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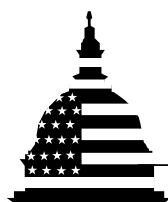
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MEDICARE

HCFA Faces Challenges to Control Improper Payments

Statement of Leslie G. Aronovitz, Associate Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



G A O

Accountability * Integrity * Reliability

Medicare: HCFA Faces Challenges to Control Improper Payments

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss Medicare program integrity issues. You have heard from the Department of Health and Human Services Office of the Inspector General (HHS OIG) and the Health Care Financing Administration (HCFA) about their efforts to quantify improper payments in the Medicare program. Specifically, the OIG has reported a fee-for-service claims error rate for the past several years and HCFA is planning to estimate an error rate for each claims administration contractor, which could help guide efforts to reduce inappropriate payments. Although we believe these efforts are worthwhile, Medicare error rates provide only a partial picture of program vulnerabilities. My remarks today will focus on areas of vulnerability, highlighting the ongoing and emerging challenges HCFA faces in safeguarding Medicare payments.

In summary, major information gaps exist in the Medicare program—in both traditional Medicare and Medicare+Choice—that impede HCFA's ability to minimize program losses attributable to improper payments. In traditional Medicare, HCFA does not have a clear picture of the individual or relative performance of Medicare's claims administration contractors, which are responsible for safeguarding the program's fee-for-service payments that totaled \$171 billion in fiscal year 1999. HCFA also lacks sufficient information on newly designed payment systems to determine whether providers have delivered excessive services or stinted on patient care to inappropriately maximize payments. As for Medicare+Choice, HCFA similarly lacks the data needed to monitor the appropriateness of payments made to health plans and the services Medicare enrollees receive. Owing to a failed attempt in the 1990s to modernize Medicare's multiple information systems, HCFA's current systems remain seriously outmoded. Without effective systems, the agency is not well-positioned to collect and analyze data regarding beneficiaries' use of services—information that is essential to managing the program effectively and safeguarding program payments.

In Traditional Medicare, Claims Oversight Problems Remain and Improved Payment Methods Can Still Be Gamed

In traditional Medicare, HCFA contracts with private companies, mostly insurance companies, to review and pay providers' claims for health care delivered to program beneficiaries. How well these companies have monitored Medicare's payments and have themselves been monitored by HCFA are the subjects of recent GAO reports. We have also reported on new prospective payment methods designed to replace outmoded cost-based reimbursement methods. Both contractors' payment safeguard activities and new prospective payment systems contain existing or new opportunities for unscrupulous providers to exploit Medicare.

Better Vigilance Needed Over Medicare Contractors

In recent years, incidents have occurred in which Medicare's contract bill-payers themselves—the front-line of defense against provider fraud and abuse and erroneous Medicare payments—had engaged in fraudulent or otherwise improper activities. However, HCFA rarely uncovered these cases through its own oversight efforts. The reason, in part, is that the agency relied on contractors' self-certifications of management controls and contractors' self-reported data on performance and seldom made independent validations of contractor-provided information. In a number of the contractor integrity cases, poor management controls and falsified data were recurring themes.

Not surprisingly, our report last year on HCFA's efforts to monitor the Medicare claims administration contractors identified many weaknesses.¹ For years, HCFA's contractor evaluation process lacked the consistency that agency reviewers needed to make comparable assessments of contractor performance. HCFA reviewers had few measurable performance standards and little agencywide direction on monitoring contractor's payment safeguard activities. Under these circumstances, the reviewers in HCFA's 10 regional offices, who were responsible for conducting contractor evaluations, had broad discretion to decide what and how much to review as well as what disciplinary actions to take against contractors with performance problems. This highly discretionary evaluation process allowed key program safeguards to go unchecked and led to an inconsistent treatment of contractors with similar performance problems.

In addition to having a weak evaluation process, HCFA had not made its multiple units that were responsible for contractor oversight adequately accountable. Responsibility for various aspects of contractor activities was splintered across many central office components, while regional staff who conducted day-to-day oversight were not directly accountable to any particular central office unit.

HCFA has taken a number of promising steps to address these weaknesses and to achieve the following goals:

¹See *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

- *Greater consistency.* HCFA has begun using national review teams to conduct contractor evaluations. The teams combine the expertise and dual perspective of central and regional office staff.
- *Improved accountability.* HCFA established an executive-level position at its central office with ultimate responsibility for contractor oversight and recently announced plans for four positions in the field, reflecting the four groupings of regional offices known as consortia. The four consortium representatives responsible for contractor oversight will report both to the central office executive and to their respective consortium administrators.
- *Independent verification.* To address the need for independent verification of internal controls and contractor-reported data, HCFA hired a public accounting firm to develop standard review procedures and evaluation methodologies.
- *More meaningful error rates.* HCFA has an initiative, as you have heard today, to develop a separate error rate for each contractor. It plans to hire a “validation” contractor to randomly sample processed claims and recheck the processing and payment decisions made. From the results, HCFA could not only develop an objective measure of contractor performance but also identify which categories of services or provider types are the source of improper billing practices, thus targeting areas that need improvement.

