DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date SEP 1 1 1998

From June Gibbs Brown
Inspector General

Subject Capitation Rates for Medicare Managed Care Plans Are Inflated Due to Improper Payments Included in Rate Calculations (A- 14-97-00206)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is a copy of our report entitled, "Capitation Rates for Medicare Managed Care Plans Are Inflated Due to Improper Payments Included in Rate Calculations."

In our last two audits of the Health Care Financing Administration's (HCFA) financial statements, we found that the Medicare fee-for-service (FFS) program improperly paid providers $23.2 billion,' or 14 percent of total expenditures, in Fiscal Year (FY) 1996 and $20.3 billion,* or 11 percent of total expenditures, in FY 1997. The objective of this managed care organization (MCO) review was to determine if, considering the outcome of our financial statement audits, it would be reasonable to adjust capitation rates to MCOs to take into account the amount of improper payments that are included in MCO rate calculations.

The Balanced Budget Act (BBA) of 1997 (Public Law 105-33) revised the payment calculation methodology for MCOs effective January 1998. However, the new methodology is still linked to Medicare FFS expenditures. The calculation uses as a base the 1997 county-specific capitation rates which were based on 95 percent of the average cost of treating the beneficiary in Medicare's FFS program. As such, 95 percent of any improper FFS payments are included in the MCO capitation rates. This situation is particularly troublesome because the structure of Medicare's managed care environment, with MCOs scrutinizing care provided beneficiaries, should preclude the MCO from providing unnecessary and undocumented services--the major types of payment errors found in our financial statement audits. Therefore, the types of improper payments we

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found in our financial statement audits and, in fact, the routine errors found during HCFA's regular post payment program integrity work should not be incurred by the typical MCO.

Unless improper payments are removed from MCO rate calculations, they will continue to result in the equivalent of an overpayment in the Medicare managed care program. The effects of the inflated MCO rates will be magnified as total payments to MCOs rise due to increased enrollment. Removing the improper payments from MCO rate calculations would reduce inappropriate expenditures from the financially troubled trust funds as well as help reduce the inequities of excessive MCO payment rates.

We are therefore recommending that HCFA pursue legislation that will allow modifications to MCO capitation rates which would include an adjustment for the estimated amounts of unrecovered improper payments that are included in MCO rate calculations.

In response to our draft report, HCFA agreed that Medicare payments to MCOs have been overstated and that they should be reduced. However, HCFA did not agree that it would be appropriate at this time to seek legislation as we recommend. Given the overall payment reduction to MCOs based on BBA of 1997, HCFA questioned the merits of pursuing a second reduction based on a projection of audit findings which may change substantially from year to year. The HCFA noted the payment reductions of BBA of 1997 severed the tie between MCO capitation rates and FFS payments for MCO capitation rates beginning with 1998 and allows HCFA to adjust MCO payments for health status factors beginning in the year 2000. The full text of HCFA's comments is included as Appendix B to the report.

We agree that BBA of 1997 will address some of the problems of excessive capitation payments, however there are inherent problems in the establishment of the new payment mechanism. The BBA provision establishes the managed care rates for 1998 and subsequent years based on the 1997 capitation rates. As we've stated, these 1997 capitation rates have been based on FFS payments which our audits of the financial statements have shown to be inaccurate. Without any legislative correction, these payment errors have become locked into all future MCO payments. This is especially disconcerting since HCFA's goal is to reduce the Medicare FFS payment error rate to 5 percent by the year 2002. However, the positive actions planned by HCFA to correct the problems in FFS payments will not benefit future MCO capitation rates unless legislation is enacted to correct for the FFS errors in the 1997 base. Therefore, we believe that our recommendation, to seek legislation that allows the Secretary the latitude to adjust the capitation rates, is necessary. In order to facilitate a legislative change, we will be pleased to work further with HCFA officials to evaluate the accuracy of the 1997 base year payment amount.

Adjusting the capitation payments by the lower limit of improper payments found in our financial statement audits would result in managed care payment savings of at least 7 percent.

Based on the anticipated growth of MCO payments to $73 billion in 2002 and $153 billion in 2007, the annual savings associated with a corrected 1997 base year could be $5 billion in 2002 and increase to over $10 billion in 2007.

Also, in its comments to the draft report, HCFA expressed concern that if our recommendation was implemented across the board, it would penalize those geographic areas (counties) where there are no payment errors. Our audits of HCFA's financial statements found errors at all the contractors reviewed. The contractors that were included in our financial statement audits were selected statistically and are the servicing intermediaries and carriers for those plans whose Medicare enrollment levels represent about 70 percent of the total beneficiaries in risk managed care plans.

