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MEDICARE

HCFA Faces Multiple
Challenges to Prepare for
the 21st Century

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HCFA Faces Multiple Challenges to Prepare for the 21st Century

Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss the Health Care Financing Administration's (HCFA) preparedness for administering the Medicare program in the 21st century. Because the \$200 billion Medicare program is critical to nearly all elderly Americans (those aged 65 and older) and to many of the nation's disabled, program management, excessive spending, and depletion of the Medicare Trust Fund have been the subject of much congressional concern and scrutiny in recent years. We, the Department of Health and Human Services' (HHS) Inspector General, and others have frequently reported that too much is being spent inappropriately because of the fraudulent and abusive billing practices of health care providers, thus prompting congressional concern about program vulnerabilities. (See the list of related GAO products at the end of this statement.)

You asked us to comment on HCFA's ability to meet growing program management challenges. My statement today centers on HCFA's administration of the Medicare program, although HCFA also has shared responsibilities with the states for administering Medicaid, a program serving low-income Americans. More specifically, my remarks will focus on (1) HCFA's new authorities under recent Medicare legislation, (2) HCFA managers' views on the agency's capacity to carry out various Medicare-related functions, and (3) the actions HCFA needs to take to accomplish its objectives over the next several years.

To do this work, we obtained agency documents on HCFA's reorganization and revised processes and interviewed top agency officials, including the new Administrator. In addition, we conducted small focus groups attended by about 60 senior and midlevel managers. We also relied on our previous and ongoing work on Medicare.

In summary, substantial program growth and greater responsibilities appear to be outstripping HCFA's capacity to manage its existing workload. Legislative reforms have increased HCFA's authority to manage the Medicare program. Simultaneously, however, other factors have increased the challenges HCFA faces, including the need to make year 2000 computer adjustments and develop a new, comprehensive information management strategy; manage transitions in its network of claims processing contractors; and implement a major agency reorganization. In addition, officials report that the expertise to carry out HCFA's new functions is not yet in place and that HCFA has experienced a loss of institutional knowledge through attrition. In this environment, agency managers are

concerned that some of their responsibilities might be compromised or neglected altogether because of higher-priority work.

HCFA's approach for dealing with its considerable workload is incomplete. Heretofore, the agency lacked an approach—consistent with the requirement of the Government Performance and Results Act of 1993 to develop a strategic plan—that specified the full range of program objectives to be accomplished. HCFA has developed a schedule for responding to recent legislative reforms but is still in the process of detailing the staffing and skill levels required to meet reform implementation deadlines. While addressing new mandates, the agency also needs to specify how it will continue to carry out its ongoing critical functions.

Background

The size and nature of the Medicare program make HCFA unique in authority and responsibility among health care payers. Fee-for-service Medicare serves about 33 million beneficiaries and processes a high volume of claims—an estimated 900 million in fiscal year 1997—from hundreds of thousands of providers, such as physicians, hospitals, skilled nursing facilities, home health agencies, and medical equipment suppliers. HCFA is also responsible for paying and monitoring more than 400 managed care health plans that serve more than 5 million beneficiaries. Enrollment in these plans has been growing by about 85,000 beneficiaries monthly.

The Medicare statute divides benefits into two parts: (1) “hospital insurance,” or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services, and (2) “supplementary medical insurance,” or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. In fiscal year 1997, part A covered an estimated 39 million aged and disabled beneficiaries, while a slightly smaller number were covered by part B, which requires payment of a monthly premium.

In Medicare's fee-for-service program—used by about 87 percent of the program's beneficiaries—physicians, hospitals, and other providers submit claims and are paid for each service rendered to Medicare beneficiaries. Medicare's managed care program covers a growing number of beneficiaries who have chosen to enroll in a prepaid health plan rather than purchase medical services from individual providers. The managed care program, which is funded from both the part A and part B trust funds,

currently consists mostly of risk contract health maintenance organizations (HMO).¹ Medicare pays these HMOs a monthly amount, fixed in advance, for all the services provided to each beneficiary enrolled.

HCFA, an agency within HHS, has slightly less than 4,000 full-time employees, 65 percent of whom work in the agency's headquarters offices; the rest work in the agency's 10 regional offices across the country. In addition to the agency's workforce, HCFA oversees more than 60 claims processing contractors that are insurance companies—like Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA. In fiscal year 1997, the contractors employed an estimated 22,200 people to perform Medicare claims processing and review functions.

