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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Strategic Planning and Accountability Challenges

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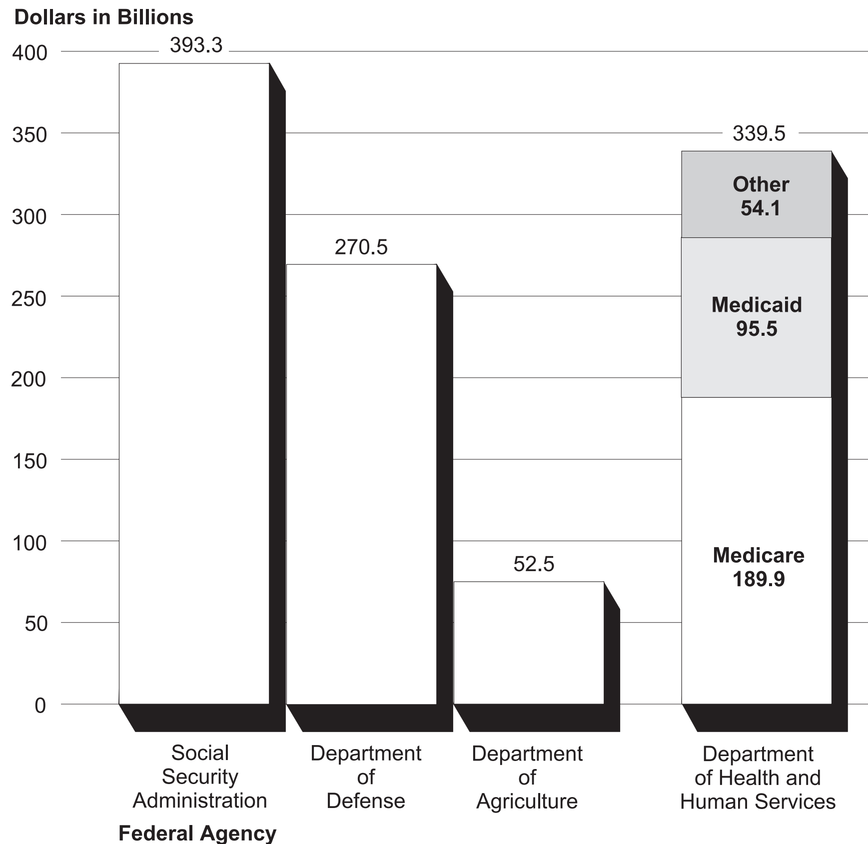
Department of Health and Human Services: Strategic Planning and Accountability Challenges

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the challenges the Department of Health and Human Services (HHS) faces in carrying out its mission effectively and cost-efficiently and in improving its accountability for the results of its efforts and its stewardship of taxpayer dollars.

One of the largest federal departments, HHS has diverse and complex programs that warrant careful oversight. In fiscal year 1997, HHS had budget outlays of $339.5 billion and employed a workforce of over 57,000. In addition, HHS is the federal government's largest grant-making agency, providing approximately 60,000 grants a year. Its Medicare program is the nation's largest health insurer, handling an estimated 900 million claims last year; Medicare alone spends far more than most cabinet departments. (See fig. 1.) Equally important, HHS' many missions affect the health and well-being of everyone in the nation. HHS provides health insurance for about one in every five Americans. Its agencies conduct medical research to expand our knowledge of curing and preventing disease; ensure the safety of food, drugs, and medical devices; provide health care services to populations who might otherwise not receive care; help needy children and families with income support; and support a range of services to help elderly people remain independent.

Figure 1: Fiscal Year 1997 Outlays of the Four Largest Federal Agencies



Note: The Department of the Treasury's budget outlay was $379.3 billion. However, $355.8 billion of that total was interest on the public debt.

I will begin my discussion today by focusing on HHS' progress in strategic planning as envisioned by the Government Performance and Results Act of 1993 (hereafter referred to as the Results Act). The Results Act presents HHS the opportunity to better manage the Department at all levels, define the types of information it needs to implement and assess its programs, and identify ways to progress toward accomplishing its goals. It also poses difficult challenges to HHS, however, in meeting the requirements for preparing strategic plans, designing performance measures, and assessing and reporting on program accomplishments.

In addition, I will highlight three underlying problems that we have often reported as obstructing HHS' effective functioning—coordinating and fixing accountability for its approximately 300 diverse programs; ensuring that it has the information systems it needs to manage and evaluate its programs and track its progress in meeting performance goals; and protecting programs vulnerable to fraud, waste, abuse, and mismanagement. By using the framework of the Results Act to address these underlying problems, HHS will be much better able to carry out its vital missions and assure the Congress and the American people that its programs are achieving desired results.

In summary, our work suggests that considering the breadth and complexity of HHS' responsibilities, the size of its budget, and the importance of its programs, it is essential that the Department successfully and efficiently fulfill its mission. We know that HHS is committed to carrying out its programs effectively, but we and others have often identified problems with HHS programs. HHS deserves credit for its progress in complying with the requirements of the Results Act. The next critical stage in improving HHS' accountability for the public's investment in its programs will be to move from its strategic planning efforts to efficiently accomplishing its goals and objectives. Successfully implementing HHS' plans will require vigilance by the Department and its agencies as well as continued congressional oversight.

Results Act and Related Legislation Provide Framework for Improved Program Performance, Cost Savings, and Accountability

Concerned that federal agencies have not always effectively managed their activities to ensure accountability, the Congress created a legislative framework to address long-standing governmentwide management challenges. The centerpiece of this framework is the Results Act. Other elements include the Chief Financial Officers (CFO) Act, the Government Management Reform Act, the Federal Financial Management Improvement Act, and the Clinger-Cohen Act.[1] These laws respond to the need for appropriate, reliable information for executive branch and congressional decision-making.