We would appreciate your views and the status of any action taken or contemplated on our recommendation within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-14-97-00206 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CAPITATION RATES FOR MEDICARE MANAGED CARE PLANS ARE INFLATED DUE TO IMPROPER PAYMENTS INCLUDED IN RATE CALCULATIONS

JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1998
A-14-97-00206

SUMMARY

In our audits of the Health Care Financing Administration's (HCFA) financial statements, we found that the Medicare fee-for-service (FFS) program *improperly paid providers $23.2 billion in* Fiscal *Year (FY)* 1996 *and* $20.3 *billion in* FY *1997.* Compounding the magnitude of these improper payments is the fact the payments to managed care organizations (MCO) are based on 1997 capitation rates which are derived from Medicare FFS program expenditures which include the improper payments. As a result, the Medicare program suffers a double effect--once from the improper payments made to providers in the FFS program and again from including these improper payments in the calculation of MCO capitation rates.

We have long been concerned that improper FFS expenditures were inappropriately inflating MCO capitation rates because our work over the years has identified many vulnerabilities in the Medicare FFS program. However, the amount of improper Medicare expenditures had never been conclusively quantified on a programwide basis prior to our audits of HCFA's financial statements. Since our financial statement audits have now quantified the magnitude of improper payments, we undertook this current review. Our objective in this review was to determine if, considering the outcome of our financial statement audits, it would be reasonable to adjust MCO capitation rates to take into account the amount of improper payments that are included in the rate calculations.

The Balanced Budget Act (BBA) of 1997 (Public Law 105-33) revised the payment calculation methodology for MCOs effective January 1998. The new methodology is still linked to Medicare FFS expenditures. The calculation uses as a base the 1997 county-specific capitation rates which were based on 95 percent of the average cost of treating the beneficiary in Medicare's FFS program. As such, 95 percent of improper FFS payments are included in the MCO capitation rates. This situation is particularly troublesome because the structure of Medicare's managed care environment, with MCOs scrutinizing care provided beneficiaries, should preclude the MCOs from providing unnecessary and undocumented services--the major types of payment errors found in our financial statement audits. Therefore, the types of improper payments we found in our financial statement audits and, in fact, the routine errors found during HCFA's regular post payment program integrity work should not be incurred by the typical MCO.

Unless improper payments are removed from MCO rate calculations, they will continue to result in the equivalent of an overpayment in the Medicare managed care program. The effects of the inflated MCO rates will be magnified as total payments to MCOs rise due to increased enrollment. Removing the improper payments from MCO rate calculations would reduce inappropriate expenditures from the financially troubled trust funds as well as help reduce the inequities of excessive MCO payment rates.

We are therefore recommending that HCFA pursue legislation that will allow modifications to MCO capitation rates which would include an adjustment for the estimated amounts of unrecovered improper payments that are included in MCO rate calculations.

In response to our draft report, HCFA agreed that Medicare payments to MCOs have been overstated and that they should be reduced. However, HCFA did not agree that it would be appropriate at this time to seek legislation as we recommend. Given the overall payment reduction to MCOs based on BBA of 1997, HCFA questioned the merits of pursuing a second reduction based on a projection of audit findings which may change substantially from year to year. The HCFA noted the payment reductions of BBA of 1997 severed the tie between MCO capitation rates and FFS payments for MCO capitation rates beginning with 1998 and allows HCFA to adjust MCO payments for health status factors beginning in the year 2000. The full text of HCFA's comments are included in Appendix B.

We agree that BBA of 1997 will address some of the problems of excessive capitation payments, however there are inherent problems in the establishment of the new payment mechanism. The BBA provision establishes the managed care rates for 1998 and subsequent years based on the 1997 capitation rates. As we stated, these 1997 capitation rates have been based on FFS payments which our audits of the financial statements have shown to be inaccurate. Without any legislative correction, these payment errors have become locked into all future MCO payments. This is especially disconcerting since HCFA's goal is to reduce the Medicare FFS payment error rate to 5 percent by the year 2002. However, the positive actions planned by HCFA to correct the problems in FFS payments will not benefit future MCO capitation rates unless legislation is enacted to correct for the FFS errors in the 1997 base. Therefore, we believe that our recommendation, to seek legislation that allows the Secretary the latitude to adjust the capitation rates, is necessary. In order to facilitate a legislative change, we will be pleased to work further with HCFA officials to evaluate the accuracy of the 1997 base year payment amount.

Adjusting the capitation payments by the lower limit of improper payments found in our financial statement audits would result in savings of at least 7 percent. Based on the anticipated growth of MCO payments to $73 billion in 2002 and $153 billion in 2007, the annual savings associated with a corrected 1997 base year could be $5 billion in 2002 and increase to over $10 billion in 2007.

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TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Managed care is defined as a health care delivery and payment structure in which the payer organization seeks to control costs and maintain uniform quality of care by exercising specific controls over the treatment provided and fees charged by the providers who agree to participate in a given health plan. Since managed care concepts have helped private sector payers contain health care costs and limit excess utilization encouraged by FFS reimbursement methodologies, the Congress recognized the potential cost-control advantages of managed care and enacted legislation to incorporate managed care options into the Medicare program.

