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159388

Health, Education and Human Services Division

B-278270

October 9, 1997

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Subject: 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

Dear Mr. Chairman:

In enacting recent legislation, the Congress has responded to major concerns regarding the problem of waste, fraud, and abuse in the Medicare program. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (P.L. 104-191) and the Balanced Budget Act of 1997 (BBA) (P.L. 105-33) contain significant anti-fraud-and-abuse reforms, including program restructuring, that address issues raised by the Inspector General of the Department of Health and Human Services (HHS) and by us. Therefore, you asked us to (1) summarize the anti-fraud-and-abuse reforms enacted in HIPAA and BBA and (2) determine whether and how the legislation responds to our recommendations and those of the Inspector General.

To respond to your request, we are enclosing (1) a summary of the anti-fraud-and-abuse provisions contained in HIPAA and BBA and (2) a brief description of GAO and HHS Inspector General recommendations and relevant legislation. Our analysis is based largely on the contents of our annual Status of Open Recommendations and the Inspector General's Red Book, both of which are compilations of key recommendations that heretofore had not been fully

159388

implemented.[1] These documents contain most of the recommendations from which we derived this synopsis.[2]

In summary, the provisions in HIPAA and BBA offer the potential to improve program management significantly. Together they address Medicare's enforcement tools, payment safeguards, and pricing and payment method problems. In addressing several aspects of waste, fraud, and abuse, the acts incorporate a substantial proportion of recommendations to the Congress and matters for congressional consideration. In many instances, the acts also address recommendations that we and the HHS Inspector General have made directly to the Department, by either emphasizing priorities or dispelling ambiguities about authority.

Enclosure I summarizes the provisions of HIPAA and BBA that address fraud and abuse. Many contain the authority for deploying new enforcement tools that will enable Medicare to pursue offenders more aggressively. For example, HIPAA makes health care fraud a separate criminal offense and establishes new fines and other penalties for federal health care offenses. BBA substantially stiffens the exclusion penalties for individuals convicted of health care fraud. It also establishes civil monetary penalties for such offenses as contracting with an excluded provider, failing to report adverse actions under the new health care data collection program, and violating the antikickback statute.

Enclosure I also summarizes HIPAA and BBA provisions that shore up payment safeguard and oversight authority. HIPAA sets aside funding specifically for anti-fraud-and-abuse activities and authorizes HCFA to contract with entities specializing in claim review activities. Addressing oversight of Medicare's health maintenance organizations (HMO), HIPAA and BBA clarify and extend the conditions under which HCFA can impose intermediate sanctions against plans that deviate from Medicare regulations. BBA's Medicare+Choice

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[1]Status of Open Recommendations: Improving Operations of Federal Departments and Agencies (GAO/OP-97-1, Jan. 24,1997); Office of Inspector General, The 1996 Red Book, Cost-Saver Handbook (Washington, D.C.: Department of Health and Human Services, n.d.).

[2]We also included recommendations contained in Inspector General reports that we identified in the course of our audit and evaluation work. However, because some relevant recommendations may exist that were not available through the Red Book or the reports we identified, our list of relevant Inspector General recommendations should not be considered exhaustive.

program–which broadens beyond HMOs the private health plans available to Medicare beneficiaries–includes several provisions addressing Medicare HMO marketing, enrollment, and quality of care issues.

Enclosure II lists recommendations that we and the HHS Inspector General have made related to HIPAA and BBA provisions. These include many of the anti-fraud-and-abuse provisions discussed above as well as certain pricing and payment method reforms addressing program policies or practices that generate unnecessary expenditures. For example, BBA's provisions mandating that prospective payment systems replace cost-based reimbursement methods respond to the overutilization and billing abuse problems reflected in Medicare's expenditures for home health and skilled nursing facility services. By eliminating certain payments and other payment revisions–including rate reductions, benefit restructuring, and new authority to determine inherent reasonableness–BBA addresses problems associated with wasteful payments. BBA also changes the method for calculating payment rates for HMOs and other Medicare+Choice plans to avoid paying more for enrolled beneficiaries than if the enrollees had remained in traditional fee-for-service.

In conclusion, we believe that the Congress has gone a long way toward providing the legislative tools necessary to combat Medicare waste, fraud, and abuse. However, HHS, and HCFA primarily, have a major challenge ahead in effectively employing these tools and in acting on program management recommendations made directly to the Department Secretary and HCFA Administrator. Our testimony to be presented to the Subcommittee today elaborates on key implementation issues.[3]

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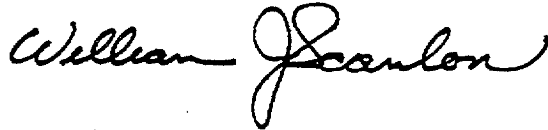
[3]Medicare: Recent Legislation to Minimize Fraud and Abuse Requires Effective Implementation (GAO/T-HEHS-98-9, Oct. 9, 1997).

If you have any questions about this letter, please contact me at 202-512-7114 or Leslie Aronovitz, Associate Director, at 312-220-7767. Lisanne Bradley, Hannah Fein, Richard Neuman, and Don Walthall also contributed to this correspondence.

Sincerely yours,



William J. Scanlon
Director, Health Financing and Systems

Enclosures - 2

SUMMARY OF ANTIFRAUD AND ABUSE PROVISIONS IN THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191) AND THE BALANCED BUDGET ACT OF 1997 (P.L. 105-33)

This enclosure summarizes anti-fraud-and-abuse-related provisions enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Balanced Budget Act of 1997 (BBA). The provisions in this enclosure are presented in the following tables:

Table I.1: Fraud and Abuse Funding and Contracting

Table I.2: Fraud Prevention and Detection

Table I.3: Criminal Penalties

Table I.4: Civil Penalties

Table I.5: Sanctions for Managed Care and Medicare+Choice Organizations

Table I.1: Fraud and Abuse Funding and Contracting	
Legislative reference	Description
HIPAA §201; BBA §4318	**Fraud and Abuse Control Program:** Directs HHS and the Department of Justice to establish a Fraud and Abuse Control Program to fight health care fraud in the public and private sectors. Appropriates funds from the Health Insurance (HI) Trust Fund that are not to exceed $104 million in fiscal year 1997, with 15-percent annual increases until 2003. For each fiscal year after 2003, the limit is to be $241 million, with no annual percentage increases; the provision directs that criminal fines and civil monetary penalties in health care cases be deposited to the HI Trust Fund. A GAO report on the operation of the Fraud and Abuse Control Program will be submitted to the Congress by June 1, 1998.
HIPAA §201(b)(4)	**Funds for the Medicare Integrity Program:** Appropriates funds from the Fraud and Abuse Control Fund for the Medicare Integrity Program not to exceed Fiscal year — $ in millions 1997 — $440 1998 — 500 1999 — 560 2000 — 630 2001 — 680 2002 — 700 2003+ — 720

HIPAA §202	**Medicare Integrity Program:** Establishes the Medicare Integrity Program and directs the HHS Secretary to enter into contracts for the performance of payment safeguard activities, as follows: (1) medical, utilization, and fraud review; (2) cost report audits; (3)overpayment determinations and recoveries; (4) payment integrity educational activities for providers, beneficiaries, and others; and (5) development of a list of medical equipment for prior authorization. The Secretary must determine what constitutes a conflict of interest situation that would preclude an entity from becoming a payment safeguard contractor. Fiscal intermediaries and carriers cannot be paid to perform the activities being performed by payment safeguard contractors.

