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# BALANCED BUDGET ACT

# Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives

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# Balanced Budget Act: Implementation of Key Medicare Mandates Must Evolve to Fulfill Congressional Objectives

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Health Care Financing Administration's (HCFA) implementation of Medicare provisions contained in the Balanced Budget Act of 1997 (BBA).[1] Taken together, the more than 200 BBA Medicare mandates amount to what are probably the most significant modifications to the program since its inception 30 years ago. For example, the new Medicare+Choice provisions of BBA will enable beneficiaries to enroll in different types of health plans previously excluded from the Medicare program, while the introduction of prospective payment systems will alter how reimbursements are made to skilled nursing facilities (SNF), home health agencies, hospital outpatient departments, and inpatient rehabilitation facilities. Collectively, the objective behind these changes is to better control the growth in Medicare expenditures while simultaneously moving the program away from its fee-for-service orientation and toward greater acceptance of the different types of managed care already available to those with private health insurance. You asked me to give an overview of how HCFA's implementation has progressed since our testimony earlier this year.[2] In addition to this overview, my testimony will provide more detailed comments on two key program elements scheduled for implementation this year that have been the subject of extensive GAO work: (1) the efforts to inform Medicare beneficiaries about the expanded health plan choices available to them in 1999, commonly referred to as the "information campaign," and (2) the prospective payment system (PPS) for SNFs, which began a 3-year phase-in this month.

To prepare this testimony, we analyzed HCFA reports that track the implementation of BBA mandates and discussed their status with HCFA officials. We also drew on our previous as well as ongoing work assessing the information HCFA and health plans provide to beneficiaries; HCFA's responsibilities under BBA for a new, annual information campaign; and the financing for that campaign. Finally, we analyzed HCFA's interim final rule dated May 12, 1998, that describes the new PPS and consolidated billing for SNFs. Our analysis relied on (1) discussions with HCFA officials and Medicare contractor staff; (2) the lessons learned from implementing the PPS for inpatient hospital services, which has been in place since the mid-1980s; and (3) our prior work on SNF services.

[1]P.L. 105-33 became law on August 5, 1997.

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

In summary, HCFA is making progress in meeting the legislatively established implementation schedules. Since the passage of BBA in August 1997, almost three-fourths of the mandates with a July 1998 deadline have been implemented. HCFA's recent publication of the Medicare+Choice and SNF PPS implementing regulations demonstrates that progress. However, HCFA officials have acknowledged that many remaining BBA mandates will not be implemented on time. In particular, they point out that achieving compliance with Year-2000 computer requirements, a critical agency priority, competes with BBA mandates for computer system resources and, as a result, implementation of a number of BBA mandates will be delayed. HCFA maintains that these delays will have a "minimal" impact on anticipated Medicare program savings.

Given the concurrent competition for limited resources and the differing importance and complexity of the many BBA mandates, the success or failure of HCFA's implementation efforts should not be judged solely on meeting deadlines. Rather, any assessment should consider whether the agency is meeting congressional objectives while taking a reasoned management approach to identifying critical BBA tasks, keeping them on track, and integrating them with other agency priorities. Continued involvement by high-level agency officials in this process as well as ongoing legislative oversight should enhance the likelihood of success.

Complying with the BBA mandate to conduct an information campaign that provides beneficiaries with the tools to make informed health plan choices poses significant challenges for HCFA and participating health plans. In the past, HCFA played almost no role in helping beneficiaries to evaluate their health plan options—that is, in deciding whether to remain in fee-for-service Medicare or switch to participating HMOs. In implementing the Medicare+Choice program, HCFA must now assemble the necessary comparative information about these options and find an effective means to disseminate it to beneficiaries. A parallel goal of the information campaign is to give beneficiaries information about the quality and performance of participating health plans to promote quality-based competition among plans. The lack of standardized information from health plans about their benefits and the imperfect state of quality and satisfaction measures have made HCFA's efforts to assemble this information more difficult. HCFA has accelerated its goals for obtaining standardized information from plans, and we believe health plan disenrollment rates provide an acceptable short-term substitute measure of plan performance. HCFA's cautious approach to implementing the information campaign is probably warranted, given its inexperience in

such an endeavor and the campaign's important role in creating a more competitive Medicare market.

Questions have been raised by health plan representatives and others about the estimated cost of the information campaign. The campaign is to be financed primarily from user fees—that is, through an assessment on participating health plans. We recently began a review of HCFA's plans for the information campaign at your request and that of the Senate Committee on Finance. Since the start of our work, HCFA modifications to its plans for the information campaign have significantly affected the estimated costs of different components.

