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MEDICARE

Progress to Date in Implementing Certain Major Balanced Budget Act Reforms

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Medicare: Progress to Date in Implementing Certain Major Balanced Budget Act Reforms

Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the implementation and impact of the Medicare provisions in the Balanced Budget Act of 1997 (BBA). The BBA contains the most significant changes to Medicare since its inception more than 30 years ago. The act's combination of constraints on provider fees, increases in beneficiary payments, and structural reforms is expected to lower program spending by $386 billion over the next 10 years. The importance of these changes cannot be overemphasized given the immediacy of Medicare's financial crisis and upcoming demographic changes. The most fundamental BBA reform was the creation of the Medicare+Choice program, designed to modernize Medicare by offering beneficiaries a wider array of health plan choices comparable to some of the options available in the private insurance market. The fee-for-service component of Medicare underwent considerable transformation as well. Most notably, this legislation continued the movement away from paying for services on the basis of providers' incurred costs and toward using prospective rates wherein the program sets payment levels in advance and has more control over its spending on services.

The ramifications of these fundamental changes—affecting beneficiaries, health care providers, and taxpayers—are substantial. Not surprisingly, some interest groups have expressed concerns about the impact of these changes and made calls to alter some provisions. In some cases, adjustments may be wise; in others, premature or imprudent. That is why it is critical that there be a thorough evaluation of these policies, singly and in their totality, to inform ongoing policy discussions.

My comments today will focus on the implementation of (1) the Medicare+Choice program, particularly the payment method and consumer information efforts, and (2) prospective payment systems for skilled nursing facilities (SNF) and home health agencies (HHA) in Medicare's traditional fee-for-service program. Our work in these areas illustrates the importance of the BBA reforms, the difficulties in implementing reforms, and the pressures to dampen their impact. My remarks are based on previously issued products as well as our ongoing work in these areas.

In brief, changes of the magnitude of those in the BBA require significant efforts to implement well and are subject to continual scrutiny. We recently reported that the efforts of the Health Care Financing Administration (HCFA) to put the BBA provisions in place have been

extensive and noteworthy, and the agency has made substantial progress in implementing the majority of the Medicare-related BBA mandates. At the same time, it has encountered obstacles. Intense pressure to resolve Year 2000 computer compliance issues has slowed HCFA's efforts. In addition, in undertaking certain major initiatives, the agency has had to cope with inadequate experience and insufficient information. Thus, achieving the objectives of the BBA will require HCFA to refine and build on its initial efforts.

Findings from our recent Medicare+Choice work focus on payments to health plans and HCFA's consumer information initiatives. Reforms of the payment methods for Medicare+Choice plans are under way. They will address the methodological flaws that have led to billions of dollars in excess payments and inappropriate payment disparities. To avoid sharp payment changes that could affect a plan's offerings and diminish the attractiveness of the Medicare+Choice program to beneficiaries, these changes are being phased in over several years. Nevertheless, the withdrawal of some managed care plans has raised questions about how to maintain desired access for beneficiaries while implementing needed changes to plan payments and participation requirements. HCFA has also initiated an information campaign to provide beneficiaries with new tools to make informed health plan choices and create stronger, quality-based competition. Some aspects of the campaign have only been piloted, and certain problems did develop; refining these efforts to make them more useful and effective for beneficiaries is now critical.

On Medicare's fee-for-service side, the BBA's mandate to replace cost-based reimbursement methods with prospective payment systems (PPS) constitutes another major program reform. The phase-in of the PPS for SNFS began on schedule on July 1, 1998. However, design flaws and the inadequacy of the underlying data used to establish the payment rates may compromise the system's ability to meet the twin objectives of slowing spending growth while promoting appropriate beneficiary care. Insufficient oversight could compound these shortcomings and further jeopardize potential cost savings. Improvements to the system design and better monitoring are feasible but may require assistance from the Congress. The interim payment system for HHAS, with the similar objective of controlling rapid expenditure growth for this benefit, is now in place. Implementation of the PPS for HHAS has been delayed until 2001 but remains a considerable challenge given the benefit's broad eligibility requirements. Concerns have been raised about the impact of the interim payment system as more than 1,400 HHAS have closed since October 1997.

