the status of previously identified financial agement weaknesses.
and	iewed CMS's FY 2001 through FY 2003 Annual Performance Plans the Comprehensive Plan for Financial Management to determine if plans included actions addressing our recommendations.
proc	ormed tests of CMS's database of financial management edures to assess its effectiveness in providing guidance to ractors.
10/31/200	6



GAO Accountability * Integrity * Reliability	Scope and Methodology (cont'd)
 Held numerous interviews with CMS Financial Officer (CFO), Deputy CFC Management's Accounting Managen Integrity Group, CMS regional finance HHS/OIG staff to obtain an understate CMS to address our recommendation 	D, staff in the Office of Financial nent Group and the Program tial management staff, and the nding of the actions taken by
 Conducted our work from January 20 accordance with generally accepted We requested comments on a draft of Chief Financial Officer (CFO), Deput program integrity officials. These off findings and the oral comments that incorporated. 	government auditing standards. of this briefing from the CMS by CFO, and senior Medicare icials generally agreed with our
10/31/2002	8

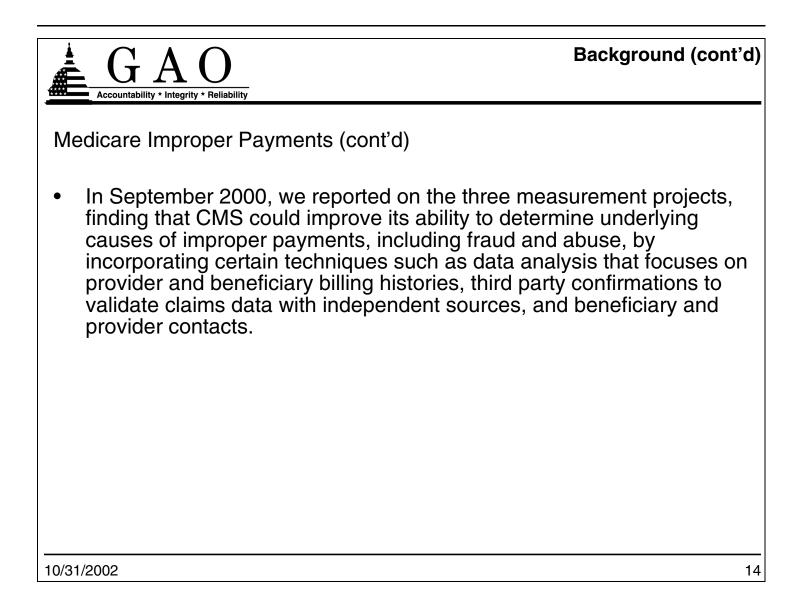
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Backgroun	d
Medicare	
 Annually, provides health care coverage to about 40 million people 65 and over and to qualifying disabled persons. Medicare costs were about \$240 billion in FY 2001. 	t
 Is a program designated by GAO as "high risk" for fraud and abuse because of its vast size, complex structure, and program management weaknesses.³ 	
CMS	
 Has primary responsibility for administering the Medicare program. 	
 Employs about 50 Medicare claims contractors⁴ that are responsible for processing fee-for-service claims, managing the billions of dollars used to pay those claims, and protecting Medicare from fraud and abuse. 	
³ U.S. General Accounting Office, <i>High-Risk Series: An Update</i> , GAO-01-263 (Washington, D.C: Jan. 2001). ⁴ There are 37 companies that CMS contracts with to process claims. CMS counts them as 50 contractors because some have two contracts toprocess both Part A and Part B Medicare claims.	s
10/31/2002	9