Legislative Reforms Substantially Increase HCFA's Authority to Manage the Medicare Program

Two recent acts grant HCFA substantial authority and responsibility to reform Medicare. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, provides the opportunity to enhance Medicare's anti-fraud-and-abuse activities. The Balanced Budget Act of 1997 (BBA), P.L. 105-33, introduces new health plan options and major payment reforms. In correspondence to this Subcommittee last October, we noted that these two pieces of legislation addressed in large measure our concerns and those of the HHS Inspector General regarding the tools needed to combat fraud and abuse.² They also address many of the weaknesses discussed in our High-Risk Series report on Medicare.³

HIPAA created for the first time a stable source of funding for Medicare fraud control. For fiscal year 1997, the act provides for up to \$440 million for program safeguard activities; the level will rise incrementally each year, reaching \$720 million in fiscal year 2003, after which it will remain constant. This was a significant step in reversing the trend of declining program safeguard funds relative to program growth in the 8 years prior to fiscal year 1997, when HIPAA funding provisions became effective. This funding comes from a HIPAA-established fraud-and-abuse control account that also funds other activities involving other HHS agencies and the Department of Justice. HIPAA also provides HCFA with explicit authority to contract with firms outside its existing claims processing contractor

¹The Medicare managed care program also includes cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans may cover only part B services. Together, both types of plans enroll less than 2 percent of the Medicare population.

²See Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

³See High-Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

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network to perform payment safeguard functions while avoiding conflicts of interest. HIPAA also adds new civil and criminal penalties to heretofore little-used enforcement powers.

BBA provides for a dramatic expansion of health plan choices available to Medicare beneficiaries and makes reforms to payment methods in traditional fee-for-service Medicare and managed care. Under the act's new Medicare+Choice program, beneficiaries will have new health plan options, including preferred provider organizations (PPO), provider sponsored organizations (PSO), and private fee-for-service plans. Medicare+Choice introduces new consumer information and protection provisions, including a requirement to disseminate comparative information on Medicare+Choice plans in beneficiaries' communities and a requirement that all Medicare+Choice plans obtain external review from an independent quality assurance organization.⁴ These provisions address problems we have worked to correct with this committee and others in the Congress.⁵

BBA also provided for revamping many of Medicare's decades-old payment systems to contain the unbridled growth in certain program components. Specifically, the act mandated prospective payment systems for services provided by about 1,100 inpatient rehabilitation facilities, 14,000 skilled nursing facilities, 5,000 hospital outpatient departments, and 8,900 home health agencies. In addition, it made changes to the payment methods for hospitals, including payments for direct and indirect medical education costs. It also adjusted fee schedule payments for physicians and durable medical equipment and authorized the conversion of the remaining reasonable charge payment systems to fee schedules. Finally, the act granted the authority to conduct demonstrations on the cost-effectiveness of purchasing items and services through competitive bids from suppliers and providers.

⁴BBA authorized the HHS Secretary, subject to appropriations, to collect \$200 million in user fees to conduct information activities associated with Medicare+Choice. Subsequently, in the HHS appropriation, the Secretary was given authority to collect \$95 million of the originally authorized amount for this purpose. HCFA was also appropriated between \$20 million and \$30 million for the administration of BBA-related activities.

⁵See Medicare: HCFA Should Release Data to Aid Consumers, Prompt Better HMO Performance (GAO/HEHS-97-23, Oct. 22, 1996) and Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

HCFA's Capacity to Accomplish Its Mission Is Diminishing Relative to Added Responsibilities

While legislative reforms are dramatically reshaping Medicare, other changes are occurring, thus compounding difficult management challenges. For example, HCFA is rethinking its strategy to develop, modernize, or otherwise improve the agency's multiple automated claims processing and other information systems. This will involve preparing systems for the year 2000, repairing the deteriorating managed care enrollment systems, and making the necessary modifications to existing systems. HCFA plans to make these changes as an interim measure until, consistent with the Information Technology Management Reform Act of 1996 (P.L. 104-106), comprehensive reengineering can take place, such as making claims processing systems and payment mechanisms more efficient, programming BBA payment changes, and modernizing the anti-fraud-and-abuse system software.⁶ HCFA is also confronting transition problems resulting from the recent loss of large-volume claims processing contractors and the need for remaining contractors to absorb the workload. Finally, HCFA recently restructured its organizational units to better focus on its mission and is experiencing the kind of disruptions common to organizational transitions.