[1]The 1990 CFO Act established a financial management leadership structure and requirements for long-range planning, audited financial statements, and strengthened accountability reporting. The Government Management Reform Act of 1994 requires each department and major independent agency to submit to the Office of Management and Budget (OMB) an audited agencywide financial statement beginning with fiscal year 1996. The Federal Financial Management Improvement Act of 1996 is intended to improve federal accounting practices and increase the government's ability to provide more reliable financial information. The Clinger-Cohen Act of 1996 elaborates on requirements that promote the use of information technology to better support agencies' missions and to improve program performance. See Managing for Results: The Statutory Framework for Performance-Based Management and Accountability (GAO/GGD/AIMD-98-52, Jan. 28, 1998).

Results Act Intended to Improve Management Governmentwide

The Results Act is aimed at improving program performance and providing the Congress and the American people with the information needed to assess whether government agencies are fulfilling their missions. It requires that agencies, in consultation with the Congress and after soliciting the views of other stakeholders, clearly define their missions and articulate comprehensive mission statements that define their basic purposes. It also requires that agencies establish long-term strategic goals and link annual performance goals to them. Agencies must then measure their performance according to the goals they have set and report publicly on how well they are doing. In addition to monitoring ongoing performance, agencies are expected to evaluate their programs and to use the evaluation results to improve programs.

The Results Act requires virtually every executive agency to develop a strategic plan covering a period of at least 5 years from the fiscal year of its submission and to submit the plan to the Congress and OMB. OMB provided guidance on the preparation and submission of strategic plans as a new part of its Circular No. A-11—the basic instructions for preparing the president's budget—to underscore the link between the Results Act and the budget process. The strategic plans are to include six elements: (1) a mission statement, (2) long-term goals and objectives, (3) approaches or strategies to achieve the goals and objectives, (4) a discussion of the relationship between long-term goals and annual performance goals, (5) key external factors beyond the agency's control that affect goals and objectives, and (6) evaluations used to establish goals and objectives and a schedule for future evaluations.

HHS, as required by the Results Act, submitted its first strategic plan to OMB and the Congress on September 30, 1997. In addition, the act requires agencies to submit annual performance plans tied to their budget requests to reinforce the connection between the long-term strategic goals outlined in the strategic plans and the daily activities of program managers and staff. HHS submitted its first annual performance plan, for fiscal year 1999, in early February. In response to a request from the Speaker, Majority Leader, and several committee chairmen of the House of Representatives, we are evaluating that plan. In addition, at the request of the Chairman of the Appropriations Committee and others in the House and Senate leadership, we developed a guide to help decisionmakers both elicit the information that the Congress needs from agencies' annual performance plans and assess the quality of those plans.[2]

[2]See Agencies' Annual Performance Plans Under the Results Act: An Assessment Guide to Facilitate Congressional Decisionmaking (GAO/GGD/AIMD-10.1.18, version 1, Feb. 1998).

HHS Can Use Results Act to Clarify and Meet Its Goals and Objectives

The Results Act offers HHS a valuable and useful management framework, shifting attention to data and performance measures that will allow the Department and the Congress to judge whether programs are accomplishing their purposes. Although meeting the act's requirements will challenge HHS, employing the discipline of the planning process could improve the Department's performance and accountability—vital goals when resources are limited and public demands are high.

The benefit of emphasizing program results instead of inputs and outputs is illustrated by our evaluations of several programs related to one of HHS' six strategic goals—improving access to health services and ensuring the integrity of the nation's health entitlement and safety net programs. In the past several years, we have issued several reports examining federal efforts to improve access to primary health care. The federal government spends billions of dollars each year on health financing and service delivery programs that, in whole or part, are aimed at achieving this objective. We found that although federal programs have provided resources to improve access to primary health care, the programs have not been held accountable for showing that access has indeed improved. Following are some examples:

- Medicare and Medicaid payment methods for rural health clinics—whose original purpose was to subsidize health care in remote rural areas lacking physicians—now cost more than $295 million a year to primarily subsidize care in cities and towns that already have substantial health care resources.[3] Our review of a sample of clinics showed that the availability of care did not change appreciably for at least 90 percent of Medicare and Medicaid beneficiaries using the clinics. Staff we interviewed at most clinics said they did not use the subsidies to expand access to underserved portions of the population or need the subsidies to remain financially viable.[4]
- The Medicare Incentive Payment program, created out of concern that physicians would not treat Medicare patients because of low Medicare reimbursement rates, pays all physicians in designated shortage areas a 10-percent bonus on Medicare billings. Physicians receive bonus payments

[3]This is the estimated additional cost to the Medicare and Medicaid programs due to higher payment rates to rural health clinics.

[4]We reviewed the health care resources of a sample of communities where 144 rural health clinics were certified in four states: Alabama, Kansas, New Hampshire, and Washington. We analyzed past access to care for Medicare and Medicaid beneficiaries using 119 of these clinics and subsequently interviewed staff at 76 of the clinics. See Rural Health Clinics: Rising Program Expenditures Not Focused on Improving Care in Isolated Areas (GAO/HEHS-97-24, Nov. 22, 1996) and related testimony (GAO/T-HEHS-97-65, Feb. 13, 1997).

now totaling over $100 million each year, even in shortage areas where Medicare patients are not underserved or where low Medicare reimbursement rates are not the cause of underservice.[5]

- Federal and state programs placing providers in underserved areas have oversupplied some communities and states with providers while other areas have received no providers. For the National Health Service Corps program alone, at least 22 percent of shortage areas receiving National Health Service Corps providers in 1993 received providers exceeding the number needed to remove federal designation as a shortage area,[6] while 785 shortage areas requesting providers received no providers at all. Of these latter areas, 143 had requested a National Health Service Corps provider for 3 years or more but received none.[7]
- Although almost $2 billion has been spent in the last decade on health professional education and training programs, HHS has not gathered the information necessary to evaluate these programs' effect on changes in the national supply, distribution, or minority representation of health professionals or their impact on access to care. Evaluations often did not address these issues, and those that did address them had difficulty establishing a cause-and-effect relationship between federal program funding and any changes that occurred.[8]

The Results Act provides an opportunity for HHS to make sure its programs to improve access to health care are on track and to identify how each program's efforts will contribute to overall access goals. Establishing the following performance goals and measures, for example, could significantly improve accountability in HHS' primary health care access programs:

- HHS now tracks the number of rural health clinics established and the number of physicians receiving health shortage area bonus payments and dollars spent. To measure access outcomes, HHS would need to assess

[5]See Health Care Shortage Areas: Designations Not a Useful Tool for Directing Resources to the Underserved (GAO/HEHS-95-200, Sept. 8, 1995).

