Department of Health and Human Services

# OFFICE OF INSPECTOR GENERAL

# DESIGN FLAWS IN THE MEDICARE INCENTIVE PAYMENT PROGRAM

## Management Advisory Report


JUNE GIBBS BROWN
Inspector General

JUNE 1994
OEI-01-93-00051

# OFFICE OF INSPECTOR GENERAL

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This report was prepared under the direction of Mark R. Yessian, Ph.D., Regional Inspector General, and Martha B. Kvaal, Deputy Regional Inspector General, Boston Region, Office of Evaluation and Inspections. Participating in the project were the following people:

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# EXECUTIVE SUMMARY

## PURPOSE

To identify design flaws in the Medicare incentive payment program for physicians in Health Professional Shortage Areas.

## BACKGROUND

The Omnibus Budget Reconciliation Acts of 1987 and 1989 provide bonus payments for physicians who treat Medicare patients in Health Professional Shortage Areas (HPSAs). The payments are intended to serve as incentives to attract new physicians to HPSAs and to retain physicians already practicing there.

Having reviewed the program, we recommend in a companion report that the Health Care Financing Administration (HCFA) seek to target the program to primary care physicians. Nonetheless, the program will still be vulnerable to fraud and waste and will likely fail to achieve its goals unless a number of concerns are addressed. We are issuing this Management Advisory Report to bring those concerns to the attention of HCFA and the Congress.

## FINDINGS

Because the availability of specialists is not considered in the HPSA designation process, Medicare may be paying incentives to specialists who are not in short supply.

Because HPSAs represent entire communities with physician access problems but the Medicare program is focused on the elderly, Medicare may not be paying incentives to physicians who are in short supply.

Physicians are eligible to receive Medicare bonus payments even when they treat patients who do not live in HPSAs.

The instability of HPSA designation over time means that the incentive payments cannot be counted on to retain physicians in particular areas for the long term.

The complex method of establishing eligibility for incentive payments makes effective financial controls very difficult, leaving the program vulnerable to inappropriate payments.

## CONCLUSION

If the incentive payment program continues in its present or a modified form, we believe the design of the program warrants review to ensure that the program is a logical mechanism for accomplishing its purported goals. The HCFA will have to

ensure that all cost-effective measures are taken to prevent inappropriate use of incentive payment funds.

## COMMENTS ON OUR DRAFT REPORT

We solicited comments on a draft of this Management Advisory Report along with our draft inspection report, "Medicare Incentive Payments in Health Professional Shortage Areas," OEI-01-93-00050, from the Health Care Financing Administration (HCFA), the Public Health Service, the Assistant Secretary for Planning and Evaluation (ASPE), the Assistant Secretary for Management and Budget, the Assistant Secretary for Legislation, and the Physician Payment Review Commission. We received comments from HCFA and ASPE that are reproduced in the final inspection report issued in June 1994.

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# INTRODUCTION

## PURPOSE

To identify design flaws in the Medicare incentive payment program for physicians in Health Professional Shortage Areas.

## BACKGROUND

The Omnibus Budget Reconciliation Acts of 1987 and 1989 provide bonus payments for physicians who treat Medicare patients in Health Professional Shortage Areas (HPSAs).[1] In Calendar Year 1992, these payments amounted to $68 million and were distributed to nearly 22,000 physicians.[2] The payments are intended to serve as incentives to attract new physicians to HPSAs and to retain physicians already practicing there.[3]

The Office of Inspector General recently conducted an inspection to determine whether the bonus payments were effective in furthering the Federal government's interest in improving access to primary health care. In the report resulting from that inspection,* we raise serious doubts about the payments' contribution to that goal.

We recommend in that report that the Health Care Financing Administration (HCFA) seek to target the program to primary care physicians. Nonetheless the program will still be vulnerable to fraud and waste and will likely fail to achieve its goals unless a number of concerns are addressed. We are issuing this Management Advisory Report to bring these concerns to the attention of HCFA and the Congress.

## SOURCES

Information for this Management Advisory Report was drawn from several sources. They include research conducted by all three branches of the Office of Inspector General, reports from the Physician Payment Review Commission and other government agencies, and Federal laws and regulations.

This report was prepared in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

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*"Medicare Incentive Payments in Health Professional Shortage Areas," OEI-01-93-00050, June 1994.

