



Testimony

Before the Subcommittee on Oversight  
and Investigations, Committee on Energy  
and Commerce, House of Representatives

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DEPARTMENT OF  
HEALTH AND HUMAN  
SERVICES

Opportunities for Financial  
Savings and Program  
Improvements in Medicare  
and Medicaid Remain

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Highlights of [GAO-12-719T](#), before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

## Why GAO Did This Study

HHS manages hundreds of complex programs benefiting the health and well-being of Americans, accounting for a quarter of all federal outlays. For fiscal year 2012, HHS is responsible for approximately \$76 billion in discretionary spending and for an estimated \$788 billion in mandatory spending. The size and critical mission of the two largest HHS programs, Medicare and Medicaid, make it imperative that HHS is fiscally prudent yet vigilant in protecting the populations that depend on these programs. In recent years, GAO has identified shortcomings and recommended actions to enhance operations and correct inefficiencies in Medicare and Medicaid, and HHS has implemented many recommendations, resulting in billions of dollars in savings. Because agencies now must do more with less, recommendations not yet implemented are opportunities for further conserving HHS funds and strengthening oversight of programs serving the nation's most vulnerable populations.

GAO was asked to testify on issues related to HHS's budget. This statement draws from GAO's prior work, including work on these two high-risk programs, in which GAO made recommendations related to (1) the management of Medicare and (2) the need for additional oversight of Medicaid. To the extent information was available, GAO updated the status of these recommendations.

View [GAO-12-719T](#). For more information, contact James Cosgrove at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) or Carolyn L. Yocom at (202) 512-7114 or [yocomc@gao.gov](mailto:yocomc@gao.gov).

May 9, 2012

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Opportunities for Financial Savings and Program Improvements in Medicare and Medicaid Remain

## What GAO Found

Over the past several years, GAO has made a number of recommendations to the Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—to increase savings in Medicare fee-for-service and Medicare Advantage (MA), which is a private plan alternative to the traditional Medicare fee-for-service program. Open recommendations that could yield billions of dollars in savings remain in many areas, such as the following:

- **Minimizing improper payments and fraud in Medicare.** GAO recommended that CMS require contractors to automate prepayment controls to identify potentially improper claims for medical equipment and supplies, expand current regulations to revoke billing privileges for home health agencies with improper billing practices, designate authorized personnel to evaluate and address vulnerabilities in payment systems, and enhance payment safeguards for physicians who use advanced imaging services.
- **Aligning coverage with clinical recommendations.** GAO recommended that CMS provide coverage for services recommended by clinical experts, as appropriate, given cost-effectiveness and other criteria.
- **Better aligning payments to MA plans.** To ensure that payments to MA plans reflect the health status of beneficiaries, GAO recommended that CMS more accurately adjust for differences between MA plans and traditional Medicare providers in reporting beneficiary diagnoses. GAO also recommended that CMS cancel the MA Quality Bonus Payment Demonstration because its design precludes it from yielding meaningful results.

GAO has made recommendations to CMS regarding Medicaid program oversight. Open recommendations remain in many areas, such as the following:

- **Improving oversight of Medicaid payments.** GAO recommended that CMS adopt transparency requirements and a strategy to ensure that supplemental payments to providers have been reviewed by CMS. These supplemental payments are separate from and in addition to those made at states' regular Medicaid rates.
- **Ensuring Medicaid demonstrations do not increase federal liability.** GAO recommended that CMS revise its approval process for demonstrations to ensure they are budget neutral, which GAO subsequently referred to Congress as a matter for consideration.

The size of Medicare and Medicaid requires CMS to focus continually on the appropriateness of the methodology for payments that these programs make and the pre- and postpayment checks that can help ensure that program spending is appropriate, overpayment recovery is expedient, and agency practices with regard to operations for these programs are efficient. Therefore, GAO urges HHS to ensure action is taken on open recommendations to advance its performance and accountability.