Table I.2: Fraud Prevention and Detection

Legislative reference	Description
HIPAA §203(a); BBA §4311(b)	**Explanations of Medicare Benefits:** Requires the HHS Secretary to provide Explanations of Medicare Benefits (EOMB) for all Medicare benefit items and services that (1) list the item or service for which payment has been made and the amount of such payment for each item or service and (2) include a notice of the individual's right to request an itemized statement. After review of an EOMB or a bill for Medicare-covered services, each beneficiary has the right to request an itemized billing statement for Medicare-covered items and services from the provider furnishing the care. Within 90 days after the receipt of a furnished itemized statement, a beneficiary may submit a written request for a review of the itemized statement to the Secretary, if there are specific allegations that items or services were not provided as claimed or if there are other billing irregularities, such as duplicate billing. The Secretary must then determine whether Medicare payments were proper and recover any improperly paid amounts.
HIPAA §203(b) and (c); BBA §4311(a)	**Program to Collect Information on Fraud and Abuse From Beneficiaries:** Establishes a program to encourage beneficiaries to report fraud, waste, and abuse in the Medicare program, with payments to reporting beneficiaries in certain cases; requires the HHS Secretary to send an annual notice to all beneficiaries regarding Medicare waste, fraud, and abuse, indicating "that because errors do occur and because Medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement . . . for accuracy and report any errors or questionable charges by calling the toll-free phone number . . . "; establishes the beneficiary's right to request an itemized statement for Medicare items and services and a description of the program to collect information on Medicare fraud and abuse; and mandates a toll-free telephone number to report complaints and information about fraud, waste, and abuse in Medicare.

HIPAA §205; BBA §§4314, 4331(a)	**Safeharbors and Advisory Opinions:** Requires the solicitation of proposals for new and modified safe harbors (that is, types of situations that the HHS Inspector General does not consider in violation of the antikickback provisions), requires the issuance of advisory opinions regarding the antikickback statute and whether physician referrals for health services to be performed by entities owned or controlled by the referring physician are prohibited, and encourages requests to the HHS Inspector General to issue special fraud alerts.
HIPAA §216	**New Safeharbor to the AntiKickback Statute for Risk-Sharing Arrangements:** Creates a new exception to the antikickback statute for managed care organizations.
HIPAA §221(a), BBA §4331(b)	**Health Care Fraud and Abuse Data Collection Program:** Establishes an adverse action database of health care providers, suppliers, or practitioners that would coordinate with and not duplicate the National Practitioner Data Bank; defines final adverse actions as not including settlements in which no findings of liability have been made but as including all types of convictions, including those resulting from "no contest" pleas; and requires that those subjected to a final adverse action would report their tax identification numbers to this database.
HIPAA §221(b)	**Imposition of Fees for Issuance of Identification Numbers:** Allows the imposition of fees on physicians to cover the costs of investigation and recertification activities for the issuance of program identifiers.
BBA §4312(a)	**Disclosure of Ownership Information for Suppliers of Durable Medical Equipment**: Provides that the HHS Secretary cannot issue or renew a provider number for a supplier of durable medical equipment unless the supplier provides the Secretary on a continuing basis with full and complete information as to the identity of each person with an ownership or control interest in the supplier or in any subcontractor in which the supplier directly or indirectly has a 5-percent or more ownership interest.

BBA §4313	**Requirements to Disclose Employer Identification Numbers and Social Security Account Numbers:** Requires providers, suppliers, carriers, and intermediaries to supply the HHS Secretary with both the employer identification number and Social Security account number of the disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity directly or indirectly has a 5-percent or more ownership interest. Such numbers are to be verified, or corrected, by the Social Security Administration and the Department of the Treasury and reported to HHS.
BBA §4317	**Requirement to Furnish Diagnostic Information:** Includes nonphysician practitioners in the requirement to provide diagnostic codes when ordering items or services to be furnished by another health care entity.
BBA §4321(a)	**Nondiscrimination in Posthospital Referral to Home Health Agencies and Other Entities:** Requires hospitals to explain as part of the discharge planning process the availability of all home health services that participate in Medicare in the area in which the patient resides and that request the hospitals to list them.
BBA §4321(b)	**Maintenance and Disclosure of Information on Posthospital Home Health Agencies and Other Entities:** Requires that a hospital that has a financial interest in a home health agency or other health care entity to which it refers Medicare beneficiaries disclose to the HHS Secretary, who shall make the information public, the nature of the financial interest, the number of individuals who were discharged from the hospital identified as requiring home health services, and the percentages of the individuals who received home health care from the related provider and from other providers.
BBA §4507	**Disclosure of Program Exclusion by Health Care Entities That Enter Into Private Contracts with Medicare Beneficiaries:** Requires that a physician or practitioner who enters into a private contract with a Medicare beneficiary for any item or service for which no claim for payment is to be submitted to the Medicare program, and for which the physician or practitioner receives no reimbursement from Medicare directly or on a capitated basis, clearly indicate in the contract, among other things, whether the physician or practitioner is excluded from participation in the Medicare program.

BBA §4001 (§1857(d)(1))	**Annual Audit to Protect Against Fraud in the Medicare+Choice Program:** Requires the annual audit of the financial records (including data relating to Medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans and requires GAO to monitor each audit.
BBA §4001 (§1857(d)(2))	**Right to Inspect, Audit, and Evaluate Medicare+Choice Contractors and Access to Records:** Provides that each contract must provide that the HHS Secretary, or any person or organization designated by the Secretary, will have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and the facilities of the organization when there is reasonable evidence of some need for inspection, and the right to audit and inspect any books and records of the Medicare+Choice organization that indicate whether the organization can bear the risk of potential financial losses, can perform the services, or should be paid under the contract.
BBA §4312	**Surety Bond Requirements:** Provides that home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies must provide the HHS Secretary on a continuing basis with a surety bond of not less than $50,000 and authorizes the Secretary to require surety bonds of some or all providers of items or services, other than physicians or other practitioners.

