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HIGH-RISK SERIES

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Medicare Program

Why Area Is High Risk

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.

What GAO Found

GAO designated Medicare as a high-risk area in 1990 because its complexity and susceptibility to improper payments, 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 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. For example, CMS has begun to provide feedback to physicians about their resource use—an important step in encouraging efficiency—and this information, along with indicators of the quality of care delivered, will be used as part of calculating the value-based payment. GAO's work on the Physician Feedback Program found that CMS was experiencing both methodological and implementation challenges. 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 problem 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. However, CMS does not obtain information to identify which advanced imaging services are self-referred and monitor their use. Further, Medicare pays the same amount for self-referred services, even though certain efficiencies may be gained when the same provider orders, performs, and interprets an advanced imaging service. In addition, Medicare prices for certain services may be too high. For example, Medicare added drugs used to treat complications of end-stage renal disease (ESRD) to its bundled payment for ESRD care services starting on January 1, 2011, but based the payment on 2007 care patterns. However, utilization of these drugs to treat ESRD patients has declined since 2007. GAO estimates that Medicare expenditures would have been $650 million to $880 million lower in 2011 if the bundled payment rate was rebased to reflect 2011 utilization of ESRD drugs. Similarly, 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 Medicare Advantage (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 report found that an adjustment CMS makes to MA plan payments to improve accuracy to account for differences in beneficiary diagnostic coding between MA plans and Medicare FFS is inadequate, resulting in excess payments to MA plans estimated to be at least $3 billion from 2010 to 2012. While federal law requires an increase in the minimum adjustment CMS must make, CMS will still need to modify its methodology to ensure the accuracy of adjustments in future years. In another report, GAO found that instead of implementing the MA quality bonus payment provisions in

the Patient Protection and Affordable Care Act (PPACA), as amended, CMS established a demonstration 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 act's MA payment reductions 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 HHS cancel the demonstration and implement the quality bonus payments provided for under PPACA. GAO also raised concerns about whether the demonstration meets the requirements of the statute under which it is being conducted and therefore, falls within CMS's authority.

- *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 nongroup health plans, program savings increased by $124 million from 2008 through 2011. However, GAO found that the increase in contractors' workload to comply with increased mandatory reporting led to problems processing the cases promptly and that CMS's guidance and communications with non-group health plans could be improved. GAO also reported that Medicare is implementing two new programs to provide incentive payments to eligible providers that adopt and use health information technology, but the programs have some inconsistent requirements and have separate reporting requirements, which could increase the burden on providers trying to access the incentives.
  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.

- *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. As reported in 2012, the rate of improper payments in Part D (3.1 percent) was lower than the target CMS set (3.2 percent)—however, the rate of improper payments in FFS and Part C—at 8.5 percent and 11.4 percent respectively—exceeded CMS's target rates of 5.4 percent and 10.4 percent. Thus, additional efforts will be needed to further reduce improper payments in FFS and Part C. If CMS reaches its targets for improper payments, it will take several more years to assess whether CMS can sustain progress in reducing improper payments. The estimation methodology for Parts C and D are relatively new, with few assessments made to develop a trend. Further, refinements to the methodology used to determine the final 2009 and 2010 FFS improper payment rates make them not comparable to estimates for earlier years.

  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.

  Sound and sufficient prepayment controls and post-payment analytic

capability to examine the appropriateness of paid claims are critical for proper payment. CMS has incorporated prepayment controls designed to automatically deny claims that do not meet Medicare's requirements, but GAO found that not all of these controls were working as intended. Further, the processes to identify the need for the controls and implement them had weaknesses that can lead to overpayments. For example, CMS has improved its corrective action process, including developing written guidance on its operation. However, the guidance still lacks procedures to specify time frames for taking corrective actions, methods for assessing the effects of corrective actions, and procedures to ensure that CMS considers instituting prepayment controls whenever possible to prevent making improper payments.

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, which 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 not fully integrated with CMS's existing information technology systems, and CMS has not defined and measured quantifiable benefits and performance goals for it. For CMS's existing information technology for detecting improper or fraudulent claims after payment has been made, 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. In 2011 CMS also had not taken all steps needed to ensure wide usage of its One Program Integrity information technology portal, a tool to help identify patterns of fraud, waste, or abuse. Nor was CMS in a position to identify, measure, and track benefits from these two information technology efforts. Since 2011, CMS has added data to its Integrated Data Repository and increased training to encourage the use of One Program Integrity.

- *Overseeing patient care and safety*. Although preventive care may reduce expenditures and improve health outcomes, GAO found in January 2012 that the use of preventive services by Medicare beneficiaries—those in FFS Medicare as well as those in MA plans—does not always align with the U.S. Preventive Services Task Force's clinical recommendations. Better alignment of preventive service use with Task Force recommendations depends on appropriate Medicare coverage and cost

sharing policies to encourage greater use of high-valued preventive services recommended by the Task Force and discourage use of low-value services for which clinical evidence suggests that the risks generally outweigh the benefits.

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 it. 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, but the agency 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, by increasing the number of facilities that will be subject to more intensive oversight and sanctions for failure to show improved care quality.

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. CMS has several efforts planned to improve the usability of the Five-Star System and provide additional information and quality measures. However, the agency 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.

What Remains to Be Done

As discussed, CMS has demonstrated high-level management commitment to measuring its payment error rate, as demonstrated by its development of a payment error rate for each part of the program. It has taken steps to reduce improper payments, such as by implementing some of the new provider enrollment requirements in PPACA and implementing certain payment controls. Further, CMS has introduced other initiatives to address its management challenges, such as implementing a competitive bidding program for DME and making serious efforts to better oversee nursing quality care and management of contracts. However, 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 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.

CMS has implemented certain GAO recommendations—for example, for nursing home and contract oversight—but further action is needed on other recommendations. 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 improve program management, CMS should

- improve the cost-effectiveness of recovery of payments made improperly because Medicare was the secondary payer in situations involving non-group health plans, and decrease the reporting burden for non-group health plans while improving communication with plans' stakeholders.

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; 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

- provide coverage for preventive services recommended by the Preventive Services Task Force, as appropriate, considering cost-effectiveness and other criteria;
- strengthen oversight of nursing home complaint investigations by improving the reliability of its complaints database and clarifying guidance for its state performance standards; and
- 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.

In addition, Congress should consider requiring the Secretary of HHS to rebase the ESRD bundled payment rate as soon as possible and on a periodic basis thereafter, using the most current available data, and requiring beneficiaries to share the cost of those preventive services that the Preventive Services Task Force has recommended against.

GAO Contact

For additional information about this high-risk area, contact James Cosgrove at (202) 512-7114 or cosgrovej@gao.gov, or Kathleen King at (202) 512-7114 or kingk@gao.gov.

Related GAO Products

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 Analysis 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.

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Nursing Homes: More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations. GAO-11-280. Washington, D.C.: April 7, 2011.