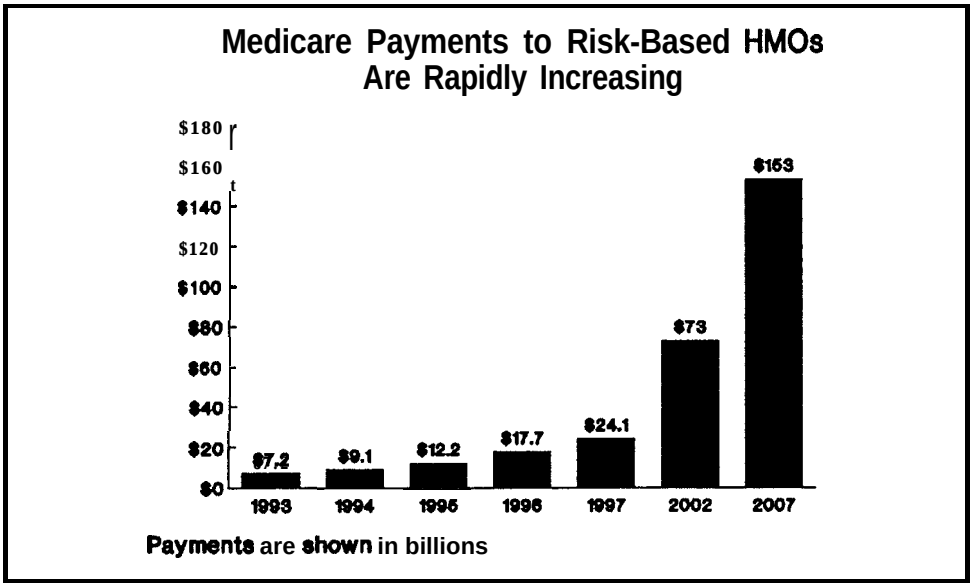
Legislation has allowed Medicare to contract with managed care organizations since 1972. The major Medicare managed care program, the Medicare risk contract program, dates back to 1982 when the Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA). This legislation was implemented in 1985 and gave Medicare enrollees the option to enroll in risk-based MCOs. Under the Medicare risk-based program, MCOs must assume responsibility for providing all Medicare-covered services in return for a predetermined capitated payment.

Since 1985, the Medicare risk program has been steadily growing. Realizing the cost-control appeal, as well as potential advantages to beneficiaries, HCFA has encouraged MCOs to contract on a risk basis. Most MCOs which contract with HCFA today do so on a risk basis. In June 1998 there were 450 managed care plans with Medicare contracts--344 of them on a risk basis.

Enrollment in managed care plans, particularly risk-based plans, has been steadily increasing especially during the last 5 years. In 1993 there were approximately 2.5 million beneficiaries enrolled in managed care plans, 1.7 million in risk-based plans. In June 1998 there were approximately 6.4 million Medicare beneficiaries enrolled in managed care plans, 5.7 million (approximately 14.6 percent of the total Medicare population) in risk-based plans. The Congressional Budget Office estimates that the number of Medicare beneficiaries who receive their medical care through risk MCOs will rise to 25 percent by 2002, and 34 percent by 2007.

Medicare payments to risk-based managed care plans have also grown significantly--from $7.2 billion in FY 1993 to $24.1 billion in FY 1997. The Congressional Budget Office

estimates that by the year 2002 reimbursement to risk MCOs will total $73 billion and by 2007 reimbursement to risk MCOs will soar to $153 billion.



Rate Setting Methodology for Risk-Based MCOs

Capitation rates for risk MCOs are linked to Medicare FFS expenditures. The TEFRA 1982 legislation stipulated that the reimbursement rates for risk MCOs be set at 95 percent of the average cost of treating the beneficiary in Medicare's FFS program.

Under this payment methodology, reimbursement rates were prospectively established by HCFA's Office of the Actuary in a complex, multi-stage process. In the first step, HCFA estimated the average national Medicare Part A and Part B trust funds expenditures per Medicare FFS beneficiary for the upcoming contract year. These estimates were developed separately for the aged, the disabled, and those beneficiaries having end stage renal disease (ESRD). These national per capita expenditures were then adjusted through several steps to a county level (statewide level for ESRD beneficiaries) that take into account the trends in the historical cost relationship between each county and the nation as a whole. Since these estimates were prospectively calculated, an adjustment to them could be made later to take into account differences between a prior year's estimated and actual Medicare expenditures. The capitation rate to MCOs was set at 95 percent of the projected average local Medicare expenditures per beneficiary, known as the adjusted average per capita cost (AAPCC). Review of legislative history reveals that the AAPCC was set at 95 percent of FFS expenditures to take into account the efficiencies of MCOs and still allow MCOs to offer

additional benefits beyond basic Medicare coverage. The actual capitation payment rate to the MCO was calculated by adjusting the AAPCC for each beneficiary's demographic characteristics, i.e., age, gender, Medicaid eligibility, and whether or not the beneficiary is in an institution such as a nursing home.