[6]In creating the federal health professional shortage area designation system, federal intervention was considered justified only if the number of health care providers was significantly less than adequate, indicating that the needs of these areas were not being met through free-market mechanisms or reimbursement programs.

[7]See National Health Service Corps: Opportunities to Stretch Scarce Dollars and Improve Provider Placement (GAO/HEHS-96-28, Nov. 24, 1995).

[8]See Health Professions Education: Role of Title VII/VIII Programs in Improving Access to Care Is Unclear (GAO/HEHS-94-164, July 8, 1994) and Health Professions Education: Clarifying the Role of Title VII and VIII Programs Could Improve Accountability (GAO/HEHS-97-117, Apr. 25, 1997).

whether these programs have improved access to care for Medicare and Medicaid populations or other underserved populations.

- The success of the National Health Service Corps and health center programs has been based on the number of providers placed or the number of people they served. To measure access outcomes, HHS would need to gather the information necessary for reporting the number of people receiving care from National Health Service Corps providers or from the health centers who were otherwise unable to gain access to the local community's primary care services.

The $4.4 billion Head Start program provides another example of how the Results Act's requirement that agencies substantiate program results can help HHS improve accountability. Although an extensive body of research exists on Head Start, only a small part of this addresses the program's impact. This body of research does not provide an adequate basis for drawing conclusions about the impact of the national program in any area in which Head Start provides services, including children's social and cognitive readiness for school.[9] Head Start has recently developed performance measures to assess program results and outcomes.

HHS' Strategic Plan Contains Key Elements but Can Be Further Improved

HHS met its first major milestone of the Results Act in September when it submitted its first 5-year strategic plan to the Congress. The plan represents a serious initial effort toward integrating program goals and activities at a departmental planning level, meeting the requirements of the Results Act, and providing the Congress with a useful document to inform its oversight and appropriation responsibilities. The plan includes all six critical elements required by the Results Act, including a mission statement that successfully captures the broad array of the Department's activities, six overarching Department-wide goals, and objectives for accomplishing these six goals. The objectives focus largely on outcomes, such as reducing the use of illicit drugs, and they are defined in measurable terms, such as increasing the percentage of the nation's children and adults who have health insurance coverage. The plan also identifies key measures of progress for each strategic objective. For example, one measure for determining reduced tobacco use is the rate of tobacco use by young people.

The plan describes HHS' activities to coordinate efforts both internally among its operating divisions and externally with other departments and

[9]See Head Start: Research Provides Little Information on Impact of Current Program (GAO/HEHS-97-59, Apr. 15, 1997).

agencies that have related missions. HHS' plan also recognizes three types of challenges that could significantly affect the Department's ability to achieve its strategic goals: external factors, such as the poverty rate among children; management issues, such as resource constraints; and data problems, such as the limits of current data administration systems.

In our review of HHS' strategic plan for the Congress, we discussed several opportunities for improving the plan.[10] HHS officials agreed that the plan can be further improved, noting that strategic planning is a continuous process. They observed that ongoing assessments and updates will be needed to strengthen the plan and ensure that it continues to provide relevant direction for HHS' program activities.

HHS' greatest opportunities for improving its strategic plan, in our view, involve discussion of the Department's strategies for accomplishing its objectives. First, the plan does not clearly link its strategies to the attendant measures of success, making it difficult to determine the strategies' contribution to the desired outcomes. For example, to increase the economic independence of families on welfare, the plan specifies three strategies: providing technical assistance, promoting employment, and improving access to child care. The plan's four measures of success for economic independence, however, all relate to providing employment, with no apparent relationship to the strategies for providing child care or technical assistance.

Another area of the plan in which linkage between strategies and measures of success can be improved involves HHS' sixth strategic goal—strengthening the nation's health sciences research enterprise and enhancing its productivity. Achieving this goal is a major function of the National Institutes of Health (NIH), which accounts for over a third of HHS' discretionary funds. The strategic plan's proposed measures of success for achieving this goal—for example, changes in the treatments for disease and disability—are too broad for effectively evaluating the impact of NIH's program activities. Assessing research outcomes is especially difficult due to a combination of factors—the unpredictable nature of research, the time lag between program inputs and results, and the problem in determining a causal link between specific research projects and results. Despite these difficulties, NIH must be held accountable for demonstrating that it is achieving intended results with its annual expenditures, $11.2 billion in fiscal year 1997.

[10]See Managing for Results: Agencies' Annual Performance Plans Can Help Address Strategic Planning Challenges (GAO/GGD-98-44, Jan. 30, 1998).

A second concern is that HHS' strategic plan does not discuss the effectiveness of the outlined strategies. The plan mentions neither existing evaluations to indicate current knowledge of these strategies' effectiveness nor plans for future evaluations to determine their effectiveness. For example, some of the strategies are based on a common HHS approach to support state-administered programs: technical assistance, training, and identifying and disseminating best practices. Yet, we have found in our work on these programs, such as child protective services and child support enforcement, that such strategies have presented problems. In some cases, HHS' technical assistance was inadequate, the regional offices had only a limited capacity to provide assistance and training, and HHS' dissemination of research and best practices was lacking. In addition to drawing on past evaluations, HHS' plans should identify future evaluations to determine the effectiveness of its strategies. Such evaluations are essential for determining whether taxpayer dollars are invested wisely.

Third, the plan does not discuss the resources required to implement the strategies. For example, strategies to enhance the fiscal integrity of the Health Care Financing Administration (HCFA) programs include consolidating Medicare payment systems to improve HHS' ability to identify aberrant billing and improve payment accuracy. The plan does not mention, however, the resources necessary to implement such a strategy.

