

January 1999

**Major Management
Challenges and Program
Risks**

Department of Health and
Human Services





**United States
General Accounting Office
Washington, D.C. 20548**

**Comptroller General
of the United States**

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The President of the Senate

The Speaker of the House of Representatives

This report addresses the major performance and management challenges that face the Department of Health and Human Services (HHS) in carrying out its mission. It also addresses corrective actions that HHS has taken or initiated to meet these challenges and further actions that are needed. For many years, we have reported significant management problems at HHS. These problems are the result of deficiencies in the coordination and oversight of HHS' numerous programs, the data and data systems needed to manage these programs, and efforts to safeguard program integrity. The problems are particularly critical for the Medicare program—our nation's largest health care insurer.

HHS is making progress in developing a framework for improving the way the Department is managed. HHS' strategic and performance plans demonstrate the Department's commitment to more effectively and efficiently manage its broad range of programs that are vital to the well-being of the American people.

Management reforms—including changes to the Medicare program—are under way, but many are in the early stages of implementation. Given the nature and extent of the challenges facing HHS in its management of the Medicare program, it will take time and sustained attention from senior officials to implement reforms and assess their

impact. Consequently, we believe, as we previously reported in 1995 and 1997, that these management deficiencies, taken together, continue to place the integrity and accountability of the Medicare program at high risk.

This report is part of a special series entitled the Performance and Accountability Series: Major Management Challenges and Program Risks. The series contains separate reports on 20 agencies—one on each of the cabinet departments and on most major independent agencies as well as the U.S. Postal Service. The series also includes a governmentwide report that draws from the agency-specific reports to identify the performance and management challenges requiring attention across the federal government. As a companion volume to this series, GAO is issuing an update to those government operations and programs that its work has identified as “high risk” because of their greater vulnerabilities to waste, fraud, abuse, and mismanagement. High-risk government operations are also identified and discussed in detail in the appropriate performance and accountability series agency reports.

The performance and accountability series was done at the request of the Majority Leader of the House of Representatives, Dick Arme; the Chairman of the House Government Reform Committee, Dan Burton; the Chairman of the House Budget Committee, John Kasich; the Chairman of the Senate Committee on Governmental Affairs, Fred Thompson; the Chairman of the Senate

Budget Committee, Pete Domenici; and Senator Larry Craig. The series was subsequently cosponsored by the Ranking Minority Member of the House Government Reform Committee, Henry A. Waxman; the Ranking Minority Member, Subcommittee on Government Management, Information, and Technology, House Government Reform Committee, Dennis J. Kucinich; Senator Joseph I. Lieberman; and Senator Carl Levin.

Copies of this report series are being sent to the President, the congressional leadership, all other Members of the Congress, the Director of the Office of Management and Budget, the Secretary of Health and Human Services, and the heads of other major departments and agencies.

A handwritten signature in black ink, appearing to read "D.M. Walker", with a long horizontal line extending to the right.

David M. Walker
Comptroller General of
the United States

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Overview

The Department of Health and Human Services (HHS) is responsible for administering many diverse and complex programs to improve the health and well-being of the American people. In fiscal year 1998, HHS had budget outlays totaling over \$359 billion and a workforce of over 57,000 employees. Medicare, the nation's largest health care insurer, spends far more than most cabinet departments; last year, it handled an estimated 800 million claims and paid out about \$200 billion. In addition, HHS is the largest federal grant-making agency, providing approximately 60,000 grants a year.

As HHS fulfills this broad range of responsibilities, it faces a number of major performance and management challenges. One of the most serious challenges is the solvency of Medicare's Hospital Insurance Trust Fund, which funds Medicare part A. In its 1998 annual report, the Fund's trustee board projected that the Trust Fund faces rapidly escalating deficits and will be depleted by 2008. The Medicare Bipartisan Commission is currently exploring various options to extend Medicare's financial viability in the long term. Beyond this critical issue, HHS faces a number of performance and management challenges that have been

identified by GAO and HHS' Office of Inspector General (OIG).

The Challenges

Scope and Complexity of HHS Programs Create Challenges With Coordination, Oversight, and Performance Measurement

Coordinating the efforts of the numerous administrators of HHS' programs—which include HHS' 11 agencies and state and local governments—is critical to ensuring program efficiency and effectiveness. HHS must also coordinate with a number of other federal, state, and local agencies that have programs with similar goals. While HHS recognizes this need, it has not delineated how it plans to ensure effective program coordination. Certain program characteristics—such as those that provide states the flexibility to design their own programs—make coordination of effort and oversight a daunting task. Compounding this difficulty is the need for the Department to develop adequate performance measures that ensure accountability.