Because these steps were taken recently, we have not evaluated their success in addressing the agency’s long-standing, fundamental problems in overseeing its contractors.

Opportunities to Game New Payment Methods Difficult to Control Without Adequate Management Information

To constrain Medicare spending on unnecessary services, the Balanced Budget Act of 1997 (BBA) introduced several payment reforms. The BBA called for HCFA to develop and implement new methods to pay for post-acute care—that is, the care Medicare beneficiaries receive principally from skilled nursing facilities, home health agencies, and rehabilitation facilities. Under cost-based reimbursement methods used to pay post-acute care providers, Medicare experienced rapid growth in post-acute care spending during the 1990s. At the same time, program funding decreased for such safeguard activities as auditing providers’ cost reports.

Under the old payment methods, post-acute care providers were reimbursed their costs (within certain limits) for all the services delivered. Under the new methods, known as prospective payment, these providers are, or soon will be, paid a prospective rate per unit of care. The

expectation is that prospective payment systems will encourage the efficient delivery of care by reducing a provider's incentive to deliver excessive services or incur unnecessary costs. Providers face the risk of loss if their costs exceed their payments, while those that can furnish care for less than the prospective payment rate will retain the difference. However, a new opportunity for providers to inappropriately boost revenues exists under this approach: providers could skimp on services and compromise the patient's quality of care. Because HCFA does not have the analytic tools available to identify and document underservice, any resulting improper payments would not be captured by error rates as currently constructed. In fiscal year 1999, Medicare's payments for skilled nursing facility and home health care together totaled \$28 billion.

Not all patients require the same amount of care, so the rate paid for each patient is "case-mix" adjusted to take into account the nature of the patient's condition and expected care needs.

These adjustments are required to ensure that providers serving patients with more intensive care needs receive adequate payments and, conversely, that providers are not overcompensated for patients with lower care needs. Used in conjunction with a prospective per-unit payment, case-mix adjustment is intended to reduce the incentive to inappropriately increase profits by furnishing more or fewer services than are needed. However, several analytical problems make ensuring the appropriate payment for each patient a thorny issue, as illustrated by the following types of post-acute care services.

- *Skilled nursing facility care.* Under the skilled nursing facility prospective payment system, facilities receive a payment for each day of a patient's care, adjusted for case mix. This approach was intended to control the rapid growth in certain skilled nursing facility care costs. As we reported last year,² however, the case-mix adjustment methodology is flawed. The case-mix groups that influence payment amounts for each patient are defined largely by service use rather than by actual patient need. Thus, a facility could increase a patient's reported service use merely to increase payments.

²*Medicare Post-Acute Care: Better Information Needed Before Modifying BBA Reforms* (GAO/T-HEHS-99-192, Sept. 15, 1999).

- *Home health care.* Under the home health prospective payment system to be implemented in October, Medicare will pay agencies a per-episode rate for up to 60 days of services for a patient. Payment will be the same regardless of the number of days of care or visits actually provided, and there are no limits on the number of episodes a beneficiary could have. This approach is intended to reward home health agencies for constraining service use within an episode by encouraging efficient service delivery. However, with no limits on the number of episodes provided, providers continue to have the opportunity to increase aggregate payments. In addition, defining an adequate level of services within an episode is a problem, given a lack of agreed-upon standards for the appropriate use of home health care. Further, HCFA does not have the monitoring capability to determine—in time to make a difference to the beneficiary—whether the services provided within an episode are too few to be considered adequate care.
- *Inpatient rehabilitation therapy.* The prospective payment system for rehabilitation facilities to be phased in beginning October 2000 is expected to be based on a single payment for all services provided during a stay, like the payment for acute-care hospitals. This approach is intended to reward providers that deliver care efficiently. However, it will be difficult to devise controls to keep facilities from merely discharging patients earlier. The shorter stays would reduce the facilities' costs but may not achieve the appropriate level of rehabilitation for the patient. Such an outcome could not only jeopardize the quality of a beneficiary's care but also raise costs for Medicare if more post-acute care is needed after discharge.

Medicare+Choice Has Its Own Set of Integrity Issues

The claims error rate is also an incomplete measure of payment problems because it does not apply to dollars paid to health care plans that participate in the Medicare+Choice program. In fiscal year 1999, Medicare's payments to these plans totaled \$37 billion, or more than 17 percent of all program spending, and this percentage is expected to grow over time. Because a Medicare+Choice plan receives a fixed monthly payment for each beneficiary it enrolls, instead of being paid separately for each service delivered, this program raises a new set of program integrity challenges.

