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MEDICARE HMO INSTITUTIONAL PAYMENTS

Improved HCFA Oversight, More Recent Cost Data Could Reduce Overpayments

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Permanent Subcommittee on Investigations
Committee on Governmental Affairs
United States Senate

The Congress has focused increasingly in recent years on rapidly growing Medicare expenditures. Between 1990 and 1997, Medicare spending grew from $107 billion to $207 billion, or about 12 percent per year. Although the bulk of program outlays is for services delivered through traditional fee-for-service Medicare, a growing number of seniors—approximately 5 million out of 38 million Medicare beneficiaries—receive care through health maintenance organizations (HMO) that participate in Medicare's risk contract program. Unlike fee-for-service providers, which are paid on a per-claim basis, these HMOs receive from Medicare a monthly fixed sum per enrolled beneficiary—a capitation rate—and assume the risk of providing beneficiary health care, regardless of the actual costs incurred.

Part of the process for setting capitation rates involves risk adjustment. The Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, adjusts the capitation rate for such factors as age and sex to reflect the expectation that different classes of beneficiaries are likely to incur higher or lower costs than the average beneficiary. For example, HCFA has determined that the estimated 2.6 million Medicare beneficiaries living in nursing homes and other long-term care facilities frequently incur greater-than-average Medicare-covered expenses. Consequently, the "institutional" risk adjuster generally raises capitation payments for the approximately 50,000 Medicare HMO enrollees residing in such facilities. The payments are intended to cover expected higher-than-average costs for Medicare-covered acute-care and post-acute-care services.

Concerned about the potential incentive for some HMOs to inappropriately classify beneficiaries as institutionalized and the possibility that flaws in the methodology for calculating the institutional rate are generating excessive payments, you asked us to examine (1) the criteria HCFA uses to determine a beneficiary's institutional status, (2) the methods HCFA employs to ensure that HMOs properly classify beneficiaries as

institutionalized, and (3) whether the higher capitation rate for beneficiaries who live in institutions is justified by higher health care costs.

To do this work, we visited selected facilities classified by HMOs as institutions; reviewed HCFA's relevant policy and procedure manuals at HCFA headquarters and the agency's reporting and verification procedures at two regional offices (San Francisco and Seattle) that cover high managed care penetration areas; and interviewed HCFA officials, industry groups, and Medicare HMO representatives. In addition, we reviewed previous research on the health cost estimates for institutional-status beneficiaries that HCFA used to set HMO rates. We also analyzed data from HCFA's Medicare Current Beneficiary Survey (MCBS) to examine cost differences for beneficiaries residing in different types of facilities. HCFA officials have reconciled the MCBS data with Medicare claims and other administrative information to produce data the agency believes to be generally accurate and complete. Given HCFA's intensive efforts, we did not independently verify the accuracy of the information in the MCBS data files. Our work was performed from January 1997 to April 1998 in accordance with generally accepted government auditing standards.

Results in Brief

Until recently, HCFA's broad definition of "institution" allowed HMOs to claim institutional status for individuals residing in facilities not likely to house sicker-than-average seniors. Some of the facilities we visited that HMOs had classified as institutional residences provided no medical care but rather offered a menu of recreational activities for seniors capable of living independently. HCFA acted on our findings and those of others by narrowing the definition of eligible institutions, effective January 1, 1998.

Even with more stringent criteria, however, HCFA relies on the HMOs to determine which beneficiaries qualify for institutional status. HCFA conducts only limited reviews, approximately every 2 years, to confirm the accuracy of HMO records. Studies by the Department of Health and Human Services (HHS) Inspector General reviewing the accuracy of HMO institutional status data support our finding that HCFA's reviews are not adequate to detect the extent of errors or overpayments resulting from HMOs' misclassification of beneficiaries. The task of ensuring accurate data may be further complicated by HCFA's policy that allows HMOs 3 years to retroactively change institutional status data in beneficiary records. The lack of a systematic approach for identifying errors limits HCFA's efforts to recover overpayments and ensure that appropriate payments are made to

HMOs. Moreover, HCFA generally waits 2 years to verify that HMOs have corrected inaccurate record-keeping systems, even when serious errors have been identified.

Finally, HCFA continues to use 20-year-old cost data in determining the payment rates for institutionalized enrollees. As a result, HCFA overcompensates HMOs for their enrolled, institutionalized beneficiaries. HCFA's own analysis confirms that updating the institutional risk factor with more recent cost data, which are available, would result in substantially lower payments for aged institutionalized enrollees. For example, an HMO would receive a little more than half the current payment rate for a 74-year-old male Medicare beneficiary classified as residing in an institution if the institutional risk factors were updated. This overpayment problem may be corrected when HCFA implements a revised set of risk factors in 2000. However, provisions of the Balanced Budget Act of 1997 (BBA)[1] that use 1997 rates as the basis for 1998 and future rates effectively preclude a revision to the institutional risk factor at this time.

While HCFA has revised its definition of eligible institutions, concerns remain that HCFA's oversight of payments for institutional status is inadequate. HCFA has no system to estimate and recover total overpayments when institutional status errors are detected or to verify HMOs' retroactive adjustment requests. Further, HCFA does not ensure timely review of those HMOs found to have submitted inaccurate institutional status data, and its use of outdated cost data in determining payments continues to overcompensate HMOs for institutionalized enrollees.