Finally, HCFA has met the July 1, 1998, implementation date for phasing in a new payment system for SNFs. We are concerned, however, that payment system design flaws and inadequate underlying data used to establish payment rates may compromise the system's ability to meet the twin objectives of slowing spending growth while promoting the delivery of appropriate beneficiary care. Insufficient planned oversight of the new payment system may compound these shortcomings and further jeopardize the potential for cost savings. In the short term, the new payment system could be improved if HCFA clearly stated that SNFs are responsible for ensuring that the claims they submit are for beneficiaries who meet Medicare coverage criteria. In the longer term, further research to improve the patient grouping methodology and new methods to monitor the accuracy of patient assessments could substantially improve the performance of the new payment system.

## Background

Medicare is the nation's health care program for the elderly and disabled, covering about 38 million people. While the organization and delivery of care has evolved considerably since the 1960s, Medicare beneficiaries are still overwhelmingly enrolled in a fee-for-service delivery system in which medical services can be obtained from any participating provider. Although private, employer-based coverage shifted decisively away from fee-for-service toward networks of providers, only a small percentage of Medicare beneficiaries are enrolled in such networks—and, almost exclusively in health maintenance organizations (HMO) that typically offer a more limited choice of providers. In contrast, many individuals with employer-based coverage are enrolled in other types of network plans that offer a broader choice of physicians. While employers migrated toward competing network-based managed care plans to help control health care costs, Medicare focused on fee-for-service payment innovations that

moved from retrospective, cost-and-charge-based reimbursements to prospective systems and fee schedules designed to contain cost growth.

The August 1997 passage of BBA dramatically changed the existing paradigm, setting Medicare on a course toward a more competitive and consumer-driven model. HCFA, the agency charged with administering the program, must accomplish this transition while continuing to oversee the processing of about 900 million claims annually. BBA contained over 350 separate Medicare and Medicaid mandates, the majority of which apply to the Medicare program. The Medicare mandates are of widely varying complexity. Some, such as the Medicare+Choice expansion of beneficiary health plan options and the implementation of PPSs for SNFs, home health agencies, and hospital outpatient services, are extraordinarily complex and have considerable budgetary and payment control implications. Others, such as updating the conversion factor for anesthesia payments, are relatively minor. Although most implementation deadlines are near term—over half had 1997 or 1998 deadlines—several are not scheduled to be implemented until 2002.

## Progress Made in Meeting BBA Mandates, but Future Delays Expected

Overall, BBA required HCFA to implement about 240 unique Medicare changes. Since August 1997, about three-quarters of the mandates with a July 1998 deadline have been implemented. HCFA's recent publication of the Medicare+Choice and SNF PPS regulations are examples of the progress HCFA has made in implementing key mandates. The remaining 25 percent missed the BBA implementation deadline, including establishment of a quality-of-care medical review process for SNFs and a required study of an alternative payment system for certain hospitals. It is clear that HCFA will continue to miss implementation deadlines as it attempts to balance the resource demands generated by BBA provisions with other competing objectives.

Implementing BBA provisions would be daunting under the best of circumstances, and the task is further complicated for HCFA by other, concurrent challenges, including new antifraud provisions and other responsibilities contained in the Health Insurance Portability and Accountability Act of 1996[3] and BBA's creation of a new program to reduce the number of uninsured children. Moreover, HCFA has just completed a major reorganization and is attempting to recruit and train staff with the skills needed to transition the agency from a passive purchaser of health care to an active manager of the competitive market being created by

[3]P.L. 104-191.

BBA-mandated changes. Finally, the need to modernize its multiple automated claims processing and other information systems, a task complicated by the Year-2000 computer challenges, is competing with other ongoing responsibilities.

HCFA has proposed that the Department of Health and Human Services seek legislative relief by delaying implementation of certain BBA provisions—those requiring major computer system changes that also coincide with Year-2000 computer renovations.[4] According to HCFA's computer contractor, simultaneously pursuing both BBA implementation and Year-2000 system changes risks the failure of both activities and threatens HCFA's highest priority—uninterrupted claims payments. The contractor advised HCFA to seek relief from competing requirements, which could allow the agency to focus instead on Year-2000 computer system renovations.

The BBA provisions to be delayed by the computer renovations include updates to the October 1999 inpatient hospital PPS rate and the January 2000 physician fee schedule, hospital outpatient PPS limits on outpatient therapy services, and billing changes for SNFs. The appendix lists other BBA mandates that are being postponed.[5]

It is difficult to assess the impact of these delays. In some instances, the effects are direct. Postponing the outpatient PPS, for instance, means that Medicare will continue to have few controls over its outlays for these services. Similarly, delays in instituting per-beneficiary limits on the amount of outpatient therapy services covered by Medicare—a rapidly expanding source of expenditures—means that anticipated savings will be lost. Some delays involve mandates that are intended to complement provisions already being implemented. We may expect further increases in spending for outpatient therapy services because of newly implemented payment constraints on other therapy providers. As another example, consolidated billing makes SNFs responsible for virtually all Medicare-covered services that residents receive, rather than allowing other providers to bill directly. The consolidated billing provision's importance is heightened by the fact that SNFs are starting to be paid under

[4]Any change in payment policy requires computer system changes. HCFA has proposed delaying system modifications required by BBA so that resources can be focused on Year 2000 priorities. Contractors are required to be Year-2000 compliant by December 31, 1998. After compliance is achieved and remaining problems are fixed, resources will be redirected to meeting delayed BBA requirements.