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Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee:

We are pleased to be here today to discuss budget considerations at the Department of Health and Human Services (HHS). As the federal government's principal agency for protecting the health of Americans and providing essential human services, especially for vulnerable populations, HHS manages over 300 highly complex programs, which account for almost a quarter of all federal outlays. For fiscal year 2012, HHS is responsible for approximately \$76 billion in discretionary spending and approximately \$788 billion in outlays of mandatory spending. With this funding, HHS provides health care insurance for one in four Americans through its two largest programs—Medicare and Medicaid—and administers more grant dollars than all other federal agencies combined. HHS also funds disease research and prevention, oversees the safety and effectiveness of medical products, and helps ensure that the nation is prepared to respond to public health emergencies, among other things. HHS's size, diverse programs, and critical mission render its finances particularly important as Congress and the administration seek to decrease the cost of government while improving its performance and accountability.

In recent years, we have examined a broad range of issues, identified program design and oversight shortcomings, and made numerous recommendations to enhance agency operations. In particular, many of these recommendations relate to the Medicare and Medicaid programs—which are the responsibility of the Centers for Medicare & Medicaid Services (CMS), an agency within HHS. HHS has implemented many of these recommendations, resulting in billions of dollars of savings. Other recommendations have led to program improvements that, while not always quantifiable, have nonetheless enhanced the efficiency of agency operations. For example, in 2004, we reported on CMS's management of its Medicare Secondary Payer debt, which occurs when Medicare pays for services that are subsequently determined to be the financial responsibility of another payer.<sup>1</sup> CMS's implementation of our recommendation that it reduce the number of contractors managing this workload resulted in savings of \$86 million from 2006 through 2010. More

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<sup>1</sup>GAO, *Medicare Secondary Payer: Improvements Needed to Enhance Debt Recovery Process*, [GAO-04-783](#) (Washington, D.C.: Aug. 20, 2004).

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recently, greater savings have been realized as a result of work on CMS's oversight of states' Medicaid supplemental payment arrangements.<sup>2</sup> In 2007, we reported on a CMS oversight initiative established in response to our work, which increased the agency's scrutiny of state Medicaid financing arrangements and resulted in savings of approximately \$3.4 billion from fiscal year 2007 through 2012.<sup>3</sup>

While HHS has successfully implemented many of our recommendations, our remarks today will focus on spending for which HHS is responsible in the context of recommendations we have made that it has yet to implement and that we therefore consider open. Specifically, we will concentrate on our recommendations to improve the Medicare and Medicaid programs. We have designated both as high-risk programs, in part because of their size, complexity, susceptibility to improper payments, and the need to improve program management.<sup>4</sup> The recommendations that we will discuss include those that were recently made, those not yet fully implemented, and others for which no actions have been taken, although several years have elapsed since they were made. These recommendations—some of which could result in financial savings—include those that address (1) missed opportunities for savings in the management of Medicare and (2) the need for additional oversight of Medicaid.

Our testimony today draws on our prior products, issued from January 2007 through April 2012, including our work on overlap and duplication of federal programs that may result in inefficient use of taxpayer funds.<sup>5</sup> To the extent that information was available, we updated the status of HHS's

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<sup>2</sup>Medicaid supplemental payments are payments separate from and in addition to those made at states' regular Medicaid rates.

<sup>3</sup>GAO, *Medicaid Financing: Federal Oversight Initiative Is Consistent with Medicaid Payment Principles but Needs Greater Transparency*, [GAO-07-214](#) (Washington, D.C.: Mar. 30, 2007).

<sup>4</sup>GAO, *High-Risk Series: An Update*, [GAO-11-278](#) (Washington, D.C.: February 2011).

<sup>5</sup>GAO, *2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*, [GAO-12-342SP](#) (Washington, D.C.: Feb. 28, 2012); *Follow-up on 2011 Report: Status of Actions Taken to Reduce Duplication, Overlap, and Fragmentation, Save Tax Dollars, and Enhance Revenue*, [GAO-12-453SP](#) (Washington, D.C.: Feb. 28, 2012); and *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, [GAO-11-318SP](#) (Washington, D.C.: Mar. 1, 2011).