However, because the number of agencies had been expanding dramatically, more than 9,000 HHAs still participate in Medicare—a larger number than did in October 1995. We have not found evidence that the interim payment system or the closures have significantly affected beneficiary access to home health care. However, our monitoring of potential access problems is continuing as more data on the effects of the interim system become available.

The BBA's significant transformations of Medicare could generate pressure to undo many of the act's provisions. In this environment the Congress will face difficult decisions that could pit particular interests against a more global interest in preserving Medicare for the long term. We believe that it would be a mistake to significantly modify the BBA's provisions without thorough analysis or giving the provisions a fair trial over a reasonable period of time.

Background

Medicare is the nation's largest health insurance program, covering about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion. Between 1990 and 1997, Medicare experienced spending increases averaging 9.8 percent per year to make it one of the fastest growing parts of the federal budget. This growth has slowed somewhat in the past 2 years. The Congressional Budget Office projects that Medicare's share of gross domestic product will rise almost one-third by 2009.

This substantial growth in Medicare spending will continue to be fueled by demographic and technological changes. Medicare's rolls are expanding and are projected to increase rapidly with the retirement of the baby boom generation. For example, today's elderly make up about 13 percent of the total population; by 2030, they will comprise 20 percent as the baby boom generation ages. Individuals aged 85 and older make up the fastest growing group of beneficiaries. So, in addition to the increased demand for health care services due to sheer numbers, the greater prevalence of chronic health conditions associated with aging will further boost utilization.

Congressional attention has recently focused on the impending depletion of Medicare's Hospital Insurance (HI) trust fund. Payroll taxes credited to the HI trust fund finance the bulk of Medicare's "hospital insurance," or part A, which covers inpatient hospital services as well as SNF, hospice, and certain home health care services. Beneficiaries' premium contributions and general revenues finance Medicare's "supplementary

medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, ambulance services, and other services and supplies. A BBA provision that shifted the financing of some home health services from part A to part B helped extend the HI trust fund's solvency.

Other BBA reforms, designed to slow program spending, address both Medicare's managed care and fee-for-service components. Medicare's managed care program covers the growing number of beneficiaries who have chosen to enroll in prepaid health plans, where a single monthly payment is made for all necessary covered services. About 6.8 million people—about 17 percent of all Medicare beneficiaries—were enrolled in more than 450 managed care plans as of December 1, 1998.[1] Most of Medicare's beneficiaries, however, receive health care on a fee-for-service basis, whereby providers are reimbursed for each covered service they deliver to beneficiaries.

BBA's Creation of Medicare+Choice

One way in which the BBA seeks to restructure Medicare is by encouraging greater managed care participation. Under the Medicare+Choice program, a broader range of health plans, such as preferred provider organizations and provider-sponsored organizations, are permitted to participate in Medicare. BBA's emphasis on Medicare+Choice reflects the perspective that increased managed care enrollment will help slow Medicare spending while expanding beneficiaries' health plan options.

Our recent work has examined two aspects of the Medicare+Choice program—payments and consumer information initiatives. BBA provisions dealing with payments to Medicare+Choice plans acknowledge that Medicare's prior managed care payment method for health maintenance organizations (HMO) and other risk plans failed to save the government money and created wide disparities in payment rates across counties. The BBA establishes a new rate-setting methodology for 1998 and future years, incorporating adjustment rates for the health and expected service use of managed care enrollees to avoid overpayment. It also guarantees health plans a minimum payment level to encourage them to locate in areas that previously had lower rates and few, if any, Medicare participating health plans. Other provisions addressing consumer information needs are designed to raise beneficiary participation in Medicare+Choice and promote more effective quality-based competition among plans.