The BBA of 1997 revised the payment calculation methodology for MCOs effective January 1998. The payment rate is now the greater of a blended capitation rate, a minimum amount rate, or a minimum percentage increase. However, the new methodology is still linked to Medicare FFS expenditures. The calculation uses as a base the 1997 county-specific AAPCC rates which were based on FFS expenditures. The law does not stipulate any adjustments to this base other than to carve out a specified portion of the rates which are for medical education expenses. The 1997 rates will be updated by the national average per capita increase in Medicare FFS expenditures minus a percentage specified in the law. Several other calculations will be performed on the base rates to blend the rates between MCO local area payment rates and an overall national MCO average payment rate. This blending is designed to reduce the current wide geographic variations in payment rates. The methodology for years after 1998 is essentially the same with various adjustment percentages specified in the law. In addition, beginning with the rates for 1999, adjustments will be made to compensate for differences between actual and estimated Medicare growth rates used in the 1998 and later calculations. The actual capitation payment rate to the MCO is still adjusted for each beneficiary's demographic characteristics, i.e., age, gender, Medicaid eligibility, and whether or not the beneficiary is in an institution such as a nursing home. Starting in the year 2000, BBA of 1997 will require a payment adjustment for beneficiary health status factors.

OBJECTIVE, SCOPE, AND METHODOLOGY

Prior to completion of our audits of HCFA's financial statements, congressional interest was shown in the issue of deleting the estimated costs of improper Medicare payments from the base upon which MCO capitation rates are calculated.

We have long shared this congressional concern since our work over the years has identified many vulnerabilities in the Medicare FFS program. However, the amount of improper Medicare expenditures had never been conclusively quantified on a programwide basis prior to our audits of HCFA's FY 1996 and 1997 financial statements. Since our financial statement audits have now quantified the magnitude of improper payments, we undertook this current review to determine if, considering the outcome of our financial statement audits, it would be

reasonable to adjust MCO capitation rates to take into account the amount of improper payments that are included in the MCO rate calculations.

To accomplish our objective, we:

- reviewed applicable laws, regulations, and legislative history concerning the Medicare MCO risk program;
- studied material prepared by HCFA's Office of the Actuary related to MCO capitation rate setting methodologies;
- reviewed reports and congressional testimonies prepared by the Office of Inspector General (OIG) and the General Accounting Office (GAO);
- analyzed materials prepared by the health care industry relating to trends in MCO rate setting;
- reviewed materials prepared by various Government agencies and private organizations dealing with fraud in managed care settings; and
- participated with the Department of Justice personnel in work groups which focused on fraud and abuse in managed care.

This limited scope review was performed in accordance with generally accepted government auditing standards during the period August to October 1997.

FINDINGS AND RECOMMENDATION

Over the years, substantial payment improprieties in Medicare's FFS sector have been identified by the OIG, GAO, and HCFA's program integrity activities. Although the consensus has always been that the Medicare program was losing substantial amounts to improper payments, the magnitude of the problem had never been conclusively quantified. However, our audits of HCFA's financial statements for FYs 1996 and 1997 established that the amount of improper Medicare payments was much higher than previously thought. We estimated that during FY 1996 about 14 percent of Medicare's FFS expenditures, or

approximately $23.2 billion, were improper. [1] For FY 1997, we estimated that 11 percent of Medicare FFS expenditures, or approximately $20.3 billion, were improper.'

Since Medicare's reimbursement methodology for MCOs is based on expenditures in the FFS sector, payment inaccuracies in FFS inappropriately inflate MCO reimbursements. As such, the Medicare program suffers twofold--once from making these improper payments to health providers in the FFS program and again by including 95 percent of these improper payments when setting MCO payment rates. As the Medicare managed care program continues to grow, any amount in the MCO capitation rate which is attributable to improper payments will significantly impact the Medicare program. This situation is particularly troublesome because the structure of Medicare's managed care environment, with MCOs scrutinizing care provided beneficiaries, should preclude the MCO from providing unnecessary and undocumented services--the major types of payment errors found in our financial statement audits.

FRAUD AND ABUSE IN MEDICARE'S FFS PROGRAM

Over the years, we have identified numerous areas of vulnerabilities and inherent risks in Medicare's FFS program. As a recent example, our four State audit of home health agency payments showed over $2.6 billion has been improperly paid during a 15 month period. We have also reported substantial payment improprieties made to numerous types of providers, including hospitals, physicians, clinical laboratories, and durable medical equipment suppliers.

