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Testimony

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Committee on Energy and Commerce,  
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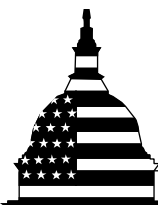
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# GAO'S 2013 HIGH-RISK UPDATE

## Medicare and Medicaid

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Washington, DC 20548

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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

Thank you for the opportunity to discuss our recent work on Medicare and Medicaid. Since 1990, GAO has regularly reported on programs as part of our high-risk series, which focuses on government operations that we have identified as high risk due to their greater vulnerability to fraud, waste, abuse, and mismanagement or their need to address economy, efficiency, or effectiveness challenges. Our high-risk series has brought much-needed focus to problems impeding effective government and costing billions of dollars each year. My remarks today on Medicare and Medicaid are drawn from GAO's 2013 high-risk update.<sup>1</sup> (See Relevant GAO Products for a list of reports that form the basis of this statement.)

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## Medicare Program

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### Background

In 2012, the Medicare program covered more than 49 million elderly and disabled beneficiaries at an estimated cost of \$555 billion, and reported improper payments estimated to be more than \$44 billion. The Centers for Medicare & Medicaid Services (CMS), which administers Medicare for the Department of Health and Human Services (HHS), is responsible for implementing payment methods that encourage efficient service delivery, managing Medicare to provide efficient and cost-effective services to beneficiaries, safeguarding the program from loss, and overseeing patient safety and care. Like health care spending in general, Medicare spending has grown faster than growth in the economy for many years. In the coming years, continued growth in the number of Medicare beneficiaries and program spending will create increasing challenges for the federal government.

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### Why Medicare is High Risk

GAO designated Medicare as a high-risk area in 1990 because of its complexity and susceptibility to improper payments, which, added to its size, have led to serious management challenges. Medicare spending must be held much more firmly in check to sustain the program over the

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<sup>1</sup>GAO, *High-Risk Series: An Update*, [GAO-13-283](#) (Washington, D.C.: February 2013).

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long term, while continuing to ensure that beneficiaries have access to appropriate health care. To help do so, GAO has identified opportunities to make Medicare payment methods more efficient and cost-effective. In addition, the size of the program makes it important for CMS to manage program functions more effectively and better oversee the program's integrity and quality of patient care. The following areas delineate where GAO has identified opportunities for improvements.

- *Reforming and refining payments.* CMS has implemented broad-based reforms to payment systems in the traditional Medicare fee-for-service (FFS) program as well as Medicare Advantage (MA) plans, where about a quarter of Medicare beneficiaries receive their care. Many reforms introduce financial incentives into payment structures to explicitly reward quality and efficiency. Important initiatives include steps toward transitioning Medicare's FFS physician payment system from one that rewards volume of services to one in which value—as measured by quality and cost of care—is used to determine payment. As CMS progresses to full implementation of its value-based payment system, it will be important for the agency to use reliable quality and cost measures and methodological approaches that maximize the number of physicians for whom value can be determined.

GAO's work identified opportunities for CMS to introduce additional payment method refinements and controls in Medicare FFS to encourage appropriate use of services. For example, self-referral, where a provider refers patients to entities in which the provider or the provider's family has a financial interest, continues to be a concern for advanced imaging services. GAO's analysis showed that providers' referrals of advanced imaging services substantially increased once they start to self-refer. GAO estimated that such additional referrals cost more than \$100 million in 1 year. Further, although Medicare's payment system gives hospitals an incentive to seek the best price for implantable medical devices (IMD), GAO determined that hospitals may vary in their ability to do so. The lack of price transparency and variation in amounts hospitals pay for some IMDs—and may pass on to the Medicare program—raise questions about whether hospitals are achieving the best prices possible.

For the MA program, CMS has made progress implementing required adjustments to plan payments to align them more closely with the cost of care in the traditional Medicare program. However, in a January 2012 report, GAO indicated that CMS could still improve the accuracy of payments to MA plans. The payment adjustment CMS makes to MA plans to account for differences in diagnostic coding between MA

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plans and Medicare FFS was \$2.7 billion in 2010 while GAO's estimate was that a more accurate adjustment would have been between \$3.9 billion and \$5.8 billion. In another report on MA plans, GAO reviewed a demonstration CMS established to test an alternative bonus payment structure. This demonstration is estimated to cost more than \$8.3 billion over 10 years and offsets a significant portion of the MA payment reductions made by the Patient Protection and Affordable Care Act (PPACA), as amended, during its 3-year time frame. GAO identified significant shortcomings in the demonstration's design that preclude a credible evaluation of the effect of incentives on plans' quality improvement. For this reason, GAO recommended that the Secretary of Health and Human Services cancel the demonstration and implement the quality bonus payments provided for under the PPACA. HHS has continued the demonstration.