Fourth, although the plan identifies key external factors that could impede HHS' achieving its strategic goals and objectives, there is little discussion of how the Department intends to address these factors. For example, a key external factor to achieving several HHS objectives is the state of the economy. However, the plan does not indicate how its strategies would adjust to changes in the economy that could, for example, increase the number of Medicaid-eligible children.

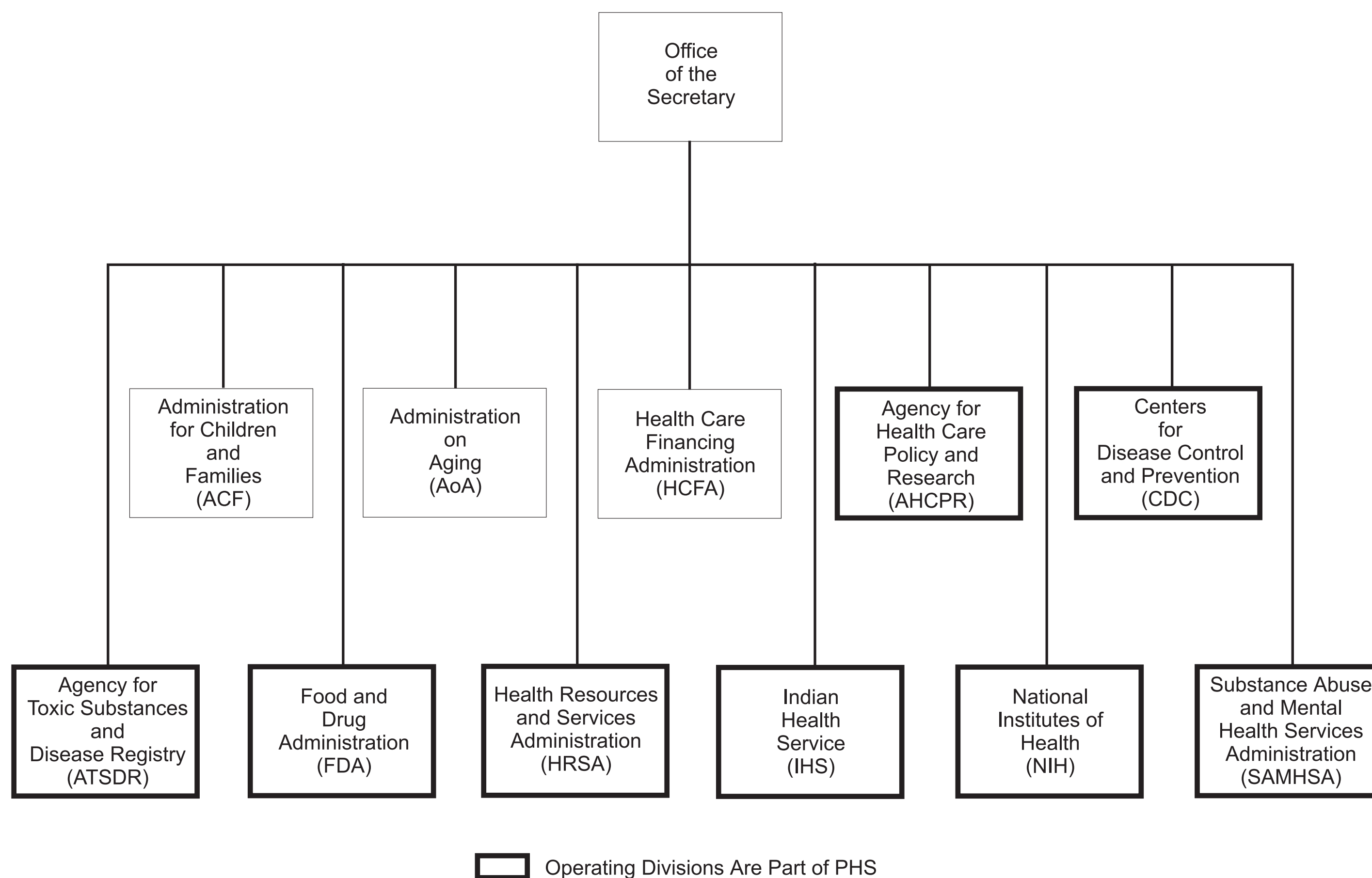
In addition, although the plan reflects a recognition of management and information challenges to achieving HHS' goals, it provides little discussion of potential solutions. For example, the plan acknowledges HHS' reliance on state, local, and tribal governments; contractors; and private entities as program and information partners and mentions the need to coordinate with them but does not specify how it would do so. Similarly, while HHS' plan recognizes the importance of improving its financial management information, it does not specify the corrective actions and timetables needed to obtain an unqualified or clean opinion on its financial statements. Finally, although the plan identified several information

technology initiatives that may help HHS achieve some program objectives, the plan does not discuss how HHS intends to identify and coordinate information technology investments to support overall Department-wide goals and missions.

Scope of HHS' Responsibilities Makes Coordination and Accountability Difficult

The sheer size and scope of HHS' mission and the resulting organizational complexity make it especially challenging for the Department to manage and coordinate its programs to give the public the best possible results and to preclude agencies' duplicating or undermining each other's efforts. HHS comprises 11 operating agencies, each of which manages a number of programs, whose many parts also must be administered. (See fig. 2.) For example, NIH is only one of the agencies within the Public Health Service (PHS), yet NIH includes 17 separate health institutes, the National Library of Medicine, and the National Center for Human Genome Research. HCFA administers the Medicare and Medicaid programs, as well as several quality of care programs such as those authorized by the Clinical Laboratory Improvement Amendments of 1988. The Administration for Children and Families (ACF) is responsible for about 60 programs, including the new federal-state welfare program; child support enforcement; and Head Start, which alone serves about 800,000 children. This array of interrelated activities and responsibilities makes it especially important for HHS managers to work together to address the Department's overarching program goals.

