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February 4, 2000

The Honorable John R. Kasich
Chairman
Committee on the Budget
House of Representatives

Subject: Medicare: Methodology to Identify and Measure Improper Payments in the Medicare Program Does Not Include All Fraud

Dear Mr. Chairman:

This letter responds to your request for information on the methodology used to estimate the $12.6 billion in Medicare improper payments,[1] as reported by the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) for fiscal year 1998. Specifically, you asked whether the methodology included tests to detect improper payments resulting from fraudulent and abusive schemes in the Medicare program. If the estimate did not include such tests, you asked us to comment as to whether the $12.6 billion estimate would be higher if the tests had been included. Overall, our work shows that because the methodology was not intended to detect all fraudulent schemes such as kickbacks and false claims for services not provided, the estimated improper payments of $12.6 billion would have been greater. How much greater, no one knows.

As we recently reported, [2] the HHS OIG developed an overall methodology to estimate the level of improper payments within the Medicare Fee-for-Service program. The OIG developed and tested the methodology during its audit of the fiscal year 1996 financial statements of the Health Care Financing Administration (HCFA). Previously, no overall methodology existed to estimate Medicare improper payments.

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[1]Improper payments are payments made for unauthorized purposes or excessive amounts, such as overpayments to program recipients or contractors. According to the HHS OIG, the majority of the improper payments were detected through medical record reviews. Once an improper payment is identified, the provider has the option to appeal the decision and provide more documentation to support the payment.

[2]*Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments* (GAO/AIMD-00-10, October 29, 1999).

The methodology was a significant step toward quantifying Medicare improper payments. Its primary purpose was to provide users of HCFA's financial statements with an estimate of Medicare fee-for-service claims that were paid in error. It was not designed to identify or measure the full extent of levels of fraud and abuse in the Medicare program. The HHS OIG testified[3] that the estimate of improper payments did not take into consideration numerous kinds of outright fraud such as "phony records" or kickback schemes.[4] The methodology assumes that all medical records received for review represent actual services provided. In response to the increased focus resulting from the HHS OIG's efforts in this area, HCFA is developing plans to enhance its efforts to identify or measure Medicare improper payments. We are currently reviewing these plans and will report to you separately on them.

We are sending copies of this letter to Representative John M. Spratt, Ranking Minority Member of the House Committee on the Budget; interested congressional committees; the Honorable Donna E. Shalala, Secretary, and the Honorable June Gibbs Brown, Inspector General, Department of Health and Human Services; and the Honorable Nancy-Ann Min De Parle, Administrator, Health Care Financing Administration.

Please contact me at (202) 512-4476 or by e-mail at *jarmong.aimd@gao.gov* if you or your staff have any questions concerning this letter. Key contributors to this letter were Deborah A. Taylor and James A. Kernen.

Sincerely yours,

Gloria L. Jarmon
Director, Health, Education, and Human Services
Accounting and Financial Management Issues

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[3]July 17, 1997, testimony of the HHS Inspector General in a hearing before the House Committee on Ways and Means, Subcommittee on Health, entitled *Audit of HCFA Financial Statements*.

[4]The Anti-Kickback Act of 1986, 41 U.S.C. sections 51-58, makes it a criminal offense to knowingly and willfully offer, provide, solicit, or accept any remuneration for the purpose of improperly obtaining or rewarding favorable treatment in connection with a contract or a subcontract for supplies or services charged to the United States, including supplies or services reimbursable by federal health care programs such as Medicare.

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