The GAO has also found that Medicare's size and mission make it an attractive target for exploitation and has identified many weaknesses in the FFS program. The GAO has identified Medicare as a high risk Federal program in each of its three high risk series of reports. In 1992, 1995, and again in 1997, GAO identified Medicare as "one of several government programs highly vulnerable to waste, fraud, and abuse.. . . "

The discrete nature of improper Medicare billings has always made it difficult to quantify the amount of improper Medicare expenditures. One of the reasons for these improper payments is that the Medicare program places great faith and trust in the hope that each individual health provider will submit Medicare claims for only authorized services. The consensus has always

[1] Our audit report, ***Report of the Financial Statement of the Health Care Financing Administration for Fiscal Year 1996 (A-17-95-00096)*** was issued in July 1997.

[2] Our audit report, ***Report of the Financial Statement of the Health Care Financing Administration for Fiscal Year 1997 (A-17-97-00097)*** was issued in April 1998.

been that the Medicare program was losing large sums to improper payments. Although the GAO estimated that up to 10 percent of Medicare's total expenditures were improper, a definitive figure for improper payments was never proven. However, our audits of HCFA's FY 1996 and 1997 financial statements has established that the amount of improper Medicare payments was much higher than previously estimated.

FINANCIAL STATEMENT AUDITS REVEALS HIGH RATE OF IMPROPER PAYMENTS

As mandated by the Chief Financial Officers Act of 1990, we are required to audit HCFA's financial statements. The purpose of HCFA's financial statements is to provide a complete picture of its financial operations, including its assets, its liabilities, and how taxpayer dollars were spent. The purpose of our audits was to independently evaluate the reliability of the financial statements.

Due to the potential vulnerabilities in Medicare's claims payment processing and dollar magnitude of claims expenditures, we undertook a comprehensive review of Medicare FFS claims expenditures. This was the first time the Medicare program was reviewed through a comprehensive, statistically valid sample of Medicare FFS claims to determine if the payments were made in accordance with Medicare law and regulations.

The results of our claims testing corroborate past program findings that the Medicare program in inherently vulnerable to improper FFS provider billing practices. Our financial statement audits found that the rate of improper payments was much higher than previously believed. We estimate that:

- *during FY 1996 net overpayments totaled $23.2 billion nationwide, or about 14 percent of the **total** $168.4 **billion** spent on Medicare FFS **benefit payments;***[3]

- *during FY 1997 net overpayments totaled $20.3 billion nationwide, or about 11 percent of the total $177.4 billion spent on Medicare FFS **benefit** payments.'*

[3]The estimated range of the improper payments at the 95 percent confidence level is $17.8 billion to $28.6 billion, or about 11 percent to 17 percent.

"The estimated range of the improper payments at the 95 percent confidence level is $12.1 billion to $28.4 billion, or about 7 percent to 16 percent.

These improper payments could range from inadvertent mistakes to outright fraud and abuse. Our estimate of improper payments does not take into consideration waste (excessive pricing) and numerous kinds of outright fraud, such as phony records or kickbacks.

ANALYSIS OF IMPROPER PAYMENTS IDENTIFIED IN OUR FINANCIAL STATEMENT AUDITS

As shown in the following chart, most of the errors our financial statement audits uncovered fell into four general categories: (1) documentation which includes both insufficient and no documentation, (2) lack of medical necessity, (3) incorrect coding, and (4) noncovered or unallowable services. A full breakdown of improper payments by type of provider is included in Appendix A.

	1996		1997	
Type of Improper Payment	***Estimated Dollars In Improper Payments (in millions)***	***Improper Payments as a Percent of Total***	***Estimated Dollars In Improper Payments (in millions)***	***Improper Payments as a Percent of Total***
Documentation (includes both insufficient and no documentation)	*$10,846*	*47%*	*$8,994*	*44%*
Luck of Medical Necessity	*8,529*	*37%*	*7,480*	*37%*
Incorrect Coding	*1,978*	*8%*	*2,975*	*15%*
Noncovered or Unallowable Services	*1,219*	*5%*	*530*	*3%*
Other	*620*	*3%*	***303***	***1%***
TOTAL	*$23,192*	*100%*	***$20,282***	***100%***

Since Medicare's MCO capitation rates are based on FFS expenditures, we are concerned that these improper FFS expenditures are inappropriately inflating MCO rates. Although our review of current MCO literature indicates that MCOs may not be immune from making improper payments, we believe that the structure of Medicare's managed care

environment should minimize the occurrences of the types of improper payments we found in our financial statement audits.

The MCOs and HCFA operate in different environments because of the distinction in their primary responsibilities. Through its contractors, HCFA is primarily responsible for processing and paying provider claims. As previously stated, HCFA must, by necessity, place great trust in the integrity of our health care delivery system that these health providers will submit only proper claims. As evidenced by the rules and regulations affecting MCOs, MCOs' primary responsibility is to arrange for the health care of beneficiaries. The MCO management has a closer, more hands-on opportunity to control the integrity of the health care services they pay for using the Medicare MCO funds.

As shown above, our financial statement audits identified significant improper Medicare FFS payments. These improper payments occurred in areas which we believe the Medicare FFS program is much more vulnerable than is the Medicare managed care program.