# FINDINGS

***Because the availability of specialists is not considered in the HPSA designation process, Medicare may be paying incentives to specialists who are not in short supply.***

HPSAs were created to identify eligible placement sites for physicians who are obligated to serve in the National Health Service Corps (NHSC). The NHSC, administered by the Public Health Service (PHS), provides scholarships and loan repayments to providers of primary health care in underserved areas. In judging whether an area qualifies as a HPSA, PHS calculates the ratio of population to primary care physicians.[4] Primary care physicians include doctors of medicine and osteopathy in the fields of general or family practice, general internal medicine, pediatrics, and obstetrics/gynecology.[5] The presence of physicians in other fields has no effect on HPSA designation.

Because of the way HPSAs are designated, Medicare is paying additional money to attract and retain specialists in areas where there may be a sufficient number or even a surplus of specialists. Because rural HPSAs generally encompass entire population centers such as counties, it may be reasonable to assume that they suffer from shortages of specialists as well as primary care physicians. Urban HPSAs, however, may be small areas such as census tracts. The distribution of physicians within urban areas may leave these HPSAs with shortages of primary care physicians but high concentrations of specialists. Many inner-city HPSAs that are unattractive to office-based primary care physicians include large hospitals. Those hospitals attract large numbers of specialists, and those specialists earn incentive payments for providing services within the hospitals.

All physicians' services provided in HPSAs count toward the incentive payments. This establishes an incentive for physicians in HPSAs to provide all types of procedures, even those that are prone to overuse.

***Because HPSAs represent entire communities with physician access problems but the Medicare program is focused on the elderly, Medicare may not be paying incentives to physicians who are in short supply.***

In defining HPSAs, the PHS strives to identify areas whose citizens have inadequate access to health care. In addition to calculating population-to-physician ratios, PHS considers some indicators of health status. Specifically, areas with more than 100 births per 1,000 women aged 15-44 or with more than 20 infant deaths per 1,000 live births are considered to have "unusually high needs for primary medical care services."[6] To address these needs, the PHS allows these areas to maintain lower population-to-physician ratios than is usually required for HPSA designation. Presumably, the types of physicians most needed in these areas are obstetricians and pediatricians. Yet these physicians are unlikely to treat many Medicare patients, so a Medicare incentive payment program is unlikely to help attract or retain them there.

At the same time, there could be areas of the country with sufficiently large numbers of obstetricians and pediatricians to prevent the areas' designation as HPSAs, but with severe shortages of physicians trained in providing care to the elderly. In these areas, Medicare enrollees could have serious problems obtaining access to medical care, but the lack of HPSA designation would prevent using the incentive payment program to attract more physicians.

***Physicians in HPSAs are eligible to receive Medicare bonus payments even when they treat patients who do not live in HPSAs.***

The ultimate goal of the incentive payment program is to improve the health status of residents of areas with shortages of physicians. The payments, in theory, would motivate physicians to locate offices close to needy patients rather than having patients travel long distances to see physicians. But the law specifies that bonus payments shall be made for all physicians' services provided within HPSAs, not just those provided to HPSA residents.

Physicians in rural HPSAs probably do not see many non-HPSA residents because of the long travel times that would be involved. But urban areas are different, because HPSAs and non-HPSAs are in close proximity and well-known hospitals attract patients from within a broad radius. Thus it is likely that a number of physicians are receiving bonus payments even when they are providing services to people who have no trouble gaining access to physicians.

The HCFA does not know what percentage of patients treated by physicians who receive incentive payments live in HPSAs. It is not required to record this information, and the cost and difficulty of collecting the information prevents it from doing so voluntarily.

***The instability of HPSA designation over time means that the incentive payments cannot be counted on to retain physicians in particular areas for the long term.***

The PHS reviews each HPSA's status periodically. If new physicians are attracted to a HPSA, their presence may bring the population-to-primary-care-physician ratio below the ratio necessary for HPSA status. This would lead to withdrawal of the HPSA designation at the next review. In October 1992, the most recent date for withdrawing HPSA designations, 81 of the approximately 1800 HPSAs lost their HPSA status.[7]

Withdrawal of HPSA designation would lead to the elimination of incentive payments for physicians in that area. This could prompt the departure of physicians who were attracted to HPSAs by the incentive payments. The threat of withdrawal also creates an incentive for physicians currently in HPSAs to deter other physicians from settling there. Once HPSA designation is withdrawn, bonus payments would cease not only for the newly arrived physicians but for all physicians in the HPSA.

*The complex method of establishing eligibility for incentive payments makes effective financial controls very difficult, leaving the program vulnerable to inappropriate payments.*

Physicians who treat Medicare patients are responsible for determining whether they (the physicians) are eligible for incentive payments and for indicating their eligibility to their Medicare carriers. They base their determinations on information, such as maps and instructions, supplied by the carriers. They indicate their eligibility by adding a code to the claim forms they submit to the carriers.

