United States General Accounting Office

GAO

Testimony

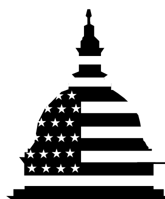
Before the Subcommittee on Health and Environment, Committee on Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, July 19, 2000

MEDICARE

Refinements Should Continue to Improve Appropriateness of Provider Payments

Statement of William J. Scanlon, Director
Health Financing and Public Health Issues
Health, Education, and Human Services Division



G A O
Accountability * Integrity * Reliability

GAO/T-HEHS-00-160

Medicare: Refinements Should Continue to Improve Appropriateness of Provider Payments

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the effects of recent Medicare payment reforms and the potential need for additional refinements. The Medicare payment provisions in the Balanced Budget Act of 1997 (BBA) were enacted to control rapid spending growth in the traditional fee-for-service program that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. Essentially, these reforms changed the financial incentives inherent in pre-BBA payment methods to more appropriately reward providers for delivering care efficiently. The BBA also created Medicare+Choice to expand beneficiaries' managed care options under Medicare and bring payments more in line with the costs of providing covered benefits in the traditional program.

Since the BBA's enactment, the Congress has faced pressure from providers to undo the act's payment reforms. With changes so sweeping, achieving perfection in all the details at the outset is unrealistic. Accordingly, the Congress has monitored experience with these changes and made certain modifications. To date, some of the act's provisions have taken effect, some have been modified by the Balanced Budget Refinement Act of 1999 (BBRA), and others have just recently begun to be phased in.

Calls for additional changes come at a time when federal budget surpluses and lower Medicare outlays could make it easier to consider accommodating enhanced Medicare payments. At the same time, however, the Congress is considering the addition of an expensive prescription drug benefit to the current program. In view of the coming upsurge in the Medicare-eligible population, the Comptroller General has cautioned repeatedly that, even before expanding benefits, projected Medicare spending threatens to absorb ever-increasing shares of the nation's budgetary and economic resources. Thus, without meaningful reform, demographic and cost trends will drive Medicare spending to levels that will prove unsustainable for future generations of taxpayers.[1]

My comments today focus on the BBA's payment reforms affecting home health agencies, skilled nursing facilities (SNF), and the health plans in Medicare's managed care program, known as Medicare+Choice. My remarks are based on our extensive published and ongoing work in each of these areas.

[1] *Medicare Reform: Leading Proposals Lay Groundwork, While Design Decisions Lie Ahead* (GAO/T-HEHS/AIMD-00-103, Feb. 24, 2000).

In brief, the reactions by providers serving Medicare beneficiaries to BBA and BBRA payment reforms share a similar scenario. Tightened payment policies have required many providers to adjust their operations. The adjustments have been particularly disruptive for providers that took advantage of Medicare's previous payment policies to finance inefficient and unnecessary care delivery. Industry representatives are advocating the partial restoration of payment cuts. Following are the recent developments that have ensued since the BBA's implementation in the areas of home health services, SNF services, and the Medicare+Choice program:

Home health services: Home health utilization has dropped substantially, well below what would have been required to remain within the BBA-imposed payment limits. We expect the new Medicare payment system for home health services, scheduled for implementation in October, to generally provide agencies a comfortable cushion to deliver necessary services.

SNF services: Some corporate chains have declared bankruptcy. The new Medicare payment system for SNF services adequately covers the cost of beneficiaries' services but no longer supports the extensive capital expansions or the ancillary service business that corporate chains relied on to boost revenues.

Medicare+Choice program: Many plans are withdrawing from Medicare. The withdrawals are tied to a combination of Medicare program changes and plans' business decisions In addition, our ongoing work shows that payments to plans for their Medicare enrollees continue to exceed the expected fee-for-service costs of these individuals. The significance of this finding is that Medicare managed care, although originally expected to achieve program savings, continues instead to add to program cost.

In our view, the basis for potential changes to BBA reforms should be how they affect beneficiaries' access to necessary services and the long-term outlook for this program. Therefore, progress needs to continue to better align provider payments with the expected costs of the beneficiaries served and to bring about the fiscal discipline needed to contain Medicare spending in these areas over the longer term. We will continue to monitor the payment reforms' effects to help the Congress ensure that beneficiary access is protected, providers are fairly compensated, and taxpayers do not shoulder the burden of excessive program spending.