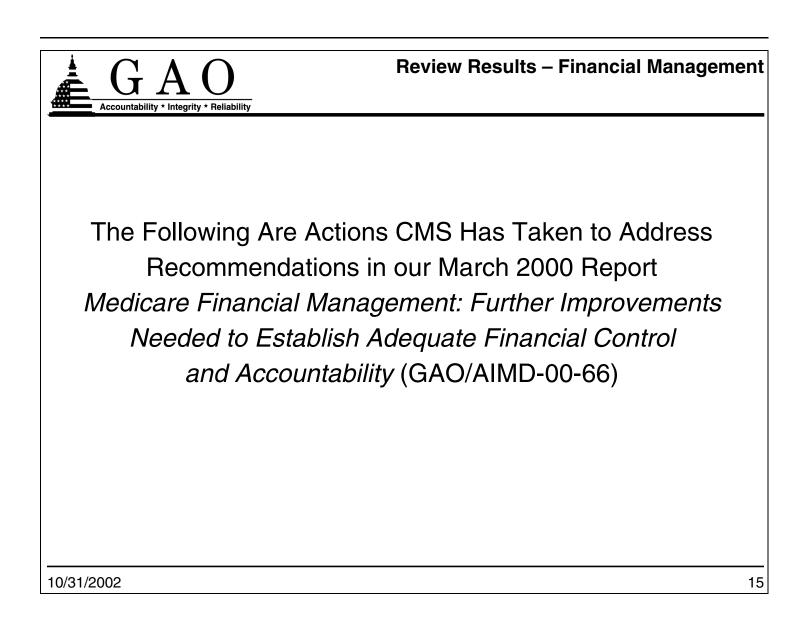
Background (cont'd)
Vedicare Financial Management
• CMS received a "clean" opinion on its FY 2001 financial statements. This was the third consecutive unqualified opinion. However, the audit of CMS's financial statements cited material internal control weaknesses including ineffective financial systems and processes, specifically the lack of an integrated accounting system and inadequacies in CMS oversight of contractors' financial data
 CMS oversees contractors financial operations annually through four types of reviews:
 Annual financial statement audits - which test expenditures and internal controls for a sample of Medicare contractors.
10/31/2002 10