[1]About 90 percent of the 6.8 million Medicare beneficiaries are enrolled in managed care plans that receive fixed monthly capitation payments. The remainder are enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

Managed Care Payment Reforms

Context for BBA's rate-setting provisions: BBA modifications to Medicare's health plan payment method acknowledge the problem of flawed capitation rates that, historically, have been paid to HMOs. Our work has demonstrated that these rates have produced billions of dollars in aggregate excess payments and inappropriate payment disparities across counties.[2]

The fundamental problem we found was that HMO payment rates were based on health care spending for the average nonenrolled beneficiary, while the plans' enrollees tended to be healthier than average nonenrollees, a phenomenon known as favorable selection. Some analysts expected excess payments to diminish with increased enrollment. Instead, the excess continued to grow, since rates were based on the rising concentrations of higher-cost beneficiaries remaining in fee-for-service.

Risk adjustment is a tool for setting capitation rates so that they reflect enrollees' expected health costs as accurately as possible. This tool is particularly important given Medicare's growing use of managed care and the potential for favorable selection, which, if not taken into account, generates excess payments. Medicare's current risk adjuster—based only on demographic factors such as age and sex[3]—cannot sufficiently lower rates to be consistent with the expected costs of managed care's healthier population. For example, a senior who was relatively healthy and another who suffered from a chronic condition—even if they were of the same age and sex—would have very different expected health care needs; but the current risk adjuster does not take those differences into account.

To correct this problem, the BBA requires HCFA to devise a new risk adjuster that incorporates patient health status factors.[4] HCFA had to develop and report on the new risk adjuster by March 1 of this year and is required to put the method in place by January 2000.

[2]Our 1997 study on payments to California HMOs, which enrolled more than a third of Medicare's managed care population, found that Medicare overpaid plans by about 16 percent in fiscal year 1995—accounting for about $1 billion in excess payments. The proportion of excess payments varied across counties. See Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

[3]The demographic indicators are age, sex, eligibility for Medicaid, employment status, and residence in an institution such as a SNF. Separate rates, using the same demographic traits, are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65). Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

[4]Technically, the law requires the Secretary of Health and Human Services to develop, report on, and implement the health-based risk adjustment method.

Design, implementation, and impact issues: HCFA's proposed interim risk adjuster—to be implemented in 2000—relies exclusively on hospital inpatient data to measure health status. While not perfect, the proposed risk adjuster does link the rates paid more closely to projections of Medicare enrollees' medical costs. Ideally, the risk adjuster would measure health status with complete and reliable data from other settings, such as physicians' offices, but these data are not currently available. Given the reliance on only hospital data, HCFA has taken steps to avoid rewarding plans that hospitalize patients unnecessarily or, conversely, penalizing efficient plans that provide care in less costly settings. A "next generation" of risk adjustment based on the services beneficiaries receive in all settings is scheduled for 2004.

HCFA plans to phase in the use of the interim risk adjuster and, in so doing, will avoid sharp payment changes that could adversely affect beneficiaries and plans. Such changes could be detrimental to beneficiaries if plans, in response, substantially scaled back their benefit packages or reconsidered their commitment to the Medicare+Choice program.

Currently, there is concern about a recent surge in plan drop-outs from Medicare+Choice. As of January 1999, 99 of the capitated plans in operation during 1998 had withdrawn or reduced their Medicare service areas. Industry representatives have stated that plans may have dropped out partially in anticipation of reduced payments, which could result when the interim risk adjuster is implemented. Plans have also cited the administrative burden associated with some of the new Medicare+Choice regulations as a significant reason for their withdrawal decisions.