Background

Medicare's home health care benefit enables beneficiaries with post-acute-care needs and chronic conditions to receive certain skilled nursing,

therapy, and aide services in their homes rather than in other settings. To qualify for Medicare's home health benefit, a beneficiary must be confined to his or her residence ("homebound") and must require intermittent skilled nursing, physical therapy, or speech therapy. A beneficiary who needs only custodial or personal care does not qualify. Beneficiaries are not liable for any coinsurance or deductibles for these services and may receive an unlimited number of visits, provided the coverage criteria are met. Historically, Medicare has reimbursed home health agencies their costs, subject to limits, for services they provide to the program's beneficiaries. A prospective payment system (PPS) for home health services will go into effect October 1, 2000.

The Medicare SNF benefit provides up to 100 days of post-acute care per spell of illness. To qualify for SNF services, a Medicare beneficiary must need daily skilled nursing or rehabilitative therapy services, or both, generally within 30 days of a hospital stay of at least 3 days in length, and must be admitted to a Medicare-certified SNF for a condition related to the hospitalization. When the beneficiary meets these conditions, Medicare covers all necessary services, including room and board; nursing care; and ancillary services such as drugs, laboratory tests, and physical therapy. Beginning on the 21st day of care, the beneficiary is responsible for a daily coinsurance payment, which equals $97 in 2000. Until 1998, Medicare reimbursed skilled nursing facilities on a cost basis. Payments for routine costs, such as room and board, were subject to cost limits, but payments for capital and ancillary costs were virtually unlimited. Medicare is phasing in a PPS for SNF services over a 3-year period that began in July 1998.

Medicare managed care plans have provided beneficiaries an attractive alternative to the traditional fee-for-service program. In return for giving up the freedom to seek care from any provider, beneficiaries who enroll in plans typically receive coverage for benefits not offered by the traditional program (such as routine physical examinations and prescription drugs) and enjoy lower out-of-pocket expenses. Medicare pays the plans a fixed monthly amount for each beneficiary, regardless of the actual costs of providing care to that individual. Previously, plan payment rates were tightly linked to average local spending in the traditional fee-for-service program and only adjusted for certain beneficiary characteristics such as age and sex. The BBA changed how plan payments were calculated beginning in 1998 by weakening the linkage to fee-for-service spending and required that, beginning in 2000, payment rates reflect differences in beneficiary health status.

Pending Home Health PPS Rates Likely to Be Adequate, but Are Untested to Date

To curb rampant spending growth, BBA overhauled the program's method of paying for home health services. Between 1990 and 1997, Medicare expenditures for home health services went up three times faster than spending for the program as a whole. This rapid rise has been attributed to many factors, including a loosened interpretation of the home health benefit criteria and few controls to protect the program from abusive billing practices at a time when Medicare paid for every home health visit with almost no scrutiny. In combination, these factors made conditions ripe for providers to deliver more services to more beneficiaries in order to increase their revenues.

In response to these problems, the BBA required, by October 1, 1999, the implementation of a new home health PPS, and until then, the implementation of an interim payment system (IPS) to slow spending growth.[2] The IPS made the existing per visit cost limits more stringent and added an annual agency revenue cap to control the number of services provided to beneficiaries.

Between 1997 and 1998, Medicare home health spending fell by nearly 15 percent, while total home health visits dropped an unprecedented 40 percent. The Congressional Budget Office (CBO) attributes the decline to agencies' tighter compliance with benefit eligibility criteria and their cautious interpretation of IPS limits.[3] Our ongoing work on home health spending shows that these declines continued in 1999 and that the drop in utilization was most pronounced in areas where, pre-BBA, use had grown the most and beneficiary utilization was the highest.

These findings suggest that part of the contraction in service delivery since the BBA may be a correction of the excessive use when Medicare did little to control home health spending. However, it may also reflect an inappropriate response to the IPS by home health agencies. While remaining within IPS payment limits, all agencies could have served more beneficiaries and many agencies could have increased the services provided each beneficiary. Yet the number of beneficiaries receiving home health services declined 14 percent between 1997 and 1998 and is

[2]The Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999, P.L. 105-277, delayed the implementation of the home health PPS until October 1, 2000

[3]*Impact of the Balanced Budget Act on the Medicare Fee-for-Service Program*, Statement of Dan L. Crippen, Director, Congressional Budget Office, before the House Committee on Commerce Sept. 15, 1999.

continuing to fall. Because the payment limits under the IPS are not adjusted to reflect the needs of individual patients, agencies must maintain a balance high-cost and low-cost patients in order to keep their costs below the IPS revenue caps. Agencies that do not fully understand how these caps are applied may restrict their admissions or reduce care to current patients further than necessary.