Background

Medicare provides health insurance for nearly all elderly Americans (those aged 65 and older) and certain of the nation's disabled. Most Medicare beneficiaries receive services through the fee-for-service sector. However, as of April 1998, roughly 15 percent of Medicare's beneficiaries—up from about 7 percent in mid-1995—were enrolled in risk contract HMOs.[2] Of these, about 50,000 beneficiaries are classified as institutionalized each month.[3]

[1]Sec. 4001 of P.L. 105-33 added sec. 1853 (42 U.S.C. 1395w-23) to the Social Security Act.

[2]Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this report.

[3]A beneficiary's institutional status can change on a monthly basis.

HCFA, an agency within HHS, administers the Medicare program and is responsible for ensuring that Medicare HMOs comply with data reporting, beneficiary protection, and care delivery requirements. HCFA seeks to ensure that HMOs meet financial solvency and enrollment requirements, do not earn excessive profits,[4] operate internal quality assurance systems, and establish grievance and appeals procedures. HCFA also implements the capitation rate formula authorized by legislation and calculates payments for each HMO. Further, HCFA is responsible for monitoring HMOs to ensure that all Medicare requirements are met, including that HMOs' reports of beneficiaries' institutional status are accurate. HCFA is also responsible for ensuring that corrective actions are taken if overpayments, underpayments, or other errors are discovered. HCFA established a national policy in 1994 permitting HMOs to seek retroactive payment adjustments—for either overpayments or underpayments—for the prior 3-year period.[5]

Size and Distribution of Medicare HMO Population With Institutional Status

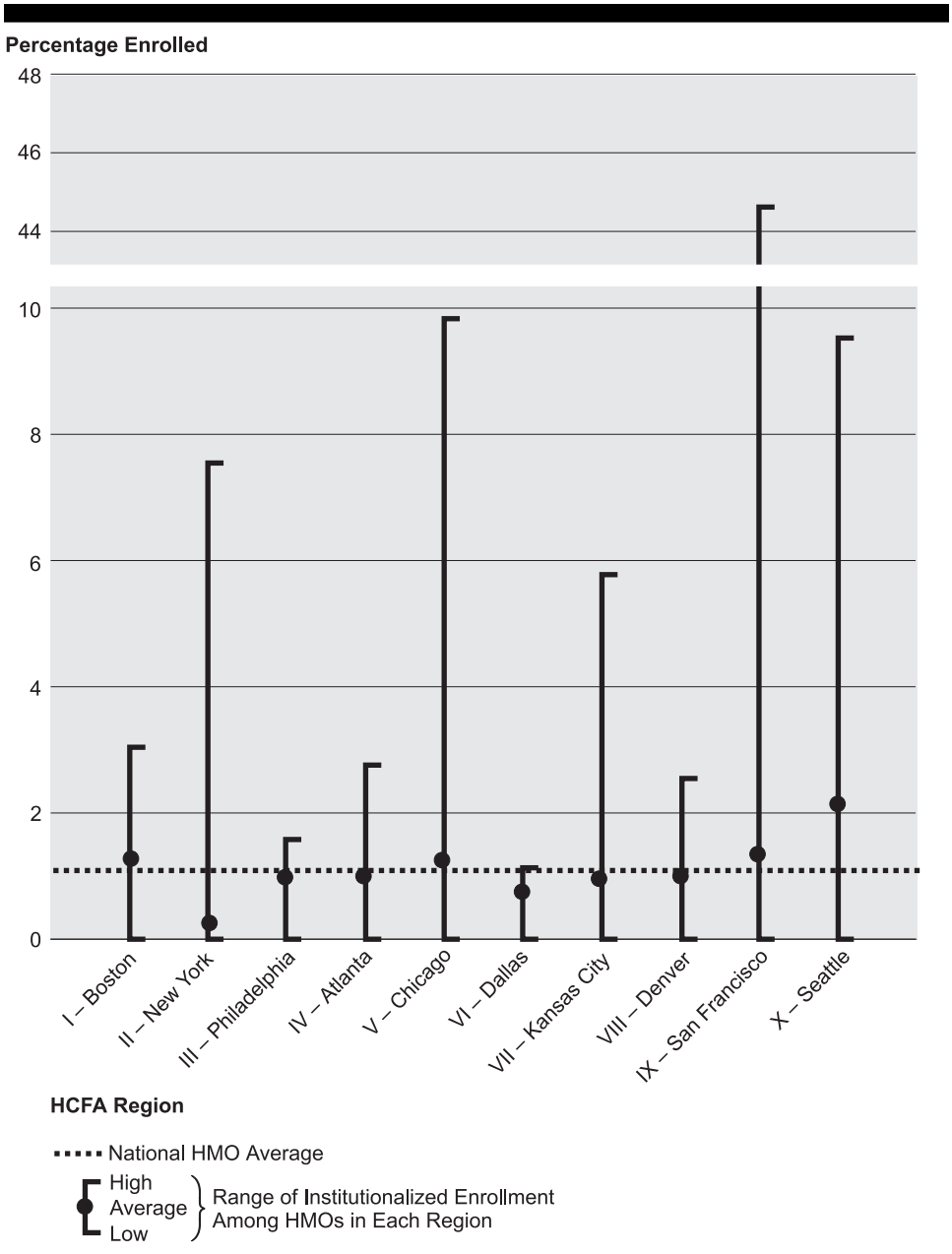
About 1 percent of Medicare's roughly 5 million HMO enrollees are classified as living in institutions, as compared with about 7 percent of beneficiaries covered under Medicare fee-for-service. In 1997, Medicare paid $197 million more to HMOs because of their enrollees' institutional status.

