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MEDICARE

Inherent Program Risks and Management Challenges Require Continued Federal Attention

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Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention

Madam Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss efforts to fight fraud and abuse in the Medicare program, one of the largest entitlement programs in the federal budget. In fiscal year 1996, federal spending for Medicare was $197 billion. Program expenditures have been growing at about 9 percent per year. Moreover, the trust fund that pays for hospital and other institutional services is projected to be depleted within 5 years. As you know, while changes to Medicare are being sought to help control program costs, the Congress is concerned that billions of dollars of these costs are lost to fraudulent and wasteful claims.

Today, I would like to address Medicare's fee-for-service and managed care programs. More specifically, with regard to these two programs, I'd like to highlight the problems bearing on protecting taxpayer and beneficiary interests in Medicare, initiatives recently taken by the Congress and federal agencies addressing these problems, and several remaining concerns.

In summary, it is not surprising that because of the program's size, complexity, and rapid growth, Medicare is a charter member of our high risk series. (See the list of related GAO products at the end of this statement.) In this year's report on Medicare, we are pleased to note that both the Congress and the Health Care Financing Administration (HCFA), the Department of Health and Human Services' (HHS) agency responsible for running Medicare, have made important legislative and administrative changes addressing chronic payment safeguard problems that we and others have identified. However, because of the significant amount of money at stake, we believe that the government will need to exercise constant vigilance and effective management to keep the program protected from financial exploitation.

Background

In 1996, Medicare's fee-for-service program covered almost 90 percent, or 33 million, of Medicare's beneficiaries. Physicians, hospitals, and other providers submit claims to Medicare to receive reimbursement. HCFA administers Medicare's fee-for-service program largely through an administrative structure of claims processing contractors. In 1965, when the Medicare program was enacted, the law called for insurance companies—like Blue Cross and Blue Shield, Travelers, and Aetna—to process and pay claims because of their expertise in performing these functions. As Medicare contractors, these companies use federal funds to

pay health care providers and beneficiaries and are reimbursed for their administrative expenses incurred in performing the work. Over the years, HCFA has consolidated some of Medicare's operations, and the number of contractors has fallen from a peak of about 130 to about 70 in 1996. Generally, intermediaries are the contractors that handle part A claims submitted by "institutional providers" (hospitals, skilled nursing facilities, hospices, and home health agencies); carriers are those handling part B claims submitted by physicians, laboratories, equipment suppliers, and other practitioners.

HCFA's efforts to guard against inappropriate payments have been largely contractor-managed operations, leaving the fiscal intermediaries and carriers broad discretion over how to protect Medicare program dollars. As a result, there are significant variations in contractors' implementation of Medicare's payment safeguard policies.

Medicare's managed care program covers a growing number of beneficiaries—nearly 5 million in 1996—who have chosen to enroll in a health maintenance organization (HMO) to receive their medical care rather than purchasing services from individual providers. The managed care program, which is funded from both the part A and part B trust funds, consists mostly of risk contract HMOs and enrolled about 4 million Medicare beneficiaries in 1996.[1] The HMOs are paid a monthly amount, fixed in advance, by Medicare for each beneficiary enrolled. In this sense, the HMO has a "risk" contract because regardless of what it spends for each enrollee's care, the HMO assumes the financial risk of providing health care within a fixed budget. HMOs profit if their cost of providing services is lower than the predetermined payment but lose if their cost is higher than the payment.

Recent Funding, Other Initiatives Revitalize Waning Efforts to Review Claims, Deter Abuse

Over the last 7 years, HCFA and its claims processing contractors have struggled to carry out critical claims review and provider audit activities with a budget that, on a per-claim basis, was seriously declining. For example, between 1989 and 1996, the number of Medicare claims climbed 70 percent to 822 million, while during that same period, claims review resources grew less than 11 percent. Adjusting for inflation and claims growth, the amount contractors could spend on review shrank from 74 cents to 38 cents per claim.

[1]Other Medicare HMOs include cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, both types of plans enroll fewer than 2 percent of the Medicare population.

Implications of Reduced Funding for Payment Safeguards

Consider the effect of inadequate funding on reviewing home health claims. After legislation in 1985 more than doubled claims review funding, contractors did medical necessity reviews for 62 percent of the home health claims processed in 1986 and 1987. By 1989, however, contractors' claims review target had been lowered to 3.2 percent. One HCFA official noted that home health agencies are aware that their Medicare intermediary reviews only a small number of claims and, therefore, they can take chances billing for noncovered services.