Against this backdrop, the themes that emerged from our individual interviews and focus groups with HCFA managers centered on (1) distribution of agency resources, (2) need for specialized expertise, (3) loss of institutional experience, and (4) reorganization issues.

Heightened Responsibilities Result in Redirected Priorities

"Robbing Peter to pay Paul" was the expression used to characterize one of the major themes from our focus groups. Specifically, managers were concerned that because of the concentrated efforts to implement BBA and solve computer problems that could arise in the year 2000, the quality of other work might be compromised or tasks might be neglected altogether. However, managers also noted that whereas some BBA-related tasks are completely new—such as conducting an open enrollment period for Medicare+Choice plans—and therefore add to the workload, others merely formalize work that was already underway but impose deadlines for completion, such as developing prospective payment methods for reimbursing several types of health care providers.

Regional and headquarters officials responsible for the oversight of claims processing contractors told us that their capacity to monitor contractors had seriously diminished. For example, one region that formerly had six

⁶See Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse (GAO/T-AIMD-97-176, Sept. 29, 1997).

staff members dedicated to contractor oversight currently has two; the others, they said, had been reassigned to work on managed care issues. This concerns us in light of our work on Medicare program management. Over the past several years, we have reported that HCFA has not adequately ensured that contractors are paying only medically necessary or otherwise appropriate claims.

Similarly, the HHS Inspector General's fiscal year 1996 financial audit found contractor oversight weaknesses. For example, some contractors selected for audit could not readily verify total Medicare expenditures, including paid claim amounts, to ensure that amounts were accurate, supported, and properly classified; did not adequately document accounts receivable; and did not have adequate internal controls over the receipt and disbursement of cash. Further, HCFA does not have a method for estimating the amount of improper Medicare payments; for fiscal year 1996, the Inspector General estimated that HCFA made about \$23 billion in inappropriate payments.

New Initiatives Create Need for New Skills

Managers also expressed a common concern about the staff's mix and level of skills. They noted that HCFA's traditional approach of hiring generalist staff and training them largely on the job is no longer well suited to the agency's need to implement recent reforms expeditiously. Instead, managers are beginning to identify the need for staff with specialized technical expertise, such as computer system analysts, survey statisticians, data analysts, market researchers, information management specialists, managed care experts, and health educators. In our discussions, several managers placed "appropriate skill sets" at the top of their wish lists.

As an illustration, the Medicare+Choice program introduces new health plan types and requires the dissemination of information about the plans to beneficiaries in 1998. Called the Medicare+Choice Information Fair, this nationwide educational and publicity campaign will be the first effort of its kind for HCFA. Managers were concerned that staff without prior experience will need to pull together information that describes and evaluates the merits of various plans.

Similar concerns emerged from our discussions about the lack of specialists in other program and agency support areas. Some managers noted the need for highly trained staff to develop, maintain, and modernize Medicare's government-owned claims processing and other automated

data systems. They also cited the need for specialists in contracting, facilities management, and telecommunications.

Retirements and Other Departures Drain HCFA of Experienced Staff

Many senior and midlevel managers and experienced technical staff have retired in recent years or are eligible to retire soon. Almost 40 percent of the organization has turned over in the past 5 years. Many were said to have spent their entire careers focused on a particular aspect of the Medicare program. A common concern in our discussions was the erosion of experienced staff to perform a variety of tasks, such as writing regulations and developing payment systems.

Managers cited the loss of experienced staff as a problem for developing and implementing the various prospective payment systems mandated by BBA. They also noted that developing one new payment system would have been manageable, but losses of expert staff make it difficult to implement multiple new payment systems concurrently. For example, experienced staff are needed to perform such technical tasks as those we mentioned in our October statement before this Subcommittee, including collecting reliable cost and utilization data to compute the new prospective payment rates, developing case mix adjusters, auditing cost reports to avoid incorporating inflated costs into the base rates, and monitoring to guard against providers' skimping on services to increase profits.⁷

Our focus group participants emphasized that it will be difficult to replace its experienced staff in the short term. Although HCFA is planning to hire new people, the time typically needed for recruiting, hiring, and orienting new employees is considerable. Managers commented that new employees, although highly educated and motivated, sometimes need extensive on-the-job training to replace lost expertise.

HCFA's Reorganization Is in Transition

In July 1997, HCFA restructured its entire organization. The new design reflected the agency's intent to, among other things, (1) combine activities to redirect additional resources to the growing managed care side of the program, (2) acknowledge a shift from HCFA's traditional role as claims payer to a more active role as purchaser of health care services, and (3) establish three components focused on beneficiaries, health plans and providers, and Medicaid and other activities conducted at the state level. It also established technical and support offices to assist these components.