The distribution of enrollees with institutional status varies among HMOs and among geographic regions. In December 1997, most institutional enrollment rates for individual HMOs ranged from 0 to about 10 percent, although one outlier exceeded 44 percent. (See fig. 1.)

[4]HMOs are permitted to retain all profits up to the level earned on non-Medicare business.

[5]Technically, every institutional rate adjustment is retroactive because it applies to the month preceding the month in which the adjustment is being reported. (The regional staff we contacted considered the months prior to the "current" adjustment month as a retroactive period.)

Figure 1: Percentage of Institutional Medicare Beneficiaries Enrolled in HMOs, December 1997



Notes: Institutional beneficiaries are those who reside in an eligible institution for at least 30 consecutive days.

The range of institutional enrollment excludes HMOs participating in certain demonstrations that, for payment purposes, classify all HMO members as institutionalized.

Source: GAO analysis of HCFA data.

The Role of the Institutional Risk Factor in Setting HMO Rates

Medicare's risk contract program was designed to save Medicare money by paying HMOs 95 percent of the amount Medicare estimated it would spend on similar beneficiaries in the fee-for-service sector. It was believed that HMOs would have lower costs because of their greater emphasis on preventive health services and their incentive to eliminate unnecessary services. The base capitation rate in each county—the amount an HMO receives each month for enrolling an average-cost beneficiary—is determined by law, largely on the basis of Medicare's per capita fee-for-service spending.[6]

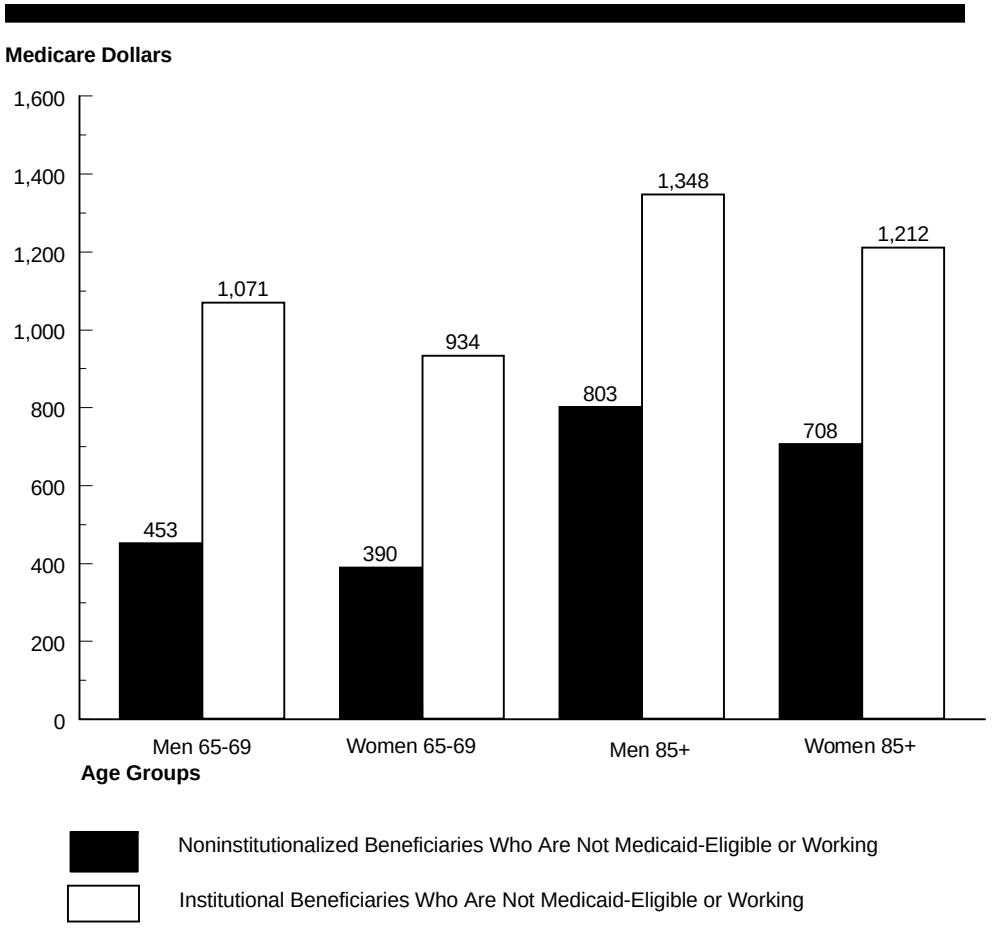
An HMO's monthly capitation payment is adjusted for the expected care costs of each individual enrolled. To make the adjustment, HCFA assigns weights to defined risk classes of beneficiaries on the basis of age; sex; and disability, Medicaid, institutional, and employment status. The weights are expressed as ratios of the national average per capita costs for each risk class relative to the overall national average. For example, in 1997, compared with the national average weight set at 1.0, the weight assigned to the risk class for men aged 85 or older with institutional status was 2.25. Thus, HCFA's estimate was that institutionalized men aged 85 and older would have health care costs that were 2.25 times the costs for the average beneficiary. HCFA adjusts capitation rates for most institutionalized beneficiaries upward to reflect the expected differential.[7]

The additional monthly payment amount associated with institutional status can be substantial. For example, in 1998 a Los Angeles HMO receives $618 more per month for a 65-year-old man living in an institution than for one who is not living in an institution ($1,071 instead of $453). (See fig. 2 for a comparison of monthly HMO payments in Los Angeles for institutional and noninstitutional enrollees.)