As for errors attributable to the lack of medical necessity and noncovered/nonallowable services, per 42 CFR 417.103(b) MCOs must have effective procedures to monitor utilization of appropriate health services and to control costs of basic and supplemental health services to achieve utilization goals. Utilization data for all types of services (inpatient, primary care physician and specialty, and ancillary) are required in order to assess how well the MCO is meeting its health care standards, to assess patterns of care, and to assure appropriateness of services. By using utilization management strategies, such as prior authorization (gatekeeper concept), concurrent review, discharge planning, and retrospective review to assure that care is appropriate, the MCO environment should be able to effectively minimize occurrences of services which are not medically necessary or which are noncovered or unallowable.

In addition, quality assurance programs are required in the MCO environment which help ensure that the care given is medically necessary and is covered and allowable. Per 42 CFR 417.106(a), each MCO must have an ongoing quality assurance program for its health services that meets the following conditions:

(1) Stresses health outcomes to the extent consistent with the state of the art.

(2) Provides review by physicians and other health professionals of the process followed in the provision of health services.

(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed change.

(4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services that ought to have been furnished have not been provided.

The required MCO quality assurance programs also create an environment in which documentation and coding errors should be minimized. As stated above, MCOs are required by Medicare regulations to have a quality assurance program in place which uses **systematic** data **collection** of performance and patient results. In addition, per 42 CFR 417.106(c) MCOs must ensure continuity of care through arrangements with a primary care gatekeeper who is primarily responsible for coordinating the beneficiary's overall health care, and

(1) A system of health and medical records that accumulates pertinent information about the enrollee's health care and makes it available to appropriate professionals.

(2) Arrangements made directly or through the MCO's providers to ensure that the MCO or the health professional who coordinates the enrollee's overall health care is kept informed about the services that the referral resources furnish to the enrollee.

In order to comply with these regulations, MCOs must record sufficient documentation of services performed, including details on the type of service performed, in their data collection system and in their system of health and medical records to properly record pertinent information about the enrollee's health care. An efficient system of collecting and recording the documentation of services performed as required by regulation, would minimize documentation and coding problems as identified in our financial statement audits.

HCFA's VULNERABILITIES ARE INHERENT TO ITS SIZE AND MISSION

As noted above, HCFA and MCOs operate in very different environments. With primary responsibility for processing and paying provider claims, much of Medicare's inherent risk for improper payments is due to its size, mission, and need to rely on each biller of service to submit only proper claims. The Medicare program is the nation's largest health insurer and operates with very complex reimbursement rules. Last year, HCFA processed an estimated 800 million claims from hundreds of thousands of health providers on behalf of 38 million beneficiaries. By the year 2000, HCFA can expect to process 1 billion claims annually. Claims are processed through a complicated

decentralized system at 45 sites by a myriad of over 70 private companies under contract with HCFA. These contractors use various computer systems to edit, authorize, adjudicate, and pay claims. In contrast, MCOs' environments are much more self-contained, that is, each MCO is only responsible for its own operation. Thus MCOs can achieve greater control over their health provider payment function and avoid the payment errors identified in our financial statement audits.

MCOs' VULNERABILITIES

We recognize that MCOs may not be completely immune from the types of improper payments identified in our financial statement audits. Although many MCOs reimburse their providers on a capitated basis, others reimburse their providers under FFS indemnity arrangements, or a combination of capitation and indemnity arrangements. In the MCOs with indemnity arrangements, some of the improper practices identified in our financial statement reviews may also be perpetrated by health providers against the MCOs.

About 38 percent of physicians affiliated with managed care plans have a capitation contract. As shown below, primary care physicians, which make up the largest group of providers in managed care environments, have the highest percentage of capitation contracts.

Reimbursement Methods Used by Managed Care Plans to Pay Physicians

Primary Care Physicians	
Some risk-sharing, which includes some capitation features	*60%*
Capitation is primary	*37%*
Fee-for-service is primary	*31%*
Specialists	
Some risk-sharing, which includes some capitation features	*43%*
Capitation is primary	*18%*
Fee-for-service is primary	*52%*

Our review of MCO industry literature indicates that the MCO industry is moving away from traditional indemnity reimbursement toward capitated reimbursement models. As such, MCOs will become even less vulnerable to the types of improper provider payments identified in our financial statement review.

CONCLUSIONS AND RECOMMENDATION

Since Medicare's reimbursement methodology for MCOs is based on 1997 capitation rates which are derived from expenditures in the FFS sector, payment inaccuracies in FFS inappropriately inflate MCO reimbursements. As such, the Medicare program suffers a double effect from improper expenditures. As noted in our financial statement audits, we estimated that the Medicare FFS program improperly paid providers $23.2 billion in FY 1996 and $20.3 billion in FY 1997. Compounding the magnitude of these improper payments is the fact that 95 percent of the improper payments are included in the MCO payment rates for 1998 and beyond. This situation is particularly troublesome because the structure of Medicare's managed care environment, with MCOs scrutinizing care provided beneficiaries, should preclude the MCO from providing unnecessary and undocumented services--the major types of payment errors found in our financial statement audits. Therefore, the types of improper payments we found in our financial statement audits and, in fact, the routine errors found during HCFA's regular post payment program integrity work should not be incurred by the typical MCO.