HHS Needs Reliable and Comprehensive Data and Data Systems to Manage Programs and Assess Results

HHS does not have access to the data needed to effectively manage the Department's extensive health insurance programs, grant-making activities, and regulatory responsibilities. Developing and maintaining systems to ensure access to such data, however, is challenging since many important HHS programs are administered by program partners, such as state and local governments. Yet without these systems, HHS cannot adequately oversee its programs. Technical concerns about computer capabilities posed by the year 2000 add further complexity to this challenge. Of particular concern is the possible interruption of Medicare services and payments.

Program Integrity Is a Continuing Challenge for HHS

Maintaining the integrity of HHS' large programs, especially Medicare, continues to be a challenge. In the past, we have designated Medicare as a high-risk area, and it remains one. Although legislation has been enacted in the past 2 years to bolster the Health Care Financing Administration's (HCFA) oversight capability, initiatives to curb fraud, waste, abuse, and mismanagement have been slow to develop. Specifically, HCFA has been slow to implement its new authority to perform

Medicare payment safeguard activities. In addition, the implementation of new payment systems that are intended to curb rapid spending increases in the Medicare program have been stalled because HCFA needs to get its critical data systems ready for the year 2000. Furthermore, implementation difficulties threaten the success of HCFA's Medicare+Choice program. HHS' financial statement audits also continue to have problems. Specifically, HHS' inability to provide adequate support for certain financial statement amounts, such as Medicare accounts receivable and grant accrual expenses, contributed to the OIG issuing a qualified opinion on HHS' fiscal year 1997 financial statements. In addition, the OIG reported that HHS and its operating divisions do not have a fully functional integrated financial reporting system capable of producing complete and reliable financial statements in a timely manner.

**Progress and
Next Steps**

As required by the Government Performance and Results Act of 1993, commonly known as the Results Act, HHS submitted to the Congress a strategic plan for fiscal years 1998-2003. While this 5-year plan and the Department's 1999 performance plan provide general information about how HHS intends

to address these challenges, HHS needs to do more to ensure that its programs achieve intended results and that it is an effective steward of taxpayer dollars.

HHS' strategic and performance plans acknowledge the need for internal and external coordination. However, HHS needs to provide more information about how it will coordinate with the state, local, and tribal governments; contractors; and private entities that are its program and information partners. To strengthen program accountability, HHS needs to continue its efforts to develop more outcome measures for assessing the results of its programs.

HHS' strategic plan identifies several information technology initiatives that could help HHS achieve some program objectives. However, the plan needs to more clearly discuss how HHS intends to identify and coordinate information technology investments to support departmentwide goals and missions. HHS' performance plan identifies data problems that could undermine the credibility of HHS' performance data, but it does not state how HHS or its agencies plan to address these data problems. Furthermore, HHS needs to present

a comprehensive strategy for addressing Year 2000 compliance problems.

HHS has made progress in its efforts to improve program integrity. In particular, HCFA has begun using the new program safeguard authorities provided by the Congress and is taking steps to improve its internal controls. However, HCFA needs to more rapidly implement its new authorities and ensure that its systems are Year 2000 compliant.

Major Performance and Management Issues

HHS' many missions affect the health and well-being of everyone in the nation. HHS provides health insurance for about one in every five Americans. Its agencies conduct medical research to expand our knowledge of curing and preventing disease; ensure the safety of food, drugs, and medical devices; provide health care services to populations who might otherwise not receive care; help needy children and families with income support; and support a range of services to help elderly people remain independent.

Managing these diverse and complex programs is a challenge for HHS, and recent legislative initiatives have intensified this challenge. For example, to implement welfare reform under the Personal Responsibility and Work Opportunity Act of 1996 and subsequent legislation, HHS must give states program flexibility while maintaining adequate oversight. The Balanced Budget Act of 1997 (BBA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gave HCFA important new resources and tools for oversight of its Medicare program, but these acts also expanded the agency's role to include significant responsibilities HCFA had not previously performed. At the same time, HHS must find a timely resolution to the Year

2000 computer problem to ensure the continued availability of benefits and services for Medicare and Medicaid beneficiaries. Furthermore, the solvency of Medicare's Hospital Insurance Trust Fund, which funds Medicare part A, is at risk. The Fund's trustee board projected in its 1998 annual report that the Trust Fund will be depleted by 2008.