[6]Medicare determines four capitation rates for each county: two rates for part A services (one for the aged and one for the disabled) and two rates for part B services (one for the aged and one for the disabled). Under the Medicare program, part A covers primarily inpatient services; part B covers physician and other services. Capitation payment provisions of the BBA, which established minimum payment amounts, minimum updates, and blended local and national rates, loosened but did not eliminate the link between local fee-for-service spending and local capitation rates.

[7]For all aged beneficiaries and most disabled beneficiaries, institutional status raises the capitation rate paid to HMOs. For a few age groups of disabled beneficiaries, institutional status can reduce HMO payments, however. In these cases, therefore, HMOs have no financial incentive to report institutional status.

Figure 2: Comparison of Monthly HMO Payments in Los Angeles for Aged Institutional and Noninstitutional Enrollees, for Selected Age Groups, 1998



Source: GAO analysis of HCFA's 1998 capitation rates.

In 2000, HCFA is required by the BBA to implement a new risk adjustment methodology that uses direct indicators of health status—in addition to any other demographic adjusters such as age and sex—to better reflect differences in individuals' expected health care costs.

Broad Criteria Have Allowed HMOs to Claim Higher Payment Rates for Certain Seniors

Until recently, HCFA has defined the term "institution" to include skilled nursing facilities, nursing homes, sanitoriums, rest homes, convalescent homes, long-term care hospitals, domiciliary homes, swing-bed facilities,[8] and intermediate-care facilities.[9] HCFA based the higher payment rates for institutional status on historical evidence that beneficiaries living in these types of facilities had greater medical needs and higher medical costs than those who lived in the community. These types of facilities, however, have evolved to serve individuals with varied health care needs. Thus, HCFA's broad criteria permitted an HMO to classify virtually any residential facility as an institution for payment purposes. Consequently, HMOs considered as institutions many facilities that were housing seniors whose expected health needs were at or below those of the average Medicare beneficiary.

HMOs have had an incentive to broadly interpret HCFA's institution criteria. For example, if an HMO classified a residential facility as an institution, the HMO would receive a much higher capitation payment—up to $766 more per month—for every enrollee living in that facility. In fact, the increased institutional payments to one relatively small HMO amounted to about an additional $135,000 for 1 month. For HMOs with larger institutionalized enrollment, the annual additional capitation payments could be on the order of $4 million to $9 million.

Medicare's payment system is based on the assumption that HMO enrollees living in institutions generate above-average health care costs. However, some facilities classified by HMOs as institutions clearly did not serve seniors with serious health problems. For example, among the designated institutions we visited, one (called by its manager an "independent living facility") provided private apartments, meals in a communal setting, and field trips to tourist and shopping sites. About 12 percent of the residents owned and drove their own cars. The facility did not provide any medical care. Another facility we visited—a retirement center—was characterized by its marketing brochure as "a clean, comfortable home for those who do not need nursing care." This facility employed a full-time activity director and housed several residents who drove their own cars.

Moreover, HCFA's institutional payment policy is unclear when a single facility offers a range of assistance levels—from independent living arrangements to skilled nursing care. For example, one residential

[8]Swing-bed facilities are hospitals that are permitted to provide skilled nursing services to Medicare beneficiaries occupying acute-care beds.

[9]To be eligible for the institutional rate during a particular month, the beneficiary must have been a resident for the 30 consecutive days immediately preceding the last day of the month.

community we visited consisted of two facilities: one, a skilled nursing care facility, provided subacute, skilled, and custodial care; the other, an independent living facility, provided limited assistance, such as helping individuals get to the communal dining room. An HMO planned to classify the entire residential community as an institution. However, the residential community's manager disagreed that the independent living facility constituted an institution. Although the HMO ultimately chose not to classify those beneficiaries living in the independent facility as institutionalized, no HCFA policy would have prevented such classification. Facilities of this nature pose continued challenges in appropriately determining which beneficiaries should be classified as institutionalized for payment purposes.

Even though some regional HCFA officials felt that some facilities should not have been classified as institutions, these officials believed they had little basis for challenging any classification. In a 1995 memorandum to HCFA headquarters, for example, the director of a HCFA region's managed care operations noted that "the manual provides no guidance regarding the level of care provided to residents [needed to qualify for institutional status]" and that "HCFA has the obligation to provide better guidance to plans regarding the types of facilities which may be designated as 'institutions.'"

On July 24, 1997, HCFA issued a policy letter that narrowed the definition of eligible institutions effective January 1, 1998. The letter cited a history of interpretation problems in using the broader definition as well as the concerns we, the HHS Inspector General, and the agency itself have raised about the potential for making improper payments to HMOs. Under the new definition, only specified Medicare- or Medicaid-certified institutions are included, thus limiting eligibility to institutions qualifying under the Social Security Act, such as skilled nursing and nursing facilities; intermediate care facilities for the mentally retarded; and psychiatric, rehabilitation, long-term care, and swing-bed hospitals. Tying eligibility to certain Medicare- and Medicaid-certified institutions effectively rules out eligibility for independent or low-level assisted living facilities.