We note that the effects of the resulting inflated MCO rates will be magnified as total payments to MCOs rise due to anticipated increased enrollment. In FY 1997, payments to MCOs totaled over $24 billion. Per the Congressional Budget Office, yearly Medicare payments to MCOs may total over $70 billion in the next few years. As the Medicare managed care program continues to grow, any amount in the MCO capitation rate which is attributable to improper payments will significantly impact the Medicare program.

Although the Medicare risk program was designed to limit the Federal Government's financial liability for covering health care costs, numerous studies have found that this has not been the case and some MCOs are receiving excessive payments. The Committee Report on the TEFRA 1982 legislation estimated that an efficient MCO could treat Medicare beneficiaries at approximately 80 percent of the AAPCC. More recent Medicare-sponsored and other studies have found that the Medicare program is spending more for MCO enrollees than their costs would have been under FFS. One 1996 study estimated that MCO enrollees' costs were 12 percent lower and another study estimated

such costs were 37 percent lower than for comparable FFS beneficiaries. The Physician Payment Review Commission estimated that excess payments to MCOs could total $2 billion.

Excessive Medicare MCO payments have been attributed to a number of causes, but including improper payments, and sometimes blatantly fraudulent payments, in the MCO payment rate calculation is aggravating the problem. Removing the improper payments from the MCO rate calculations would reduce inappropriate expenditures from the financially troubled trust funds as well as help reduce the inequities of excessive MCO payment rates.

We are therefore recommending that HCFA pursue legislation that will allow modifications to MCO capitation rates which would include an adjustment for the estimated amounts of unrecovered improper payments that are used in rate calculations. We believe that the Secretary should have broad authority to make necessary adjustments to MCO rates, similar, for example, to the authority given the Secretary to make adjustments "deemed to be appropriate" under the FFS prospective payment system for hospital services.

Each taxpayer dollar spent on improper payments is wasteful, and the waste is repeated by allowing the improper payments to generate higher MCO capitation rates. Unless improper payments are removed from the MCO rate calculations they will continue to plague the Medicare managed care program.

HCFA COMMENTS

In response to our draft report, HCFA agreed that Medicare payments to MCOs have been overstated and that they should be reduced. However, HCFA did not agree that it would be appropriate at this time to seek legislation that would give the Secretary the authority to adjust capitation rates as we recommended. The HCFA cites several changes to MCO payments brought about by the passage of the BBA of 1997. One major change of BBA was to sever the tie between MCO capitation rates and FFS payments for MCO capitation rates beginning with 1998. However, this change uses the 1997 rates, which are based on local FFS spending levels, as the base for the new payment methodology. The HCFA also views the overstatement in payments to MCOs to be primarily the result of favorable selection (plans enrolling healthier beneficiaries than those in FFS). The BBA provisions will allow HCFA to adjust MCO payments for health status factors beginning in the year 2000. Based on the BBA reductions that will occur in overall payments to MCOs, HCFA questioned the merits of pursuing a second reduction based on a projection of audit findings which may change

substantially from year to year. The full text of HCFA comments are contained in Appendix B to this report.

OIG RESPONSE

We agree that BBA will address some of the problems of excessive capitation payments, however there are inherent problems in the establishment of the new payment mechanism. The BBA provisions establish the managed care rates for 1998 and subsequent years based on the 1997 capitation rates. These 1997 capitation rates have been based on FFS payments which our audits of the financial statements have shown to be inaccurate. As stated in our report, we found payment errors in the Medicare FFS program totaling about $23.2 billion, or 14 percent of total expenditures, to providers in FY 1996 and $20.3 billion nationwide, or about 11 percent, in FY 1997. Therefore, we can only conclude that the 1997 base year establishing future capitation rates are inflated since they inherently contain payment errors. The BBA provisions do not address nor correct the impact of these excessive payments on future capitation rates.

Without any legislative correction, these payment errors have become locked into all future MCO payments. This is especially disconcerting since HCFA is taking a concerted effort to make corrections to the FFS payment errors. In its corrective action plan (in response to both audits of the financial statements), HCFA is planning to reduce the Medicare payment error rate to 5 percent by the year 2002. However, the positive action to correct the problems in FFS payments will not benefit future MCO capitation rates unless some type of legislation is enacted. Therefore, we believe that our recommendation to seek legislation that allows the Secretary the latitude to adjust the capitation rates is necessary. In order to facilitate a legislative change, we will be pleased to work further with HCFA officials to evaluate the accuracy of the 1997 base year payment amount.