[5]Our list is based on provisions identified in a July 8, 1998, HCFA BBA Implementation Tracking Report.

the new PPS rates, which cover both services previously billed by the SNF and by certain outside providers. Without this provision, it may be more difficult to adequately monitor whether bills for SNF residents are being submitted appropriately.

## Adequate Information Critical to Success of Medicare+Choice

BBA establishes a new Medicare+Choice program, which will significantly expand the health care options that can be marketed to Medicare beneficiaries beginning in the fall of 1998. In addition to traditional Medicare and HMOs, beneficiaries will be able to enroll in preferred provider organizations, provider-sponsored organizations, and private fee-for-service plans. Medical savings accounts will also be available to a limited number of beneficiaries under a demonstration program. The goal is a voluntary transformation of Medicare via the introduction of new plan options. Capitalizing on changes in the delivery of health care, these new options are intended to create a market in which different types of health plans compete to enroll and serve Medicare beneficiaries. Recognizing that consumer information is an essential component of a competitive market, BBA mandated a national information campaign with the objective of promoting informed plan choice. From the beneficiary's viewpoint, information on available plans needs to be (1) accurate, (2) comparable, (3) comprehensible, and (4) readily accessible. Informed beneficiary choice will be critical since BBA phases out the beneficiary's right to disenroll from a plan on a monthly basis and moves toward the private sector practice of annual reconsideration of plan choice.

The responsibility for informing beneficiaries about plan choices is dual, falling on both HCFA and participating Medicare+Choice health plans. In keeping with provisions of BBA to inform beneficiaries about new and existing health care options, HCFA is attempting to summarize health plan coverage information and make it accessible in a comparative format. To ensure accessibility, BBA requires that comparative information be available to beneficiaries via the Internet, through a toll-free telephone number, and in printed form by mail. Recognizing that expanding the array of health plan choices and organizing a top-notch information campaign is an enormous undertaking, BBA mandates a two-step phase-in. In 1998, HCFA is only responsible for a "special information campaign" that gives beneficiaries data on existing HMO options and any new Medicare+Choice plans. Only a few new options are expected to be available and, though not required to do so this year, HCFA is already providing comparative data via the Internet. Beginning in 1999, however, the agency is charged with the orchestration of a "nationally coordinated educational and publicity

campaign" that includes comparative data on the available health plan choices. This publicity campaign will support what is to become an annual event each November—an open enrollment period in which beneficiaries may review the options and switch to a different health plan. As in the past, health plans will continue to provide beneficiaries with marketing information that includes a detailed description of covered services. In fact, HCFA comparative summaries will refer beneficiaries to health plans for more detailed information.

HCFA is taking a cautious approach and testing the key components of its planned information campaign. This caution is probably warranted by the important role played by information in creating a more competitive Medicare market and by the agency's inexperience in this type of endeavor. In March 1998, the agency introduced a database on the Internet called "Medicare Compare," which includes summary information on health plans' benefits and out-of-pocket costs. The toll-free telephone number will be piloted in five states—Arizona, Florida, Ohio, Oregon and Washington—and gradually phased in nationally during 1999. Because of some concerns about its readability, HCFA has also decided to pilot a new beneficiary handbook in the same five states instead of mailing it to all beneficiaries this year. The handbook, a reference tool with about 36 pages, will describe the Medicare program in detail, providing comparative information on both Medicare+Choice plans as well as the traditional fee-for-service option. For beneficiaries in all other states, HCFA will send out a five- to six-page educational pamphlet that explains the Medicare+Choice options but contains no comparative information. This schedule will allow HCFA to gather and incorporate feedback on the effectiveness of and beneficiary satisfaction with the different elements of the information campaign into its plans for the 1999 open enrollment period.

## Lack of Standardized Comparative Data Hampers HCFA and Beneficiaries

Until BBA, Medicare lagged behind other large purchasers in helping beneficiaries choose among plans. The Federal Employees Health Benefits Program, the California Public Employees' Retirement System, Xerox Corporation, and Southern California Edison all provide their employees with comparative information on premiums, benefits, out-of-pocket costs, and the results from member satisfaction surveys. HCFA, on the other hand, has not routinely provided plan-specific information directly to beneficiaries. In 1996, we reported that beneficiaries received little or no

comparative information on Medicare HMOs.[6] Among other things, we recommended that HCFA produce plan comparison charts and require plans to use standard formats and terminology in benefit descriptions.

