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Testimony

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MEDICARE

Program Remains at High  
Risk Because of Continuing  
Management Challenges

Statement of Kathleen King  
Director, Health Care





# Highlights

Highlights of [GAO-11-430T](#), a testimony before the Subcommittee on Oversight and Investigations, Committee on Energy and Commerce, House of Representatives

## Why GAO Did This Study

In the February 2011 High-Risk Series update, GAO continued designation of Medicare as a high-risk program because its complexity and susceptibility to improper payments, combined with its size, have led to serious management challenges. In 2010, Medicare covered 47 million people and had estimated outlays of \$509 billion. The Centers for Medicare & Medicaid Services (CMS) has estimated fiscal year 2010 improper payments for Medicare fee-for-service and Medicare Advantage of almost \$48 billion.

This statement focuses on the nature of the risk in the program, progress made, and specific actions needed. It is based on GAO work developed by using a variety of methodologies—including analyses of Medicare claims, review of policies, interviews, and site visits—and information from CMS on the status of actions to address GAO recommendations.

## What Remains to Be Done

CMS needs a plan with clear measures and benchmarks for reducing Medicare's risk for improper payments, inefficient payment methods, and issues in program management and patient care and safety. Further, CMS's effective implementation of recent laws will be critical to helping reduce improper payments. CMS also needs to take action to address GAO recommendations, such as to develop an adequate corrective action process, improve controls over contracts, and refine or better manage payment for certain services.

View [GAO-11-430T](#) or key components. For more information, contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov)

March 2, 2011

## MEDICARE

### Program Remains at High Risk Because of Continuing Management Challenges

## What GAO Found

As GAO reported in its 2011 High-Risk Series update, Medicare remains on a path that is fiscally unsustainable over the long term. This fiscal pressure heightens CMS's challenges to reform and refine Medicare's payment methods to achieve efficiency and savings, and to improve its management, program integrity, and oversight of patient care and safety. CMS has made some progress in these areas, but many avenues for improvement remain.

**Reforming and refining payments.** Since January 2009, CMS has implemented payment reforms for Medicare Advantage and inpatient hospital and other services, and has taken other steps to improve efficiency in payments. The agency has also begun to provide feedback to physicians on their resource use, but the feedback effort could be enhanced. CMS has taken steps to ensure that some physician fees recognize efficiencies when certain services are furnished together, but the agency has not targeted the services with the greatest potential for savings. Other areas that could benefit from payment method refinements include oxygen and imaging services.

**Improving program management.** CMS's implementation of competitive bidding for medical equipment and supplies and its transfer of fee-for-service claims workload to new Medicare Administrative Contractors have progressed, with some delays. Of greater concern is that GAO found pervasive internal control deficiencies in CMS's management of contracts that increased the risk of improper payments. While the agency has taken actions to address some GAO recommendations for improving internal controls, it has not completely addressed recommendations related to clarifying the roles and responsibilities for implementing certain contractor oversight responsibilities, clearing a backlog of contacts that are overdue for closeout, and finishing its investigation of over \$70 million in payments GAO questioned in 2007.

**Enhancing program integrity.** CMS has implemented a national Recovery Audit Contractors (RAC) program to analyze paid claims and identify improper overpayments for recoupment, set performance measures to reduce improper payments, issued regulations to tighten provider enrollment, and created its Center for Program Integrity. However, the agency has not developed an adequate process to address vulnerabilities to improper payments identified by RACs, nor has it addressed three other GAO recommendations designed to reduce improper payments, including one to conduct postpayment reviews of claims submitted by home health agencies with high rates of improper billing.

**Overseeing patient care and safety.** The agency's oversight of the quality of nursing home care has increased significantly in recent years, but weaknesses in the survey methodology and guidance for surveillance could understate care quality problems. In addition, CMS's current approach for funding state surveys of facilities participating in Medicare is ineffective. However, CMS has implemented, or is taking steps to implement, many recommendations GAO has made to improve nursing home oversight.

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss GAO's 2011 High-Risk Series update on the Medicare program.<sup>1</sup> My testimony today will focus on information in our 2011 update on the nature of the risk in the Medicare program, progress made since our last high-risk update in 2009, and the specific actions CMS needs to take to make additional progress.

We have designated Medicare as a high-risk program because its complexity and susceptibility to improper payments, combined with its size, have led to serious management challenges. An improper payment is any payment that should not have been made or that was made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements.<sup>2</sup> In 2010, Medicare covered 47 million elderly and disabled beneficiaries and had estimated outlays of \$509 billion. The Centers for Medicare & Medicaid Services (CMS)—the agency in the Department of Health and Human Services that administers Medicare—has estimated improper payments for Medicare of almost \$48 billion for fiscal year 2010.<sup>3</sup> However, this improper payment estimate did not include all of the program's risk since it did not include improper payments in its Part D prescription drug benefit, for which the agency has not yet estimated a total amount.<sup>4</sup>

CMS is responsible for implementing payment methods that encourage efficient service delivery, managing the program to serve beneficiaries and safeguard it from loss, and overseeing patient safety and care. However, CMS faces growing challenges in coming years resolving issues that put

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<sup>1</sup>GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011).