Table I.3: Criminal Penalties	
Legislative reference	Description
HIPAA §204	**Application of Some Medicare and Medicaid Criminal Penalties to Other Health Care Programs**: Extends criminal penalties for acts involving Medicare or state health care programs to all federal and state health care programs, defined as (1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, that is funded directly in whole or in part by the U.S. government, other than the Federal Employees Health Benefit Program, or (2) any state health care program.
HIPAA §241	**Definitions Relating to Federal Health Care Offenses:** Amends title 18 of the U.S. Code to define a "federal health care offense" as including violations of specific criminal provisions if related to health care. The definition of "federal health care offense" does not apply to the offenses listed in §1128B of the Social Security Act. Enactment of specific health care-related criminal authorities does not prohibit the use of more general criminal authorities in cases in which those statutes may be more appropriately used; amends title 18 of the U.S. Code to define a "health care benefit program" as a public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity that is providing a medical benefit, item, or service for which payment may be made under the plan or contract.
HIPAA §242	**Criminal Offense of Health Care Fraud**: Defines "health care fraud" as the knowing and willful execution of or attempt to execute a scheme or artifice to defraud any health care benefit program or to obtain by means of false or fraudulent pretenses, representations, or promises any of the money or property owned by, or under the custody or control of, any health care benefit program; authorizes criminal fines or imprisonment of up to 10 years or both, unless the violation results in serious bodily injury or death, in which cases, respectively, imprisonment may be up to 20 years or for life. Criminal fines are to be deposited into the HI Trust Fund.
HIPAA §243	**Health Care Theft or Embezzlement**: Provides for fines or imprisonment of up to 10 years or both for theft or embezzlement relating to health care programs.

HIPAA §244	**False Statements Related to Health Care Matters:** Provides for fines or imprisonment of up to 5 years or both for false statements relating to health care matters.
HIPAA §245	**Obstruction of Criminal Investigations of Health Care Offenses:** Provides for fines or imprisonment of up to 5 years or both for obstruction of criminal health care investigations.
HIPAA §246	**Laundering of Monetary Instruments:** Explicitly makes it a crime to launder money that comes from the commission of a federal health care offense.
HIPAA §247	**Injunctive Relief Relating to Health Care Offenses:** Authorizes injunctive relief and freezing of assets in cases involving federal health care offenses.
HIPAA §248	**Authorized Investigative Demand Procedures:** Authorizes the issuance and enforcement of subpoenas of records and testimony of the custodians of those records by the Attorney General or her designee for investigations relating to health care offenses.
HIPAA §249	**Forfeitures for Federal Health Care Offenses:** Authorizes forfeiture of property that constitutes or is derived from proceeds traceable to the commission of a health care offense. The amount of the forfeiture of property is to be deposited into the HI Trust Fund.
HIPAA §262 (§1177)	**Wrongful Disclosure of Individually Identifiable Health Information:** Provides that obtaining, disclosing, or using individually identifiable health information is punishable by fines of up to $50,000 or imprisonment of up to 1 year or both, unless the offense was under false pretenses. The fine may be up to $100,000, imprisonment up to 5 years; with intent to sell, transfer, and so on for commercial advantage, personal gain, or malicious harm, the fine may be up to $250,000; imprisonment, up to 10 years.

Table I.4: Civil Penalties	
Legislative reference	Description
Program exclusions	
HIPAA §211	**Mandatory Exclusion From Participation in Medicare and State Health Care Programs:** Adds new mandatory exclusions from Medicare and Medicaid for felony convictions related to health care fraud or controlled substances.
HIPAA §211	**Permissive Exclusion from Participation in Medicare and State Health Care Programs:** Allows permissive exclusions from Medicare and Medicaid for misdemeanor convictions related to health care fraud or controlled substances.
HIPAA §212	**Minimum Periods of Exclusion:** Establishes a minimum exclusionary period of 3 years for criminal misdemeanors related to health care fraud or controlled substances or conviction of obstruction of a health care investigation; exclusions because of license revocation or suspension are to be the length of revocation or suspension.
HIPAA §213	**Permissive Exclusion of Individuals With Ownership or Control Interest in Sanctioned Entities:** Adds new permissive exclusion from Medicare and Medicaid for individuals who have an ownership or control interest in or are managing employees of a sanctioned entity.
HIPAA §214	**Sanctions Against Practitioners and Persons for Failure to Comply With Statutory Obligations:** Establishes a minimum exclusionary period of 1 year for a practitioner who has failed to successfully complete a Peer Review Organization corrective action plan or who has grossly failed to meet quality standards.
BBA §4001 (§1852(k))	**Penalties for Improper Billing for Medicare+Choice Enrollees by Physicians and Entities Who Are Not Employees of the Medicare+Choice Organization:** Allows the same sanctions for physicians or entities improperly billing beneficiaries enrolled in Medicare+Choice organizations as would be applied if the beneficiary were not enrolled with a Medicare+Choice organization.

BBA §4301	**Permanent Exclusion for Those Convicted of Three Health Care Related Crimes:** Provides that if an individual has been convicted on one previous occasion of one or more offenses for which an exclusion may be imposed, the period of the exclusion will be not less than 10 years and, if on 2 or more previous occasions, the exclusion will be permanent.
BBA §4302	**Authority to Refuse to Enter Into Medicare Agreements With Individuals or Entities Convicted of Felonies:** Allows the HHS Secretary to refuse to enter into, terminate, or renew an agreement with a provider, physician, or supplier who has been convicted of a felony under federal or state law that the Secretary determines is detrimental to the best interests of the program or program beneficiaries.
BBA §4303	**Exclusion of Entity Controlled by Family Member of a Sanctioned Individual:** Allows the exclusion of an entity that was owned or controlled by a sanctioned individual who has transferred ownership or control interest in anticipation of, or following, a conviction, penalty assessment, or exclusion to an immediate family member or a member of the household.
BBA §4331(c)	**Exclusions Applicable to All Federal Health Care Programs:** Expands the scope of Medicare exclusions to include exclusion from all other federal and state health care programs, other than the Federal Employees Health Benefit Program.
BBA §4551(c)(1)(C)	**Sanctions Related to Payments for Upgraded Durable Medical Equipment:** Allows the HHS Secretary to establish sanctions, by regulation, including exclusions of suppliers that have engaged in coercive or abusive practices.

Civil monetary penalties	
HIPAA §231(a) and (c)	**Civil Monetary Penalties (CMP):** Extends many current Medicare-Medicaid CMPs to all health care programs; Inspectors General of departments with federal health care programs can initiate CMPs with respect to their own programs and, in certain cases, with respect to other federal health care programs; increases the amount of authorized penalties from $2,000 per false item or service claimed to $10,000; CMPs and assessments are to be used to pay back Medicare and Medicaid loss; remaining dollars are to go to the Health Care Fraud and Abuse account.
HIPAA §231(b)	**Civil Monetary Penalties for Excluded Persons Who Retain Ownership of a Health Care Entity:** Provides that persons excluded from Medicare or a state health care program and who maintain a direct or indirect ownership or control interest of 5 percent or more in an entity or who is an officer or managing employee of a Medicare or state health care program entity are to be subject to CMPs.
HIPAA §231(e)	**Civil Monetary Penalties for Patterns of Incorrect Coding or Medically Unnecessary Services:** Allows CMPs to be assessed against persons who claim payment for codes that they know will result in greater payment than is applicable and against persons who claim payment for services that they know are not medically necessary.
HIPAA §231(h)	**Civil Monetary Penalties for Offering Inducements to Beneficiaries to Influence the Health Care They Use:** Allows CMPs to be assessed against persons offering remuneration, including waiving coinsurance and deductible amounts, except when those waivers are exempted from the antikickback provisions, to induce an individual to order from a particular provider or supplier receiving Medicare or state health care funds.
HIPAA §232	**Civil Monetary Penalty for False Certification for Home Health Services:** Provides a new CMP of the greater of $5,000 or three times the amount incorrectly paid for a physician's false certification of the need for home health services.
HIPAA §261 (§1176)	**Penalty for Failure to Comply With Administrative Simplification Requirements and Standards:** Allows the imposition of a $100 penalty for each violation, up to $25,000, for violation of any single requirement or prohibition.