- *Improving program management.* CMS has overcome some challenges in managing Medicare as it implemented some recent program improvements. For example, GAO had previously reported that Medicare sometimes overpaid for durable medical equipment (DME) items relative to other payers. To achieve Medicare savings, in 2009 CMS began implementing a DME competitive bidding program. In this program, CMS contracts with select suppliers to provide DME to beneficiaries and pays them at competitively determined prices based on the bids. GAO found that beneficiary access and satisfaction appeared stable in early assessments, and the competitive bidding program has led to savings. Similarly, in the past, CMS was sometimes hampered in identifying situations when Medicare should be the secondary payer, and the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 mandated reporting of such situations. Since CMS's implementation of the mandatory reporting for non-group health plans, program savings increased by \$124 million from 2008 through 2011.

CMS has improved its overall guidance and oversight of contracts, an area where GAO found pervasive internal control weaknesses in 2009 that put billions of taxpayers' dollars at risk. Improvements include adding internal controls and testing the agency's review of contract payments, adding new checklists and policies to document compliance with federal acquisition requirements, and enhancing its policies and procedures for tracking, investigating, and resolving contract audit and evaluation findings.

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- *Enhancing program integrity.* The Administration and CMS have made reducing improper payments one of their priority initiatives. CMS has made progress in error rate measurement and in 2011 was able to report the error rate for all Medicare components for the first time, including the prescription drug benefit (Part D). CMS's performance plan has set targets for percentages of improper payments, with the targets slightly lower in each year. However, as reported in 2012, the rate of improper payments in FFS and Part C exceeded CMS's target rates. Thus, additional efforts will be needed to further reduce improper payments in FFS and Part C.

CMS has also taken steps to try to strengthen Medicare program integrity and reduce vulnerabilities to improper payment, but some problems have yet to be fully addressed. For example, GAO's previous work found persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of providing billing privileges to entities intent on defrauding the program. CMS has implemented provisions in PPACA designed to strengthen provider enrollment procedures in several ways, such as designating risk levels for categories of providers and applying different screening procedures for providers at each level. In addition, CMS contracted with two new entities at the end of 2011 to assume centralized responsibility for automated screening of provider and supplier enrollment and for conducting site visits of providers. However, CMS has not completed other actions required by this legislation, including (1) determining which providers will be required to post surety bonds to help ensure the recovery of payments made for fraudulent billing, (2) contracting for fingerprint screening services for high-risk providers, (3) issuing a final regulation to require providers to disclose additional information, and (4) establishing core elements for provider compliance programs.

CMS also has implemented the Fraud Prevention System (FPS), which uses analytic methods to examine claims before payment to help identify and prioritize investigations of potential fraud. Specifically, FPS analyzes Medicare claims data using models of potentially fraudulent behavior, which results in automatic alerts on specific claims and providers. These alerts are then prioritized for program integrity analysts to review and investigate as appropriate. According to program integrity officials, FPS is intended to help facilitate the agency's shift from focusing on recovering fraudulent payments after they have been made, to taking actions more quickly when aberrant billing patterns are identified. However, the system is

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not fully integrated with CMS's existing information-technology systems, and CMS has not defined and measured quantifiable benefits and performance goals for it. In addition, GAO reported in 2011 that CMS had not incorporated all the data into its Integrated Data Repository, as planned, which limited the repository's use for identifying potentially fraudulent claims.

- *Overseeing patient care and safety.* For some of the most vulnerable beneficiaries—those in nursing homes—weaknesses remain in oversight of the quality of care, although CMS has taken steps to improve the oversight. For example, CMS contracts with state survey agencies to investigate complaints about nursing homes and helps ensure the adequacy of complaint processes by issuing guidance, monitoring data that state survey agencies enter into CMS's database, and annually assessing state agencies' performance against specific standards. However, CMS has found that states had difficulties meeting some of its standards for their complaint processes. CMS has taken steps to address GAO's recommendations to improve nursing home oversight, such as strengthening enforcement against nursing homes that have provided poor quality care and by increasing the number of facilities that will be subject to more intensive oversight and sanctions.