There are many possible ways for providers to submit invalid claims, including both honest mistakes and outright fraud. Among the scenarios are:

- Physicians who practice from locations both within and outside HPSAs, yet who claim bonus payments for services delivered from all locations.
- Physicians who practice in areas that used to be HPSAs but whose HPSA status has been withdrawn.
- Providers of services other than physicians' services who submit claims for incentive payments even though they are not eligible.

The potentially confusing boundaries of HPSAs (especially in urban areas, where HPSAs may be defined not by county but by census tract), along with the possibility of HPSA status changing from year to year, make mistakes likely. For example, among a sample of 49 providers who received incentive payments in one State for a 3-month period in 1992, 7 (14 percent) were later found to have been ineligible for the payments.[8] The carrier in that State had to contact these providers in an attempt to have the money refunded. Although the claims error rate for the entire program has declined in recent quarters, problems persist.[9]

Programming the carriers' computers to detect all errant claims for incentive payments would be extremely difficult and expensive. The HCFA does not require the carriers to do so. Instead, the carriers must annually review a sample of claims from the providers who claim the most incentive money and resolve any discrepancies.[10] Retrospective reviews of samples of claims may be sufficient to detect the most egregious cases of fraud and abuse. They may be insufficient, however, to ensure the overall financial integrity of the program.

# CONCLUSION

We believe the design and administration of the program warrants review. The authorizing legislation for this program needs to be modified to ensure that it is a logical mechanism for accomplishing its stated goals. The administrators of the program, the Health Care Financing Administration, will have to ensure that all cost-effective measures are taken to prevent inappropriate disbursement of incentive payment funds.

# COMMENTS ON THE DRAFT REPORT

We solicited comments on a draft of this Management Advisory Report along with our draft inspection report, on whether the bonus payments promote access to primary care in underserved areas, from the Health Care Financing Administration (HCFA), the Public Health Service, the Assistant Secretary for Planning and Evaluation (ASPE), the Assistant Secretary for Management and Budget, the Assistant Secretary for Legislation, and the Physician Payment Review Commission. We received comments from HCFA and ASPE. However, none of the comments were specific to this report so we did not provide a response to them here. We discuss them fully and reproduce them verbatim in the final inspection report " Medicare Incentive Payments in Health Professional Shortage Areas," OEI-01-93-00050, June 1994.

# APPENDIX A

## NOTES

1. P.L. 100-203, Sec. 4043; P.L. 101-239, Sec. 6102(c). For current law, see 42 U.S.C. 1395l(m). Health Professional Shortage Areas were originally known as Health Manpower Shortage Areas (HMSAs).

2. Memorandum and attachments from Edward A. King, Health Care Financing Administration, to Stewart Streimer, Health Care Financing Administration, February 22, 1993. The figure of 22,000 excludes physicians reported by Medicare's Railroad Retirement Board carrier, because most if not all of these physicians are also reported by the carriers in the physicians' own States.

3. Health Policy Research Consortium, *Medicare Bonus Payments to Physicians in Health Manpower Shortage Areas: Final Report*, Cooperative Agreement No. 18-C-98526/1-05, report prepared for Health Care Financing Administration, April 1989, p. 1:1.

4. The PHS designates several types of HPSAs. Some HPSAs are areas with shortages of dentists, psychiatrists, optometrists, podiatrists, pharmacists, or veterinarians. Some are population groups rather than geographic areas. Medicare incentive payments, however, are available only in geographic, primary care HPSAs.

5. 42 C.F.R. 5, Appendix A.

6. 42 C.F.R. 5.

7. 57 Fed. Reg. 48919, October 28, 1992, and Public Health Service, Division of Shortage Designation, "Selected Statistics on Health Professional Shortage Areas (as of December 31, 1992)," Table 1. These totals include geographic-area HPSAs only, not population-group or facility HPSAs.

8. This State was one of the 10 States included in a survey of incentive payment recipients conducted by the Office of Evaluation and Inspections, Office of Inspector General. For more information on the survey, see "Medicare Incentive Payments in Health Professional Shortage Areas," OEI-01-93-00050, June 1994.

9. Memorandum from Director, Office of Program Operations Procedures, BPO, HCFA, to Associate Regional Administrators for Medicare, June 30, 1993.

10. Health Care Financing Administration, *Medicare Carriers Manual*, section 3350 (revised March 1991).