Over the past several years, our reports, reports from HHS' OIG, and the National Performance Review have documented problems with HHS' performance and management and have recommended reforms. This report highlights some of the serious management challenges related to coordination and accountability, data and information systems, and program integrity that HHS must overcome to meet its strategic goals. This report also indicates how HHS has addressed some of these issues in its 5-year strategic plan and its fiscal year 1999 annual performance plan, which were developed in response to the Results Act.

**Scope and
Complexity of
HHS Programs
Create
Coordination,
Oversight, and
Performance
Measurement
Challenges**

Each of HHS' 11 operating agencies administers a number of programs. Many of these agencies have overlapping jurisdictions and concerns, and many of their programs share like goals with programs administered by other federal agencies. To effectively meet these program goals, coordination both within HHS and with other agencies is essential. Yet such coordination is a challenge, given the scope and complexity of these programs. In addition, HHS programs are frequently administered by program partners, including state and local governments and nongovernmental organizations that receive block grant or categorical funding. HHS needs to make sure that these partners are accountable for program results, which is often a challenge because of the flexibility states have in administering programs and because of limited research on program effectiveness.

HHS' strategic and performance plans provided an opportunity for HHS to demonstrate how it will coordinate its diverse programs to achieve common objectives. HHS' strategic plan acknowledges the need for coordination among the Department's operating divisions and describes a range of approaches for

improving internal coordination. However, while the plan also mentions the need to coordinate with state, local, and tribal governments; contractors; and private entities that HHS relies on as program and information partners, it does not specify how HHS would do so.

**Many HHS Programs
Require Internal and
External
Coordination**

Within HHS, a large number of programs share related objectives; many HHS programs also share objectives with other federal agencies. For example, 27 different HHS programs support teen pregnancy prevention efforts, and 8 other federal agencies—the Departments of Agriculture, Defense, Education, Housing and Urban Development, Justice, and Labor; the Corporation for National Service; and the Office of National Drug Control Policy—provide funding for teen pregnancy prevention programs. With so many stakeholders involved, intraagency and interagency coordination become increasingly necessary—and complex.

Implementing welfare reform exemplifies the coordination challenges HHS faces. The principal responsibility for carrying out the legislation rests with the Administration for Children and Families (ACF). In addition to

coordinating its own programs, which include Temporary Assistance for Needy Families and Head Start, ACF must coordinate with related programs in other HHS agencies, such as those dealing with substance abuse and mental health services. HHS must also coordinate with the Departments of Labor and Education regarding education, training, and employment programs that can help former welfare recipients. A diverse set of program partners, such as state and local governments and nonprofit and community-based organizations, develop and implement ACF programs and deliver the many services they sponsor. For example, state and county agencies, the courts, banks, and credit bureaus help ACF implement its child support enforcement program. Similarly, public and private school systems, community action agencies, and other nonprofit groups operate Head Start programs locally.

HHS' 1999 performance plan has a general discussion of the need for internal and external coordination, but details about coordination efforts were left to individual agency plans. While some agencies' plans carefully delineate coordination efforts, others do not provide sufficient information

to allow the Congress to assess whether their activities will be adequately coordinated internally and externally. For example, it is not clear how numerous HHS programs will coordinate efforts to accomplish the President's stated goal of reducing smoking among young people by 50 percent by 2003—a goal HHS adopted. According to its strategic plan, HHS plans to achieve this goal through research support by the National Institutes of Health; prevention activities by the Indian Health Services (IHS), the Centers for Disease Control and Prevention (CDC), and the Health Resources and Services Administration; enforcement efforts by the Food and Drug Administration (FDA); and technical assistance to states by the Substance Abuse and Mental Health Services Administration (SAMHSA). However, of the agencies that were identified as contributing to this effort, only FDA and IHS acknowledged in their performance plans that they would coordinate their work with the other agencies.

**Balancing Program
Flexibility and
Oversight**

In administering programs that are the joint responsibility of state governments or that involve local grantees, HHS must continually balance program flexibility with maintaining

program controls. With welfare reform and other recent legislation, states received greater flexibility in designing and implementing their assistance programs within federal guidelines. However, at the same time, HHS is responsible for ensuring states comply with federal laws and regulations. The new welfare law also gives HHS authority to impose penalties if states fail to comply with certain requirements and provide bonuses if states meet certain performance standards.

The effectiveness of some HHS strategies to ensure that states comply with federal requirements is questionable. For example, Head Start, which was designed to ensure maximum local autonomy, uses on-site inspections as the primary tool for ensuring that Head Start's more than 1,400 local grantees comply with program regulations. Head Start performs on-site inspections after a grantee's initial operating year and at least once every 3 years after that. We have reported, however, that ACF regional office staff and outside researchers have raised concerns about the consistency of on-site inspections. Although the full impact of this problem is unknown, data based on these inspections may not be as valuable as they could be for managing the program and

making decisions about Head Start policy. We also found that Head Start could do more to ensure that it accurately measures the program's actual impact by examining program outcomes at the grantee level.