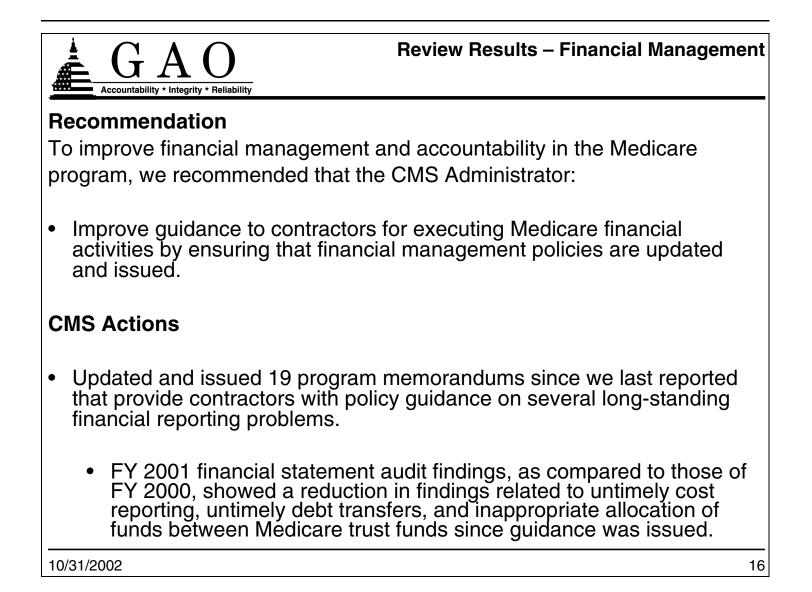


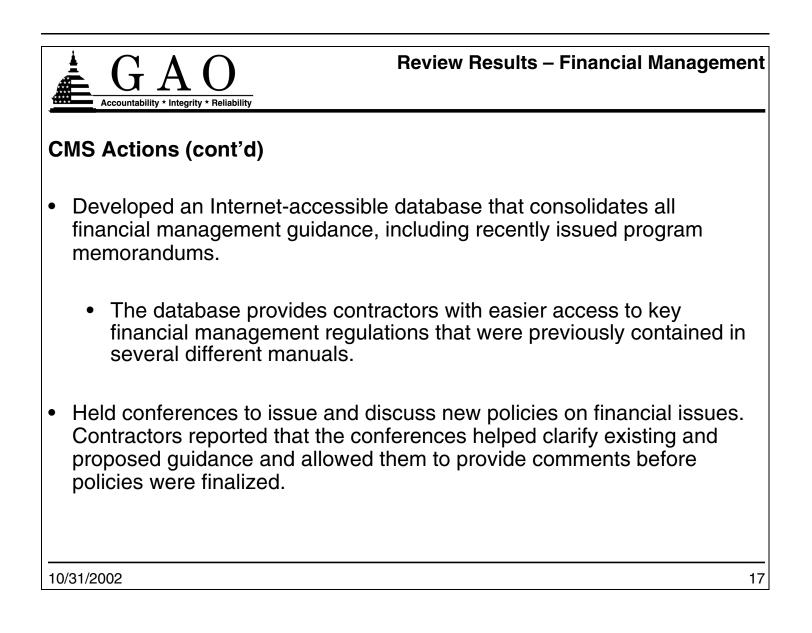
	Background (cont Accountability * Integrity * Reliability	'd)
Μ	ledicare Financial Management (cont'd)	
•	In March 2000, we reported on CMS's financial management, finding that CMS had not addressed long-standing weaknesses. Specifically, CMS had not improved its oversight of contractor financial activities, documented its accounting policies and procedures, resolved audit findings in a timely manner, or developed a financial management strategy.	
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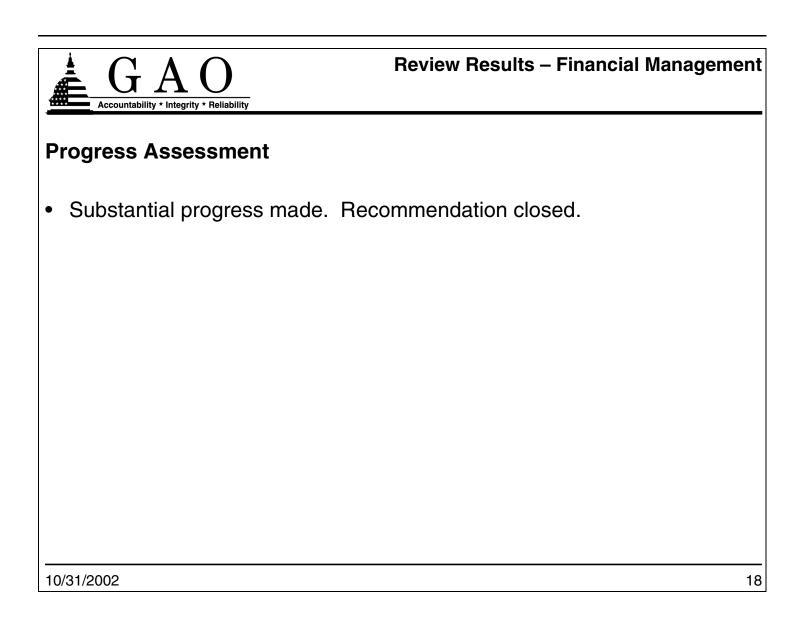
Background (cont'd)
Medicare Improper Payments
 Since 1996, the OIG has estimated the level of improper Medicare payments. In fiscal year 2001, the OIG reported an estimated \$12.1 billion of improper payments, which is 6.3 percent of total fee- for-service payments.
 In 2000, CMS had three improper payment measurement projects designed to enhance its ability to measure and reduce the rate of improper payments in various stages of development.
 The Comprehensive Error Rate Testing (CERT) project and the Payment Error Prevention Program (PEPP) were designed to provide improper payment estimates by provider, contractor, type of service, and geographic location.
 The Model Fraud Rate Project was designed to test the use of a variety of investigative techniques and develop a methodology for measuring fraud and abuse.
10/31/2002 13