Also, in its comments to the draft report, HCFA expressed concern that if our recommendation were implements across the board, it would penalize some counties unfairly (those counties where there are no payment errors). Based on our audits of HCFA's financial statements, we found errors at all the contractors reviewed. The contractors that were included in our audits were selected statistically and are the servicing intermediaries and carriers for those plans whose enrollment levels represent about 70 percent of the total beneficiaries in risk managed care plans.

It should also be noted that we have modified the final report to include the results of our audit of HCFA's financial statements for FY 1997.

Comparison of FYs 1996 and 1997 Types of Provider Categories
Highest Estimated Dollars in Improper Payments

		1997		1996	
	Type of Provider	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total	Estimated Dollars in Improper Payments (in millions)	Improper Payments as a Percent of Total
1	**Physician**	**$5,905**	**29.11%**	**$5,027**	**21.67%**
	Documentation	3,153	15.55%	2,756	11.88%
	Medically unnecessary/ noncovered	763	3.76%	943	4.07%
	Incorrectly coded	1,698	8.37%	1,070	4.61%
	Remaining errors	291	1.43%	258	1.11%
2	**Inpatient PPS**	**4,061**	**20.02%**	**5,239**	**22.59%**
	Documentation	724	3.57%	1,040	4.49%
	Medically unnecessa ry/ noncovered	2,336	11.52%	3,301	14.23%
	Incorrectly coded	1,001	4.93%	900	3.88%
	Remaining errors			(2)	-0.01%
3	**Home Health Agency**	**2,553**	**12.59%**	**3,650**	**15.74%**
	Documentation	68	0.34%	1,684	7.26%
	Medically unnecessary/ noncovered	2,485	12.25%	1,935	8.34%
	Remaining errors			31	0.14%
4	**Outpatient**	**1,957**	**9.65%**	**2,810**	**12.12%**
	Documentation	1,480	7.30%	2,286	9.86%
	Medically unnecessary/ noncovered	467	2.30%	441	1.90%
	Incorrectly coded	8	0.04%	1	0.01%
	Remaining errors	2	0.01%	82	0.35%
	Subtotal	14,476	71.37%	16,726	72.12%
5	**Other Types of Providers**	**5,806**	**28.63%**	**6,466**	**27.88%**
	Documentation	3,569	17.60%	3,080	13.28%
	Medically unnecessary/ noncovered	1,959	9.66%	3,128	13.49%
	Incorrectly coded	268	1.32%	7	0.03%
	Remaining errors	10	0.05%	251	1.08%
	Total	$20,282	100.00%	$23,192	100.00%

Note: This page is excerpted from the "Report on the Financial Statement Audit of the Health Care Financing Administration for Fiscal Year 1997" (A-17-97-00097)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JUL -9 1998

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Capitation Rates for Health Maintenance Organizations Are Inflated Due to Improper Payments Included in Rate Calculations," (A- 14-97-00206)

We reviewed the above-referenced report that examines if it would be reasonable to adjust capitation rates to health maintenance organizations (HMOs) to take into account the amount of improper payments that are included in HMO rate calculations. The report asserts that as the Medicare managed care program continues to grow, any amount in the HMO capitation rate which is attributable to improper payments will significantly impact the Medicare program.

Our detailed comments are as follows:

OIG Recommendation

HCFA should pursue legislation that will allow modifications to HMO capitation rates which would include an adjustment for the estimated amounts of unrecovered improper payments that are used in rate calculations.

HCFA Response

We agree that Medicare payments to managed care plans have been overstated and that they should be reduced, but do not agree that seeking legislation of the type recommended by the OIG is appropriate at this time. First, the appropriateness of using Medicare's fee-for-service payments as the basis for payments to HMOs has been a matter of debate for many years. During the budget deliberations that led to enactment of the Balanced Budget Act of 1997 (BBA), Congress and the Administration decided to use the 1997 rates, which are based on local fee-for-service spending levels, as the base for the new payment methodology, but beginning with the 1998 rates, to sever the tie between local fee-for-service payments and Medicare HMO payment levels.

Second, HCFA views the overstatement in paym nts to managed care plans to be primarily the result of favorable selection. HCFA is in the process of implementing a BBA requirement that payments be adjusted for health status factors beginning in 2000. Given the justified reductions that will occur in overall payments to plans, HCFA questions the merits of pursuing a second reduction based on a projection of audit findings which may change substantially from year to year.

Technical Comments

We note that if the approach recommended in this report were to be considered, it would probably not be appropriate to apply the 14 percent national figure found in the OIG audit uniformly to all counties. It may well be the case that the level of inappropriate payments varies, possibly significantly, among counties. If this is the case, a uniform application would penalize some counties unfairly, However, we view this as a theoretical concern because of (1) the policy decision to sever the tie to local fee-for-service payments, and (2) the requirement to risk-adjust payments.