BBA §4304(a)	**Civil Money Penalties for Persons Who Contract With Excluded Individuals**: Allows penalties to be imposed on individuals or entities that contract, by employment or otherwise, with an individual or entity that they know or should know is excluded from participation in the Medicare program to provide health care services for which Medicare payment may be made.
BBA §4304(b)	**Civil Money Penalties for Kickbacks**: Allows penalties of $50,000 for each act and damages of not more than three times the remuneration offered, paid, solicited, or received to be imposed on persons guilty of violating the antikickback statute.
BBA §4311(b)	**Civil Money Penalty for Failure to Furnish an Itemized Statement**: Allows the HHS Secretary to impose a civil money penalty of not more than $100 for each failure to furnish an itemized statement on the request of a Medicare beneficiary.
BBA §4331(d)	**Sanctions for Failure to Report Adverse Actions:** Authorizes the imposition of a civil penalty of not more than $25,000 on any health plan for each adverse action not reported to the Health Integrity and Protection Data Bank.

Table I.5: Sanctions for Managed Care and Medicare+Choice Organizations	
Legislative reference	Description
BBA §4001 (§1857(g)(1))	**Sanctions for Medicare Managed Care and Medicare+Choice Organizations:** Provides for, in addition to any other sanctions applicable, intermediate sanctions when the Medicare+Choice organization (1) fails substantially to provide legally required, medically necessary items and services, if the failure would affect the individual adversely; (2) imposes premiums in excess of the monthly basic and supplemental beneficiary premiums; (3) expels or refuses to reenroll an individual who is in violation of law; (4) engages in any practice that has the effect of denying or discouraging enrollment by beneficiaries whose medical conditions indicate a need for substantial future medical services; (5) misrepresents or falsifies information furnished to the HHS Secretary or to beneficiaries or to health care providers; (6) fails to comply with the anti-"gag-rule" and balance billing provisions; and (7) employs or contracts for health care, utilization review, medical social work, or administrative services with a provider that is excluded from participation in the Medicare program.
BBA §4001 (§1857(g)(2))	**Intermediate Sanctions:** Authorizes several types of sanctions for managed care and Medicare+Choice organizations: (1) generally, civil penalties of not more than $25,000 for each incident, except that, (a) for incidents of discouraging or denying enrollment to a beneficiary who could be expected to have a need for substantial medical services or false or fraudulent statements to the HHS Secretary, penalties of not more than $100,000 for each such determination; (b) for incidents in which a beneficiary was charged excessive premiums, double the excess amount charged, with the excess amount charged to be deducted from the penalty and returned to the beneficiary; and (c) for incidents in which the organization has been discouraging or denying enrollment to beneficiaries with a need for substantial medical services, $15,000 for each individual not enrolled as a result of the practice involved; (2) suspension of enrollment until the Secretary is satisfied that the basis for the suspension has been corrected and is not likely to recur; or (3) suspension of payment to the organization for individuals enrolled after the date the Secretary notifies the organization of the suspension and until the Secretary is satisfied that the basis for the suspension has been corrected and is not likely to recur;

BBA §4001 (§1857(c)(2) and (g)(3))	**Other Intermediate Sanctions:** Provides for the following intermediate sanctions when the HHS Secretary terminates a contract with a Medicare+Choice organization because of the organization's (1) substantial failure to carry out the contract, (2) carrying out the contract in a manner inconsistent with the efficient and effective administration of the Medicare program, or (3) no longer substantially meeting the conditions for participation in the program: (1) civil money penalties of not more than $25,000 for each determination, if the deficiency that is the basis of the determination has directly adversely affected, or has the substantial likelihood of adversely affecting, an individual covered under the organization's contract; (2) civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency continues; and (3) suspension of enrollment of individuals after the date the Secretary notifies the organization of a determination and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.
BBA §4001 (§1857(h))	**Termination of Medicare+Choice Contracts:** Allows for the termination of a contract with a Medicare+Choice organization in accordance with formal investigation and compliance procedures established by the HHS Secretary under which the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination to terminate and the Secretary provides the organization with reasonable notice and opportunity for hearing before terminating the contract, except when the Secretary determines that a delay in termination would pose a threat of imminent and serious risk to enrolled individuals.

PROVISIONS OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 AND THE BALANCED BUDGET ACT OF 1997 ADDRESSING RECOMMENDATIONS BY GAO AND THE HHS OFFICE OF THE INSPECTOR GENERAL

This enclosure provides recommendations against fraud, waste, and abuse made by the General Accounting Office (GAO) and the Department of Health and Human Services (HHS) Office of the Inspector General that were open when either the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the Balanced Budget Act of 1997 (BBA) were passed. The Congress has responded to virtually all these recommendations with provisions in HIPAA and BBA designed to address the underlying problems or to mandate actions by the Health Care Financing Administration (HCFA). The recommendations in this enclosure are organized in the following manner:

Table II.1: Fee-for-Service: Payment Safeguards and Beneficiary Protections

Table II.2: Fee-for-Service: Pricing and Payment Methods

Table II.3: Managed Care and Medicare+Choice: Payment Safeguards and Beneficiary Protections

Table II.4: Managed Care and Medicare+Choice: Pricing and Payment Methods

Table II.1: Fee-for-Service: Payment Safeguards and Beneficiary Protections	
Provision	Documentation
Payment safeguard funding	**Recommendation:** The Congress should consider appropriating additional funds for contractor safeguard activities to prevent inappropriate program payments, especially medical review, audit, and Medicare Secondary Payer monitoring and recovery. **Relevant legislation:** HIPAA §201(b) Ensures funding for payment safeguard activities at payment safeguard contractors (Medicare Integrity Program contractors), as well as new earmarked funding for fraud investigations and prosecution. **Related reports:** GAO/HEHS-96-16; GAO/HRD-91-67; HHS-OIG-A-14-94-00391; HHS-OIG-A-14-94-00392; HHS-OIG-A-09-91-00103; HHS-OIG-OEI-03-90-00763; HHS-OIG-OEI-07-90-00760; HHS-OIG-A-09-89-00100; HHS-OIG-A-10-86-62016
Alternative funding proposal	**Recommendation:** The Congress may wish to consider enacting legislation directing the Health Care Financing Administration (HCFA) to carry out a pilot demonstration in which, once improper billing by a home health agency has been detected, the cost of follow-up audit work would be assessed against the provider and the money from such assessments would be earmarked for HCFA's payment safeguard activities. **Relevant legislation:** None **Related report:** GAO/HEHS-97-108