Figure 2: HHS' Major Operating Divisions



Better Internal and External Coordination Could Improve Program Results and More Efficiently Use Federal Funds

Coordination among HHS programs with related responsibilities is essential to efficiently and effectively meeting program goals. Moreover, many HHS programs share goals with or relate closely to programs administered by other federal agencies. In addition to coordinating the activities of its own agencies, HHS must also coordinate its efforts with these other agencies. Furthermore, a number of HHS programs, including Medicaid and Temporary Assistance for Needy Families (TANF) block grants, require both federal and state involvement. Therefore, HHS must work with all the state governments—and at times local jurisdictions—to coordinate implementation of these programs.

Implementing the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and subsequent legislation, for example, requires HHS to focus on both internal and external coordination. Employment, training, and education programs administered by the Departments of Labor and Education will probably be essential to HHS' goal of promoting self-sufficiency and parental responsibility for poor families receiving assistance through TANF block grants. Coordinating Head Start and other HHS child care programs may help low-income families gain access to the child care they need to find or maintain employment. In addition, HHS substance abuse and mental health programs may play an important role in helping welfare families with multiple barriers to employment move toward self-sufficiency.

Other examples of program areas requiring both internal and external coordination include alcohol and other drug abuse treatment and prevention, child abuse and neglect, and child support enforcement. For example, programs addressing alcohol and other drug abuse issues reside not only in several HHS agencies—including the Substance Abuse and Mental Health Services Administration, NIH, ACF, and the Centers for Disease Control and Prevention—but also in 15 other federal agencies. These include the Departments of Education, Housing and Urban Development, Justice, and Veterans Affairs.[11] HHS also administers 58 programs that address the problems of at-risk and delinquent youth. An additional 73 programs focused on this population reside in 15 other federal departments and agencies, including the Departments of Agriculture, Education, Housing and Urban Development, Justice, and Labor.[12] In addition to coordinating within the government, HHS must also coordinate its activities with many private organizations. For example, HCFA must coordinate with about 70 Medicare claims contractors, more than 400 managed care plans, insurance companies providing supplemental coverage to Medicare beneficiaries, and beneficiary and provider associations.

Partnership With State and Local Agencies Makes Accountability for Results Difficult

Many HHS programs are operated by states, localities, or nongovernmental organizations, which requires HHS agencies to develop ways to make their many partners accountable for program results. The Department has observed in its fiscal year 1999 performance plan that virtually all of the

[11] See Drug and Alcohol Abuse: Billions Spent Annually for Treatment and Prevention Activities (GAO/HEHS-97-12, Oct. 8, 1996).

[12] See At-Risk and Delinquent Youth: Multiple Federal Programs Raise Efficiency Questions (GAO/HEHS-96-34, Mar. 6, 1996).

approximately $400 billion that will be expended for HHS programs in that year will be spent not by HHS employees—but by program partners. In administering programs that are the joint responsibility of state governments or that involve many local grantees, HHS must continually balance program flexibility with oversight and maintaining program controls. To further complicate HHS' task, state data necessary for meaningful performance measurement may not be available or may not be comparable from state to state.

Managing the TANF block grant exemplifies many of these difficulties. Under TANF, states have flexibility in designing and implementing their own assistance programs within federal guidelines. Meanwhile, HHS has a broad range of responsibilities for ensuring accountability from the states. The law also gives HHS authority to assess penalties if states fail to comply with certain requirements and provides for states to receive bonuses if they meet certain performance standards. HHS must work closely with the states to develop effective performance measures that promote the goals of the 1996 welfare law. The experience of the Office of Child Support Enforcement (OCSE) in working with states to develop national goals and objectives for the child support enforcement program demonstrated that although developing performance measures for federal-state programs is a challenge, HHS and its state partners can, with time and effort, make progress toward producing results-oriented program management.[13]

Administering the Medicaid program presents the same difficulty in balancing flexibility and accountability. Federal statutes and regulations allow states substantial flexibility in designing and administering their Medicaid programs. Flexibility can be positive for beneficiaries as well as the states; however, HCFA's ongoing monitoring and oversight are essential to ensure the appropriate use of federal funds.

Another example is Head Start, which was designed to ensure maximum local autonomy. The accountability structure established to oversee the program is based on largely self-enforcing performance standards. Head Start performs on-site monitoring reviews every 3 years to ensure that its more than 1,400 grantees are in compliance with the standards. Head Start supplements information from these reviews with data grantees provide annually about their program activities. These annual data are self-reported and unvalidated. Several HHS Office of the Inspector General (IG) reports have raised questions about accountability in Head Start. For

[13]See Child Support Enforcement: Reorienting Management Toward Achieving Better Program Results (GAO/HEHS/GGD-97-14, Oct. 25, 1996).

example, a May 1993 report found significant differences between the number of services grantees reported they had provided and the number they had actually documented in their files. The IG also found that grantee files and records were often incomplete, inconsistent, and hard to review.[14]

Reliable and Comprehensive Management Information Systems Crucial to HHS Success

To effectively manage its large health insurance programs, extensive grant-making activities, and vital regulatory responsibilities, HHS must have access to data about its programs and their effects that are both reliable and appropriate to the task. Without these data, HHS will not know whether it is accomplishing its goals or its programs' effect on the American people. Nor will HHS be able to give the Congress the information it needs to evaluate the Department's success. Creating and implementing the sophisticated systems to give HHS managers the data they need presents a major challenge. Because several important HHS programs, including Medicaid and TANF, are joint federal-state endeavors, the current lack of comparable state data increases the difficulty of obtaining timely and reliable data. Another critical task related to information management is HHS' timely resolution of the "year 2000" problem.

Welfare Reform Presents HHS With Many Information Challenges

The new welfare reform law gives HHS new administrative and oversight responsibilities, the performance of which will rely on state-provided data. HHS needs to ensure that it receives comparable and reliable data from the states to help it fulfill its oversight responsibilities under the new legislation, namely, ensuring that states enforce the federal 5-year time limit on receiving welfare benefits, meet minimum work participation rates, and maintain a certain level of welfare spending. Enforcing the time limit, for example, will be difficult because information on the total amount of time someone has received welfare is often unavailable in a state, let alone across states. In addition, HHS will need to collect state data to determine performance penalties and bonuses. With the increased flexibility of states in designing their programs, obtaining comparable and reliable data to assess the effect of welfare reform on children and families could be difficult for HHS.