⁷Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-98-9, Oct. 9, 1997).

(See HCFA's organization chart in app. I.) In announcing the planned reorganization, the Administrator explained that as Medicare has evolved over the years, new programs and projects were layered onto existing structures. Over time, he noted, this became cumbersome and confusing.

Many managers we spoke with considered the reorganization to be theoretically sound. Some also told us that it was long overdue, because HCFA's structure encouraged work on narrow issues within self-contained groups—an approach that did not benefit from the expertise existing across the agency. However, a consensus of focus group participants and high-level officials believed that the timing of the reorganization's implementation is unfortunate. They explained that they are currently facing full agendas with tight deadlines, which add to the stresses associated with any organizational change.

Managers described their difficulties in establishing new communication and coordination links within units as well as across the agency. For some, new efforts to coordinate have proved time-consuming to the point of being counterproductive. Managers commented that sign-off sheets formalizing coordination have enough names to take on the appearance of a staff roster.

They noted that the situation was particularly acute in light of the fact that people have not yet moved to the actual location of their new units. Managers in one division said staff were scattered in as many as seven places around HCFA's building. HCFA now hopes to have staff relocated by late spring, although this plan appears to be optimistic.

HCFA Lacks a Comprehensive Plan to Accomplish Its Short-Term Agenda

We observed that managers appeared to be clear on top management's expectations for completing BBA-related activities and for making sure that contractors' claims processing systems would comply with the millennium changes. They were less certain, however, about the agency's strategy for meeting other mission-related work.

To articulate the importance of BBA, HCFA established a tracking system that enumerates all the activities related to BBA mandates, identifies responsible agency units, and specifies completion deadlines. HCFA recently required lead units to prepare detailed BBA project plans that outline tasks, time periods, and resource needs. However, we did not find similar plans to detail the activities for other agency priorities or ongoing Medicare functions. As a result, HCFA does not have a comprehensive view

of its workload that would enable the agency's senior decisionmakers to consider whether resources are, in fact, adequate or properly distributed and which activities could be at risk of being neglected.

One example that came to our attention concerned the legislative mandates for reporting to the Congress on specific activities and programs. Currently, neither top management nor the Office of Legislation compiles a list of reports due and their deadlines. Unit managers are concerned because, although they are aware that certain reports for which they are responsible will be late, there is no systematic way to keep top management informed. Top management, in turn, cannot decide to heighten the priority for a particular report or develop a strategy to mitigate the consequences of others being late.

The illustration above and our discussions with agency officials suggest that while HCFA may be ready to assert its BBA-related resource needs, it is not likely to be in a position to adequately justify the resources it seeks to carry out its other Medicare program objectives. This observation calls to mind our July 1997 report on the adequacy of HHS's draft strategic plan under the Government Performance and Results Act.⁸ We noted that the plan failed to address certain major management challenges, including Medicare-related problems. Specifically, the plan did not address long-standing concerns about Medicare's existing claims processing systems or HCFA's efforts to acquire a billion-dollar integrated database system. In addition, it did not address the issue of information security that was identified in the fiscal year 1996 financial statement audit of HCFA, specifying that systems weaknesses created the risk of unauthorized access to sensitive medical history and claims data.

Observations

HCFA is an agency facing many challenges. Even before BBA made major changes, Medicare was a vast and complex program. Volumes of reports by us and others demonstrate, in numerous areas, HCFA's need to address program vulnerabilities. Because of the risks associated with a program of Medicare's magnitude, the need for HCFA to be vigilant cannot be overstated.

HIPAA and BBA have given HCFA many of the tools it needs to tame and police excessive spending. Although some resources accompanied HCFA's new authorities, senior and midlevel managers contend that HCFA is

⁸The Results Act: Observations on the Department of Health and Human Services' April 1997 Draft Strategic Plan ([GAO/HEHS-97-173R](#), July 11, 1997).

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struggling to carry out Medicare's numerous and challenging activities. In addition, they assert that the loss of experienced staff has further diminished HCFA's capacity. Nevertheless, senior managers do not appear to be adequately informed about the status of the full range of Medicare activities or associated resource needs. Under these circumstances, HCFA seems to be focusing most of its energy on important deadlines and pressures, but other critical functions may be receiving back-burner attention.