HHS' weak oversight of programs where states share enforcement responsibilities can fail to protect vulnerable citizens. For example, nursing homes that receive federal payments through Medicare and Medicaid—which in 1997 totaled \$28 billion—must comply with certain federal requirements. As required by statute, HCFA delegated to the states responsibility to inspect nursing homes and certify that they meet federal standards. However, we have identified problems in both inspection and enforcement. For example, in analyzing recent inspection and complaint information in California, we found that nearly one in three nursing homes were cited by state surveyors for providing care with serious or potentially life-threatening problems. Although the state identified serious deficiencies, HCFA's enforcement policies were not effective in ensuring that the deficiencies were corrected and stayed corrected. This is a national problem—one in nine nursing homes in the United States was cited in its last two inspections for

conditions that harmed residents or put residents in immediate jeopardy.

Until recently, HCFA had taken a lenient stance toward enforcing compliance with federal standards, encouraging states to grant almost all noncompliant homes a grace period to correct deficiencies without penalty, regardless of past performance. HCFA is currently developing plans to (1) improve state inspection practices, (2) revise oversight of state inspection agencies, (3) strengthen enforcement actions against poorly performing nursing homes, and (4) disseminate information to consumers and providers about nursing homes' performance records and about best practices for certain common care problems. In addition, recent legislation requires the Department of Justice to develop a mechanism that would allow nursing homes to check whether potential employees have criminal or abusive backgrounds.

Developing Effective
Performance
Measures Could
Strengthen
Accountability

Whether a program's goal is better nursing home care or better preschool experiences for children in Head Start, HHS needs to be able to adequately measure program performance to ensure program accountability. However, program scope and

complexity—as well as various methodological and resource constraints—make measuring performance difficult. For example, in measuring the effectiveness of drug abuse treatment, certain factors, such as reliance on self-reported information and insufficient client follow-up, limit confidence in the data on treatment outcomes. Furthermore, comparisons of study results are complicated by differences in how outcomes are defined and measured as well as differences in program operations and client factors.

HHS' strategic plan was a serious initial effort to describe goals, objectives, and outcome measures of program performance. However, it could have better contributed to efforts to improve accountability by discussing the Department's plans for future evaluations to determine program effectiveness. In HHS' performance plan, many agencies, such as CDC, provided succinct and concrete statements of expected performance, but others did not. Most of the agencies' plans provide at least some appropriate and quantifiable performance measures to track progress toward performance goals. However, HHS and its agencies acknowledged that future

performance plans should include more outcome goals to supplement output and process goals, and they indicated that they have begun efforts to develop them.

HHS has made progress in working with state governments to develop effective performance measures that promote the goals of its various programs. For example, the Office of Child Support Enforcement and the states developed national goals and objectives for the child support enforcement program. The Maternal and Child Health Block Grant Program has collaborated with its state partners to develop a set of core performance measures that have now become the basis for awarding and monitoring grants under the program. Furthermore, HHS' strategic plan indicates that SAMHSA is currently working with states to develop outcome indicators for substance abuse and mental health services and that CDC, through its categorical grant programs, is working with states to develop health status indicators, uniform data sets, and public health surveillance systems.

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**HHS Needs
Reliable and
Comprehensive
Data and Data
Systems to
Manage Programs
and Assess
Results**

To effectively manage its extensive health insurance programs, grant-making activities, and regulatory responsibilities, HHS must have access to data about its programs and their effects that are both reliable and appropriate to the task. These data would allow HHS to know whether or not it is accomplishing its goals and how its programs affect the American people. They also would provide the Congress the information it needs to evaluate the Department's success in meeting its goals. However, data needed to manage and evaluate HHS' programs are often unavailable, inaccurate, or inconsistent. Obtaining comparable data from programs carried out by state and local partners is particularly difficult. The automated systems challenges presented by the year 2000 will simply compound these problems; they could also put benefits and services at risk.

**Balancing Flexibility
and Accountability
Creates Data
Challenges**

To help fulfill its oversight responsibilities, HHS needs comparable and reliable data from states. However, state data, where available, are often incomplete or inconsistent. For example, HHS will use state data to ensure states meet new welfare reform requirements, including the 5-year time limit on receiving welfare benefits. However, state

information on the length of time an individual has received welfare is often unavailable or inconsistent, making it difficult for HHS to enforce federal benefit time limits.