Similarly, to strengthen child support enforcement, HHS is required to use state-provided data to establish a national directory of newly hired

[14]Evaluating Head Start Expansion Through Performance Indicators, HHS Office of Inspector General, OEI-09-91-00762 (May 1993) and Summarization of Concerns With the Financial Management Systems and Control Structures Found at Head Start Grantees, HHS Office of the Inspector General, A-17-93-00001 (Sept. 1993).

employees and registry of child support orders so these data can be cross matched. In addition, the law requires HHS to implement, by fiscal year 2000, a new child support enforcement incentive structure that will be based on performance data generated by statewide information systems that are not yet fully implemented or certified. We reported in 1997 that OCSE's mandatory oversight of state systems has been narrowly focused and, as a result, neither effective nor timely in assessing state systems' approaches and progress.[15]

HCFA Needs Better Information About Enrollees and Services to Manage Medicaid Program

HHS also faces information challenges in managing the $168 billion Medicaid program. Medicaid, a joint federal-state program administered by HCFA, provides health coverage for 36 million low-income people, including 17.6 million children. Medicaid also pays for nursing home coverage for low-income elderly and other vulnerable members of society, accounting for almost half of total national spending for nursing home care. The Medicaid program's federal fiscal year 1997 expenditures totaled about $96 billion, with state expenditures totaling about $72 billion.

Despite the size of the Medicaid program, the federal government has only limited data on its results and the accuracy of these data is questionable. Using state-supplied information, HCFA creates a statistical report that has data about beneficiaries served, their eligibility categories, types of services they received, and vendor payments. It also generates a regular financial report. Problems with the accuracy and consistency of the state data, however, compromise the usefulness of these reports. Some of these problems stem from collecting data from 50 states and the District of Columbia, which do not all identically define data categories. An additional limitation is the difficulty of crosswalking some types of information between these two reports. Problems in the quality of the data and in the ability to link data across data sources make it difficult for HCFA and others to analyze and evaluate Medicaid's results.

For example, HCFA has had a problem with duplicate reporting on the number of people enrolled in Medicaid managed care programs. Furthermore, Medicaid's data problems could worsen because of the program's growing reliance on managed care to provide health services to beneficiaries. The proportion of Medicaid beneficiaries enrolled in managed care, as reported by HCFA, quadrupled from about 10 percent in 1991 to about 40 percent in 1996. Because Medicaid pays many managed

[15]See Child Support Enforcement: Leadership Essential to Implementing Effective Automated Systems (GAO/T-AIMD-97-162, Sept. 10, 1997) and Child Support Enforcement: Strong Leadership Required to Maximize Benefits of Automated Systems (GAO/AIMD-97-72, June 30, 1997).

care organizations a defined fee for providing a range of services, HCFA usually lacks the detailed utilization data that are available under the fee-for-service billing system. These data problems make it difficult to assess the effect of managed care on Medicaid services and costs.

An additional challenge will arise as HCFA and the states begin to implement the new $20.3 billion Children's Health Insurance Program. HCFA needs to provide timely guidance to the states on data reporting to allow them to collect uniform information on beneficiaries, costs, and services. This would then supply HCFA with the uniform aggregated data it will need to assess the program's effects.

Information Management Critical to Prevent Fraud and Abuse in the Medicare Program

HHS faces vast information management challenges regarding the Medicare program, which accounts for over half of HHS' annual budget. The Medicare Transaction System (MTS) was intended to create a single integrated database of information on all beneficiaries, providers, and plans as well as to perform functions such as claims processing and managed care enrollment. If properly planned and designed, MTS could have played an important role in reducing Medicare fraud and abuse. Such a single integrated database would, for example, have helped prevent unscrupulous providers from billing multiple contractors for the same service or piece of medical equipment. Throughout its development, the MTS project was fraught with design and management problems that increased its cost and risk. In August 1997, HCFA determined that the contractor could not deliver the system on schedule and within budget and terminated the contract as of January 1, 1998. While exploring other strategies to improve its systems for Medicare, HCFA is working to improve the efficiency of its claims process by reducing the number of claims processing systems from eight to three, one of which will process only durable medical equipment claims.

HHS Must Act Quickly to Reduce Year 2000 Risk

As we approach the year 2000, information systems worldwide could malfunction or produce incorrect information simply because they have not been designed to handle dates beyond 1999. Unless this problem is resolved ahead of time, every federal agency—including HHS—faces risk of massive system failures. The impact of these failures could be widespread and costly. For example, HCFA expects to process over 1 billion Medicare claims and pay $288 billion in benefits a year by 2000.

HHS' progress in preparing for the year 2000 has been too slow: less than 25 percent of its mission-critical systems have been converted and tested. As a result, in its November 15, 1997, report on the progress on year 2000 conversion, OMB placed HHS on its list of agencies that had not made sufficient progress to date, which could result in restrictions on HHS' funding for information technology investments unless they are directly related to correcting the year 2000 problem. These restrictions would remain in place until HHS demonstrates that it is adequately addressing this problem.

We reported in May 1997 that HCFA was relying on its Medicare systems contractors to assess, plan, and implement essential changes for the year 2000 issue but was not closely monitoring these activities or receiving certifications or assurances from contractors that they will address the problems.[16] HCFA has since hired a chief information officer to address these and other technology issues. The scope of contractors' needed work is much broader than past systems changes contractors have had to make. It requires reviewing all software programs and systems interfaces and components that can be affected by the year 2000 problem; this includes hardware, operating systems, communications applications, and databases. Unless timely, effective systems changes are implemented as the year 2000 approaches, HCFA may be unable to process claims accurately and within required time frames.

Safeguarding Vulnerable Programs Requires Constant Vigilance and Innovation

With HHS' broad range of programs, large number of grantees and contractors, huge volume of vendor payments, and millions of beneficiaries, the Department must always be vigilant in protecting its programs from fraud, waste, abuse, and mismanagement. The sheer dollar size of HHS' programs makes them attractive targets, and the consequences can be severe. HHS needs to improve its processes for identifying and preventing fraud, waste, abuse, and mismanagement and maintain constant vigilance in the future. The $200 billion Medicare program exemplifies the importance of such efforts.