In principle, this change could significantly improve HCFA's ability to ensure that the higher capitation rate is being paid on behalf of only those beneficiaries likely to have higher health care needs and costs. However, in practice, the collocation of independent living arrangements with eligible institutions and HCFA's infrequent and narrow review of HMO

records, as discussed in the next section, may limit the practical impact of HCFA's new policy.

HCFA Oversight Is Inadequate to Prevent and Recover Inappropriate HMO Payments

The process HCFA uses to verify that HMOs appropriately claim the institutional payment rate is inadequate. HCFA relies on the HMOs themselves to identify and report the names of beneficiaries for whom the HMOs should receive the institutional rate. Using these mostly unaudited, HMO-reported data, HCFA adjusts the capitation payments for the HMOs' Medicare members who live in institutions.

HCFA does not conduct either comprehensive or spot checks at the institutional facilities to assess the accuracy of the institutional status data reported by HMOs. Instead, HCFA regional staff make site visits to each HMO about every 2 years and examine a small sample of beneficiary records maintained by the HMO. Results of previous HHS Inspector General audits and our work show that the lack of effective oversight fails to hold HMOs accountable for submitting accurate records and thus does not ensure that HMOs receive appropriate payments.

HCFA Relies on Error-Prone Data to Determine Whether to Increase HMO Payment

HCFA bases its institutional rate adjustments solely on HMO-reported data. Each HMO is responsible for establishing a system to identify and report its institutionalized beneficiaries to receive the pay adjustment from HCFA. The reporting process works roughly as follows: Each month, the HMO identifies those members who have resided in eligible facilities for 30 consecutive days prior to the reporting month and sends HCFA a list of beneficiaries qualifying for institutional status.[10] Using the HMO's information, HCFA then develops and sends to the HMO its monthly report of the HMO's qualifying beneficiaries (the HMO is responsible for informing HCFA of any further changes in beneficiary status). On the basis of the final, HMO-corrected report, HCFA adjusts—generally substantially increasing—the HMO's capitation payment for each institutionalized beneficiary.

HCFA regional staff and HMO staff concur that, for a variety of reasons, HMO data on institutionalized beneficiaries can be inaccurate. The financial incentive for HMOs to classify beneficiaries as institutionalized is one possible explanation for inaccurate data. Other explanations include

[10]The list of institutional beneficiaries becomes part of a larger report sent to HCFA that includes other demographic information about the HMO's Medicare enrollees.

financial incentives for physicians to misclassify beneficiaries, inaccurate data reported by institutions, and data entry errors by HMOs.

Some HMOs may have difficulty ensuring accurate data because their providers financially benefit if enrollees are classified as living in institutions. For example, the primary care providers in the Minnesota-based HMO cited in a 1995 HHS Inspector General's report[11] received from 85 to 90 percent of Medicare's per capita payment, while the HMO kept the remainder. The HMO required these providers to notify it when their Medicare patients entered or left an institutional setting or otherwise changed their status. However, the Inspector General found that the providers failed to do so and did not correct HMO reports sent to them for reconciliation purposes. As a consequence, the HMO substantially overreported the number of enrollees living in institutions.

HMO staff also reported difficulty obtaining accurate information on beneficiaries' current residence in particular facilities. HMO staff who were responsible for verifying enrollees' institutional status said they typically contacted facilities by phone or mail monthly to determine which enrollees resided in those facilities. However, facilities housing an HMO's Medicare enrollees do not necessarily have a contractual or financial relationship with the HMO. Consequently, these facilities have no compelling reason to comply with an HMO's information requests. HMO staff reported instances of not learning of changes in beneficiaries' institutional status, even when the HMOs had requested verification and received regular responses from facility personnel.

Data entry errors are a third possible reason for inaccurate data. The 1995 Inspector General's report attributed some instances of institutional status misclassification and Medicare overpayments to the HMO's own data entry errors.

HCFA Allows HMOs a 3-Year Period to Adjust Payments for Institutional Enrollees

Verifying HMOs' historical institutional status data is even more difficult than ensuring the accuracy of current data. The period of time being scrutinized is longer, and HCFA's policy of allowing HMOs 3 years to correct institutional status data and adjust payments accordingly compounds the problem. For example, after a 1992 monitoring review of an HMO, HCFA required the HMO to correct problems in its procedures for verifying its Medicare enrollees' institutional status and to conduct an audit of its own

[11]See HHS, Office of Inspector General, Review of Medicare Payments for Institutionalized Beneficiaries (A-05-94-00053) (Washington, D.C.: HHS, May 1995).

institutional status records. As a result of the audit, the HMO reported nearly $5 million in overbillings and more than $4.5 million in underbillings to Medicare during a 2-1/2-year period. HCFA accepted the results of the HMO's self-audit and the HMO's request to repay Medicare the difference between the two amounts (approximately $500,000). The accuracy of the HMO's audit results was found to be questionable, however, when, according to one HCFA official we interviewed, the HMO later attempted to reverify its audit findings and was unable to do so because facilities had changed the information they had originally reported to the HMO.

Concerned about potential errors in HMOs' historical institutional status data, three of the four HCFA regional offices we contacted for this study do not permit, or permit only by exception, retroactive reimbursements. Officials in HCFA's central office said that the regional offices should be following the national policy, which allows corrections in institutional status, and related reimbursements, for up to 3 years. They also said, however, that they are aware that regional offices are not doing so. These officials said that, because of the frequent changes in HMOs' historical institutional status data, following the national policy would require substantial additional regional work to validate and update the necessary corrections to HCFA's payment system.