Provider ownership information	**Recommendation:** HCFA should refuse to enter into agreements with providers whose owners or principals have criminal records or who are the relatives of the owner of a provider that had defrauded the Medicare program. **Relevant legislation:** HIPAA §§213, 231(b); BBA §§4302, 4303, 4304(a) Provides authority to exclude individuals who have an ownership or control interest (that is, owner of a mortgage, deed of trust, or other security interest secured by the entity) in sanctioned entities; provides civil monetary penalties for entities owned or controlled by an excluded person; authorizes the HHS Secretary to refuse to enter into agreements that the Secretary determines are detrimental to the best interests of the program or program beneficiaries with providers, physicians, or suppliers that have been convicted of felonies; allows the Secretary to exclude entities that were owned or controlled by a sanctioned person but transferred to a family or household member; and prohibits providers from contracting with or employing excluded persons. **Related reports:** GAO/HEHS-95-210; GAO/HRD-92-76; HHS-OIG-OEI-09-96-00110

Better identification of those who own or control providers	**Recommendation:** HCFA should develop procedures and provide policy guidance to Medicare contractors concerning the use of available information on ownership and to identify and review individuals who have been involved in fraudulent or abusive activity or have an ownership interest in entities to which they refer patients. Durable medical equipment suppliers and home health agencies should be required to provide Social Security numbers and employer identification numbers when they are supplying required ownership information. **Relevant legislation:** BBA §§4312, 4313 Authorizes the refusal of a billing number to a provider that does not provide complete ownership and control information; requires entities participating in the Medicare and Medicaid programs to provide Social Security numbers and employer identification numbers to the HHS Secretary for their businesses, persons with an ownership or control interest in the businesses, and managing employees and subcontractors of the businesses. **Related reports:** GAO/HEHS-95-210; GAO/HRD-92-76; HHS-OIG-OEI-09-96-00110
Surety bonds	**Recommendation:** Durable medical equipment (DME) suppliers and home health agencies (HHA) should post surety bonds as a condition of participation in the Medicare program. **Relevant legislation:** BBA §§4312(a), 4724(g) Requires DME suppliers, HHAs, and others that participate in the Medicare program to post a surety bond of a minimum of $50,000. **Related report:** HHS-OIG-OEI-09-96-00110

Quality of care for patients receiving oxygen services	**Recommendation:** There should be sufficient patient monitoring by oxygen companies. **Relevant legislation:** BBA §4552(c) Mandates that the HHS Secretary develop service standards for oxygen provided in the home. **Related report:** HHS-OIG-OEI-03-91-01710
Rural health clinic (RHC) certification	**Recommendation:** HCFA should modify the certification process to increase state involvement; recertification should be required of RHCs within a specific time limit–for example, 5 years–applying new criteria to document the need for the RHC and the RHC's effect on access to care. **Relevant legislation:** BBA §4205(d) Stipulates that the shortage area requirements designation for each RHC will be reviewed triennially. **Related report:** HHS-OIG-OEI-05-94-00040
Carrier audit and recovery procedures	**Recommendation:** HCFA should identify legal issues that constrain carriers' audit and recovery efforts and make recommendations to the Congress to eliminate such constraints. It should also amend Medicare procedures, such as those involving the projection of sample results, to enhance carriers' audit and recovery efforts. **Relevant legislation:** HIPAA §231(e) Authorizes a new civil monetary penalty for upcoding and patterns of claims for medically unnecessary services. **Related report:** GAO/HEHS-94-42

Antifraud systems technology	**Recommendation:** HCFA should develop a plan for implementing antifraud systems technology, including the conduct of a pilot or demonstration program using systems, such as those used to detect code manipulation, in use by commercial plans. **Relevant legislation:** HIPAA §202 (§1893(b)) Provides that payment safeguard contractors (Medicare Integrity Program contractors) must perform medical and utilization review and fraud review, employing similar standards, processes, and technologies used by private health plans–including equipment and technologies used in the review of claims. **Related reports:** GAO/HEHS-95-210; GAO/AIMD-95-77; GAO/AIMD-95-135
Medicare secondary payer reporting	**Recommendation:** The Congress should require the HHS Secretary to report annually on the status of HCFA's ongoing and planned efforts to improve identification and recovery of claims from other insurers. **Relevant legislation:** None **Related report:** GAO/HEHS-94-147
Medicaid and Medicare crossover claims	**Recommendation:** The Congress should amend Medicaid law by authorizing HCFA to withhold federal matching funds when states do not comply with federal requirements for identification and recovery of claims from other insurers, including Medicare. **Relevant legislation:** None **Related report:** GAO/HEHS-94-147

Medicare secondary payer statutory authority	**Recommendation:** The Congress should extend the Medicare secondary payer (MSP) provisions for end-stage renal disease (ESRD) beneficiaries. **Relevant legislation:** BBA §4631 Extends permanently current MSP policies, including disabled beneficiaries in large group health plans and beneficiaries with ESRD. **Related report:** HHS-OIG-A-10-86-62016
Medigap insurance	**Recommendation:** The Congress should consider amending federal Medigap law to require insurers to offer Medicare beneficiaries who have been continuously covered by Medigap insurance guaranteed-issue policies with benefit packages comparable to those of the policies they currently hold. Consideration should also be given to extending this protection to beneficiaries whose employer-sponsored retiree health plans are terminated or curtailed and who must, or choose to, leave their managed care plans. **Relevant legislation:** BBA §4031 Guarantees issuance of specified Medigap policies for certain continuously enrolled individuals, including those who were previously covered by Medigap policies with an insurer that becomes bankrupt and those who had been enrolled in a managed care organization. **Related report:** GAO/HEHS-96-180

Contractor performance standards for payment safeguard activities	**Recommendation:** HCFA should develop precise measures of carrier performance in such key medical review areas as (1) effectiveness of carrier data analysis capabilities, (2) adequacy of carrier medical policies, (3) scope and effectiveness of prepayment screens, (4) significance of carrier medical review savings, and (5) postpayment review performance. HCFA should hold the contractors accountable for implementing local policies; prepayment screens, including autoadjudicated screens; or other corrective actions to control payments for procedures that are highly overused on a nationwide basis. **Relevant legislation:** HIPAA §202 (§1893(d)) Provides that payment safeguard contracts (Medicare Integrity Program contracts) can be renewed only if the current contractor has met or exceeded the performance standards in the contract. **Related reports:** GAO/HEHS-96-49; GAO/HEHS-94-42; GAO/HEHS-94-35

Table II.2: Fee-for-Service: Pricing and Payment Methods	
Provision	Documentation
Disproportionate share hospital adjustments	**Recommendation:** The Congress should consider whether disproportionate share hospital adjustments should be reduced, if not eliminated. **Relevant legislation:** BBA §4403 Makes a reduction in the disproportionate share payment for a hospital of 1 percent in fiscal year 1998, 2 percent in fiscal year 1999, 3 percent in fiscal year 2000, 4 percent in fiscal year 2001, and 5 percent in fiscal year 2002. **Related report:** HHS-OIG-A-04-87-00111
Hospital capital payments	**Recommendation:** The Congress should consider whether capital payments should be reduced and whether excess capacity or unused beds should be considered in the capital cost policy. **Relevant legislation:** BBA §4402 Rebases capital payments with an additional reduction of 2.1 percent. **Related reports:** HHS-OIG-A-07-95-01127; HHS-OIG-A-14-93-0380; HHS-OIG-A-09-91-00070
Hospital sale basis	**Recommendation:** The Congress should consider whether the requirement that Medicare make adjustments for gains and losses when hospitals undergo changes of ownership should be eliminated. **Relevant legislation:** BBA §4404 Eliminates the requirement that Medicare make adjustments for gains and losses for a hospital that is changing ownership by setting the Medicare capital asset sales price equal to the book value. **Related report:** HHS-OIG-OEI-03-96-00170