The issue of plan drop-outs is complex, however, because the reasons for plans' decisions are not clear cut. As we have previously reported, many nonpayment factors—such as commercial managed care enrollment levels—influence plans' Medicare participation decisions.[5] Some areas of the country with relatively low payment rates have many Medicare managed care plans and enrollees. Moreover, the extent to which new Medicare+Choice regulations could have precipitated the withdrawals is unclear since few managed care organizations withdrew from Medicare completely. Most plans that pulled out of certain geographic areas continue to serve beneficiaries in other areas. In response to plans' concerns, however, HCFA recently revised a number of the Medicare+Choice regulations to make them less burdensome. Finally,

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

while some plans are dropping out of the program, others are interested in signing new contracts. In fact, 16 applications for new or expanded service areas have recently been approved and 44 more are pending.

Medicare+Choice Information Campaign

Context for BBA's information campaign provisions: Capitalizing on changes in the delivery of health care, BBA's introduction of new health plan options is intended to create a market in which different types of health plans compete to enroll and serve Medicare beneficiaries. The BBA reflects the idea that consumer information is an essential component of a competitive market. From the beneficiary's viewpoint, information on available plans needs to be accurate, comparable, accessible, and user-friendly. Informed choices are particularly important as the BBA phases out the beneficiary's opportunity to disenroll from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

The BBA mandated that, as part of a national information campaign, HCFA undertake several activities that could help beneficiaries make enrollment decisions regarding Medicare+Choice. Each October, prior to a mandated annual, coordinated enrollment period, HCFA must distribute to beneficiaries an array of general information on, among other things, enrollment procedures, rights, and the potential for Medicare+Choice contract termination by a participating plan. The BBA also required HCFA to provide beneficiaries with a list of available participating plans and a comparison of these plans' benefits. The agency must also maintain a toll-free telephone number and an Internet site as general sources of information about plan options, including traditional fee-for-service Medicare.

Design, implementation, and impact issues: The BBA-mandated information campaign is a first-time and massive undertaking for HCFA. The effort is well under way, but relative to the ideal—a market in which informed consumers prod competitors to offer the best value—many challenges lie ahead.

We have reported that, unlike many enrollees in the private sector and individuals covered by plans in the Federal Employees Health Benefits Program (FEHBP), Medicare beneficiaries receive little comparative information on their health plan options. We have also reported that, unlike FEHBP, HCFA does not require that plans' marketing materials follow a consistent format or use common terminology, thus making plan

comparisons difficult for beneficiaries. Standardized language on benefit and coverage definitions would facilitate (1) HCFA's oversight functions to ensure accurate information, (2) plans' compliance with reporting requirements, and (3) beneficiary decisionmaking. HCFA intends to require plans to begin using a standardized format for some information in anticipation of the November 1999 enrollment period.

HCFA is also in the process of making summary data available through several sources. In 1998, as part of a five-state pilot project, HCFA provided beneficiaries with a handbook containing comparative information on the Medicare+Choice plans available in their area and access to a toll-free telephone line. It also established an Internet site with similar information about plans available nationwide. These efforts made important strides, but because of plan pull-outs late in the year, some of the information beneficiaries received was inaccurate.

Critical now is a thorough evaluation of these efforts to ensure that the information provided is clear, sufficient, and helpful to beneficiaries' decisionmaking. Assessing how to make these efforts cost-effective—that is, targeting the right amounts and types of information to different groups of beneficiaries—is also of vital importance.

Selected BBA Reforms of Medicare Fee-for-Service

The BBA also makes fundamental changes to Medicare's fee-for-service component, which represents about 87 percent of program outlays and covers about 33 million beneficiaries. Mandated PPSs will alter how reimbursements are made to SNFs, HHAs, hospital outpatient departments, and rehabilitation facilities. Instead of generally paying whatever costs providers incur, HCFA's mandate is to establish rates that give providers incentives to deliver care and services more efficiently. Our work on SNF and home health benefits shows the importance of the design and implementation details of PPSs to achieving expected BBA savings and ensuring that Medicare beneficiaries have access to appropriate services.