HCFA's Oversight Fails to Ensure Accurate Payments

Our review and the Inspector General audits underscore the need for HCFA to improve its oversight of the HMO data used in determining Medicare payments to HMOs. HMOs' records are normally checked by HCFA only during routine monitoring visits, which occur about every 2 years. During a monitoring visit, HCFA staff focus primarily on whether the HMO has a data verification system in place. That is, they review the HMO's policies and procedures for both updating the HCFA report on institutionalized beneficiaries and contacting facilities to verify residence and length-of-stay information. HCFA regional staff also contact a few facilities to confirm the residence and length of stay of some beneficiaries. Specifically, HCFA protocol requires regional staff to verify the status of 30 enrollees living in at least three different institutions and to contact three of the institutions.

HCFA's verification practices may be too superficial to determine whether HMOs accurately report beneficiaries' institutional status. For example, after HCFA reviewed one Minnesota-based HMO's institutional reporting procedures and records and found no problems, an Inspector General audit of the same HMO revealed significant errors. The Inspector General examined the records of 100 enrollees randomly selected from the 1,941

Medicare beneficiaries the HMO listed as living in an institution during April 1994.[12] By checking the HMO's records against those of the institutions, the Inspector General determined that 15 of the 100 beneficiaries did not reside in the listed institution. The Inspector General also checked historical records and found that some of the 15 misclassified beneficiaries had never lived in an institution while enrolled in the HMO. In some cases, the HMO had misclassified the beneficiaries and collected the institutional payment rate for over 5 years. Total overpayments for the 15 misclassified beneficiaries amounted to $93,252.

In 1993, the Inspector General cited two Massachusetts-based HMOs for receiving enhanced payments on the basis of HMO data that inaccurately classified beneficiaries as institutionalized.[13] Moreover, the HMOs' internal reporting systems did not accurately reflect the discharge dates of some institutionalized beneficiaries. The Inspector General identified overpayments of about $215,000 for the two HMOs over roughly a 2-year period ending June 30, 1993.[14]

When HCFA staff identify faulty HMO data on institutional beneficiaries, the agency frequently does little to determine the full extent of the errors or the total overpayments generated by the faulty data. HCFA generally requires only that the HMO develop a corrective action plan describing how the HMO intends to generate better data. In some cases, HCFA also requires HMOs to self-audit their prior institutional reporting.

After HCFA identifies HMO data errors, mandates corrective actions, and approves a corrective action plan, it often waits 2 years or more before verifying HMO compliance. Once HCFA has approved an action plan to correct an identified problem, the agency typically does not check to determine whether the HMO has implemented the plan until HCFA staff conduct the next routine monitoring review. Sometimes this monitoring review is delayed beyond the routine 2-year schedule, even when a serious reporting problem was found to have existed earlier. Such was the case for the Minnesota-based HMO cited in a previous example. HCFA did not review the HMO's institutional records until the fall of 1997, over 2 years after the Inspector General reported the HMO's inaccurate record-keeping and

[12]See HHS, Review of Medicare Payments for Institutionalized Beneficiaries, May 1995.

[13]See HHS, Office of the Inspector General, Premium Payments for Medicare Beneficiaries Enrolled in Risk-Based Health Maintenance Organizations, (A-01-93-00500) (Washington, D.C.: Dec. 1993).

[14]The Inspector General also identified approximately $115,000 in premium payments made on behalf of Medicare beneficiaries who were deceased. In some cases, the beneficiaries had been deceased for over 2 years.

resulting overpayments, even though the HMO continued to maintain a rate of institutionalized enrollment that was five times the national average.

The Inspector General is completing a study designed to determine the extent of institutional status misreporting and to project total national overpayments. The Inspector General is reviewing the institutional records at eight HMOs to determine whether beneficiaries resided in the facilities listed in the HMOs' records for the dates indicated. If data errors are found, the Inspector General intends to project and recoup overpayments from these specific HMOs and also use the projections to estimate national overpayments. Preliminary results indicate data problems at five of the eight HMOs. Because the Inspector General's study does not attempt to determine whether the listed facilities fit HCFA's criteria for an eligible institution, the study's overpayment estimate may understate the full extent of the problem.

HCFA Lacks a Systematic Approach to Recovering Overpayments

HCFA's procedures do not ensure that Medicare overpayments are recovered when HMO data reporting errors are found. In such cases, HCFA requires HMOs to improve data reporting in the future, but often the agency makes no attempt to estimate and recover overpayments resulting from the faulty data. HCFA sometimes, but not always, requires HMOs to perform self-audits and bases payment adjustments on the results. However, beyond the limited number of beneficiary records reviewed during routine monitoring visits, HCFA does not attempt to verify HMO data or the results of HMOs' self-audits.

A random sample of records of beneficiaries listed as living in institutions can be useful in projecting and recovering total Medicare overpayments. For example, in the case of the Minnesota-based HMO discussed earlier, the Inspector General found that the status of 15 out of 100 randomly selected beneficiaries classified by the HMO as living in institutions had been misreported. The overpayments associated with the 15 beneficiaries amounted to $93,252. On the basis of the random sample, the Inspector General projected that the HMO had inappropriately received at least $861,000, and perhaps as much as $2.8 million, from January 1989 through September 1994 for all enrollees misclassified as living in institutions. The Inspector General's findings enabled HCFA to recoup about $861,000 from the HMO.[15]

[15]The Inspector General estimated that the HMO had been overpaid by $1,810,021 during the 5-year period. However, every statistical projection has an associated "confidence interval." In this case, the Inspector General determined that the overpayments ranged somewhere between $861,615 and $2,758,428. HCFA adopted a conservative approach and required the HMO to repay the lower amount.