Hospital outpatient departments	**Recommendation:** Payments for outpatient services should be comparable to the applicable ambulatory surgical center rate. **Relevant legislation:** BBA §§4521-4523 Eliminates formula-driven overpayments in fiscal year 1998, extends capital and noncapital cost limits, and establishes a prospective payment system for outpatient services for fiscal year 1999. **Related reports:** HHS-OIG-A-14-89-00221; HHS-OIG-OEI-09-88-01003; HHS-OIG-OAI-85-09-0046
Skilled nursing facility payments	**Recommendation:** The Congress should consider bundling payment for all medical equipment, supplies, and services into a per diem rate, paid to nursing facilities under Medicare and Medicaid. HCFA should clarify that billings for "dietary services" in nursing homes specifically include the costs for parenteral and enteral nutrition. **Relevant legislation:** BBA §4432 Establishes a prospective payment system for Medicare skilled nursing facility stays that includes payment for all ancillary items and services. **Related reports:** GAO/HEHS-95-23; HHS-OIG-OEI-03-94-00790; HHS-OIG-OEI-03-94-00791; HHS-OIG-OEI-03-94-00792; HHS-OIG-OEI-03-94-00770; HHS-OIG-OEI-03-94-00772; HHS-OIG-OEI-06-92-00861; HHS-OIG-OEI-06-92-00863; HHS-OIG-OEI-06-92-00864.
Hospices	**Recommendation:** HCFA should restructure the fourth benefit period under the hospice benefit. **Relevant legislation:** BBA §4443 Replaces the current unlimited fourth benefit period with an unlimited number of 60-day benefit periods, each requiring recertification. **Related report:** HHS-OIG-OEI-05-95-00250

Home health agency payment system	**Recommendation:** The Congress should mandate a prospective payment system for home health agencies, with an accurate baseline that does not include utilization patterns of the higher-reimbursement agencies in its base, so that program payments for home health care are not inappropriately inflated. **Relevant legislation:** BBA §4603 Mandates that a prospective payment system be adopted for which the total payments in fiscal year 2000 would be equal to those of the current system if the cost limits were reduced by 15 percent, which will be adjusted annually for any increases in the home health market basket, and provides for interim payment reductions until a new system is in place. **Related report:** HHS-OIG-OEI-04-93-00260
Home health agency payments	**Recommendation:** The Congress should consider eliminating periodic interim payments to home health agencies. **Relevant legislation:** BBA §4603(b) Eliminates the periodic interim payment method. **Related report:** HHS-OIG-OEI-09-96-00110
Costs not associated with patient care	**Recommendation:** The differences between costs for employee benefits and costs for entertainment should be clarified; costs of entertainment, goods or services for personal use, alcohol, all fines, penalties and associated interest, dues, and membership costs associated with civic and community hospitals should be unallowable. **Relevant legislation:** BBA §4320 Prohibits "reasonable cost" payments for items such as entertainment, gifts, donations, educational expenses, and the personal use of automobiles. **Related reports:** HHS-OIG-A-04-93-02067; HHS-OIG-A-03-92-00017

Indirect Medicare education payments	**Recommendation:** The Congress should reduce the indirect teaching adjustment factor, which is designed to compensate teaching hospitals for their relatively higher costs. **Relevant legislation:** BBA §4621(a) Gradually lowers the indirect medical education adjustment factor through fiscal year 2001. **Related reports:** GAO/HRD-89-33; HHS-OIG-A-07-88-00111
Graduate medical education (GME) payments	**Recommendation:** HCFA should revise the regulations to remove from a hospital's allowable GME base year costs any cost center with little or no Medicare utilization. **Relevant legislation:** BBA §§4623, 4626 Limits the number of residents and rolling average full-time-equivalent count of residents and offers incentive payments for voluntary reductions in the number of residents. **Related report:** HHS-OIG-A-06-92-00020
Bad debt payments	**Recommendation:** The Congress should consider legislation to modify the bad debt payment methodology. **Relevant legislation:** BBA §4451 Prohibits providers from counting reductions in copayments as bad debt and reduces bad debt payments to providers by 25 percent during fiscal year 1998, by 40 percent for fiscal year 1999, and by 45 percent during subsequent fiscal years. **Related report:** HHS-OIG-A-14-90-00339

Competitive bidding	**Recommendation:** The Congress should consider directing HCFA to participate more fully in the competitive health care marketplace. Competitive bidding should be authorized as a means of purchasing Medicare services, so that lower prices for commonly furnished health care items and services can be obtained. **Relevant legislation:** BBA §§4011, 4319 Provides authority to do competitive bidding demonstrations in both the Medicare+Choice and fee-for-service programs; authorizes up to five competitive bidding demonstrations in the fee-for-service program, one of which must purchase oxygen and each of which can have multiple sites. (Demonstrations must be completed by December 31, 2002.) **Related reports:** GAO/HEHS-95-210; HHS-OIG-OEI-03-96-00230; HHS-OIG-OEI-03-94-00021; HHS-OIG-OEI-06-92-00866
Adjustment of payment amounts to those "inherently reasonable"	**Recommendation:** The Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified. **Relevant legislation:** BBA §4316 Applies the "inherent reasonableness" process to all part B services other than physicians' services. **Related reports:** GAO/T-HEHS-96-138; GAO/HEHS-95-171; HHS-OIG-OEI-03-94-00392

Coordinated billing for part B-Reimbursable items and services for nursing home patients	**Recommendation:** The Congress should consider whether part B billings for nursing home patients ought to be consolidated and billed by the nursing home; payments for enteral nutrition were especially noted as needing inclusion in the skilled nursing facility benefit. **Relevant legislation:** BBA §4432(b) Requires consolidated billing–that is, that payment be made to the nursing facility for all part B items and services. **Related reports:** HHS-OIG-OEI-03-94-00790; HHS-OIG-OEI-06-92-00861; HHS-OIG-OEI-06-92-00865; HHS-OIG-OEI-06-92-00864; HHS-OIG-OEI-06-92-00863
Therapy in nursing homes	**Recommendation:** HCFA should set explicit limits to ensure that Medicare pays no more for therapy services than would any prudent purchaser. **Relevant legislation:** BBA §4541(a) Establishes a fee schedule for therapy services provided by an outpatient rehabilitation facility in nursing homes and other settings. **Related report:** GAO/HEHS-95-23
Enteral and parenteral nutrition pricing	**Recommendation:** Payments for enteral nutrition should be reduced or competitive acquisition strategies should be employed. **Relevant legislation:** BBA §§4316, 4551(b) Freezes payments for enteral and parenteral nutrition, equipment, and supplies for 1998 through 2002 and simplifies the process used to reduce inherently unreasonable prices by 15 percent; provides authority to do competitive bidding demonstrations in the fee-for-service program. **Related reports:** HHS-OIG-OEI-03-96-00230; HHS-OIG-OEI-03-94-00021; HHS-OIG-OEI-06-92-00866; HHS-OIG-OEI-06-92-00861