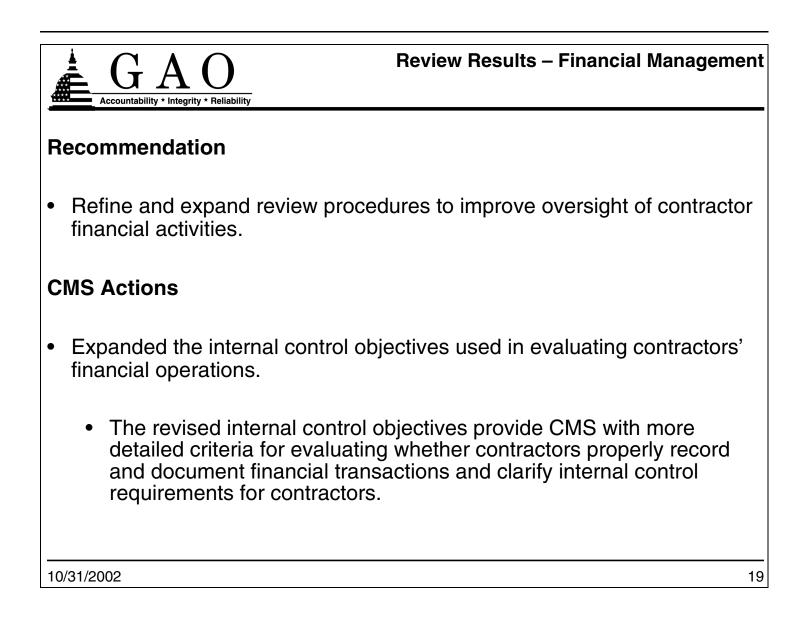






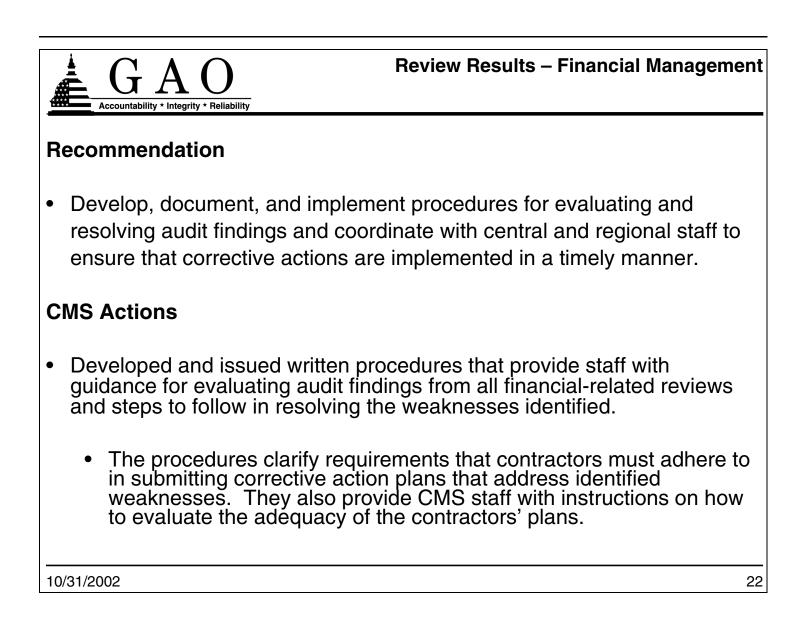






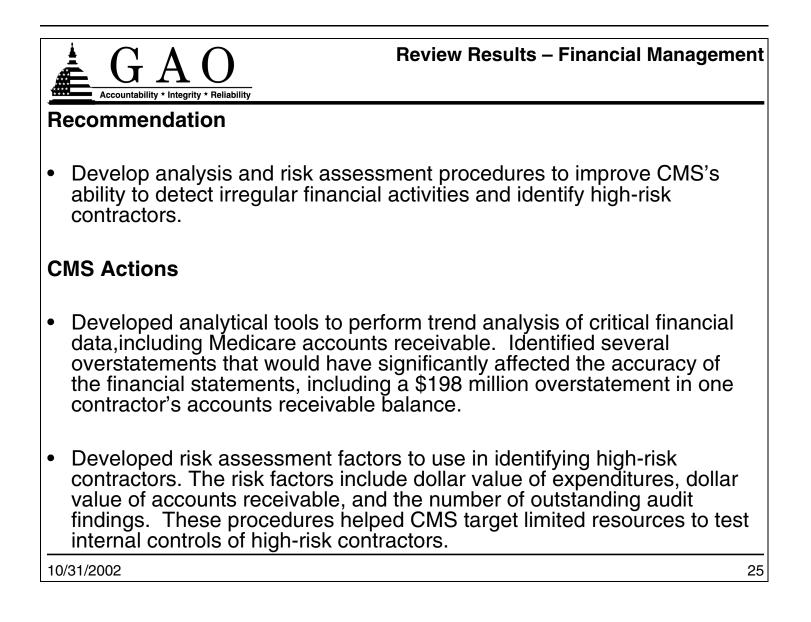
Accountability * Integrity * Reliability	Review Results – Financial Management
CMS Actions (cont'd)	
 Refined the types of interna 	I control reviews conducted annually.
controls designed for M	3 of the 50 contractors that tested if internal edicare activities were in place and compared to previous reviews that only internal controls.
	rify the process contractors follow in their internal control. The number of internal f-reported by contractors significantly cess was implemented.
After the validation p	s reported 42 material weaknesses and 308 s in their financial operations in FY 2000. rocess, contractors reported 300 material 00 reportable conditions in FY 2001.
10/31/2002	20

G A O Accountability * Integrity * Reliability	Review Results – Financial Management
Progress Assessment	
Additional action is needed. Rec	commendation remains open.
and expand review of contra included ongoing review at a	icant improvements, its efforts to refine actors' financial activities have not all contractors of monthly expenditure t control for monitoring contractor
 The monthly expenditure re expended by each contractor reported to CMS by contractor and properly classified. 	port includes a reconciliation of funds or that helps ensure that amounts tors are accurate, supported, complete,
 CMS has developed proced expenditure reports and rec at six Medicare contractors. more contractors in FY 2003 	lures for reviewing the monthly ently applied the procedures in reviews CMS expects to expand reviews to 3.
10/31/2002	21