<sup>2</sup>This definition includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except where authorized by law), and any payment that does not account for credit for applicable discounts. Pub. L. No. 111-204, § 2(e), 124 Stat. 2224, 2227 (2010) (codified at 31 U.S.C. § 3321 note).

<sup>3</sup>Department of Health and Human Services, *Fiscal Year 2010 Agency Financial Report*, (Washington, D.C.: November 2010).

<sup>4</sup>Medicare consists of four parts. Medicare Parts A and B are known as original Medicare or Medicare fee-for-service. Part A covers hospital and other inpatient stays. Medicare Part B covers hospital outpatient, physician, and other services. Part C is Medicare Advantage, under which beneficiaries receive benefits through private health plans. Part D is the Medicare prescription drug benefit.

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the program at risk, given the rapid growth expected in the number of Medicare beneficiaries and program spending.

Our 2011 High-Risk Series update on Medicare is based on a body of work comprising more than 11 products that were developed by using a variety of methodologies, including analyses of Medicare claims, review of relevant policies and procedures, interviews with agency officials and other stakeholders, and site visits.<sup>5</sup> It also includes information CMS has provided on the status of its actions to address recommendations made in these and prior reports on Medicare. Our work was performed in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit 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 findings and conclusions based on our audit objectives.

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## 2011 High-Risk Series Update on the Medicare Program

As we report in our 2011 High-Risk Series update, Medicare remains on a path that is fiscally unsustainable over the long term. This fiscal pressure heightens the need for CMS to reform and refine Medicare's payment methods to achieve efficiency and savings, and to improve its management, program integrity, and oversight of patient care and safety. CMS has made some progress in these areas, but many avenues for improvement remain.

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### Reforming and Refining Payments

Since January 2009, CMS has implemented payment reforms for Medicare Advantage (Part C) and inpatient hospital, home health, and end-stage renal disease services. The agency has also begun to provide feedback to physicians on their resource use and is developing a value-based payment method for physician services that accounts for the quality and cost of care. Efforts to provide feedback and encourage efficiency are crucial because physician influence on use of other services is estimated to account for up to 90 percent of health care spending.

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<sup>5</sup>For more detailed information on the methodologies used in our work, please consult the list of GAO products at the end of this statement.

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In addition, CMS has taken steps to ensure that some physician fees recognize efficiencies when certain services are furnished together, but the agency has not targeted the services with the greatest potential for savings. Under the budget neutrality requirement, the savings that have been generated have been redistributed to increase physician fees for other services. Therefore, we recommended in 2009 that Congress consider exempting savings from adjusting physician fees to recognize efficiencies from budget neutrality to ensure that Medicare realizes these savings.

Our examination of payment rates for home oxygen also found that although these rates have been reduced or limited several times, further savings are possible. As we reported in January 2011, if Medicare used the methodologies and payment rates of the lowest-paying private insurer of eight private insurers studied, it could have saved about \$670 million of the estimated \$2.15 billion it spent on home oxygen in 2009. Additionally, we found that Medicare bundles its stationary equipment rate payment for oxygen refills, but refills are required only for certain types of equipment, so a supplier may still receive payment for refills even if the equipment does not require them. Therefore, we suggested that Congress should consider reducing home oxygen payment rates and recommended that CMS remove payment for portable oxygen refills from payment for stationary equipment, and thus only pay for refills for the equipment types that require them.

Our work has also shown that payment for imaging services<sup>6</sup> may benefit from refinements. Specifically, CMS could add more front-end approaches to better ensure appropriate payments, such as requiring physicians to obtain prior authorization from Medicare before ordering an imaging service. CMS also has opportunities to improve the way it adjusts physician payments to account for geographical differences in the costs of providing care in different localities. We have recommended that the agency examine and revise the physician payment localities it uses for this purpose by using an approach that is uniformly applied to all states and based on the most current data. CMS agreed to consider the recommendation but was concerned about its redistributive effects. The

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<sup>6</sup>Medical imaging is a noninvasive process used to obtain pictures of the internal anatomy or function of the anatomy using one of many different types of imaging equipment and media for creating the image. Examples of imaging services include x-rays, computed tomography, and magnetic resonance imaging scans.

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agency subsequently initiated a study of physician payment locality adjustments. The study is ongoing, and CMS has not implemented any change.