In developing comparative information for Medicare Compare, HCFA attempted to use information submitted by health plans as part of the contracting process. Like beneficiaries, HCFA had difficulty reconciling information from different HMOs because it was not standardized across plans. HCFA's Center for Beneficiary Services, the new unit responsible for providing information to Medicare enrollees, has been forced to recontact HMOs and clarify benefit descriptions. Recognizing that standardized contract information would reduce the administrative burden on both health plans and different HCFA offices that use the data, the agency has accelerated the schedule for requiring standard formats and language in contract benefit descriptions. Although originally targeted by 2001, the new timetable calls for contract standardization beginning with submissions due in the spring of 1999. If available on schedule, standardized contracts should facilitate the production of comparative information for the introduction of the annual open enrollment period in November 1999.

While comparative data from HCFA will provide a starting point for selecting a health plan, beneficiaries will probably continue to rely on marketing information and detailed benefit descriptions provided by plans in making their ultimate choice. Such materials may be both difficult to use and misleading because plan marketing material is not standardized. In our recent review of marketing materials from Medicare HMOs in Tampa, Florida, we found that the formats and benefit categories varied considerably from plan to plan and sometimes omitted key details, as in the following examples:

- Marketing materials often failed to inform beneficiaries that they face higher out-of-pocket costs if they choose a brand-name drug over a generic.
- HMOs differed in the terms used to describe the same benefit or used technical terms but did not define them. Thus, some used the term "formulary" to describe the prescription drug benefit but did not explain

[6]Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996).

that the use of nonformulary drugs may result in substantially higher out-of-pocket costs.[7]

- Only five of eight Tampa plans mention mammograms in their benefit summaries—even though all plans covered mammograms. Most plans listed mammograms under the "preventive service" benefit category. One plan, however, included them under hospital outpatient services.

Consistent presentation is important because beneficiaries may rely on plans' benefit summaries when comparing coverage and out-of-pocket cost information. Federal employees and retirees can readily compare benefits among health plans in the Federal Employees Health Benefits Program because the Office of Personnel Management requires that plan brochures follow a common format and use standard terminology. It is encouraging that HCFA wants to accelerate a similar requirement for Medicare+Choice plans. In the fall of 1999, HCFA expects to require health plans to use standard formats and terminology to describe covered services in the summary-of-benefits portion of the marketing materials.

## Reliable Plan Performance Data Essential to Quality-Based Competition

Comparative data on quality and performance are a key component of the information campaign mandated by BBA and an essential underpinning of quality-based competition. Recognizing that the measurement and reporting of such comparative data is a "work in progress," the act directed broad distribution of such information as it becomes available. Categories of information specifically mentioned by BBA include beneficiary health outcomes and satisfaction, the extent to which health plans comply with Medicare requirements, and plan disenrollment rates. While disenrollment rates could be prepared for publication in a matter of months, other types of quality-related information have accuracy or reliability problems or are still being developed.

The best-known quality-of-care measures available focus on a health plan's history in delivering preventive services such as mammography, flu shots, and eye exams for diabetics. These indicators, referred to by the acronym HEDIS (Health Plan Employer Data and Information Set), were jointly developed by a group of large purchasers, including HCFA, and health plans. HCFA has already collected data on many HEDIS measures from Medicare HMOs with the intent of publishing them. Since the HEDIS data are self-reported by plans, HCFA contracted for an audit to verify the accuracy. HCFA recently reported serious accuracy problems that it attributed to

[7]In general, a formulary is a list of drugs that health plans prefer their physicians to use. The formulary includes drugs that plans have determined to be effective and that suppliers may have favorably priced for the plan.

immature health plan information systems and ambiguities in the HEDIS measurement specifications. Though committed to making the HEDIS information available as quickly as possible, HCFA emphasized that its premature release would be unfair to both plans and beneficiaries. Finally, efforts have been under way for some time to develop measures that actually demonstrate the quality of the care delivered—often referred to as "outcome" measures. As noted, the current HEDIS measures look at how frequently a health plan delivers specific services, such as immunizations, not at outcomes. The development and dissemination of reliable health outcome measures is a much more complicated task and remains a longer-term goal.[8]

Before passage of BBA, HCFA had funded a survey to measure and report beneficiaries' satisfaction with their HMOs. For example, Medicare enrollees were asked how easy it was to gain access to appropriate care and how well their physicians communicated with them about their health status and treatment options. HCFA plans to make the survey results available on its Medicare Compare Internet site this fall and to include the data in mailings to beneficiaries during the fall 1999 information campaign. We believe that the usefulness of HCFA's initial satisfaction survey for identifying poor performing plans is limited because it surveyed only those individuals satisfied enough with their plan to remain enrolled for at least 12 months. HCFA is planning a survey of those who disenrolled, which could help distinguish among the potential causes of high disenrollment rates in some plans, such as quality and access issues or beneficiary dissatisfaction with the benefit package.

