

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

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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.