The home health PPS, which replaces the IPS on October 1 of this year, is a more appropriate payment tool than the IPS because it is designed to align payments with patient needs. Medicare will pay agencies a per-episode rate based on historical, national average utilization for each 60-day period during which a patient receives services. PPS rates are scheduled to be tightened a year later by 15 percent. The per-episode payments are designed to control service provision during the episode, while giving home health agencies the flexibility to vary the intensity or mix of services delivered. Home health industry advocates generally support the PPS, but argue that the 15-percent payment reduction is unnecessary.

In our view, the new home health PPS rates overall are likely to provide agencies a comfortable cushion to deliver necessary services. These rates are based on pre-BBA beneficiary use levels, which are widely regarded as excessive. PPS rates will provide sufficient resources to restore a considerable portion of the service reductions of the past 3 years. They will not support, however, widely divergent levels of utilization where some agencies supplied many more services than others for comparable patients.

Unfortunately, the new PPS has the potential to be advantageous to agencies at the expense of beneficiaries and taxpayers. Under the per-episode method of payment, agencies can increase profits by skimping on the number of visits provided within the episode. Agencies can also inappropriately expand the number of episodes provided by protracting the delivery of care over a longer period. No standards exist for what the right amount of care is for specific types of patients, particularly the right amount of home health aide care, which composed almost half of all visits in 1997. Implementing safeguards to ensure Medicare payments are used to deliver services to meet beneficiaries' needs is a difficult task.

The home health PPS, while having a design superior to the IPS, is largely untested. It is built on the concept of paying for episodes of care, yet there is no consensus on what an episode should entail. In addition, similar to other new PPSs, which vary payments according to patients' expected needs, the potential exists for payments to be too low for some episodes

involving very sick patients and too high for others. To minimize the potential for adverse effects for the program and individual agencies, we recommended in April this year that HCFA implement a risk-sharing provision whereby the government shares in any home health agency's losses under the PPS but also protects the program from any agency's excessive gains.[4]

SNF PPS Rates Cover Medicare-Related Costs

Under Medicare's SNF PPS, facilities receive a payment for each day of covered care provided to a Medicare-eligible beneficiary. Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-covered services. Although there were limits on the payments for the routine portion of care (that is, general nursing, room and board, and administrative overhead), payments for ancillary services, such as rehabilitative therapy, were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary.

By establishing fixed per diem payments for all services provided to beneficiaries, the PPS attempts to provide incentives for SNFs to deliver care more efficiently. SNFs that previously boosted their Medicare revenue—by using more or higher-priced ancillary services—will need to modify their practices more than others.

Recent accounts of nursing home chain bankruptcies raise questions about the adequacy of Medicare's SNF payments under the PPS. Our published and ongoing work identifies several factors that contributed to the poor financial performance of these corporations.[5] Some corporations invested heavily in the nursing home and ancillary service businesses in the years immediately before the enactment of the PPS, both expanding their acquisitions and upgrading facilities to provide higher-intensity services. Under tighter payment constraints, these debt-laden enterprises are particularly challenged. The PPS not only puts a premium on operating their SNFs efficiently, it changes the market for their ancillary services business as well. It makes other SNF operators sensitive to the costs of

[4]A risk-sharing arrangement that limits the amount a home health agency can lose or gain would involve a year-end settlement that compares an agency's actual Medicare-allowed costs with its total Medicare payments. Payments above the costs would be constrained to a specific percentage, as would agency losses. For further detail, see *Medicare Home Health: Prospective Payment System Will Need Refinement As Data Become Available* (GAO/HEHS-00-9, Apr. 7, 2000).