The plunge in the number of cost report audits has also weakened Medicare's efforts to avoid paying excessive costs. Providers subject to these audits are those paid under Medicare's cost-based reimbursement systems—such as hospital outpatient departments, skilled nursing facilities, and home health agencies. These providers are reimbursed on the basis of the actual costs of providing services, rather than on charges. Each year, cost-based providers submit reports that detail their operating costs throughout the preceding year and specify the share related to the provision of Medicare services. Using this information, the intermediaries determine how much Medicare should reimburse the provider institutions, some of which have received interim Medicare payments throughout the year based on estimates of expected costs. Without an audit of the provider's cost report, however, the intermediary can only reconcile the figures provided and cannot determine the appropriateness of the costs reported. In practice, only a fraction of providers is subject to audits. Between 1991 and 1996, the chances, on average, that an institutional provider would be audited fell from about 1 in 6 to about 1 in 13.

The Impact of Recent Legislation and Other Initiatives

With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the cycle of declining funding for anti-fraud-and-abuse activities has been broken. For fiscal year 1997, the act boosts the contractors' budget for program safeguard activities to 10 percent higher than it was in 1996; by 2003, the level will be 80 percent higher than in 1996, after which it remains constant. These additional amounts, however, essentially stabilize per-claim safeguard expenditures at about 1996's level. For example, we project that payment safeguard spending for 2003 will be just over one-half the level of 1989 spending after adjusting for inflation.

In addition to funding, the act has several other provisions to improve vigilance over Medicare benefit dollars, including specifying the flexibility to use contractors other than those processing claims to perform utilization review, provider audit, and other safeguard activities;

establishing a program run jointly by the Department of Justice and HHS to coordinate federal, state, and local law enforcement efforts against fraud in Medicare and other health care payers; establishing a national health care fraud data collection program; and enhancing penalties and establishing health care fraud as a separate criminal offense.

Another important fraud-fighting effort is the 2-year, multiagency project called Operation Restore Trust. Participating agencies include the HHS Inspector General, HCFA, and the Administration on Aging, as well as the Department of Justice and various state and local agencies. The project targets Medicare abuse and misuse in the areas of home health, nursing homes, and medical equipment and supplies. In its first year, Operation Restore Trust reported recovering $42.3 million in inappropriate payments: $38.6 million were returned to the Medicare trust fund and $3.7 million to the Treasury as a result of these efforts. It also resulted in 46 convictions, imposed 42 fines, and excluded 119 fraudulent providers from program participation. In addition, many of the targeted home health agencies were decertified. Operation Restore Trust is scheduled to be closed out as a demonstration project in May 1997. This effort, as well as HCFA's progress in adopting fraud and abuse detection software and its development of a national provider tracking system, is discussed further in our high risk report.

Management Problems Also Affect Medicare Payments and Operations

Notwithstanding funding increases, several problems independent of adequate funding and related to HCFA's oversight of Medicare have implications for curbing unnecessary spending and conducting program operations effectively. One chronic problem is that HCFA has not coordinated contractors' payment safeguard activities. For example, as was anticipated when the program was set up, part B carriers establish their own medical policies and screens, which are the criteria used to identify claims that may not be eligible for payment. Certain policies and the screens used to enforce them have been highly effective in helping some Medicare carriers avoid making unnecessary or inappropriate payments. However, the potential savings from having these policies and screens used by all carriers have been lost, as HCFA has not adequately coordinated their use among carriers. For example, for just six of Medicare's top 200 most costly services in 1994, the use of certain carriers' medical policy screens by all of Medicare's carriers could have saved in the millions to hundreds of millions of dollars annually. However, HCFA's leadership has been absent in this area, resulting in the loss of opportunity to avoid significant Medicare expenditures.

In addition, several technical and management problems have hampered HCFA's acquisition of the Medicare Transaction System (MTS), a major claims processing system that aims at consolidating the nine different claims processing systems Medicare currently uses. First, HCFA had not completely defined its requirements 2 years after awarding a systems development contract. Second, HCFA's MTS development schedule has had significant overlap among the various system-development phases, increasing the risk that incompatibilities and delays will occur. Finally, HCFA has conducted the MTS project without adequate information about the system's costs and benefits.

Before MTS is completed, HCFA must oversee several essential information management transitions in the Medicare claims processing environment. One involves the shifting of claims processing workloads from contractors who leave the program to other remaining contractors. Similar workload shifts in the past have produced serious disruptions in processing claims promptly and accurately, delays in paying physicians, and the mishandling of some payment controls. A second issue involves HCFA's plan to consolidate Medicare's three part A and six part B systems into a single system for each part. This plan will require several major software conversions. A third issue involves the "millennium" problem—revising computerized systems to accommodate the year-digit change to 2000. HCFA does not yet have plans for monitoring contractors' progress in making their systems "millennium compliant."

Medicare Managed Care Incurs Separate Risks

Risk contract HMOs, Medicare's principal managed care option, bear their own set of risks for taxpayers and beneficiaries. These plans currently enroll about 10 percent of Medicare's population and have shown rapid enrollment growth in recent years. Because HMOs have helped private sector payers contain health care costs and limit the excess utilization encouraged by fee-for-service reimbursement, these HMOs have cost-control appeal for Medicare, while offering potential advantages to beneficiaries.