SNF PPS

Context for SNF PPS provisions: Medicare spending for SNF services rose at an average annual rate of 23.2 percent from 1990 to 1996, much faster than overall program spending growth. Medicare's SNF payment method has been cited as one reason for this growth. Before the changes mandated in the BBA, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. There were limits on payments for the routine portion of care—that is, general nursing, room and board, and

administrative overhead. Payments for ancillary services, such as physical, occupational, or speech therapy, however, were virtually unlimited. These unchecked ancillary service payments have been a major contributor to significant increases in daily reimbursements to SNFs. Because providing more of these services generally triggered higher payments, facilities had no incentive to deliver services efficiently or only when necessary. The BBA called for phasing in a PPS for SNF care beginning after July 1, 1998, to bring program spending under control.

Design, implementation, and impact issues: Under the PPS, SNFs receive a payment for each day of care provided to a Medicare beneficiary. The payment, called a per diem rate, is based on the average daily cost of providing all Medicare-covered SNF services, as reflected in facilities' 1995 costs. Since not all patients require the same amount of care, the per diem rate is "case-mix" adjusted to take into account the nature of each patient's condition and expected care needs. Facilities that can care for beneficiaries for less than this case-mix-adjusted per diem amount will benefit financially, whereas SNFs with costs higher than the adjusted per diem rate will be at risk for the difference between their costs and the payments. The SNF PPS is expected to control Medicare spending because the per diem rate covers all services, so SNFs have an incentive to provide services efficiently and judiciously. Moreover, since payments vary with patient needs, the PPS is intended to ensure access to these services.

We are concerned, however, that the design of the case-mix adjuster preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services.[6] As stated, the SNF PPS divides beneficiaries into case-mix groups to reflect differences in patient needs that affect the cost of care. Each group is intended to define clinically similar patients who are expected to incur similar costs. An adjustment is associated with each group to account for these cost differences. A facility then receives a daily payment that is the same for each patient within a group. Since the payments do not vary with the actual costs incurred, a SNF has an incentive to reduce the costs of caring for the patients in each case-mix group.

The design of the case-mix groups allows a SNF to reduce its costs and increase its payments by manipulating the services provided, rather than increasing efficiency. Since the SNF groups are largely defined by the services the patient is to receive, a facility can provide only the minimum

[6]See Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives (GAO/T-HEHS-98-214, July 16, 1998).

level of services required for placement in a particular group. This reduces the average cost for the SNF's patients in that case-mix group but does not reduce the Medicare payments for these patients. Thus, expected Medicare savings may not be achieved.

We are also concerned that the data underlying the SNF rates overstate the reasonable costs of providing services and may not appropriately reflect costs for patients with different care needs. Most of the cost data used to set the SNF rates were not audited. Of particular concern are therapy costs, which are likely inflated because there have been few limits on these payments. Even if additional audits were to uncover significant inappropriate costs, HCFA maintains that it has no authority to adjust the base rates after the implementation of the new system. Furthermore, the case-mix adjusters are based on cost information on about 4,000 patients. This sample may simply be too small to reliably estimate these adjusters, particularly given the substantial variation in treatment patterns among SNFs. As a result, the case-mix-adjusted rates may not vary appropriately to account for the services facilities are expected to provide—rates will be too high for some types of patients and too low for others.

Under the SNF PPS, whether a SNF patient is deemed eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients and its judgment. Monitoring these assessments and determinations is key to realizing expected savings from the system. Texas, which implemented a similar reimbursement system for Medicaid, conducts on-site reviews to monitor the accuracy of patient assessments and finds a continuing error rate of about 20 percent. HCFA has no plans to undertake as extensive a monitoring effort. However, without adequate vigilance, inaccurate, inappropriate, and even fraudulent assessments could compromise the benefits of the PPS.