For the short term, disenrollment rates for health plans provide a broad indicator of satisfaction that has long been available through HCFA's enrollment database. Only since passage of BBA has HCFA begun to develop formats to make these data useful for public consumption. We have urged the dissemination of disenrollment rates in reports to the Congress over the past 3 years, and we have published comparative rates for individual markets to illustrate the wide variability in HMOs' ability to satisfy and retain enrollees. Our most recent report shows that many HMOs had relatively high voluntary disenrollment rates.[9] In many markets, the highest disenrollment rates exceeded the lowest by more than fourfold. In a few markets, the range in rates was even wider. For example, in

[8]HCFA's current HEDIS initiative contains a single outcome measure that will require data collection and analysis over several years.

[9]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, Apr. 30, 1998).

Houston, Texas, the highest disenrollment rate was nearly 56 percent, while the lowest was 8 percent. The large range in disenrollment rates among HMOs suggests that this single variable could be a powerful tool in alerting beneficiaries about potentially significant differences among plans and the need to seek additional information before making a plan choice.

## Estimating Cost of Information Campaign Complicated by Lack of Experience

Questions have been raised by health plan representatives and others about the estimated cost of the information campaign. The campaign is to be financed primarily from user fees—that is, an assessment on participating health plans. We are conducting a review of HCFA's information campaign plans at your request and that of the Senate Committee on Finance. Our work began recently, and since then HCFA has modified its plans significantly, affecting the estimated costs of different components. While we cannot yet make an overall assessment, it is clear that the operation of the toll-free number is the most expensive component and, because of a lack of prior experience, is the most difficult cost to estimate.

The cost of the toll-free number comprises 44 percent of the total information campaign budget. HCFA projects fiscal year 1998 costs of $50.2 million to support set up as well as operations during fiscal year 1999. All but $4 million will come from user fees collected from existing Medicare HMOs. For fiscal year 2000, operations costs are projected to grow to $68 million.[10]

As noted earlier, HCFA will gradually make the toll-free number available nationwide between October 1998 and August 1999. HCFA's approach to establishing the toll-free number appears to be geared toward controlling costs. Customer service representatives will attempt to handle straightforward information requests on the spot but will refer beneficiaries with more complicated or detailed questions to the Medicare+Choice plans or to state and local counselors.[11] This referral concept should limit the duration of calls and hence their cost. It is

[10]During its first operational year, the primary costs associated with the toll-free number will be for a contract to provide trained customer service representatives. Smaller contracts will support the leasing of phone lines and the provision of recorded messages; the mailing of requested printed materials and the processing of disenrollment requests; and referrals of complex questions to HCFA.

[11]The toll-free number will offer prerecorded information 24 hours a day with customer service representatives available from 8:00 a.m. to 4:30 p.m. weekdays. These representatives will answer basic questions about Medicare+Choice rules and the types of plans available in specific areas. In answering benefit questions, the service representatives will rely on the Medicare Compare summary data that are also available on the Internet. Finally, the service representatives will refer requests for printed comparative information, disenrollment, or difficult policy issues to a separate contractor.

important that the toll-free number meet beneficiaries' reasonable needs or expectations. However, until HCFA actually gains experience with the toll-free number, it has no firm basis to judge either the duration of the calls or the type of information beneficiaries will find useful. The phased implementation of the toll-free numbers should give HCFA a better idea of what beneficiaries want and may necessitate adjustments to current plans.

Ultimately, the design of this and other aspects of the information campaign should be driven less by cost and more by how effective they are in meeting beneficiary needs and contributing to the intended transformation of the Medicare program. Consequently, we will be looking at (1) whether the estimated cost of the planned activities is appropriate and efficient in the near term, and (2) whether, over the longer term, the impact and effectiveness of these activities might be increased.

## Anticipated Savings at Risk With New SNF Payment System

On July 1, 1998, HCFA began phasing in a Medicare PPS for SNFs, as directed by BBA.[12] Under the new system, facilities receive a payment for each day of care provided to a Medicare-eligible beneficiary (known as the per diem rate). This 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.

Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-allowed services. There were limits on the costs that were reimbursed for the routine portion of care, that is, general nursing, room and board, and administrative overhead. Payments for capital costs and ancillary services, such as rehabilitation therapy, however, were virtually unlimited. Cost-based reimbursement is one of the main reasons the SNF benefit has grown faster than most components of the Medicare program. Because providing more services generally triggered higher payments, facilities have had no incentive to restrict services to those necessary or to improve their efficiency.