However, as we recently testified, a methodological flaw in HCFA's approach to paying HMOs has produced excess payments for some plans. Moreover, because higher HMO enrollment produces higher excess payments, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending unless the method of setting HMO rates is revised.

A second problem, of particular concern to beneficiaries, is that HCFA has been lax in enforcing HMO compliance with program standards, while not keeping beneficiaries adequately informed of the benefits, costs, and performance of competing HMOs. In 1995, we reported that, despite efforts to improve its HMO monitoring, HCFA conducted only paper reviews of HMOs' quality assurance plans, examining only the description rather than the implementation of HMOs' quality assurance processes. Moreover, the agency was reluctant to take action against noncompliant HMOs, even when there was a history of abusive sales practices, delays in processing beneficiaries' appeals of HMO decisions to deny coverage, or patterns of poor quality care.

HCFA also misses the opportunity to supplement its HMO regulatory efforts by not keeping the Medicare beneficiary population well-informed about competing HMOs. As we reported in 1996, HCFA has a wealth of data, collected for program administration and contract oversight purposes, that it does not package or disseminate for consumer use. For example, HCFA does not provide beneficiaries with any of the comparative consumer guides that the federal government and other employer-based health insurance programs routinely distribute to their employees and retirees. Instead, HCFA collects information only for its internal use—records of each HMO's premium requirements and benefit offerings, enrollment and disenrollment data (monthly reports specifying for each HMO the number of beneficiaries that joined and left that month), records of enrollees' complaints, and results of certification visits to HMOs. By not publishing disenrollment rates or other comparative performance measures, HCFA misses an opportunity to show beneficiaries which plans have a good record and hinders HMOs' efforts to benchmark their own performance.

Initiatives Intended to Address Risk Contract Program Problems

HCFA acknowledges the problems we identified in Medicare's risk contract program. To tackle the difficulties in setting HMO payment rates, HCFA has been conducting several demonstration projects that examine ways to modify or replace the current method of determining HMO payment rates. In addition, HIPAA gives HCFA more flexible sanction authority, such as suspending an HMO's right to enroll Medicare beneficiaries until deficiencies are corrected, while providing HMOs the statutory right to develop and implement a corrective action plan before HCFA imposes a sanction.

Finally, HCFA is developing several consumer information efforts, including plans to make HMO comparison charts available on the Internet. Providing

the information in an electronic format rather than in print, however, may make it less accessible to the very individuals who would find it useful. The information, according to HCFA, will have to be "downloaded and customized for local consumption." HCFA expects the primary users of this information to be beneficiary advocates and Medicare insurance counselors. HCFA is also planning a survey to obtain beneficiaries' perceptions of their managed care plans and does not expect preliminary results before the end of 1997. In another key initiative, HCFA is helping to develop a new version of the Health Plan Employer Data and Information Set (HEDIS 3.0) that will incorporate measures relevant to the elderly population. The measures will enable comparisons to be made among plans of the enrollees' use of such prevention and screening services as flu shots, mammography, and eye exams for diabetics. As of January 1997, Medicare HMOs are required, from the time they renew their contract, to report on HEDIS 3.0 clinical effectiveness measures. HCFA intends to summarize the results and include them in comparability charts currently being developed.

Conclusion

Many of Medicare's vulnerabilities are inherent in its size and mission, making it a perpetually attractive target for exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance and increasingly sophisticated ways to protect against gaming the system. Judicious changes in Medicare's day-to-day operations involving HCFA's improved oversight and leadership, its appropriate application of new anti-fraud-and-abuse funds, and the mitigation of MTS acquisition risks are necessary ingredients to reduce substantial future losses. Moreover, as Medicare's managed care enrollment grows, HCFA must work to ensure that payments to HMOs better reflect the cost of beneficiaries' care, that beneficiaries receive information about HMOs sufficient to make informed choices, and that the agency's expanded authority to enforce HMO compliance with federal standards is used. To adequately safeguard the Medicare program, HCFA needs to meet these important challenges promptly.

This concludes my statement. I am happy to take your questions.

Contributors

For more information on this testimony, please call Donald C. Snyder, Assistant Director, on (202) 512-7204. Other major contributors to this statement included Thomas Dowdal and Hannah F. Fein.

Related GAO Products

High Risk Series Reports on Medicare

Medicare (GAO/HR-97-10).

Medicare Claims (GAO/HR-95-8).

Medicare Claims (GAO/HR-93-6).

Medicare Fee-for-Service

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

Medicare Transaction System: Strengthened Management and Sound Development Approach Critical to Success (GAO/T-AIMD-96-12, Nov. 16, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare Managed Care

Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates (GAO/T-HEHS-97-78, Feb. 25, 1997).

Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

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