Medicare payments for oxygen	**Recommendation:** HCFA should lower the amounts paid for oxygen, since Medicare allowed, on average, 174 percent more than the VA for oxygen concentrators. **Relevant legislation:** BBA §4552(a) Reduces Medicare reimbursement for oxygen 25 percent until 1999 and 30 percent for each subsequent year. **Related report:** HHS-OIG-OEI-03-91-00711
Pharmaceutical payments	**Recommendation:** HCFA should reduce payments for drugs reimbursable by the Medicare program. **Relevant legislation:** BBA §4556 Reduces by 5 percent Medicare payments for drugs whose payments are based on the average wholesale price. **Related reports:** HHS-OIG-OEI-03-95-00420; HHS-OIG-OEI-03-94-00390
Physician payment-geographic adjusters	**Recommendation:** HCFA should test whether Internal Revenue Service data provide a superior basis for setting or updating the geographic adjusters for physician payments and, if so, obtain and use these data. **Relevant legislation:** BBA §§4501-4503 Although geographic adjusters were not addressed, changes the single practice-type conversion factor for 1998, requires a new resource-based relative value system to be developed, and replaces the volume performance standard with a sustainable growth rate standard. **Related report:** GAO/HRD-93-93

Physical therapy in physician offices	**Recommendation:** HCFA should apply the physical therapy coverage guidelines for skilled nursing facilities to other settings such as physician offices. **Relevant legislation:** BBA §4541(b) Extends the guidelines to physical therapy provided in physicians' offices. **Related report:** HHS-OIG-OEI-02-90-00590
Technical component payments for radiation services	**Recommendation:** HCFA should survey the technical component costs incurred by facilities providing radiology services and revise the fee schedule to more accurately reflect the unit costs incurred by high-volume, efficient providers. **Relevant legislation:** BBA §4521 Eliminates formula-driven overpayments for outpatient hospital radiology services. **Related report:** GAO/HRD-92-59
Payments for clinical laboratory tests	**Recommendation:** The Congress should give HCFA the authority to adjust the cap or maximum rates for individual test procedures where relative rate inequities are apparent and not in line with the prices charged physicians. **Relevant legislation:** BBA §4553 Provides for reducing fee schedule payments by lowering the cap to 74 percent of median for payment amounts after 1997, with no inflation update for 1998 through 2002. **Related reports:** GAO/HRD-91-59; HHS-OIG-A-09-93-00056; HHS-OIG-OAI-02-89-01910; HHS-OIG-A-09-89-00031

Ambulance services for end-stage renal disease (ESRD) patients	**Recommendation:** HCFA should ensure fairer payment for services rendered and may consider combining two or more of the following strategies: (1) establish a payment schedule for ambulance transport to maintenance dialysis and set the fee lower than what is paid for unscheduled, emergency transports; (2) negotiate preferred provider agreements with ambulance companies to provide scheduled transportation for ESRD beneficiaries; (3) undertake competitive bidding to establish a price for scheduled transports for ESRD beneficiaries or to select companies that agree to provide such services; (4) establish a rebate program for companies that routinely transport ESRD beneficiaries; and (5) provide an add-on to the composite rate Medicare pays dialysis facilities and allow the facility to negotiate agreements with ambulance companies. **Relevant legislation:** BBA §§4531, 4532 Establishes a prospective fee schedule, effective January 1, 2000, for ambulance services provided directly by a supplier or provider or under an arrangement with a provider that is to establish definitions for ambulance services that link payments to the type of services provided and provides for a capitated payment to up to three demonstration projects with units of local government to provide ambulance services to Medicare beneficiaries. **Related report:** HHS-OIG-OEI-03-90-02131
Provider-based Rural Health Clinic (RHC) payment	**Recommendation:** Caps should be placed on Medicare provider-based RHCs and states should be encouraged to find other ways to make reimbursement between provider-based and independent RHCs more equitable. **Relevant legislation:** BBA §4205(a) Extends the per-visit payment limits to provider-based clinics. **Related report:** HHS-OIG-OEI-05-94-00040

Managed care techniques in the fee-for-service program	**Recommendation:** HCFA should examine the feasibility of allowing Medicare's commercial contractors to adopt for their Medicare business such managed care features as preferred provider networks, case management, and enhanced utilization review. **Relevant legislation:** BBA §4016 Authorizes a Medicare Coordinated Care Demonstration to explore some of these options. **Related reports:** GAO/T-HEHS-96-138; GAO/HEHS-95-210

Table II.3: Managed Care and Medicare+Choice: Payment Safeguards and Beneficiary Protections

Provision	Documentation
Health status screening of beneficiary applicants	**Recommendation:** Medicare risk health maintenance organizations should be monitored for inappropriate screening of beneficiaries' health status at application. **Relevant legislation:** BBA §4001 (§1852(b)) Provides that a Medicare+Choice organization may not deny, limit, or place conditions on the coverage or provision of benefits based on any health status-related factor; provides for civil money penalties for either expelling or refusing to reenroll a beneficiary or engaging in any practice that could reasonably be expected to have the effect of denying or discouraging enrollment. **Related reports:** HHS-OIG-OEI-06-91-00736; HHS-OIG-OEI-06-91-00730
Standards for managed care marketing	**Recommendation:** HCFA should establish standards for sales force training and monitoring and hold health maintenance organizations accountable for maintaining those standards. **Relevant legislation:** BBA §4001 (§1856(b)) Authorizes the Secretary to establish standards other than those related to solvency for Medicare+Choice organizations. **Related report:** HHS-OIG-OEI-04-91-00630

Better quality assurance for managed care	**Recommendation:** HCFA should routinely monitor managed care quality assurance and utilization management practices and integrate its findings into compliance monitoring reports. HCFA should examine beneficiary perceptions of problems with making routine appointments, declining health caused by health maintenance organization care, and an HMO's refusal to provide certain services. HCFA should establish an on-line system to identify and review cases of frequent enrollment change. Persons who disenroll from their managed care plans should be encouraged to communicate as many reasons for leaving the HMO as are applicable to their situation, and HCFA should consider conducting exit surveys by mail with computer-generated forms. **Relevant legislation:** BBA §4001 (§1852(e)) Requires that Medicare+Choice plans have both an internal quality assurance program, which includes measures of beneficiary satisfaction, and review by an independent quality assurance review and improvement organization. **Related reports:** GAO/HEHS-95-155; HHS-OIG-OEI-06-91-00730; HHS-OIG-OEI-06-91-00734; HHS-OIG-OEI-06-91-00736; HHS-OIG-OEI-04-91-00630; HHS-OIG-OEI-04-91-00640
Beneficiary service access	**Recommendation:** Service access problems reported by disabled or end-stage renal disease beneficiaries should be carefully examined, as they are an especially vulnerable group. **Relevant legislation:** BBA §4001 (§1852(d)) Medicare+Choice organizations must make benefits available and accessible to each individual electing the plan. **Related reports:** HHS-OIG-OEI-06-91-00736; HHS-OIG-OEI-06-91-00730