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implementation of these recommendations in May 2012. Detailed information on the scope and methodology for our prior work can be found in the reports that we have cited throughout this testimony. We conducted the underlying performance audits in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audits to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our statement today.

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## Missed Opportunities for Savings in Medicare

In the past several years, we have made a number of recommendations for CMS to address missed opportunities for savings in the Medicare program, which the agency has not fully implemented. These include recommendations related to the Medicare fee-for-service (FFS) and Medicare Advantage (MA) programs.

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## Medicare Fee-for-Service

**Minimizing improper payments and fraud.** We have a body of issued and ongoing work about improper payments in Medicare. In 2007, we reported on program integrity activities conducted by CMS contractors to minimize improper payments for medical equipment and supplies.<sup>6</sup> We recommended that CMS require its contractors to develop automated prepayment controls to identify potentially improper claims when billing reaches atypical levels. CMS agreed with the recommendation, but has not implemented it. The agency has added other prepayment controls to flag claims for services that were unlikely to be provided in the normal course of medical care. However, implementing our recommendation and adding additional prepayment controls could enhance identification of improper claims before they are paid to reduce reliance on “pay and chase” strategies.<sup>7</sup> In 2009, we reported that fraudulent and abusive practices in home health agencies, such as overstating the severity of a beneficiary’s condition, contributed to Medicare home health spending and utilization.<sup>8</sup> To strengthen controls on improper payments in home

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<sup>6</sup>GAO, *Medicare: Improvements Needed to Address Improper Payments for Medical Equipment and Supplies*, [GAO-07-59](#) (Washington, D.C.: Jan. 31, 2007).

<sup>7</sup>We have ongoing work updating CMS’s progress in implementing prepayment controls.

<sup>8</sup>GAO, *Medicare: Improvements Needed to Address Improper Payments in Home Health*, [GAO-09-185](#) (Washington, D.C.: Feb. 27, 2009).

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health agencies, we recommended that CMS amend current regulations to expand the types of improper billing practices that are grounds for revocation of billing privileges. CMS told us that it has begun to explore its authority to expand the types of practices that are grounds for revocation of billing rights. We believe that CMS should do so expeditiously.

In 2010, we recommended that CMS designate responsible personnel with authority to evaluate and promptly address vulnerabilities identified to reduce improper payments.<sup>9</sup> CMS concurred with this recommendation and has begun to implement this process, but does not yet have written policies and procedures for a fully developed corrective action process that includes monitoring of actions taken.<sup>10</sup> Likewise, we recently testified before the Senate Committee on Finance regarding CMS efforts to combat Medicare fraud.<sup>11</sup> We reiterated our prior recommendation and noted that CMS could do more to strengthen provider enrollment screening to avoid enrolling those intent on committing fraud, improve pre- and postpayment claims review to identify and respond to patterns of suspicious billing activity more effectively, and identify and address vulnerabilities to reduce the ease with which fraudulent entities can obtain improper payments.

**Enhancing payment safeguard mechanisms.** In 2008, we reported on rapid spending growth for advanced imaging services.<sup>12</sup> We recommended that CMS examine the feasibility of adding front-end approaches, such as prior authorization, to improve payment safeguard mechanisms. CMS has not implemented our recommendation, but is currently engaged in a demonstration project to assess the appropriateness of physicians' use of advanced diagnostic imaging services furnished to Medicare beneficiaries.

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<sup>9</sup>GAO, *Medicare Recovery Audit Contracting: Weaknesses Remain in Addressing Vulnerabilities to Improper Payments, Although Improvements Made to Contractor Oversight*, [GAO-10-143](#) (Washington, D.C.: Mar. 31, 2010).

<sup>10</sup>We have ongoing work updating CMS's progress in implementing these recommendations.