[5]*Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access* (GAO/HEHS-00-23, Dec. 14, 1999).

ancillary services, so they are no longer willing to purchase them at high prices. Thus, while SNFs have to adapt to the PPS constraints, these large post-acute care providers may have greater adjustments to make as a result of the strategic decisions they made during a period when Medicare was exercising too little control over its payments.

There are indications that SNF payment rates under the BBA are likely to provide sufficient—or, in some cases, even generous—compensation for services provided to a facility's Medicare beneficiaries. Medicare's average daily rate under the SNF PPS in fiscal year 1999 was higher than the average daily SNF payment in fiscal year 1997. The significance of this comparison is that 1997 payments were thought to be excessive because they reflected 7 years of cost increases of more than 14 percent per year. In fact, some providers have been eager to adopt the PPS rates well ahead of schedule. Currently, PPS rates are being phased in over a 3-year period, which began in July 1998. This transition period was designed to allow facilities time to adapt to the new payment system by continuing to tie a facility's payment rates to its historical costs. The BBRA gives SNFs the option of forgoing this transition period. Although a current tally is not available, HCFA estimates that about half of Medicare-certified SNFs will opt to forgo the transition period to receive fully prospective rates as soon as possible.

Beneficiary access to SNFs, moreover, does not appear compromised under the new PPS. Utilization levels in 1999 were higher than those in 1997. Hospital lengths of stay for admissions likely to lead to a SNF stay have continued to decline, suggesting that hospitalized patients continue to find SNF care.

Nevertheless, the SNF PPS initially proposed by HCFA was not flawless. Last year, we testified before the full Committee about PPS design problems.[6] A primary concern was the possibility that facilities treating a disproportionate number of high-cost cases might not receive adequate payments. HCFA is in the process of refining its method to account for patient needs in its payments. The goal is to redistribute payments across types of cases so that they more appropriately reflect each patient's expected costs. HCFA recently proposed such refinements to the case-mix

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

adjustment system, which are scheduled to be implemented on October 1 of this year.[7]

In the meantime, BBRA included a provision that temporarily boosts payments for certain cases by 20 percent,[8] which will add an estimated $200 million to Medicare SNF spending in fiscal year 2000. The provision is scheduled to expire on October 1, 2000, or when HCFA implements a refined case-mix adjustment system, whichever comes later. Industry advocates favor prolonging the life of the BBRA provision and delaying the implementation of HCFA's proposed payment modifications, which they assert are not sufficiently refined. CBO estimates that if the 20 percent payment increase remained in effect for 5 years, spending would increase by $1.4 billion. In our view, the BBRA increase was helpful as a stopgap measure, but fiscal prudence argues for implementing research-based improvements to the rates as soon as practicable. Such improvements aim to distribute existing payments more appropriately and thereby address the problem originally identified, while avoiding the unwarranted expenditure of an additional hundreds of millions of dollars each year.

Medicare+Choice Payments Remain Problematic

Although Medicare managed care plans have provided beneficiaries an attractive alternative to the traditional program, they have never been a bargain for taxpayers. Prior to the BBA, studies by us, other government agencies, and private researchers concluded that, instead of producing expected savings, Medicare's managed care option substantially increased program spending. Plans tended to attract relatively healthy, low-cost beneficiaries, while Medicare's payment rates reflected the expected costs of a beneficiary in average health with average health expenses. Consequently, plans received payments for their Medicare enrollees that well exceeded what Medicare would have paid had these individuals remained in the traditional fee-for-service program. Our study of Medicare plans in California showed that aggregate plan payments exceeded plan enrollees' estimated fee-for-service costs by more than an estimated $1 billion in 1995. This finding suggests that many of the additional benefits enjoyed by plan enrollees were the direct result of Medicare's overly generous payment rates, not of efficiencies achieved under managed care.[9]

[7] The proposed rule is contained in 65 *Fed. Reg.* 19188-19291 (Apr. 10, 2000) (to be codified at 42 C.F.R. pts. 411 and 489).

[8] We could not determine what criteria were used to select these cases.

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

The BBA sought to improve Medicare's financial posture by changing the methodology used to establish managed care payment rates. Accordingly, the BBA slowed the growth in payment rates relative to the growth in per capita fee-for-service spending for 5 years and required HCFA to improve its risk adjustment of plan payments so that they more closely matched beneficiaries' expected health care costs. The BBA also included payment changes and other provisions to achieve a second goal: increase the availability of plans and allow new types of plans to participate in Medicare.