Prospective payment is intended to slow spending growth by controlling the increase in Medicare payments per day of SNF care. Facilities that can

[12]HCFA has had problems with computer system changes to implement the system. As a result, providers with cost reporting periods beginning July 1 through September 30, 1998, will receive interim payments based on the old payment system that will be adjusted retroactively on or about October 1. To avoid major disruptions to the industry, the PPS will be phased in. For the first 3 years, SNFs will receive a blended payment of old and new rates.

care for beneficiaries for less than the case-mix adjusted payment will benefit financially. Those with costs higher than the per diem amount will be at risk for the difference between costs and payments. The PPS for hospitals is credited with controlling outlays for inpatient hospital care. Similarly, the Congressional Budget Office (CBO) estimates that over 5 years the SNF PPS could save $9.5 billion compared with what Medicare would have paid for covered services.

Although HCFA met the deadline for issuing the implementing regulations for the new SNF per diem payment system, features of the system and inadequate data used to establish rates could compromise the anticipated savings. As noted in previous testimony, design choices and data reliability are key to implementing a successful payment methodology.[13] We are concerned that the system's design preserves the opportunity for providers to increase their compensation by supplying potentially unnecessary services. Furthermore, the per diem rates were computed using data that overstate the reasonable cost of providing care and may not appropriately reflect the differences in costs for patients with different care needs. In addition, as a part of the system, HCFA's regulation appears to have initiated an automatic eligibility process—that is, a new means of determining eligibility for the Medicare SNF benefit, that could expand the number of beneficiaries who will be covered and the length of covered stays. The planned oversight is insufficient, increasing the potential for these aspects of the regulations to compromise expected savings. Immediate modifications to the regulations and efforts to refine the system and monitor its performance could ameliorate our concerns.

## Rates Paid for Many Patients Based on Service Use Instead of Need

To reflect differences in patient needs that affect the cost of care, the SNF PPS divides beneficiaries into 44 case-mix groups. Each group is intended to define clinically similar patients who are expected to incur similar costs.[14] An adjustment is associated with each group to account for these cost differences. A facility then receives the same daily payment for all of its patients in each group. The case-mix classification method used in this PPS relies heavily on service use, particularly rehabilitation therapy

[13]Medicare Post-Acute Care: Home Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO-T-HEHS-97-90, Mar. 4, 1997); Medicare Post-Acute Care: Cost Growth and Proposals to Manage It Through Prospective Payment and Other Controls (GAO/T-HEHS-97-106, Apr. 9, 1997); Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-HEHS-98-9, Oct. 9, 1997).

[14]The groups are defined by a classification system developed by HCFA contractors. The categories in this system are known as Resource Utilization Groups. For the Medicare SNF PPS, version III of the classification system, commonly called RUGS-III, is being used.

(physical, occupational, or speech therapy), to assign patients to the different groups. Categorizing patients on the basis of expected service use conflicts with a major objective of a PPS—to break the direct link between providing services and receiving additional payment.

A SNF has incentives to reduce the costs of the patients in each case-mix group. Because the groups are largely defined by the services the patient is to receive, a facility could do this by providing the minimum level of services that characterize patients in that group (see table 1). This would reduce the average cost for the SNF's patients in that case-mix group, but not lower Medicare payments for these patients. For patients needing close to the maximum amount of therapy services in a case-mix group, facilities could maximize their payments relative to their costs by adding more therapy so that the beneficiary was categorized in the next higher group. An increase in daily therapy from 140 to 144 minutes, for example, would change the case-mix category of a patient with moderate assistance needs from the "very high" to the "ultra high" group, resulting in a per diem payment that was about $60 higher. By thus manipulating the minutes of therapy provided to its rehabilitation patients, a facility could lower the costs associated with each case-mix category and increase its Medicare payments. Rather than improve efficiency and patient care, this might only raise Medicare outlays.

**Table 1: SNF Prospective Per Diem System for Rehabilitation Groups**

| Rehabilitation groups | Average daily therapy (for 5 days per week) | Per diem payment (federal unadjusted rate for urban facilities) |
|---|---|---|
| Ultra high | 144+ minutes | $345.90 |
| Very high | 100 to 143 minutes | 286.30 |
| High | 65 to 99 minutes | 249.64 |
| Medium | 30 to 64 minutes | 238.87 |

Notes: Rates listed are for patients receiving this amount of therapy who also need moderate assistance with personal care, such as getting in and out of bed, toileting, moving from a chair to a bed, and eating.

Source: GAO analysis of data from HCFA's May 12, 1998, interim final rule.

HCFA needs to continue research efforts to move away from a patient classification system so closely linked to service use. If the case-mix categories were more dependent on patient characteristics, the facility would have to improve the efficiency with which it provides care to maximize its Medicare payments relative to costs. We recognize that this will be a challenging task. It is difficult to group patients by the amounts of

care needed using methods that are less susceptible to manipulation by a SNF. Nevertheless, being able to classify patients appropriately is critical to ensuring that Medicare can control its SNF payments and that SNFs are adequately compensated for their mix of patients.