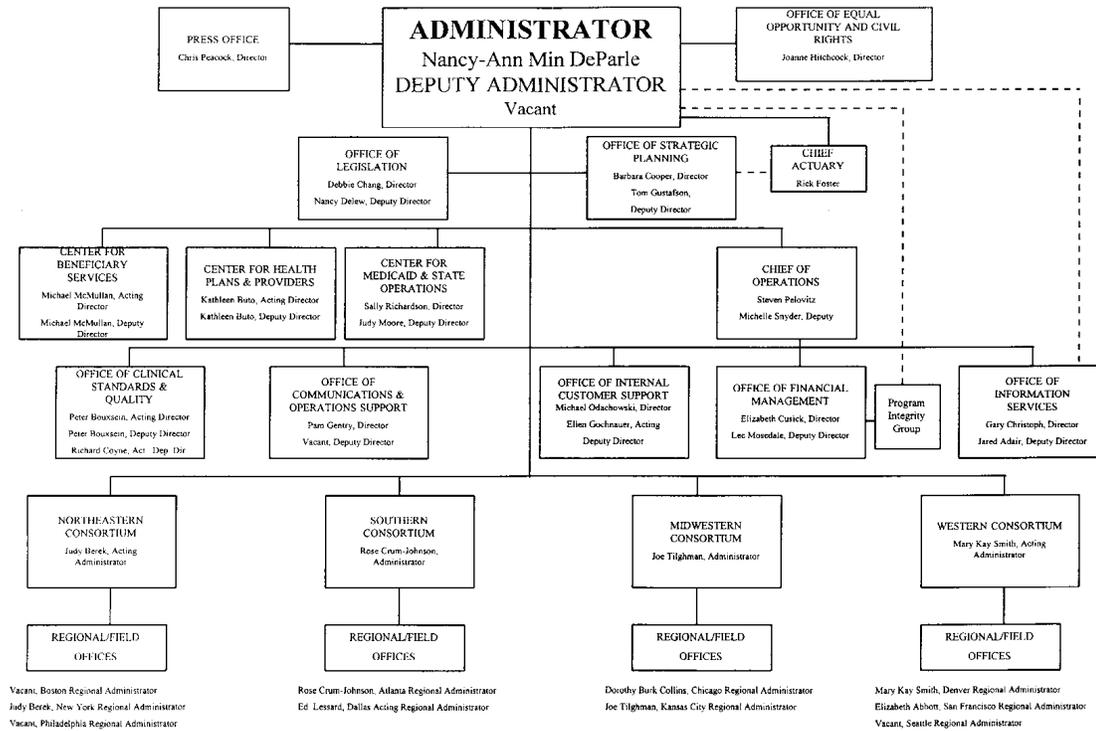
We have work underway to assess the status of HCFA's efforts to implement aspects of HIPAA and BBA and modernize the agency's information systems. We will also continue to monitor the progress of HCFA's reorganization efforts.

Mr. Chairman, this concludes my statement. I will be happy to answer your questions.

HCFA's Organization

HCFA ORGANIZATIONAL STRUCTURE

Date: 01/21/98



Related GAO Products

Medicare: Effective Implementation of New Legislation Is Key to Reducing Fraud and Abuse ([GAO/HEHS-98-59R](#), Dec. 3, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 ([GAO/HEHS-98-18R](#), Oct. 9, 1997) and related testimony entitled Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation ([GAO/T-HEHS-98-9](#), Oct. 9, 1997).

Medicare Automated Systems: Weaknesses in Managing Information Technology Hinder Fight Against Fraud and Abuse ([GAO/T-AIMD-97-176](#), Sept. 29, 1997).

Medicare Home Health Agencies: Certification Process Is Ineffective in Excluding Problem Agencies ([GAO/T-HEHS-97-180](#), July 28, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings ([GAO/HEHS-97-108](#), June 13, 1997).

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

Medicare ([GAO/HR-97-10](#)) and related testimony entitled Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention ([GAO/T-HEHS-97-89](#), Mar. 4, 1997).

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

Medicare: Millions Can Be Saved by Screening Claims for Overused Services ([GAO/HEHS-96-49](#), Jan. 30, 1996).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements ([GAO/HEHS-95-171](#), Aug. 8, 1995).

Medicare: Increased HMO Oversight Could Improve Quality and Access to Care ([GAO/HEHS-95-155](#), Aug. 3, 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending ([GAO/HEHS-94-42](#), Apr. 28, 1994).

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