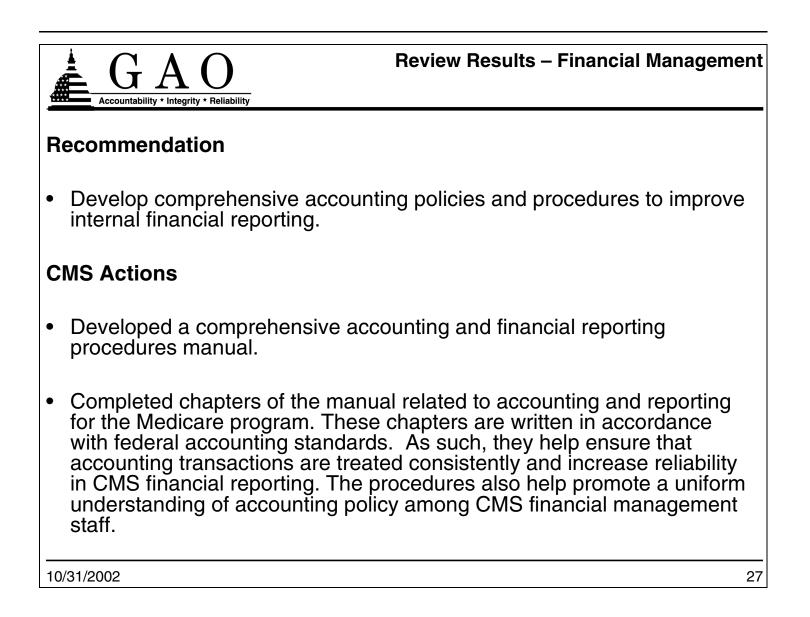


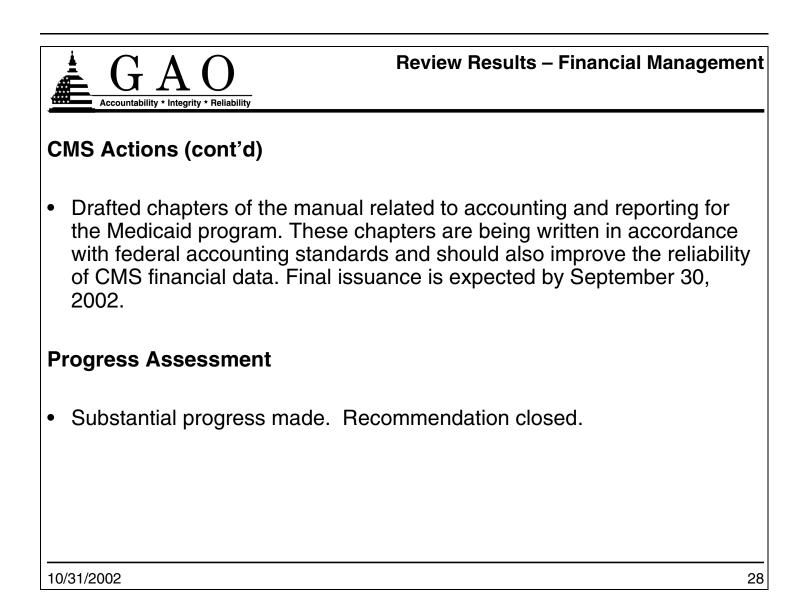
Á	E G A O Review Results – Financial Management
4	Accountability * Integrity * Reliability
С	IS Actions (cont'd)
•	Developed and implemented systems to track findings from the four types of contractor financial oversight reviews conducted annually. These systems have helped ensure that all findings reported to CMS are being tracked.
•	Established a work group of central and regional staff to develop a strategy for ensuring that contractors take action to address weaknesses identified from audits. This work group is responsible for developing procedures for monitoring contractors' actions and designating the central and regional staff to carry out the procedures.
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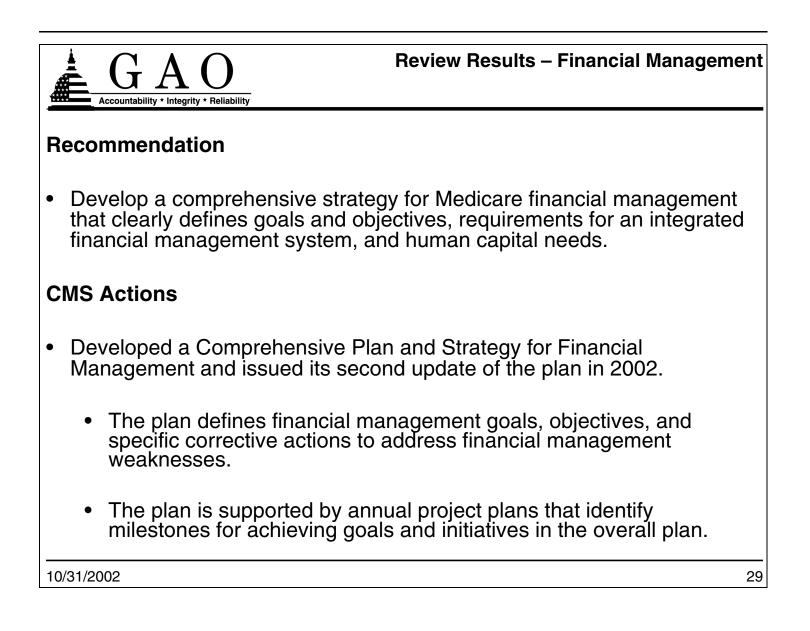
Review Results – Finance	ial Management	
Progress Assessment		
Additional action is needed. Recommendation remains op	en.	
 While improvements have been made, the current pro tracking audit findings is inefficient. Staff must manual findings from different audits into s ability to obtain a c summary of contractor problems and ensure resolution 	cess for ly enter audit omprehensive n of all issues.	
 CMS recently began developing a combined system for audit findings and contractor corrective action plans the current inefficiencies. Implementation is expected in 2 	or tracking at will address 2003.	
 CMS continues to formulate an agreement between ceregional staff on responsibility for overseeing contracted implementation of corrective action plans. The work gradient of the state of t	ors' oup that CMS	
10/31/2002	24	