Inherent Vulnerabilities Reside in Program of Medicare's Size and Scope

Most Medicare services are provided through the fee-for-service sector, where any qualified provider can bill the program for services rendered. In fiscal year 1997, Medicare processed an estimated 900 million claims. Through its claims processing contractors, Medicare pays hundreds of

[16]See Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD-97-78, May 16, 1997).

thousands of providers, such as physicians, hospitals, skilled nursing facilities, home health agencies, and medical equipment suppliers. In addition, HCFA pays and monitors more than 400 managed care health plans that serve more than 5 million beneficiaries. The managed care program consists mostly of risk contract health maintenance organizations (HMO). Medicare pays these HMOs a monthly amount, fixed in advance, for all the services provided to each beneficiary enrolled. Both the fee-for-service and managed care delivery systems have vulnerabilities.

Inherent in Medicare's fee-for-service program—used by about 87 percent of the program's beneficiaries—is an incentive for providers to deliver more services than necessary, driving up program costs. Spending growth for services until now not subject to cost containment reforms—such as home health care and skilled nursing facility care—has skyrocketed, growing much faster than spending for inpatient and physician services. Policymakers have therefore looked to the managed care experience of private-sector payers for solutions. Prepaid plans have appeal for Medicare because, in principle, they are designed to contain health care costs and limit the excess utilization encouraged by fee-for-service reimbursement. No payment method is perfect, however: the method of paying providers a fixed amount in advance creates an incentive for providers to skimp on services to increase profits at the expense of quality care.

Legislative Reforms Substantially Increase HCFA's Authority to Manage the Medicare Program

Two recent acts grant HCFA substantial authority and responsibility to reform Medicare. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides the opportunity to enhance Medicare's antifraud and abuse activities. The Balanced Budget Act of 1997 (BBA) introduces new health plan options and major payment reforms. These two acts address in large measure our concerns and those of the HHS IG regarding the tools needed to combat fraud and abuse.[17] They also address many of the weaknesses discussed in our High-Risk Series report on Medicare.[18] The effectiveness of these new antifraud and abuse tools provided by HIPAA and BBA, however, will depend on their being well designed and promptly implemented.

[17] See Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

[18] See High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

HIPAA created for the first time a stable source of funding for Medicare fraud control. For fiscal year 1997, the act provides for up to $440 million for program safeguard activities; funding will rise incrementally each year, reaching $720 million in fiscal year 2003, after which it will remain constant. This was a significant step in reversing the trend of declining program safeguard funds relative to program growth in the 8 years before fiscal year 1997, when HIPAA funding provisions became effective. This funding comes from a HIPAA-established fraud-and-abuse control account that also funds other activities involving other HHS agencies and the Department of Justice. HIPAA also provides HCFA with explicit authority to contract with firms outside its existing claims processing contractor network to perform payment safeguard functions, while avoiding conflicts of interest. In addition, HIPAA adds new civil and criminal penalties to previously little-used enforcement powers.

BBA dramatically expanded health plan choices for Medicare beneficiaries and reformed payment methods in traditional fee-for-service Medicare and managed care plans. Under the act's new Medicare+Choice program, beneficiaries will have new health plan options, including preferred provider organizations (PPO), provider sponsored organizations (PSO), and private fee-for-service plans. Medicare+Choice introduces new consumer information and protection provisions, including a requirement to distribute comparative information on Medicare+Choice plans in beneficiaries' communities and a requirement that all Medicare+Choice plans obtain external review from an independent quality assurance organization.[19] These provisions address problems we have worked with the Congress to correct and give HCFA newly mandated consumer protection and oversight responsibilities for a potentially larger number of plans.[20]

BBA also provided for revamping many of Medicare's decades-old payment systems to contain the unbridled growth in certain program components. Specifically, the act mandated prospective payment systems for services provided by about 1,100 inpatient rehabilitation facilities, 14,000 skilled nursing facilities, 5,000 hospital outpatient departments, and 8,900 home

[19]BBA authorized the Secretary of HHS, subject to appropriations, to collect $200 million in user fees to conduct information activities associated with Medicare+Choice. Subsequently, in the HHS appropriation, the Secretary was given authority to collect $95 million of the originally authorized amount for this purpose. HCFA was also appropriated between $20 million and $30 million for the administration of BBA-related activities.

[20]See Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996) and Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

health agencies. In addition, it changed the payment methods for hospitals, including payments for direct and indirect medical education costs. It also adjusted fee-schedule payments for physicians and durable medical equipment and authorized converting the remaining reasonable charge payment systems to fee schedules. Finally, the act granted the authority to conduct demonstrations on the cost-effectiveness of purchasing items and services through competitive bids from suppliers and providers.

Effective Management of Resources and HCFA Leadership Needed to Protect Integrity of Medicare Program

While legislative reforms are dramatically reshaping Medicare, other changes are occurring, increasing difficult management challenges.[21] For example, HCFA is rethinking its strategy to develop, modernize, or otherwise improve the agency's multiple automated claims processing and other information systems. HCFA is also confronting transition problems resulting from the recent loss of large-volume claims processing contractors and the need for remaining contractors to absorb the workload. Finally, HCFA recently restructured its organizational units to better focus on its mission and is experiencing the kind of disruptions common to organizational transitions.

Our recent work at HCFA interviewing senior and mid-level managers indicates that distribution of agency resources, need for specialized expertise, loss of institutional experience, and reorganization are serious management problems that could increase program vulnerability. In the case of agency resources, managers were concerned that the concentrated efforts to implement BBA and solve computer problems that could arise in the year 2000 could compromise the quality of other work or that tasks might be neglected altogether. For example, regional and headquarters officials who oversee claims processing contractors told us that their capacity to monitor contractors had severely diminished. One region that formerly had six staff members dedicated to contractor oversight now has two; the other staff, they said, had been reassigned to work on managed care issues. This concerns us because, in the past several years, we have reported that HCFA has not adequately ensured that contractors are paying only medically necessary claims.