To provide information to consumers and improve provider quality, in 2008, CMS implemented the Five-Star Quality Rating System, which assigns each nursing home an overall rating and three component ratings—health inspections, staffing, and quality measures—based on the extent to which the nursing home meets CMS's quality standards and other measures. However, CMS lacks GAO-identified leading strategic planning practices—the use of milestones and timelines to guide and gauge progress toward desired results and the alignment of activities, resources, and goals—that could help it more efficiently and effectively improve the Five-Star System.

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## What Remains to Be Done

CMS has not met GAO's criteria to have the Medicare program removed from the High-Risk List. For example, although CMS has made progress in measuring and reducing improper payment rates in different parts of the program, it has yet to demonstrate sustained progress in lowering the rates. Because the size of Medicare relative to other programs leads to aggregate improper payments that are extremely large, continuing to reduce improper payments in this program should remain a priority for CMS. Further, CMS should complete some actions required by PPACA that were designed to improve the integrity of the program, such as

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determining which providers must post surety bonds to help in recovering payments for fraudulent billing, using fingerprint screening for high-risk providers, issuing a final regulation that requires providers to disclose additional information, and establishing core elements for provider compliance programs.

To refine Medicare payment methods to encourage efficient provision of services, CMS should

- ensure the implementation of an effective physician profiling system, to help support use of value-based modifiers;
- develop and implement approaches to identify self-referred claims, reduce payments to recognize efficiencies achieved when the same provider refers and provides the service, and take steps to ensure the appropriateness of service provision;
- cancel the current MA Quality Bonus Demonstration and implement the quality bonus payment provisions in PPACA, as amended; and
- improve the accuracy of the adjustment of payments to MA plans for diagnostic coding differences, such as by using more current data in determining the amount of the adjustment.

To enhance program integrity, CMS should

- improve the structure and processes related to use of prepayment controls and assess the feasibility of increasing contractors' incentives for their use; and
- develop or finalize schedules and plans for its information technology efforts related to improper payments and fraud, including the FPS; define quantifiable benefits, measurable performance targets, and goals for these efforts; and use the targets and goals to determine their effectiveness.

To improve oversight of patient care and safety, CMS should

- strengthen oversight of nursing home complaint investigations by improving the reliability of its complaints database and clarifying guidance for its state performance standards, and

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- use strategic planning to guide and gauge the progress of its planned efforts to meet the goals of the Five-Star Quality Rating System for nursing homes.

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## Medicaid Program

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### Background

The Medicaid program is a federal and state program that covered acute health care, long-term care, and other services for about 70 million low-income people in fiscal year 2011; it is one of the largest sources of funding for medical and health-related services for America's most vulnerable populations. Medicaid consists of more than 50 distinct state-based programs. The federal government matches state expenditures for most Medicaid services using the Federal Medical Assistance Percentage, a statutory formula based in part on each state's per capita income. Medicaid is a significant expenditure for the federal government and the states, with total expenditures of \$436 billion in 2011. CMS is responsible for overseeing the program at the federal level, while states administer their respective programs' day-to-day operations.

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### Why Medicaid is High Risk

GAO designated Medicaid as a high-risk program because of its size, growth, diversity of programs, and concerns about the adequacy of fiscal oversight, which is necessary to prevent inappropriate program spending. Both Congress and the administration have demonstrated commitment and leadership to making Medicaid fiscal and program integrity a priority. In 2012, committees in Congress held hearings on reducing Medicaid improper payments and on improving oversight of the program. HHS continues to review and report on the rate of Medicaid improper payments, and continues to train and provide technical assistance to states on approaches to prevent improper payments. Among other actions, CMS issued guidance to states on removing providers from their Medicaid programs who have been terminated for committing fraud in other states' Medicaid programs or in Medicare, and required improved reporting and independent audits of states' Medicaid supplemental payments made to certain providers known as disproportionate share hospitals. However, stronger federal oversight of Medicaid is warranted as the program continues to grow in size and spending. For example, potential Medicaid expansions under PPACA are estimated to result in the enrollment of about 7 million additional individuals in 2014, growing to 11 million in 2022. The federal government is responsible for paying more than 90 percent of the increased costs associated with this expansion.



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CMS will need new tools and resources as the law is implemented, including more reliable data for assessing expenditures, measuring performance, and preventing improper payments. Areas where program oversight has been insufficient include the following:

- *Improper payments to Medicaid providers serving program beneficiaries.* Improper payments to providers who submit inappropriate claims can result in substantial financial losses to states and the federal government. In its 2012 financial report, HHS estimated—on the basis of individual state error rates from a sample of 17 states reviewed on an annual rotating basis—a national improper payment rate for Medicaid of 7.1 percent (with the federal share estimated at \$19.2 billion).