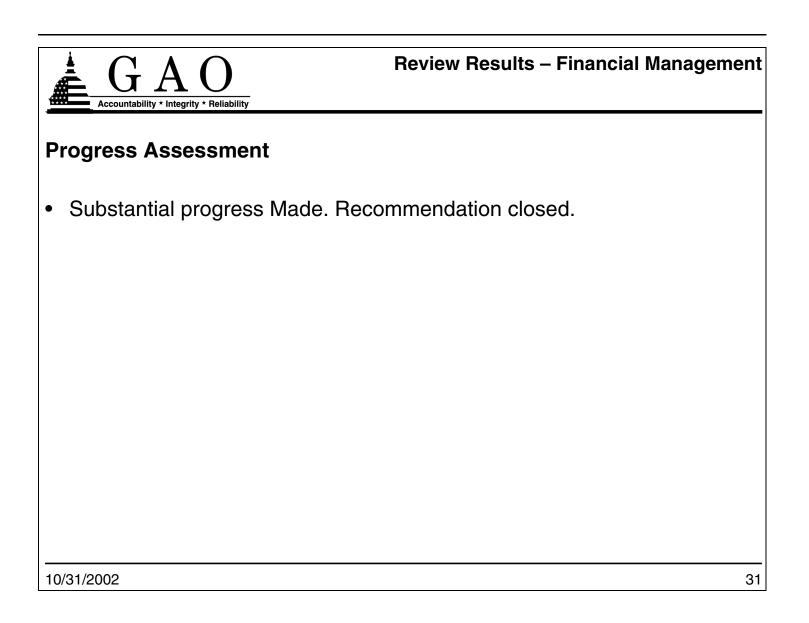
G A O Accountability * Integrity * Reliability	Review Results – Financial Management
Progress Assessment	
• Additional action is needed.	Recommendation remains open.
 Additional action is needed. Recommendation remains open. The risk assessment procedures that CMS developed have been effective in identifying certain high-risk contractors. However, deficiencies in CMS's financial/trending analysis procedures have been cited. For example, the HHS-OIG noted in the FY 2001 Financial Statement Audit Report that CMS did not document its trending analysis results and has not yet established mechanisms to archive results and historical data for future analysis. CMS has already begun taking action intended to improve it financial analysis by issuing detailed instructions to Medicare contractors and regional office staff for performing financial/trend analysis procedures. The instructions were effective June 30, 2002. 	
10/31/2002	26