HCFA Data Show Medicare Overpaying for Institutionalized Beneficiaries

HCFA's most recent data show that the current institutional risk adjuster substantially overcompensates HMOs for the institutionalized beneficiaries they serve. As a result, in July 1997, HCFA proposed new weights for the institutional risk adjuster to more accurately reflect the health care costs of institutional beneficiaries. However, in September of 1997, HCFA halted implementation of the new weights, announcing that provisions of the recently passed BBA precluded the agency from modifying any of the risk factors' weights at that time. Nonetheless, HCFA's new criteria for eligible institutions—which exclude facilities housing beneficiaries with relatively low expected health care costs—should help reduce overpayments to HMOs serving institutional beneficiaries.

New Data Would Substantially Lower Capitation Payments for Institutionalized Beneficiaries

In the course of our review, HCFA developed new cost estimates for institutionalized beneficiaries that were based on the 1993 MCBS data. The expected health care costs for institutionalized beneficiaries, based on the 1993 MCBS, were much lower than those estimated from the 1974-76 survey data, which are currently used to set the risk factor for institutional beneficiaries. Using the new cost data, HCFA calculated lower adjustments to the capitation payments for aged institutionalized beneficiaries.[16] For example, a Medicare HMO that enrolls a 74-year-old male beneficiary living in an institution in Los Angeles receives a monthly payment of about $1,307 in 1998. If HCFA had implemented its revised rates, the HMO would be receiving about $761 per month[17]—an amount that more accurately reflects the expected costs associated with institutionalized beneficiaries. Table 1 shows that the Medicare part A component of the monthly capitation payments would have fallen by as much as 24 percent for beneficiaries aged 85 and older and by as much as 62 percent for beneficiaries aged 65 to 84. The decrease in the part B component would have been somewhat less.

[16]Because risk factors represent relative weights, a change in any one risk factor must be offset by changes in others. In this instance, the dramatic drop in the institutional risk factor for the small number of institutional beneficiaries would have been accompanied by a very small increase in the risk factors for the more numerous noninstitutional beneficiaries. While overall Medicare payments, theoretically, might not have been affected, payments to individual HMOs could have changed substantially.

[17]This estimate is based on the 1998 county rate for Los Angeles, which would be somewhat different had HCFA adopted new weights for the risk adjustment factors.

Table 1: Comparison of Current Weights and Weights HCFA Calculated Using More Recent Cost Data for the Institutionalized Aged

Age	Existing weights	Proposed weights	Percentage change from existing to proposed payment rate
Medicare part A—male			
65 - 69	1.75	0.80	–54
70 - 74	2.25	1.05	–53
75 - 79	2.25	1.40	–38
80 - 84	2.25	1.75	–22
85 +	2.25	2.15	–4
Medicare part A—female			
65 - 69	1.45	0.55	–62
70 - 74	1.80	0.75	–58
75 - 79	2.10	1.05	–50
80 - 84	2.10	1.30	–38
85 +	2.10	1.60	–24
Medicare part B—male			
65 - 69	1.60	1.10	–31
70 - 74	1.80	1.40	–22
75 - 79	1.95	1.65	–15
80 - 84	1.95	1.80	–8
85 +	1.95	1.85	–5
Medicare part B—female			
65 - 69	1.50	1.05	–30
70 - 74	1.65	1.30	–21
75 - 79	1.65	1.45	–12
80 - 84	1.65	1.60	–3
85 +	1.65	1.65	0

Source: HCFA.

Although HCFA announced plans in July 1997 to recalculate the weights of the current demographic risk factors, including the institutional risk adjuster, it halted this effort after the enactment of the BBA in August 1997. HCFA reverted to the old factors for the 1998 rate calculations because the BBA specified a new methodology for setting the basic capitation rate in each county that explicitly used the established 1997 county rates as a base. HCFA officials stated that the new weights could only have been

applied to capitation payment calculations if the weights had also been used in the calculation of the county rates.

Variation in Expected Costs for Institutional Beneficiaries Provides Opportunities for Overpayment

Although HCFA uses the institutional risk adjuster to take into account the expected higher costs of health care for institutionalized beneficiaries, research on the risk adjuster indicates that institutional residence is actually only weakly related to a beneficiary's expected health care costs. In a 1977 report, HCFA staff suggested that the average medical expenditures for institutionalized beneficiaries could vary widely by type of facility "to the extent that legal requirements and administrative policies of institutions differentiate among the characteristics of their residence." Our own analysis of the 1992-94 MCBS, the most recent data available at the time of our analysis, found substantial differences in Medicare costs among beneficiaries living in institutions. The average annual Medicare cost for beneficiaries in nursing homes—at about $8,000, for example—was more than $3,700 higher than the average annual cost for beneficiaries in assisted living facilities.

HMOs could benefit financially if they were able to draw their institutional populations disproportionately from those types of institutions whose average beneficiary costs were lower than those of other institutions. HCFA's new definition of eligible institutions includes certified nursing facilities but generally excludes assisted living facilities. This narrower definition could potentially improve the accuracy of HMO payments for the beneficiaries they serve by limiting the potential variation in average expected health care costs among different types of institutions.