Home Health PPS and Related Reforms

Context for home health provisions: Medicare spending for home health care rose even more rapidly than spending for SNF services—at an average annual rate of 27.9 percent between 1990 and 1996. Several factors accounted for this spending growth, particularly relaxed coverage requirements that, over time, have made home health care available to more beneficiaries, for less acute conditions, and for longer periods of time. Essentially, Medicare's home health benefit gradually has been transformed from one that focused on patients needing short-term care after hospitalization to one that serves chronic, long-term-care patients as well.

To control spending while ensuring the appropriate provision of services, the BBA mandated important changes in the payment method and provider requirements for home health services. HCFA is required to establish a PPS for HHAS by fiscal year 2001.[7] Designing an appropriate system for HHAS will be particularly challenging because of certain characteristics of the benefit. Home health care is a broad benefit that covers a wide variety of patients, many of whom have multiple health conditions; and the standards for care are not well defined. Consequently, the case-mix adjuster and payment rates must account for substantial variation in the number, type, and duration of visits. Further, the wide geographic variation in the use of home health care makes it difficult to determine appropriate treatment patterns that must be accounted for in the overall level of payment. A final concern has to do with the quality and adequacy of services. Since the services are delivered in beneficiaries' homes, oversight is particularly critical when payment changes are implemented to constrain program outlays.

Recognizing the difficulty of developing and implementing a PPS, the BBA required HCFA to pay HHAS under an interim system. The interim system builds on payment limits already in place by making them more stringent and by providing incentives for HHAS to control the number and mix of visits to each beneficiary.

Design, implementation, and impact issues: Under the interim payment system, which took effect October 1, 1997, HHAS are paid their costs subject to the lower of two limits. The first limit builds on the existing aggregate per-visit cost limits but makes them more stringent. The second limit caps total annual Medicare payments on the basis of the number of beneficiaries served and an annual per-beneficiary amount. The annual per-beneficiary amount is based on agency-specific and regional average, per-beneficiary payments, and the limit aims to control the number of services provided to users. The blending of agency-specific and regional amounts is intended to account for the significant differences in service use across agencies and geographic areas.

There has been widespread concern about the impact of the interim payment system on HHAS and access to home health care.[8] Indeed, between October 1, 1997, and January 1, 1999, over 1,400 HHAS closed. However,

[7]The BBA required the PPS to be implemented in fiscal year 2000. Subsequent legislation delayed this by 1 year.

[8]See Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services (GAO/HEHS-98-238, Sept. 9, 1998).

historic growth in the home health industry has been such that there were still over 9,000 HHAS—more than there were in October 1995—to provide services to Medicare beneficiaries. Further, half of the closures were in just four states—California, Louisiana, Oklahoma, and Texas—three of which had experienced agency growth well above the national average. The closures could be a market correction for overexpansion in light of the BBA's signal that Medicare would not support the double-digit increases in spending of the previous few years.

The closures alone are not a measure of any impact on access for Medicare beneficiaries to home health services—which is the predominant concern. Since home health agencies require little physical capital, other agencies may be able to quickly absorb the staff and patients of closing agencies.

We have attempted to monitor the impact of the interim payment system on access for this Committee as well as for the House Committees on Commerce and Ways and Means. Last fall, we reported that interviews with hospital discharge planners and local aging organization representatives in seven states with high numbers of closures had not indicated a change over the past year in the willingness or ability of HHAS in their areas to serve Medicare beneficiaries. We are continuing this work, expanding the number of areas examined. Recently available claims information will allow us to extend this monitoring further—pinpointing areas where there has been a decline or leveling off of home health utilization. We will provide the Committee a report next month and another this summer on our ongoing work to assess access to home health care.

Conclusions

The brief experience with some of the major Medicare provisions of the BBA demonstrates the challenges to implementing meaningful reform. HCFA has fallen behind in instituting some changes and has had difficulty implementing others because of constrained resources, lack of experience, or inadequate data. At the same time, various provider groups have increasingly come to the Congress for relief. We believe that any significant alterations to key BBA provisions should be based on thorough analysis or sufficient experience to fully understand their effects.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or the Committee Members may have.

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