## Inadequate Data Likely Inflate and Distort Payment Rates

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. The rates to be paid SNFs are computed in two steps. First, a base rate reflecting the average per diem costs of all Medicare SNF patients is calculated from 1995 Medicare SNF cost report data. This base rate may be too high, because the reported costs are not adequately adjusted to remove unnecessary or excessive costs. Second, a set of adjustors for the 44 case-mix groups is computed using information on the costs of services used by about 4,000 patients. This sample may simply be too small to reliably estimate these adjustors.

Most of the cost data used to set the SNF prospective per diem rates were not audited. At most, 10 percent of the base year—1995—cost reports underwent a focused audit in which a portion of the SNFs' expenses were reviewed. Of particular concern are therapy costs, which are likely inflated because there have been no limits on cost-based payments.[15] HCFA staff report that Medicare has been paying up to $300 per therapy session. These high therapy costs were incorporated in the PPS base rates. Even if additional audits were to uncover significant inappropriate costs, HCFA maintains that it has no authority to adjust the base rates after the July 1, 1998, implementation of the new payment system.

The adjustors for each category of patients are based on data from two 1-day studies of the amount of nursing and therapy care received by fewer than 4,000 patients in 154 SNFs in 12 states. Almost all Medicare patients will be in 26 of the 44 case-mix groups. For about one-third of these 26 groups, the adjustors are based on fewer than 50 patients. Given the variation in treatment patterns among SNFs, such a small sample may not be adequate to estimate the average resource costs for each group. 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.

[15]Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995); Medicare: Early Resolution of Overcharges for Therapy in Nursing Homes Is Unlikely (GAO/HEHS-96-145, Aug. 16, 1996).

## Automatic Eligibility Process Could Expand Medicare Coverage

Medicare's SNF benefit is for enrollees who need daily skilled care on an inpatient basis following a minimum 3-day hospitalization. Before implementation of the prospective per diem system, SNFs were required to certify that each beneficiary met these criteria.[16] With the new payment system, the method for establishing eligibility for coverage will also change. Facilities will assign each patient to one of the case-mix groups on the basis of an assessment of the patient's condition and expected service use, and the facility will certify that each patient is appropriately classified. Beneficiaries in the top 26 of the 44 case-mix groups will automatically be deemed eligible for SNF coverage. If facilities do not continue to assess whether beneficiaries meet Medicare's coverage criteria, "deeming" could represent a considerable new cost to the program.

Some individuals who are in one of these 26 deemed categories may only require custodial or intermittent skilled care, but HCFA's regulations appear to indicate that they could still receive Medicare coverage. Medical review nurses who work with HCFA payment contractors indicated in interviews that some patients included in the 26 groups would not necessarily need daily skilled care. This may be particularly true at a later point in the SNF stay, since SNF coverage can only begin after a 3-day hospitalization. Individuals with certain forms of paralysis or multiple sclerosis who need extensive personal assistance may also need daily skilled care immediately following a hospital stay for pneumonia, for example. After a certain period, however, their need for daily skilled care may end, but their Medicare coverage will continue because of deeming. Similarly, certain patients with minor skin ulcers will be deemed eligible for Medicare coverage, whereas previously only those with more serious ulcers believed to require daily care were covered. Thus, more people could be eligible and Medicare could be responsible for longer stays unless HCFA is clear that Medicare coverage criteria have not been changed.

Deeming eligibility would not be a problem if all patients in a case-mix group met Medicare's coverage criteria. To redefine the patient groups in this way would require additional research and analysis. However, an immediate improvement would be for HCFA to clarify that Medicare will only pay for those patients that the facility certifies meet Medicare SNF coverage criteria.

[16]Medicare coverage criteria are that the patient require skilled nursing services or skilled rehabilitation services, that is, services that must be performed by or under the supervision of professional or technical personnel; that these skilled services be required on a daily basis; and, as a practical matter, considering economy and efficiency, that the services can be provided only on an inpatient basis in a SNF.

## Lack of Stringent Oversight Could Further Diminish Savings

Whether a SNF patient is eligible for Medicare coverage and how much will be paid are based on a facility's assessment of its patients. Yet, HCFA has no plans to monitor those assessments to ensure they are appropriate and accurate. In contrast, when Texas implemented a similar reimbursement system for Medicaid, the state instituted on-site reviews to monitor the accuracy of patient assessments and to determine the need for training assessors. In 1989, the first year of its system's operation, Texas found widespread over-assessment. Through continued on-site monitoring, the error rate has dropped from about 40 percent, but it still remains at about 20 percent.

The current plans for collecting patient assessment information actually discourage rather than facilitate oversight. A SNF will transmit assessment data on all its patients, not just those eligible for Medicare coverage, to a state agency that will subsequently send copies to HCFA.[17] However, the claim identifying the patient's category for Medicare payment is sent to the HCFA claims contractor that pays the bill. At the time it is processing the bill, the claims contractor will not have access to data that would allow confirmation that the patient's classification matches the assessment.