Retroactive disenrollment	**Recommendation:** HCFA should issue regulations specifying the purpose of retroactive disenrollments and the circumstances, criteria, and procedures that must be met in authorizing such actions. HCFA should also establish a policy limiting enrollment to one "open season" (opportunity to enroll) per year. **Relevant legislation:** BBA §4001 (§1851) Provides for annual coordinated enrollment periods beginning in 2002, one change in coverage per enrollment period; changes in coverage cannot be retroactive beginning with the first Medicare+Choice enrollments. **Related reports:** GAO/HRD-88-73; HHS-OIG-OEI-04-91-00630; HHS-OIG-OEI-04-91-00640
Better comparative information for beneficiaries	**Recommendation:** HCFA should continue its efforts to educate Medicare beneficiaries about managed care options and should routinely publish (1) comparative data it collects on health maintenance organizations such as complaint rates, disenrollment rates, distinguishing between administrative and nonadministrative disenrollments, and rates and outcomes of appeals; (2) the results of its investigations or any findings of noncompliance by HMOs; and (3) benefit and cost comparison charts with all Medicare options available for each market area. It should widely publicize the availability of the charts to all beneficiaries in markets served by Medicare managed care plans. **Relevant legislation:** BBA §4001 (§1851(d)) Requires HCFA to publish comparative information on Medicare+Choice plans, including disenrollment rates, information on enrollee satisfaction, information on health outcomes, and the plan's compliance record with Medicare requirements. **Related reports:** GAO/HEHS-97-23; GAO/HEHS-95-155; HHS-OIG-OEI-04-93-00142; HHS-OIG-OEI-04-93-00151; HHS-OIG-OEI-06-91-00736; HHS-OIG-OEI-06-91-00730

Better managed care plan information for beneficiaries	**Recommendation:** HCFA should require standard formats and terminology for managed care informational materials for beneficiaries, including benefits descriptions. **Relevant legislation:** BBA §4001 (§1852(c)) Requires that each Medicare+Choice plan disclose essential information, including information on benefits offered, in a standardized format. **Related reports:** GAO/HEHS-97-23; GAO/HEHS-95-155; HHS-OIG-OEI-07-94-00280; HHS-OIG-OEI-7-94-00281; HHS-OIG-OEI-07-94-00282; HHS-OIG-OEI-07-94-00283
Payment of providers employed by managed care organizations	**Recommendation:** HCFA should develop standards that will require managed care organizations to pay their providers accurately and in a timely manner. **Relevant legislation:** BBA §4001 (§§1856, 1857(f)) Requires the Secretary to establish financial and other standards by June 1, 1998, and requires managed care organizations to make prompt payment of claims submitted for services and items provided to enrollees. **Related report:** GAO/HRD-92-11

Streamlined appeals for managed care	**Recommendation:** HCFA should explore options to streamline the managed care appeals process and ensure that health maintenance organizations properly distinguish and process appeals and grievances and beneficiaries should receive better information on their appeal rights. **Relevant legislation**: BBA §4001 (§1852(c) and (g)) Requires Medicare+Choice organizations to disclose in clear, accurate, and standardized form information about the plan, including plan appeal or grievance rights and procedures, and to offer an expedited review process when the life or health of an enrollee could be seriously jeopardized by the normal time periods for review. **Related reports:** GAO/HEHS-95-155; HHS-OIG-OEI-07-94-00280; HHS-OIG-OEI-7-94-00281; HHS-OIG-OEI-07-94-00282; HHS-OIG-OEI-07-94-00283; HHS-OIG-OEI-06-91-00736; HHS-OIG-OEI-06-91-00730
Medicare Health Maintenance Organization (HMO) monitoring	**Recommendation:** HCFA should more actively monitor HMOs, targeting HMOs based on disenrollment data; require HMOs to report minimum statistical information; and establish minimum requirements for case file documentation. **Relevant legislation:** BBA §4001 (§§ 1856, 1857(d)) Requires the Secretary to establish financial and other standards by June 1, 1998; provides for the annual auditing of the financial records of at least one-third of all Medicare+Choice organizations; gives the Secretary the right to audit, inspect, and evaluate the quality, appropriateness, and timeliness of services and the ability of the organization to bear the risk of potential financial losses. **Related reports:** HHS-OIG-OEI-07-94-00280; HHS-OIG-OEI-7-94-00281; HHS-OIG-OEI-07-94-00282; HHS-OIG-OEI-07-94-00283; HHS-OIG-OEI-06-91-00734

Intermediate sanctions for managed care organizations	**Recommendation:** HCFA should establish policies that specify the circumstances under which it will impose sanctions on managed care organizations that are violating Medicare requirements. **Relevant legislation:** BBA §4001 (§1857(g)) Provides for intermediate sanctions that apply to seven types of situations, including failing to provide medically necessary items and services; imposing excessive premiums; refusing to enroll an eligible beneficiary; engaging in practices that would discourage enrollment by persons with the need for intensive health care; making false statements; failing to comply with balance billing and "gag rule" provisions; and employing or contracting with an individual or entity for the provision of health care, utilization review, medical social work, or administrative services that have been excluded from the Medicare program. **Related report:** GAO/HRD-92-11

Table II.4: Managed Care and Medicare+Choice: Pricing and Payment Methods

Provision	Documentation
Managed care risk adjusters	**Recommendation:** HCFA should sponsor further research and demonstration work on the risk adjusters used for determining managed care payments. **Relevant legislation:** BBA §4001 (§1853(a)(3)) Requires HHS to establish risk adjusters, such as age, disability status, gender, and institutional status, for Medicare+Choice payments; study risk adjusters and determine their actuarial soundness and establish adjusters for health status and other demographic factors based on this study, effective January 1, 2000; and report to the Congress the results of an evaluation of the actuarial soundness of the various adjusters by an independent actuary. **Related report:** GAO/HEHS-94-119
Adjustment of managed care rates	**Recommendation:** The Congress should consider giving HCFA authority to reduce Medicare managed care payment rates in selected market areas, including the ability to conduct demonstration projects on alternative payment methods. **Relevant legislation:** BBA §4011 Authorizes seven demonstrations (four of which must be conducted) in which payments to Medicare+Choice organizations are determined by competitive pricing. **Related reports:** GAO/HEHS-97-16; GAO/HEHS-96-21

Non-fee-for-service basis for managed care payments	**Recommendation:** HCFA should conduct research on bases for managed care payments other than fee-for-service reimbursement. **Relevant legislation:** BBA §4001 (§1853) Provides that although the new rates will be based on the 1997 average adjusted per capita cost, which is based on the Secretary's estimate for a geographic area of what will be paid for fee-for-service beneficiaries, updates will be based on increases in the national per capita growth percentage. **Related report:** GAO/HEHS-94-119

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