Broadly speaking, the following three situations illustrate the program integrity issues that potentially exist in Medicare+Choice. First, plans could purposely seek to attract and retain only those beneficiaries who are relatively healthy and low-cost. Second, plans could fail to deliver required services to beneficiaries. Finally, since payment rates are based in part on plan-provided information, erroneous or misreported data could

lead to inappropriate payments. Previous work by us and the HHS OIG has uncovered instances in which plans received inappropriate payments or did not deliver services that they were paid to deliver. Although the full extent of these problems is not known, the available information suggests that HCFA needs to improve its capacity to monitor plan performance and ensure that payments are appropriate and that plans fulfill their obligations. The following elaborates on the program integrity challenges in Medicare+Choice.

- *Favorable selection of healthier beneficiaries.* Plans gain financially when their enrolled Medicare beneficiaries are, as a group, healthier than beneficiaries in traditional Medicare—a phenomenon known as favorable selection. This gain occurs because healthy beneficiaries cost less to serve than chronically or acutely sick beneficiaries and Medicare’s payment is not adequately “risk adjusted” to reflect that fact. Our recent work examining those who join Medicare+Choice plans confirms varying degrees of favorable selection among the health plans. This enrollment pattern could have a benign explanation: healthy beneficiaries may be more willing to enroll than sick beneficiaries, who could have attachments to providers that might not belong to the selected plan’s provider network. However, it is also possible that some plans—through their marketing practices or provider incentive arrangements—attract healthier beneficiaries and have more of their sick members disenroll. Regardless of the cause, the consequences of favorable selection in the presence of an inadequate risk adjuster are huge—resulting in billions of dollars in excess payments.³
- *Failure to deliver required services.* Plans could also profit by not providing services that they are paid to deliver. Last year we reported that a large Medicare+Choice plan provided a prescription drug benefit with less coverage than it agreed to in its contract with HCFA.⁴ This case was discovered in our review of plan marketing materials, which found that several plans distributed misleading, inaccurate, or incomplete information about covered benefits. Until recently, when plans started submitting data on hospital admissions, HCFA had no systematic information regarding the services managed care enrollees received.

³*Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments* (GAO/HEHS-97-16, Apr. 25, 1997).

⁴*Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature* (GAO/HEHS-99-92, Apr. 12, 1999).

Instead, the agency relied, and to a great extent continues to rely, on beneficiaries being aware of the services to which they are entitled and complaining when those services are not provided. This weak oversight mechanism cannot ensure program integrity. Medicare is a complex program, and many beneficiaries do not understand what benefits the program covers. Flawed plan marketing materials contribute to the misunderstandings. In addition, beneficiaries may not know where or how to complain. We reported last year that several plans failed to adequately inform beneficiaries that they could appeal a plan's decision to deny services or payment for services.⁵

- *Misreported or erroneous data that increase payments.* A final area of potential concern relates to the data used for payment purposes. For example, in 1998 we reported that some plans took advantage of an overly broad Medicare definition to classify healthy beneficiaries living in retirement communities as living in "institutions" and thereby substantially increase their Medicare payments.⁶ HCFA has since adopted our recommendation to tighten the definition of an institution for payment purposes, but the extent to which the new definition is being enforced is uncertain. The OIG has reported numerous instances in which erroneous data resulted in inappropriate plan payments. For example, the OIG found cases in which Medicare paid plans for deceased beneficiaries and for beneficiaries receiving services in traditional Medicare. The OIG also found plans that inappropriately collected enhanced payments by misreporting their beneficiaries' institutional status. Reliable information about plan enrollees will become even more critical in the future as Medicare phases in a new risk adjustment methodology. Under this new methodology, payment rates will be determined largely by provider encounter data submitted by plans. Any errors in the encounter data will thus result in inaccurate plan payments.

⁵ *Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights* (GAO/HEHS-99-68, Apr. 12, 1999).

⁶ *Medicare HMO Institutional Payments: Improved HCFA Oversight, More Recent Cost Data Could Reduce Overpayments* (GAO/HEHS-98-153, Sept. 9, 1998).