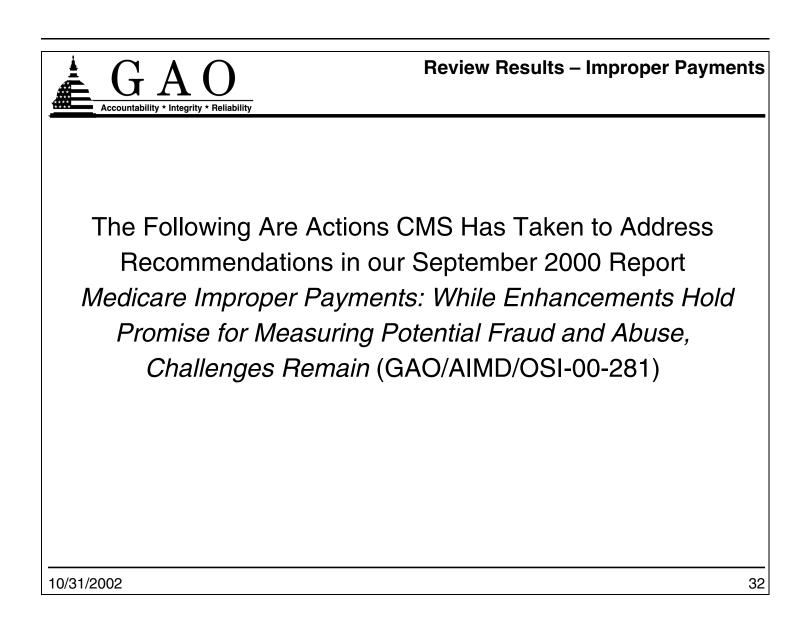


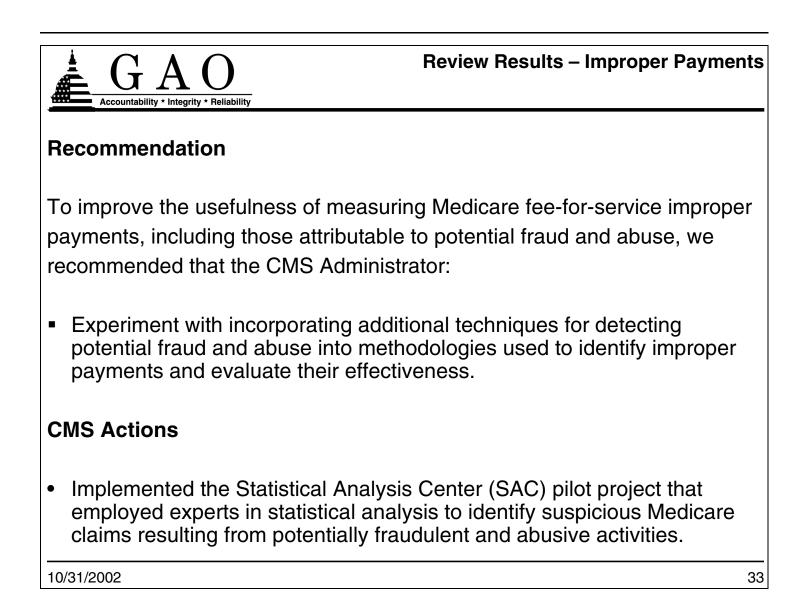




Accountability * Integrity * Reliability	Review Results – Financial Management
CMS Actions (cont'd)	
skills and competencies neede	s assessment project that is scheduled to fort is supposed to determine the required ed for Medicare financial management and a strategy for addressing deficiencies.
Healthcare Integrated General which is designed to eliminate to record and report financial in	architecture and project plans for the Ledger Accounting System (HIGLAS), the ad hoc spreadsheet applications used nformation and fully integrate Medicare g systems. Implementation is expected by
 The HIGLAS project plans Joint Financial Managemen Financial Management System ensure that the system is p promote consistency and r 	are being developed in accordance with nt Improvement Program's Federal stems Requirements. This should help properly designed and implemented to reliability in Medicare financial information.
10/31/2002	30







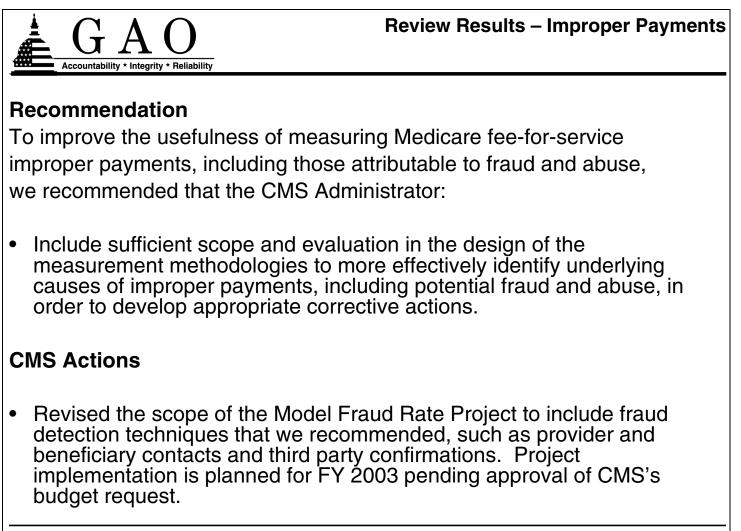
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	Review Results – Improper Payments	
CMS Actions (cont'd)		
•	Evaluated the effectiveness of techniques used in the SAC project and determined that they would yield substantial findings when applied to other claims data in the future.	
•	Accomplished the following through the SAC Project:	
	 Gained experience aggregating Medicare claims for doctor visits, hospital services, and medical equipment into one database–claims are usually maintained in separate databases by different claims contractors across states. 	
	 Gained experience applying data mining techniques to the database to identify questionable payments. Identified unusual billing patterns of providers, claims that contain illogical data or conflicting identifying information, and beneficiary claims for duplicate or similar services. 	
10	/31/2002 34	