Positive steps toward improving transparency and reducing improper payments have been taken in recent years. In May 2011, CMS issued guidance to states on processes to remove providers from their program when the providers have been terminated from another state's Medicaid program or terminated from Medicare as required by PPACA. In addition, CMS has committed to (1) redesigning its national Medicaid audit program, which relied on data that were incomplete, unreliable, and untimely, and, as a result cost significantly more than the potential overpayments it identified; and (2) using its comprehensive reviews of state integrity program activities to better target audits toward states with significant weaknesses in their ability to detect overpayments. Separate from this initiative, CMS is also testing the cost-effectiveness and feasibility of establishing a fraud prevention system for Medicaid by April 1, 2015; however key challenges remain, including improving key data systems so that they provide reliable and complete data needed to implement effective programs to identify and prevent improper payments; eliminating duplication between CMS and state program integrity efforts; and refocusing national audit efforts on approaches that are cost-effective.

- *Financing methods that are inappropriate, and large supplemental payments that are not always transparent.* Some states have established varied financing arrangements involving Medicaid supplemental payments that inappropriately increase federal Medicaid matching payments. The total amount of supplemental payments has increased in recent years. In fiscal year 2011, states reported spending at least \$43 billion, up from \$32 billion in fiscal year 2010 and \$23 billion in fiscal year 2006. GAO and others have reported concerns with states' Medicaid supplemental payments over the last decade, including the use of supplemental payment arrangements to

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increase federal funding without a commensurate increase in state funding, and concerns that the payments were not used for Medicaid purposes. Large increases in reported supplemental payments have been identified as a major factor that contributed to increased Medicaid spending on hospital services in 2010.

A variety of federal legislative, regulatory, and CMS actions have helped curb inappropriate arrangements, but gaps remain. In 2003, CMS began an initiative to closely review state supplemental payments and required states to end those it found inappropriate; however, in 2008, GAO reported that CMS had not reviewed all supplemental payment arrangements to ensure payments were appropriate and were for Medicaid purposes. Starting in 2010, CMS implemented new transparency and accountability requirements for certain Medicaid supplemental payments, known as Disproportionate Share Hospital (DSH) payments, including new reporting and auditing requirements for these payments. In 2012, GAO found that the new requirements improve CMS's ability to oversee DSH payments by better assuring that states comply with federal requirements, including accurate calculation of payment amounts to ensure payments are not excessive. However, similar standards for calculating, reporting, and auditing of other types of Medicaid supplemental payments—referred to here as non-DSH supplemental payments—have not been established even though these payments have increased significantly in recent years and exceeded DSH supplemental payments in total amounts. Although Medicaid payments are not limited to the costs of delivering Medicaid services, Medicaid payments that greatly exceed Medicaid costs raise questions about the purpose of the payments, how payments relate to Medicaid services, whether payments are consistent with economy and efficiency, and whether payments contribute to beneficiaries' access to quality care.

- *Managed care rate setting and quality of data used to set such rates has not been consistently reviewed by CMS.* Requirements for Medicaid managed care rates to be actuarially sound are key safeguards in efforts to ensure that federal spending is appropriate. In 2010, GAO reported that CMS had been inconsistent in ensuring that states are complying with the actuarial soundness requirements. Further, GAO found that CMS efforts were not sufficient to ensure the quality of the data used by states to set managed care rates. With limited information on data quality, CMS cannot ensure that states' managed care rates are appropriate, which places billions of dollars at risk for misspending.

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- *Demonstrations that inappropriately increase federal costs.* HHS has the authority to waive certain statutory provisions to allow states to implement demonstrations that test ideas for achieving program objectives. By policy, demonstrations should not increase federal costs. However, GAO reported in 2008 that HHS had approved two state demonstrations that could substantially increase the federal financial liability. At the time of GAO's work in 2007, HHS disagreed with GAO's recommendation to improve the demonstration review 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. Consequentially, GAO elevated this recommendation to Congress for consideration. HHS subsequently reported taking steps, such as monitoring the spending under ongoing approved demonstrations, to improve its oversight; however, as of December 2012, HHS had not planned on any changes in the criteria and methods used to determine budget neutrality of demonstrations prior to approving them.

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## What Remains to Be Done

Congress, HHS, and CMS have taken steps to improve the fiscal integrity of Medicaid, and CMS has implemented certain GAO recommendations, such as improving the information collected on certain supplemental payments and issuing guidance to states to better prevent payment of improper claims. However, more federal oversight of Medicaid's fiscal and program integrity is needed. For example, CMS oversight of program integrity has been challenged by data systems that do not provide reliable, complete, and timely data. States also have key roles in reducing improper payments to providers in developing, implementing, and evaluating the effectiveness of corrective plans to reduce improper payments.