Outmoded Information Systems Limit HCFA's Ability to Manage Medicare

A major structural issue underlies HCFA's efforts to safeguard Medicare payments: the need for reliable management information. This is true whether the information pertains to payment of claims, new post-acute care payment methods, or Medicare+Choice payments. To protect taxpayer dollars from unnecessary program spending, HCFA needs the information to ensure that claims payments are accurate and that payment rates are set at the appropriate level. To protect beneficiaries from providers' withholding needed services, HCFA needs information on beneficiaries' health status and use of services. The following are among HCFA's major information challenges:

- *Traditional Medicare.* In addition to a long-standing need to upgrade its claims analysis capabilities, HCFA requires information on patient health needs. As discussed earlier, major gaps in information make prospective payment systems vulnerable to manipulation, thus undermining the potential for the prospective payment approach to constrain Medicare costs. For example, payments for skilled nursing facility and home health care would be more accurate if linked to patient need rather than to service use, but HCFA has only begun collecting the data necessary to develop standards of appropriate care.
- *Medicare+Choice.* As with the case-mix adjuster for post-acute care payment methods, Medicare needs an improved risk adjustment system to ensure that payments better reflect the expected health care costs of managed care enrollees. Recently, HCFA launched several initiatives, including a beneficiary satisfaction survey, the collection of selected self-reported plan performance measures, and the collection of hospital admissions data to improve Medicare's risk adjustment methodology. Collection of more comprehensive encounter data is planned for the future. However, HCFA lacks a coordinated strategy to analyze these data and use the results to improve its oversight responsibilities.

HCFA's information needs are not being met with Medicare's existing fragmented and aged set of computerized information systems. Seriously affected are the systems that support traditional Medicare, Medicare+Choice, and HCFA's financial management efforts.

In the early 1990s, HCFA launched a systems acquisition initiative to replace Medicare's multiple, contractor-operated claims processing systems with a single and more technologically advanced system, called the Medicare Transaction System (MTS). HCFA envisioned that a modernized, single system would (1) save administrative dollars and simplify making system changes, (2) enhance HCFA's ability to manage the Medicare contractors by obtaining uniformly formatted, comparable

data, and (3) greatly improve the ability to spot, both on-line and after payment, improper billing practices. Although MTS was based on the sound notion that a comprehensive, integrated system was needed, it failed operationally, through a series of planning and implementation missteps. HCFA's failure to acquire an integrated system left the program with numerous aging information systems that needed year 2000 renovation.

Similarly, HCFA's managed care information systems, developed a decade ago, may have reached their capacity to accommodate modifications associated with an increasingly complex and demanding program. An outside firm's assessment of HCFA's managed care information capacity found, among other problems, that the current system makes it difficult to extract information for policy decisions and program management; is labor-intensive to modify and validate; and, because of its batch processing structure, does not provide timely information on beneficiary enrollment or other plan transactions.

Finally, with regard to financial management, HCFA cannot ensure that key financial data are reliable and available or that sensitive beneficiary data are kept confidential. In repeated annual audits, the OIG found that HCFA's and the contractors' systems can be penetrated, leaving sensitive claims and medical record information inadequately protected. The focus on year 2000 system renovations has, in part, delayed HCFA's efforts to address the security weaknesses identified. HCFA also lacks an integrated accounting system to examine Medicare expenditures at the contractor level, depending instead on labor-intensive processes to prepare financial statements. HCFA has an initiative under way to develop an integrated accounting system, but it will not be fully operational until 2004 at the earliest.

While it is clear from the problems outlined that investment in HCFA's information systems is warranted, such an investment must be coupled with a clear strategy to ensure that investment is made wisely. In efforts to run the program economically, HCFA has been left with fewer and fewer administrative dollars to handle increasingly complex tasks. In 1998, HCFA's administrative expenses represented about 1 percent of its outlays from the Hospital Insurance Trust Fund and about 2 percent of outlays from the Supplementary Medical Insurance fund. Even after accounting for marketing costs and profit, no private health insurer would attempt to manage such a large and complex program with so small an administrative budget. HCFA's ability to provide assistance to beneficiaries, monitor the quality of provider services, and protect against fraud and abuse is dependent on adequate administrative funding.

Nevertheless, providing increased funds for upgrading systems would be imprudent without an effective strategic plan. Such a plan would, among other things, envision how to transform the data collected into useful management information. We are aware that HCFA has started down this path, and we will be interested in its evolving planning efforts.

Conclusions

Despite BBA reforms and HCFA's many important initiatives, Medicare remains a high-risk program. Its coverage policies and payment systems, affecting almost 40 million beneficiaries and hundreds of thousands of providers, are highly complex and susceptible to exploitation. HCFA's most significant tools for combating the problem of improper payments are the systems that produce information about beneficiaries' use of services. Over the last 2 years, HCFA's information technology efforts focused largely on preparing Medicare's systems to meet year 2000 readiness requirements. The time lost while HCFA was focused on other priorities makes modernizing Medicare's multiple information systems now all the more compelling.

Mr. Chairman, this concludes my prepared statement. I would be happy to answer any questions you or other Subcommittee Members may have.

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call Leslie G. Aronovitz, Associate Director, Health Financing and Public Health Issues, at (312) 220-7767. Other individuals who made key contributions include Sheila K. Avruch, James C. Cosgrove, Hannah F. Fein, Sandra D. Gove, and Dana K. Kelley.

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