<sup>11</sup>GAO, *Medicare: Important Steps Have Been Taken, but More Could Be Done to Deter Fraud*, [GAO-12-671T](#) (Washington, D.C.: Apr. 24, 2012).

<sup>12</sup>GAO, *Medicare Part B Imaging Services: Rapid Spending Growth and Shift to Physician Offices Indicate Need for CMS to Consider Additional Management Practices*, [GAO-08-452](#) (Washington, D.C.: June 13, 2008).

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**Aligning coverage for services with clinical recommendations.** We reported in early 2012 that Medicare beneficiaries' use of preventive services did not always align with the U.S. Preventive Services Task Force's recommendations.<sup>13</sup> We concluded that opportunities exist to improve the appropriate use of preventive services through means such as revising coverage and cost-sharing policies and educating beneficiaries and physicians. In the case of osteoporosis screening, for instance, Medicare coverage rules may preclude utilization of the recommended screening by all those for whom the service is recommended. Conversely, given that the Task Force recommended against prostate cancer screening for men aged 75 or older, the absence of cost sharing for that population may encourage inappropriate use of this service. To better align preventive service use with clinical recommendations, we recommended that CMS provide coverage for Task Force recommended services, as appropriate, given cost-effectiveness and other criteria. In response to our recommendation, the agency stated that it had recently used its authority to expand benefits to cover several new preventive services. This additional coverage, however, does not address the misalignment that remains between Medicare coverage for certain services and the corresponding Task Force recommendations. We also offered a matter for congressional consideration. We suggested that Congress consider requiring beneficiaries to share the cost of the services if they receive services the Task Force recommends against.

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## Medicare Advantage

### **Better reflecting beneficiary health status in payments to MA plans.**

In 2010, the federal government spent about \$115 billion on the MA program, a private plan alternative to the Medicare FFS program. In January 2012, we reported that CMS could achieve billions of dollars in additional savings by more accurately adjusting for differences between MA plans and Medicare FFS providers in the reporting of beneficiary diagnoses.<sup>14</sup> CMS uses this diagnosis data and other information to construct a risk score for each beneficiary. Higher risk scores result in

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<sup>13</sup>GAO, *Medicare: Use of Preventive Services Could Be Better Aligned with Clinical Recommendations*, [GAO-12-81](#) (Washington, D.C.: Jan. 18, 2012).

<sup>14</sup>GAO, *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Practices*, [GAO-12-51](#) (Washington, D.C.: Jan 12, 2012).

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increased Medicare payments to plans, while lower risk scores result in reduced Medicare payments to plans. Risk scores should be the same among all beneficiaries with the same medical conditions and demographic characteristics, regardless of whether they are in MA or Medicare FFS. MA plans have an incentive to code diagnoses more comprehensively because doing so affects plan payments, which is not the case in Medicare FFS. CMS is required by law to make an adjustment to MA risk scores to bring them in line with those of Medicare FFS. In this report, we found that CMS's adjustment for diagnostic coding differences was too small. We estimated that MA beneficiary risk scores in 2010 were from 4.8 to 7.1 percent higher than they likely would have been if they had been enrolled in FFS, while CMS's adjustment for diagnostic coding differences was only 3.4 percent. Compared to CMS's analysis, our analysis incorporated more recent beneficiary data and accounted for additional beneficiary characteristics that affect risk scores, such as health status and sex. A revised methodology that incorporated this information could have saved Medicare between \$1.2 billion and \$3.1 billion in 2010 in addition to the \$2.7 billion in savings from the adjustment CMS made. We expect that savings in 2011 and future years would be even greater. CMS has continued to use its 2010 adjustment method for 2011 and 2012, even though both we and CMS noted an upward trend in the impact of coding differences over time. To improve the accuracy of the adjustment made for differences in coding practices over time, we recommended that the Secretary of HHS direct the Administrator of CMS to incorporate the most recent data available in its estimates; identify and account for all years of diagnostic coding differences that could affect the payment year for which any adjustment is made; account for the upward trend of the annual impact of coding differences in its estimates; and to the extent possible, account for all relevant differences in beneficiary characteristics between the MA and Medicare FFS populations. CMS stated that it found our findings informative, but did not comment on our recommendations.