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## Improving Program Management

CMS's implementation of competitive bidding for medical equipment and supplies and its new Medicare Administrative Contractors (MAC) have progressed, with some delays. Congress halted the first round of competitive bidding and required CMS to improve its implementation. In regard to contracting reform, because of delays resulting from bid protests filed in connection with the procurement process, CMS did not meet the target that it set for 2009 and 2010 in transferring workload to MACs. As of December 2010, CMS transferred Medicare fee-for-service claims workload to the new MACs in all but six jurisdictions. For those six jurisdictions, CMS is transferring claims workload in two jurisdictions and has ongoing procurement activity for the remainder. Some new MACs had delays in paying providers' claims, but overall, CMS's contractors continued to meet the agency's performance targets for timeliness of claims processing in 2009.

Regarding Medicare Advantage, CMS has not complied with statutory requirements to mail information on plan disenrollment to beneficiaries, but it did take steps to post this information on its Web site. In addition, the agency took enforcement actions for inappropriate marketing against at least 73 organizations that sponsored Medicare Advantage plans from January 2006 to February 2009.

Of greater concern is that we found pervasive internal control deficiencies in CMS's management of its contracting function that put billions of taxpayer dollars at risk of improper payments or waste. We recommended that CMS take actions to address them. Recently, CMS has taken several actions to address the recommendations and correct certain deficiencies we had noted, such as revising policies and procedures and developing a centralized tracking mechanism for employee training. However, CMS has not made sufficient progress to complete actions to address recommendations related to clarifying the roles and responsibilities for implementing certain contractor oversight responsibilities, clearing a backlog of contacts that are overdue for closeout, and finishing its investigation of over \$70 million in payments we questioned in 2007.

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## Enhancing Program Integrity

New directives, implementing guidance, and legislation designed to help reduce improper payments will affect CMS's efforts over the next few years. The administration issued Executive Order 13520 on reducing improper payments in 2009 and related implementing guidance in 2010. In addition, the Improper Payments Elimination, and Recovery Act of 2010 amended the Improper Payments Information Act of 2002 and established additional requirements related to accountability, recovery auditing, compliance and noncompliance determinations, and reporting.

CMS has already taken action in some areas—for example, as required by law, it implemented a national Recovery Audit Contractors (RAC) program in 2009 to analyze paid claims and identify overpayments for recoupment. CMS has set a key performance measure to reduce improper payments for Parts A and B (fee-for-service) and Part C and is developing measures of improper payments for Part D. CMS was not able to demonstrate sustained progress at reducing its fee-for-service error rate because changes made to improve the methodology for measurement make current year estimates noncomparable to any issued before 2009. Its 2010 fee-for-service payment error rate of 10.5 percent will serve as the baseline for setting targets for future reduction efforts. However, with a 2010 Part C improper payment rate of 14.1 percent, the agency met its target to have its 2010 improper payment rate lower than 14.3 percent. For Part D, the agency is working to develop a composite improper payment rate, and for 2010 has four non-addable estimates, with the largest being \$5.4 billion. Other recent CMS program integrity efforts include issuing regulations tightening provider enrollment requirements and creating its Center for Program Integrity, which is responsible for addressing program vulnerabilities leading to improper payments.

However, having corrective action processes to address the vulnerabilities that lead to improper payments is also important to effectively managing them. CMS did not develop an adequate process to address the vulnerabilities to improper payments identified by the RACs and we recommended that it do so. Further, our February 2009 report indicated that Medicare continued to pay some home health agencies for services that were not medically necessary or were not rendered. To help address the issue, we recommended that postpayment reviews be conducted on claims submitted by home health agencies with high rates of improper billing identified through prepayment review and that CMS require that physicians receive a statement of home health services that beneficiaries received based on the physicians' certification. In addition, we recommended that CMS require its contractors to develop thresholds for unexplained increases in billing by providers and use them to develop

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automated prepayment controls as a way to reduce improper payments. CMS has not implemented these four recommendations. The agency indicated it had taken other actions; however, we believe these actions will not have the same effect.

CMS's oversight of Part D plan sponsors' programs to deter fraud and abuse has been limited. However, CMS has taken some actions to increase it. For example, CMS officials indicated that they had conducted expanded desk audits and were implementing an oversight strategy.