Review Results – Improper Paymer	nts	
CMS Actions (cont'd)		
 Gained experience using techniques such as data sharing to cross- reference claims data with independent sources, including Social Security Administration records. Identified claims for services provided after beneficiary date of death. 	-	
 Identified about \$38.26 million in potentially fraudulent payments from the data mining and data sharing techniques applied, and referred the results of the analysis to claims contractors for further investigation and collection. 		
 Collected about \$490,000 of the improper payment amounts identified by the end of our field work. 		
 Demonstrated the benefit of applying statistical analysis to rapidly assess whether a potential pattern of abuse exists, according to program integrity officials. 		
10/31/2002	35	

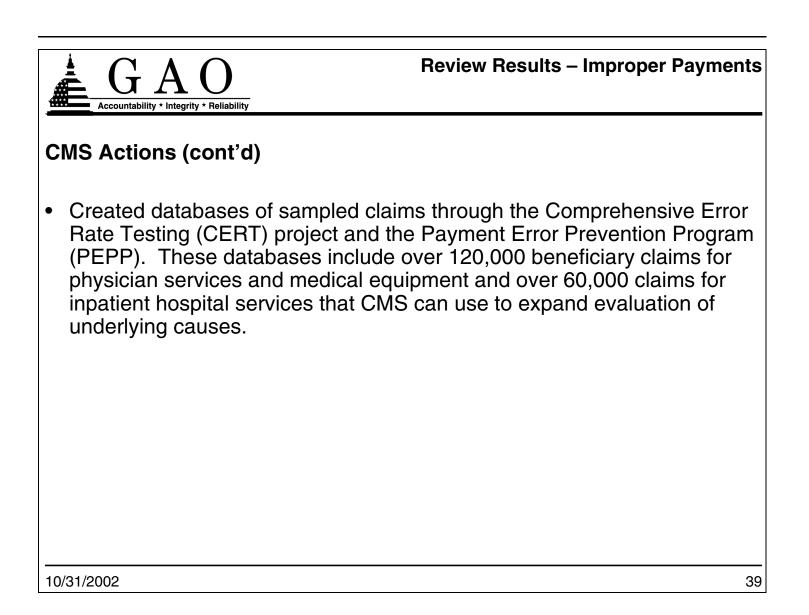
Accountability * Integrity * Reliability	Improper Payments	
CMS Actions (cont'd)		
 Added to CMS's experiences with employing comp expertise in data mining, statistical analysis, and a 		
 In addition, 		
 CMS plans to continue the type of analysis perform with Program Safeguard Contractors (PSC)⁴ that it the next 2 years. PSCs are expected to have the d capabilities necessary to identify new program risk conduct fraud case development, follow up on tips enforcement, and perform innovative data analysis 	plans to hire over ata tools and and expertise to support law	
⁵ The Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorized CMS to contract with entities safeguard functions.	to perform certain program	
10/31/2002	36	

GAO Review Results – Improper Payments Accountability * Integrity * Reliability
Progress Assessment
Substantial progress made. Recommendation closed.
 Through the SAC pilot, CMS successfully experimented with various analysis techniques that we recommended for identifying claims resulting from potentially fraudulent and abusive activities.
 The knowledge and experience gained from the SAC pilot provides CMS with proven techniques that can be incorporated into its measurement methodologies to further analyze claims data and enhance future fraud and abuse detection.
 In addition, PSCs are to help ensure that the latest techniques are used to identify potential fraud and that improper payments are investigated and amounts inappropriately paid are collected.
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GACCOUNTABILITY * Integrity * Reliability	Review Results – Improper Payments	
Progress Assessment		
Additional action is needed. Recom	mendation remains open.	
 While the Model Fraud Rate Protection techniques such as provider and confirmations to evaluate claims implemented. 	pject will include in its scope d beneficiary contacts and third party s, this project has not been	
 The CERT and PEPP projects p databases for applying data min analysis techniques similar to th project. However, CMS has not additional evaluation and analys enhance future fraud and abuse 	provide CMS with valuable ing, data sharing, and statistical ose proven effective by the SAC implemented procedures to perform is of the CERT and PEPP claims to detection.	
(190079)		
10/31/2002	40	