**Canceling the MA Quality Bonus Payment Demonstration.** We recently reported that CMS could achieve billions of dollars in savings by canceling the MA Quality Bonus Payment Demonstration—which CMS's Office of the Actuary has estimated will cost more than \$8 billion over

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10 years.<sup>15</sup> Rather than implement the quality bonus payments prescribed in the 2010 Patient Protection and Affordable Care Act (PPACA), as amended, CMS is conducting a nationwide demonstration to test whether a scaled bonus structure would lead to larger and faster annual quality improvement for MA plans at various performance levels. Compared with PPACA's quality bonus payment system, the demonstration extends the bonuses to average-performing plans, accelerates the phase-in of the bonuses for plans with above-average performance, and increases the size of the bonuses in 2012 and 2013. We found that the demonstration's estimated \$8.35 billion cost offsets more than one-third of PPACA's MA payment reductions during its 3-year time frame and that most of the additional spending will go to average-performing plans rather than to high-performing plans. The MA Quality Bonus Payment Demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact. It is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and is greater than the combined budgetary impact of all those demonstrations. For a variety of reasons, the design of the demonstration precludes a credible evaluation of its effectiveness in achieving CMS's stated research goal. We therefore believe that it is unlikely that the demonstration will produce meaningful results. Accordingly, we recommended that the Secretary of HHS cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect. HHS did not concur with our recommendation, stating that it believed the demonstration supports a strategy to improve the delivery of health care services, patient health outcomes, and population health.

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## Need for Additional Oversight of Medicaid

We have conducted a substantial body of work on Medicaid program management. Our recommendations have involved a variety of topics and have included different aspects of payment arrangements with states.<sup>16</sup>

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<sup>15</sup>GAO, *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, [GAO-12-409R](#) (Washington, D.C.: Mar. 21, 2012).

<sup>16</sup>We recently testified about CMS's oversight of Medicaid program integrity. See GAO, *Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement*, [GAO-12-674T](#) (Washington, D.C.: Apr. 25, 2012). We also have ongoing work in this area.

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**Improving oversight of supplemental payments.** We have reported on varied financing arrangements involving supplemental payments—disproportionate share hospital (DSH) payments that states are required to make to certain hospitals and other non-DSH supplemental payments—that increase federal funding without a commensurate increase in state funding.<sup>17</sup> Our work has found that while a variety of federal legislative and CMS actions have helped curb inappropriate financing arrangements, gaps in oversight remain. For example, while there are federal requirements designed to improve transparency and accountability for state DSH payments, similar requirements are not in place for non-DSH supplemental payments, which may be increasing. From 2006 to 2010, state-reported non-DSH supplemental payments increased from

\$6.3 billion to \$14 billion; however, according to CMS officials, reporting was likely incomplete. We made numerous recommendations aimed at improving oversight of supplemental payments. We have recommended that CMS adopt transparency requirements for non-DSH supplemental payments and develop a strategy to ensure that all state supplemental payment arrangements have been reviewed by CMS. CMS has taken action to address some of these recommendations, but we continue to believe additional action is warranted. CMS has raised concern that congressional action may be necessary to fully address our recommendations.