Managers also expressed a common concern about the staff's mix and level of skills. As an illustration, the Medicare+Choice program introduces new health plan types and requires distributing information on the plans to beneficiaries in 1998. Called the Medicare+Choice Information Fair, this

[21]See Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85, Jan. 29, 1998).

nationwide educational and publicity campaign will be HCFA's first effort of this kind. Managers were concerned that inexperienced staff will need to gather information that describes and evaluates the merits of various plans.

Managers also cited the loss of experienced staff as a problem for developing and implementing the various prospective payment systems mandated by BBA. They noted that developing one new payment system would have been manageable, but losses of expert staff make it difficult to implement multiple new payment systems concurrently.[22]

In addition, managers noted the difficulties of simultaneously implementing recent legislative reforms, responding to critical information system problems, and carrying out a major agency reorganization. In July 1997, HCFA restructured its entire organization to, among other things, redirect additional resources to the growing managed care side of the program; acknowledge a shift from HCFA's traditional role as claims payer to its role as purchaser of health care services; and sharpen the focus on beneficiaries, health plans and providers, and state-level activities. Although generally favoring the reorganization in concept, managers described their difficulties in establishing new communication and coordination links within units and agencywide. They noted that the situation was particularly acute because people have not yet moved to their new units' actual locations.

HCFA managers appeared to be clear about top management's expectations for completing BBA-related activities and for making sure that contractors' claims processing systems would comply with the millennium changes. They were less certain, however, about the agency's strategy for meeting other mission-related work. One example of this uncertainty concerns the legislative mandates for reporting to the Congress on specific topics such as Medicare's reimbursement of telemedicine services. Currently, the agency's top managers do not compile a list of reports due and their deadlines. Unit managers are concerned because, although they know that certain reports they must produce will be late, they have no systematic way to keep top management informed. Top management, in turn, cannot decide whether to raise the priority for a particular report or develop a strategy to mitigate the consequences of others being late.

[22]See Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-HEHS-98-9, Oct. 9, 1997).

The illustration above and our discussions with agency officials suggest that although HCFA may be ready to assert its BBA-related resource needs, it is not likely to be able to adequately justify the resources it seeks to implement its other Medicare program objectives. In short, because senior managers do not appear to be adequately informed about the status of the range of Medicare activities or associated resource needs, HCFA's senior decisionmakers cannot determine whether resources are adequate or properly distributed and which activities could be at risk of neglect.

HCFA's Financial Statement Audits Continue to Have Problems

An additional area of Medicare vulnerability on which we have previously reported is HHS' difficulty in complying with the requirements of the Government Management Reform Act of 1994. The HHS IG could not express an opinion on HHS' fiscal year 1996 combined financial statements primarily because of (1) a lack of adequate supporting documentation for $18.3 billion in Medicare Accounts Payable, $2.7 billion in Medicare Accounts Receivable, $22.6 billion in Net Position balances, and $3.1 billion in Pension Liability and (2) difficulty in determining what, if any, adjustments needed to be made to the Medicare cost settlements reported in the fiscal year 1996 financial statements.

The fiscal year 1996 financial statement audit identified additional material internal control weaknesses. HCFA has no method for estimating the national error rate for improper Medicare fee-for-service payments, which the IG estimated at $23 billion for fiscal year 1996. HHS lacks important internal controls for grant management, including the abilities to accrue grant expenditures at year's end and to track the audits of grantees required by the Single Audit Act of 1984. Some operating divisions, including HCFA and NIH, have weaknesses in the general controls of their electronic data processing (EDP) systems. These EDP controls are critical to ensuring the reliability, confidentiality, and availability of HHS data and affect the integrity of transactions processed at HHS data processing facilities, including $206 billion in insurance claims and indemnities provided to more than 38 million Medicare beneficiaries in fiscal year 1996. In addition, the IG identified systemic weaknesses in controls for estimating and processing transactions that affect accounts payable and receivable.

Conclusions

Considering the magnitude of HHS' responsibilities, the size of its budget, and the extent to which the American people rely on HHS for essential services and support, we believe it is critical for the Department to focus

on achieving its many missions as effectively and efficiently as possible. Although HHS' commitment to carrying out its missions is clear, we and others continue to find many problems with HHS' programs. The Results Act now provides HHS with an excellent opportunity to direct its management toward producing its programs' intended results and to engage in regular self-assessment. Specifically, the Department needs to

- ensure coordination among its own agencies and with its public and private partners;
- develop the information systems it needs to manage its programs and report on their progress; and
- maintain the integrity of programs vulnerable to exploitation by remaining vigilant against fraud, waste, abuse, and mismanagement.

As you are aware, we worked with the Congress as it conducted its reviews of draft and final HHS strategic plans and have already committed to working with the Congress as it conducts its review of HHS' performance plan and other submissions under the Results Act. As we review HHS' performance plan, we will assess the degree to which the plan addresses the long-standing management challenges I have discussed today.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions that you or members of the Subcommittee may have.

Related GAO Products

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse (GAO/HEHS-98-59R, Dec. 3, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T-AIMD-97-176, Sept. 29, 1997).

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies (GAO/T-HEHS-97-180, July 28, 1997).

Child Protective Services: Complex Challenges Require New Strategies (GAO/HEHS-97-115, July 21, 1997).

Medicare: Problems Affecting HCFA's Ability to Set Appropriate Reimbursement Rates for Medical Equipment and Supplies (GAO/HEHS-97-157R, June 17, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/HEHS-97-133, May 19, 1997).

Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-86, May 16, 1997).

Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention (GAO/T-HEHS-97-89, Mar. 4, 1997).

Public Health: A Health Status Indicator for Targeting Federal Aid to States (GAO/HEHS-97-13, Nov. 13, 1996).

Child Support Enforcement: Reorienting Management Toward Achieving Better Program Results (GAO/HEHS/GGD-97-14, Oct. 25, 1996).

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