Conclusions

Recent data clearly show that HMOs can be overcompensated for the institutional beneficiaries they enroll. Although provisions of the BBA prevent HCFA from eliminating these excess payments at this time, HCFA will have an opportunity to fully address this problem when it develops a new set of risk adjusters, mandated by the BBA, to be implemented in 2000.

By tightening the definition of what constitutes an institution, HCFA has taken a step toward improving the accuracy of HMO payments. For example, HMOs should no longer receive enhanced capitation payments for serving beneficiaries in independent living facilities. Nonetheless, given HCFA's HMO monitoring practices, it is doubtful that the agency can quickly or effectively determine the extent to which HMOs are complying with the new definition.

Moreover, the Medicare program remains open to potential abuse by HMOs because HCFA performs only infrequent and limited checks of HMO-reported data. HCFA's use of unaudited HMO data to determine payments to HMOs engenders little confidence in the accuracy of the data and resulting payments. HCFA also lacks a systematic approach for identifying and recovering total overpayments once HMO reporting errors are discovered. Instead, HCFA typically requires HMOs only to develop corrective plans to gather and report more accurate data in the future. Even when serious HMO reporting errors—resulting in substantial overpayments—have been discovered, HCFA may wait 2 years or more before checking to see if the HMO has implemented a revised data gathering and reporting system.

Recommendations to the Administrator of the Health Care Financing Administration

To better protect the integrity of Medicare capitation payments, we recommend that the HCFA Administrator take the following actions:

- Establish a system to estimate and recover total overpayments when institutional status data errors are detected.
- Allow HMOs to revise records and claim retroactive payment adjustments for beneficiaries with institutional status only when HMO records have been verified by an independent third party.
- Conduct timely follow-up reviews of those HMOs found to have submitted inaccurate institutional status data.
- Use more recent cost data to calculate the institutional risk adjuster in the event HCFA continues to include institutional status as a part of its new risk adjustment methodology.

Agency Comments

HCFA agreed with our recommendations to improve the integrity of capitation payments for institutionalized beneficiaries. HCFA noted several initiatives it is considering to improve oversight and rate-setting methods. We believe that these initiatives are a step in the right direction but that HCFA must remain committed to implementing the new methodologies. The full text of HCFA's comments appears in appendix I.

As arranged with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services; the Director, Office of Management and Budget; the Administrator of the Health Care Financing Administration; and other

interested parties. We will also make copies available to others upon request.

This work was done under the direction of James Cosgrove, Assistant Director. If you or your staff have any questions about this report, please contact Mr. Cosgrove at (202) 512-7029 or me at (202) 512-7114. Other GAO contacts and staff acknowledgments are listed in appendix II.

William J. Scanlon
Director, Health Financing
and Systems Issues

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUN 30 1998

TO: William J. Scanlon
Director, Health Financing and Systems Issues
General Accounting Office

FROM: Nancy-Ann Min DeParle NMD
Administrator
Health Care Financing Administration

SUBJECT: GAO Draft Report, "Medicare HMOs: HCFA Institutional Criteria, Rates, and Weak Oversight Can Result in Excess Payments"

We appreciate the opportunity to review your draft report to Congress concerning the institutional criteria, rates, and oversight of Medicare health maintenance organizations. Our comments are attached. Should you have any questions or require additional information, please contact Rita Reinsel of the Office of Financial Management at (410) 786-7444.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report, "Medicare HMOs: HCFA Institutional Criteria, Rates, and Weak Oversight Can Result in Excess Payments"GAO/HEHS-98-153

GAO Recommendation

We recommend that, to better protect the integrity of Medicare capitation payments, the Secretary of HHS direct the HCFA Administrator take the following actions:

-- Establish a system to estimate and recover total overpayments when institutional status data errors are detected.

HCFA Comment

We agree that a system needs to be developed to recover total overpayments when errors in institutional rates are detected. We plan to develop and implement new monitoring methodologies to address all types of special status categories of enrollment which could result in capitation vulnerability, e.g., working aged, Medicaid status, and institutional status.

GAO Recommendation

-- Allow HMOs to revise records and claim retroactive payment adjustments for beneficiaries with institutional status only when HMO records have been verified by an independent third party.

HCFA Comment

We agree that a methodology for verifying institutional status needs to be developed. We are currently working on a proposal to seek contractors to assist in the development of a methodology for collecting and verifying all categories of enrollments which could result in increased capitation vulnerability.

GAO Recommendation

-- Conduct timely follow-up reviews of those HMOs found to have submitted inaccurate institutional status data.

HCFA Comment

We agree with this recommendation and it will be part of the new methodology for monitoring enrollment data.

GAO Recommendation

-- Utilize more recent cost data to calculate the institutional risk adjuster in the event HCFA continues to use institutional status as a part of its new risk adjustment methodology.

HCFA Comment

We agree. When health status risk adjusters are implemented in year 2000 (per the Balanced Budget Act of 1997), both the underlying methodology and the data used to calculate institutional adjustments will be updated.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Marie Cushing James, Co-Project Manager, (202) 512-3597
Bonnie Hall, Co-Project Manager

Staff Acknowledgments

The following team members also made important contributions to this report: Hannah F. Fein, Senior Evaluator; Robert DeRoy, Assistant Director; and George Bogart, Senior Attorney.

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