**Ensuring Medicaid demonstrations do not increase federal liability.** HHS has authority to waive certain statutory provisions to allow states to implement Medicaid demonstrations that are likely to assist in achieving program objectives. By policy, these demonstrations should not increase federal costs. However, we reported in 2008 that HHS had approved two state Medicaid demonstrations that could increase the federal financial liability substantially.<sup>18</sup> This report followed earlier work that had identified similar concerns with HHS approvals of state Medicaid demonstrations that were not budget neutral. At the time of our work in 2007, HHS disagreed with our recommendation to improve the demonstration review

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<sup>17</sup>GAO, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, [GAO-08-614](#) (Washington D.C.: May 30, 2008) and GAO, *Medicaid: Ongoing Federal Oversight of Payments to Offset Uncompensated Hospital Care Costs Is Warranted*, [GAO-10-69](#) (Washington D.C.: Nov. 20, 2009).

<sup>18</sup>GAO, *Medicaid Demonstration Waivers: Recent HHS Approvals Continue to Raise Cost and Oversight Concerns*, [GAO-08-87](#) (Washington, D.C.: Jan. 31, 2008).

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process through steps such as clarifying the criteria for reviewing and approving states' proposed spending limits and ensuring that valid methods were used to demonstrate budget neutrality. Consequently, we referred this to Congress for consideration. HHS subsequently reported taking steps, such as monitoring the budget neutrality of ongoing demonstrations, to improve its oversight. However, no changes are planned in the methods used to determine budget neutrality of demonstrations to ensure that demonstrations do not increase the federal financial liability.

**Improving rate-setting methodologies.** In August 2010, we reported that CMS had not ensured that all states were complying with federal Medicaid requirements that managed care rates be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.<sup>19</sup> For example, we found significant gaps in CMS's oversight of 2 of the 26 states reviewed—CMS had not reviewed one state's rate setting in multiple years and had not completed a full review of another state's rate setting since the actuarial soundness requirements became effective in August 2002. Variation in practices across CMS regional offices contributed to these gaps and other inconsistencies in the agency's oversight of states' rate setting. This work also found that CMS's efforts to ensure the quality of the data used to set rates were generally limited to requiring assurances from states and health plans—efforts that did not provide the agency with enough information to ensure the quality of the data used. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of federal and state dollars at risk for misspending. We made recommendations to improve CMS's oversight of states by implementing a mechanism to track state compliance with Medicaid managed care actuarial soundness requirements, clarifying guidance on rate-setting reviews, and making use of information on data quality in overseeing states' rate setting. HHS agreed with these recommendations, and as of May 2012, CMS officials indicated that they were reviewing and updating the agency's guidance and exploring the incorporation of information about data quality into its review and approval of Medicaid managed care rates.

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<sup>19</sup>GAO, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*, [GAO-10-810](#) (Washington, D.C.: Aug. 4, 2010).

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## Concluding Observations

Improved financial stewardship of federal programs is becoming increasingly important as the pressure to reduce spending mounts. In an agency as large as HHS, the need for vigilance in continuously seeking out cost savings cannot be overstated. In our work, we have examined many aspects of HHS operations and made recommendations to help HHS prevent unnecessary spending, save money, recover funds that should rightfully be returned, improve the efficiency of agency operations, and improve service for beneficiaries. HHS has implemented many of our recommendations that have proven to be financially beneficial while also enhancing program management. However, there are still recommendations we have made that remain open. While we recognize that some of the recommendations we have highlighted today are relatively new, others are several years old. HHS has made clear that it is committed to improving the nation's health and well-being while simultaneously contributing to deficit reduction. We therefore urge HHS to expedite action on our open recommendations to further advance its performance and accountability.

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Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, this completes our prepared statement. We would be pleased to respond to any questions that you may have at this time.

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## GAO Contacts and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact us at (202) 512-7114 or [cosgrovej@gao.gov](mailto:cosgrovej@gao.gov) and [yocomc@gao.gov](mailto:yocomc@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony are listed in appendix I.

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# Appendix I: GAO Contacts and Staff Acknowledgments

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## GAO Contacts

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## Staff Acknowledgments

In addition to the contacts named above, Geri Redican-Bigott, Assistant Director; Kelly DeMots; Helen Desaulniers; David Grossman; Elizabeth T. Morrison; and Kate Nast made key contributions to this statement.

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