The declining participation of health plans in the Medicare+Choice program suggests that the BBA's cost containment and expansion goals may be irreconcilable. Since the BBA's enactment, 168 plans have either left the program or reduced the geographic areas they served. Recently, more plans announced that they will terminate their contracts or reduce their service areas effective January 1, 2001. Industry representatives have largely attributed the withdrawals to the BBA's payment rate changes. The representatives contend that Medicare is no longer a sufficiently profitable line of business for some plans and that other plans have had to reduce the benefits they offer and raise beneficiary premiums. They warn that the Medicare+Choice program will continue to flounder unless payments are increased.

Our published and ongoing work suggests that several factors influenced plans' decisions about whether to participate in Medicare+Choice or to participate only in certain areas. As we reported last year, the 1999 withdrawals represented plans that were recent market entrants, had enrolled few beneficiaries, or faced competitors that had substantially larger market shares, suggesting that plans made business decisions or used business strategies that could be sustained only in an era of more generous Medicare payments.[10] We will issue a report soon on the withdrawals in 2000 and 2001. While information on the 2001 withdrawals has only been available for a few weeks, our analysis of the withdrawals in 2000 indicate a pattern similar to that found for 1999.

Some health plans may find the payment rates established by the BBA to be too low to warrant their future participation in Medicare+Choice. However, in our ongoing work, when we compared plan payments for enrolled beneficiaries in 1998 with the estimated Medicare fee-for-service costs for these individuals, we found that plans received payments that

[10] *Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues* (GAO/HEHS-99-91, Apr. 27, 1999).

substantially exceeded what Medicare would have paid for the plans' enrollees had they been covered under the fee-for-service program. This paradox stems from differences in the intent of Medicare+Choice and its evolution. On the one hand, Medicare+Choice plans are paid too much relative to the original intent of Medicare managed care—to provide beneficiaries the package of Medicare-covered services at less cost than the traditional fee-for-service program. On the other, the plans may be paid too little for what they have been offering to attract beneficiaries—a more comprehensive benefit package beyond that authorized for fee-for-service beneficiaries for only modest or no premiums.

Efforts to expand the Medicare+Choice program, particularly one in which plans cover prescription drugs, have been important, because the traditional Medicare program has not provided such coverage, and this program alternative has provided an avenue for some beneficiaries to obtain drug coverage. However, if the Congress adopts a prescription drug benefit for the entire Medicare program, there may be less reason to have Medicare+Choice payments exceed the costs of providing services in the traditional program. The problem of excess payments can be addressed in part by better adjusting payments for the actual health status of enrollees. Such a step would also protect those plans that attract sicker-than-average enrollees.

Conclusions

As anticipated, the BBA reforms have had significant effects on the delivery, cost, and use of Medicare services. Changes in providers' incomes and services to beneficiaries are becoming a reality. We have seen a rapid fall-off in home health use, the bankruptcies of several large SNF chains, and continued health plan withdrawals from the Medicare+Choice program. Although providers have been quick to attribute these changes to inadequate Medicare payments and call for extra federal dollars, careful analysis indicates that these responses are adaptations to appropriately tightened payments following a period of unchecked growth.

Needed refinements to the BBA's new payment policies for home health, SNF, and managed care services are under development or are soon to be implemented. In assessing the merit of these refinements, prudence suggests that beneficiary needs and the program's prospects for long-term sustainability, not provider profitability, should be paramount. We have several studies under way to inform these decisions and we will continue to work with you to provide this important information.

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

GAO Contacts and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114 or Laura A. Dummit at (202) 512-7118. Individuals making key contributions to this testimony included James C. Cosgrove, Hannah F. Fein, Dana K. Kelley, Erin M. Kuhls, and James E. Mathews.

(201090)

Ordering Information

Orders by Internet

For information on how to access GAO reports on the Internet, send an e-mail message with “info” in the body to:

Info@www.gao.gov

or visit GAO’s World Wide Web home page at:

http://www.gao.gov

To Report Fraud, Waste, and Abuse in Federal Programs

Contact one:

Web site: http://www.gao.gov/fraudnet/fraudnet.htm

E-mail: fraudnet@gao.gov

1-800-424-5454 (automated answering system)