To some extent, the implementation of the SNF prospective per diem system reduces the opportunities for fraud in the form of duplicate billings or billing for services not provided. Since a SNF is paid a fixed per diem rate for most services, it would be fraudulent to bill separately for services included in the SNF per diem. Yet, the new system opens opportunities to mischaracterize patients or to assign them to an inappropriate case-mix category. Also, as was the case with the former system, methods to ensure that beneficiaries actually receive required services could be strengthened. As with the implementation of any major payment policy change, HCFA should increase its vigilance to ensure that fraudulent practices discovered in nursing homes, similar to problems noted in our prior work, do not resurface.[18]

## Conclusions

HCFA faces numerous concurrent challenges, many of them the result of significant changes to the Medicare program mandated by BBA. Given the

[17]The assessment of all SNF patients is actually a requirement of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), which established requirements for SNFs participating in Medicare and Medicaid. The SNF prospective payment system rule added a requirement that these assessment data be given to the appropriate state agency. Previously, they had remained with the SNF.

[18]Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse (GAO/T-HEHS-97-114, Apr. 16, 1997); Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

BBA workload alone, implementation delays were probably inevitable. And now, HCFA has been advised by its contractor that its highest priority—uninterrupted claims processing through the timely completion of Year-2000 computer renovations—may be jeopardized by some BBA mandates that also require computer system changes. Though HCFA is implementing what will become an annual information campaign associated with Medicare+Choice, it has little experience in planning and coordinating such an undertaking. The ability of the campaign to provide accurate, comparable, comprehensive, and readily accessible information will help to determine the success of the hoped for voluntary movement of Medicare beneficiaries into less costly, more efficient health care delivery systems. While BBA computer system-related delays may jeopardize some anticipated program savings, slower Medicare expenditure growth is also at risk because of weaknesses in the implementation of other mandates. HCFA could take short-term steps to correct deficiencies in the new SNF PPS. However, longer-term research is needed to implement a payment system that fully realizes the almost $10 billion in savings projected by CBO.

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

# BBA Provisions Delayed by Year 2000 Computer Renovations

| BBA section | Provision | Required implementation date |
|---|---|---|
| 4001 | Collection of non-inpatient encounter data from plans | No date specified |
| 4011, 4012 | Medicare+Choice competitive pricing demonstration | 1/1/99 |
| 4014 | SHMO: Plan for integration of part C and SHMO | 1/1/99 |
| 4015 | Medicare subvention: Project for military retirees | 1/1/98[a] |
| 4103 | Prostate cancer screening | 1/1/00 |
| 4313 | Reporting and verification of provider identification numbers (employer identification numbers and Social Security numbers) | No date specified |
| 4402 | Maintaining savings from temporary reductions in capital payments for PPS hospitals | 10/1/97[b] |
| 4403 | Disproportionate share payment adjustment | 10/1/97[c] |
| 4432 | PPS rates for SNFs | 7/1/98[d] |
| 4432 | SNF consolidated billing for part B services | 7/1/98 |
| 4441 | Payment update for hospice services | 10/1/97[e] |
| 4502 | Update to conversion factor | 1/1/99[f] |
| 4505 | Implementation of resource-based practice expense RVUs | 3/1/98[g] |
| 4505 | Implementation of resource-based malpractice RVUs | 1/1/00 |
| 4523 | Hospital outpatient PPS | 1/1/99 |
| 4531 | Prospective payment fee schedule for ambulance services | 1/1/00 |
| 4541 | Application of $1,500 annual limit to outpatient rehabilitation therapy services | 1/1/99 |
| 4551 | DME payment provisions | 1/1/98[h] |
| 4555 | Ambulatory surgical center update | 10/1/97[i] |

(continued)

| BBA section | Provision | Required implementation date |
|---|---|---|
| 4602 | Interim payment for home health services: per beneficiary limit | 10/1/97[j] |
| 4603 | Prospective payment for home health services | 10/1/99 |
| 4603 | Requirements for home health payment information | 10/1/98 |
| 4624 | Payments to hospitals for direct costs of graduate medical education of Medicare+Choice enrollees | 1/1/98[k] |

[a]Collection of encounter data may be delayed.

[b]October 1, 1999, updates and changes may be delayed.

[c]October 1, 1999, updates and changes may be delayed.

[d]October 1, 1999, updates may be delayed.

[e]October 1, 1999, updates may be delayed.

[f]January 1, 2000, update may be delayed.

[g]January 1, 2000, transition may be delayed.

[h]January 1, 2000, update for orthotics and prosthetics may be delayed.

[i]October 1, 1999, update may be delayed.

[j]Implementation of proration provision delayed.

[k]January change may be delayed.

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