Insight

Medicare Continues Struggling to Detect Fraud, Waste

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A recent study by the HHS Office of the Inspector General (OIG) reveals that from 2009 to 2011, Medicare spent nearly $30 million on Part D benefits for people unlawfully living in the United States. Federal health care benefits are allowable under the law if a person is a U.S. Citizen, U.S. national, or within certain categories of lawfully present aliens. Individuals residing in the country unlawfully, due to a lack, lapse, or revocation of legal status, are barred from receiving these benefits, including Medicare.

Despite the clear rules, CMS is not equipped with appropriate protocols in place to deny the payment to Part D insurance plans that cover unlawful beneficiaries. As a result, millions of dollars are being improperly spent each year by Medicare, an overstretched program already struggling to detect and prevent fraud across the entire beneficiary population.

CMS utilizes a computer system which, based upon alien status data within its Medicare Enrollment Database, is supposed to automatically reject claims for beneficiaries who have lost their lawful status. However, the system as it is currently implemented detects and prohibits only Part A and B payments for these individuals – no similar detection process exists for Part D, allowing improper Part D claims to slip through the system, ultimately violating federal law. The OIG study found that CMS improperly approved Part D payments to plans for covered prescription drugs totaling $28,990,718 on behalf of 4,139 unlawfully present beneficiaries over the course of two years.

Some might suggest that subjecting Part D claims to the same detection system would alleviate this problem; however, the current detection procedure is not foolproof. Another OIG study from earlier this year revealed that between 2009 and 2011, over $91 million was improperly spent on Part A and B claims for unlawfully present individuals. In both studies, the OIG has recommended that CMS not only recoup improper past payments, but also develop and implement “controls” to prevent future enrollment of unlawful beneficiaries and payment for services rendered to those individuals. Based upon the totals gleaned from these two studies, after adjusting for inflation, a total of $43.8 million worth of improper Medicare payments could be made on behalf of unlawful individuals in 2013. This number is set to increase each year unless CMS revamps its detection protocols.

The amount of Medicare Part D payments made to unlawfully present individuals is not a large amount compared to the hundreds of billions spent on Medicare beneficiaries each year. But CMS’s failure to implement the necessary controls, which are already in place for Parts A and B, does not inspire confidence in its ability to prevent and detect Medicare fraud.