CMS should also continue taking steps to improve oversight of Medicaid managed care payment rate-setting and Medicaid supplemental payments. In November 2012, GAO suggested that Congress require CMS to take certain steps to improve the transparency of and accountability for Medicaid non-DSH supplemental payments, including requiring improved reporting and independent audits of these payments. In addition, GAO's suggestion that Congress require HHS to improve the criteria and methods used to ensure the budget neutrality of Medicaid demonstrations remains valid.

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Thank you, Chairman Pitts, Ranking Member Pallone, and Members of the Committee. This concludes our testimony. We would be pleased to answer any questions.

If you or your staff have any questions about this testimony, please contact Kathleen King at 202-512-7114 or [kingk@gao.gov](mailto:kingk@gao.gov) or Carolyn Yocom at 202-512-7114 or [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. Martin T. Gahart, Assistant Director; Kristin Ekelund; and Krister Friday were key contributors to this statement.

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# Relevant GAO Products: Medicare

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*Medicare Physician Payment: Private-Sector Initiatives Can Help Inform CMS Quality and Efficiency Incentive Efforts.* [GAO-13-160](#). Washington, D.C.: December 26, 2012.

*End-Stage Renal Disease: Reduction in Drug Utilization Suggests Bundled Payment Is Too High.* [GAO-13-190R](#). Washington, D.C.: December 7, 2012.

*Medicare Program Integrity: Greater Prepayment Control Efforts Could Increase Savings and Better Ensure Proper Payment.* [GAO-13-102](#). Washington, D.C.: November 13, 2012.

*Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness.* [GAO-13-104](#). Washington, D.C.: October 15, 2012.

*Medicare: Higher Use of Advanced Imaging Services by Providers Who Self-Refer Costing Medicare Millions.* [GAO-12-966](#). Washington, D.C.: September 28, 2012.

*Medicare Advantage: Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns.* [GAO-12-964T](#). Washington, D.C.: July 25, 2012.

*Medicare: Progress Made to Deter Fraud, but More Could Be Done.* [GAO-12-801T](#). Washington, D.C.: June 8, 2012.

*Nursing Homes: CMS Needs Milestones and Timelines to Ensure Goals for the Five-Star Quality Rating System Are Met.* [GAO-12-390](#). Washington, D.C.: March 23, 2012.

*Medicare Secondary Payer: Additional Steps Are Needed to Improve Program Effectiveness for Non-Group Health Plans.* [GAO-12-333](#). Washington, D.C.: March 9, 2012.

*Medicare: Lack of Price Transparency May Hamper Hospitals' Ability to Be Prudent Purchasers of Implantable Medical Devices.* [GAO-12-126](#). Washington, D.C.: January 13, 2012.

*Medicare Physician Feedback Program: CMS Faces Challenges with Methodology and Distribution of Physician Reports.* [GAO-11-720](#). Washington, D.C.: August 12, 2011.

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*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use.* [GAO-11-475](#). Washington, D.C.: June 30, 2011.

*Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigation.* [GAO-11-280](#). April 7, 2011.

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# Relevant GAO Products: Medicaid

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*Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed.* [GAO-13-48](#). Washington, D.C.: November 26, 2012.

*Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance.* [GAO-13-55](#). Washington, D.C.: November 15, 2012

*Medicaid Integrity Program: CMS Should Take Steps to Eliminate Duplication and Improve Efficiency.* [GAO-13-50](#). Washington, D.C.: November 13, 2012.

*Medicaid: Data Sets Provide Inconsistent Picture of Expenditures.* [GAO-13-47](#). Washington, D.C.: October 29, 2012.

*Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases.* [GAO-12-820](#). Washington, D.C.: September 7, 2012.

*Medicaid: States Reported Billions More in Supplemental Payments in Recent Years.* [GAO-12-694](#). Washington, D.C.: July 20, 2012.

*National Medicaid Audit Program: CMS Should Improve Reporting and Focus on Audit Collaboration with States.* [GAO-12-627](#). Washington, D.C.: June 14, 2012.

*Medicaid: Federal Oversight of Payments and Program Integrity Needs Improvement.* [GAO-12-674T](#). Washington, D.C.: April 25, 2012.

*Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States.* [GAO-12-288T](#). Washington, D.C.: December 7, 2011.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives.* [GAO-12-292T](#). Washington, D.C.: Dec 7, 2011.

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