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## Overseeing Patient Care and Safety

CMS's oversight of the quality of nursing home care has increased significantly in recent years, but weaknesses in surveillance remain that could understate care quality problems. Under contract with CMS, states conduct surveys at nursing homes to help ensure compliance with federal quality standards, but a substantial percentage of state nursing home surveyors and state agency directors identified weaknesses in CMS's survey methodology and guidance. In addition to these methodology and guidance weaknesses, workforce shortages and insufficient training, inconsistencies in the focus and frequency of the supervisory review of deficiencies, and external pressure from the nursing home industry may lead to understatement of serious care problems. CMS established the Special Facility Focus (SFF) Program in 1998 to help address poor nursing home performance. The SFF Program is limited to 136 homes because of resource constraints, but according to our estimate, almost 4 percent (580) of the roughly 16,000 nursing homes in the United States could be considered the most poorly performing. CMS's current approach for funding state surveys of facilities participating in Medicare is ineffective, yet these surveys are meant to ensure that these facilities provide safe, high-quality care. We found serious weaknesses in CMS's ability to (1) equitably allocate more than \$250 million in federal Medicare funding to states according to their workloads, (2) determine the extent to which funding or other factors affected states' ability to accomplish their workloads, and (3) guarantee appropriate state contributions. These weaknesses make assessing the adequacy of funding difficult.

However, CMS has implemented many recommendations that we have made to improve oversight of nursing home care. Of the 96 recommendations made by GAO from July 1998 through March 2010, CMS has fully implemented 45, partially implemented 4, is taking steps to implement 29, and did not implement 18. Examples of key recommendations implemented by CMS include (1) a new survey methodology to improve the quality and consistency of state nursing home

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surveys and (2) new complaint and enforcement databases to better monitor state survey activities and hold nursing homes accountable for poor care.

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## What Remains to Be Done

When legislative and administrative actions result in significant progress toward resolving a high-risk problem, we remove the high-risk designation from the program. The five criteria for determining whether the high-risk designation can be removed are (1) a demonstrated strong commitment to, and top leadership support for, addressing problems; (2) the capacity to address problems; (3) a corrective action plan; (4) a program to monitor corrective measures; and (5) demonstrated progress in implementing corrective measures.

CMS has not met our criteria for removing Medicare from the High-Risk List—for example, the agency is still developing its Part D improper payment estimate and has not yet been able to demonstrate sustained progress in lowering its fee-for-service and Part C improper payment estimates. CMS needs a plan with clear measures and benchmarks for reducing Medicare’s risk for improper payments, inefficient payment methods, and issues in program management and patient care and safety.

One important step relates to our recommendation to develop an adequate corrective action process to address vulnerabilities to improper payments. Without a corrective action process that uses information on vulnerabilities identified by the agency, its contractors, and others, CMS will not be able to effectively address its challenges related to improper payments. CMS has implemented certain recommendations of ours, such as in the area of nursing home oversight. However, further action is needed on our recommendations to improve management of key activities. To refine payment methods to encourage efficient provision of services, CMS should take action to

- ensure the implementation of an effective physician profiling system;
- better manage payments for services, such as imaging;
- systematically apply payment changes to reflect efficiencies achieved by providers when services are commonly furnished together; and
- refine the geographic adjustment of physician payments by revising the physician payment localities using an approach uniformly applied to all states and based on current data.

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In addition, further action is needed by CMS to establish policies to improve contract oversight, better target review of claims for services with high rates of improper billing, and improve the monitoring of nursing homes with serious care problems.

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Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

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## Contacts and Acknowledgments

For further information about this statement, please contact Kathleen M. King at (202) 512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Sheila Avruch, Assistant Director; Kelly Demots; and Roseanne Price were key contributors to this statement.

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# Related GAO Products

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

*Medicare Home Oxygen: Refining Payment Methodology Has Potential to Lower Program and Beneficiary Spending.* [GAO-11-56](#). Washington, D.C.: January 21, 2011.

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

*Medicare Contracting Reform: Agency Has Made Progress with Implementation, but Contractors Have Not Met All Performance Standards.* [GAO-10-71](#). Washington, D.C.: March 25, 2010.

*Nursing Homes: Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment.* [GAO-10-70](#). Washington, D.C.: November 24, 2009.

*Medicare: CMS Working to Address Problems from Round 1 of the Durable Medical Equipment Competitive Bidding Program.* [GAO-10-27](#). Washington, D.C.: November 6, 2009.

*Centers for Medicare and Medicaid Services: Deficiencies in Contract Management Internal Control Are Pervasive.* [GAO-10-60](#). Washington, D.C.: October 23, 2009.

*Medicare Physician Payments: Fees Could Better Reflect Efficiencies Achieved When Services Are Provided Together.* [GAO-09-647](#). Washington, D.C.: July 31, 2009.

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

*Medicare Advantage: Characteristics, Financial Risks, and Disenrollment Rates of Beneficiaries in Private Fee-for-Service Plans.* [GAO-09-25](#). Washington, D.C.: December 15, 2008.

*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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*Medicare: Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency.* [GAO-07-307](#). Washington, D.C.: April 30, 2007.

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