HCFA faces particular challenges in collecting and publishing consistent information to inform policymakers about Medicaid and the new State Children's Health Insurance Program (SCHIP) created by BBA. Medicaid, a \$160-billion federal and state program, provides health insurance coverage for 36 million low-income people—about half of whom are children; SCHIP was established to expand health insurance coverage for low-income children. States have primary responsibility for administering these programs but share responsibility with HCFA for data collection and management. HCFA uses state enrollment data to create statistical reports on Medicaid beneficiaries served, their eligibility categories, types of services they received, and vendor payments. However, these data are often inaccurate and inconsistent. For example, while HCFA data indicate that Medicaid enrollment has been dropping as states implement welfare reform, our review of these data in 16 selected states found discrepancies between state and HCFA data.

Similarly, state program variations complicate uniform reporting for SCHIP. For example, states do not have consistent income standards for children's enrollment in SCHIP, and they vary in how they count family income to determine program eligibility. These data problems will make it difficult to assess the impact of welfare reform on Medicaid enrollment and the overall effectiveness of SCHIP.

In some cases, the data HHS needs to manage its programs and assure the Congress that it is achieving intended results are not available. For example, the federal government provides about \$3 billion annually to fund drug abuse prevention and treatment activities; however, precisely determining the need for treatment services is difficult due to limitations in national and state data. SAMHSA's national estimates of drug abuse treatment need are primarily derived from the agency's National Household Survey on Drug Abuse, which, when used for this purpose, has several limitations, including reliance on self-reported data and the exclusion of certain groups at high risk of drug use, such as persons who are homeless or in prisons. It also does not identify a large enough sample of certain subpopulations, such as pregnant

women, to adequately estimate treatment need. State estimates of drug treatment need are also problematic. Although states are required to report these estimates in applications for federal block grant funds, our review of fiscal year 1997 block grant applications showed that not all states submitted such data, and some submitted incomplete or inaccurate data.

**Lack of Reliable and
Comprehensive Data
May Put Individuals
at Risk**

The data system problems that affect HHS' ability to carry out its oversight and regulatory responsibilities can result in risks to the public's health. For example, there are weaknesses in FDA's approach for determining whether medical device manufacturers are operating tracking systems capable of quickly locating and removing defective devices from the market and notifying patients who use them. These weaknesses could result in unnecessary impairment—even death—if it became necessary to notify patients who use a device, such as a heart valve or pacemaker, that had been found to be defective.

Detecting problems with pharmaceuticals is particularly difficult. Eighty percent of bulk pharmaceutical chemicals are imported. To identify foreign pharmaceutical

manufacturers, plan foreign inspections, track inspection results, and monitor enforcement actions, FDA relies on 15 separate automated systems, most of which do not interface. As a result, essential foreign drug inspection data are not readily accessible to the different FDA units that are responsible for planning, conducting, and reviewing inspections and taking enforcement actions against foreign manufacturers.

**Year 2000
Challenges Put
Benefits and
Services at Risk**

HCFA's automated, mission-critical systems supporting the Medicare program are not yet Year 2000 compatible—and time is running out. Although HCFA recently established an internal Year 2000 organization and hired independent contractors to assist in overseeing the Year 2000 work, we reported in September 1998 that HCFA was far behind schedule in repairing, testing, and implementing these systems due, in part, to the complexity and magnitude of the problem. For example, HCFA reported that as of June 30, 1998, less than one-third of Medicare's 96 mission-critical systems had been fully renovated, and none had been validated or implemented. (See Status of HCFA's Year 2000 Effort: Quarterly Progress Report [Washington, D.C.: HHS, Aug. 15,

1998].) If not corrected, these systems could malfunction or produce incorrect information beginning in January 2000, putting benefits and services in jeopardy.

To help avoid the interruption of Medicare services and payments, we reported that HCFA needed to implement several key management practices, including

- developing a risk-management process,
- planning for and scheduling an integrated end-to-end test of all key systems to ensure that Medicare-wide renovations will work as planned,
- ensuring that all external and internal systems' data exchanges have been identified and agreements signed between the data exchange partners, and
- accelerating the development of business continuity and contingency plans to allow time to ensure that they would be reliable and ready if needed.

HCFA's Administrator responded that the agency would take immediate steps to address our recommendations and would take whatever actions are needed to ensure that there is no interruption of Medicare services and claims payments.

HHS also faces the possibility of massive systems failures for state Medicaid programs—but the responsibility for systems renovations lies with the states, not directly with HCFA. Most states are far from having their automated Medicaid systems ready for the year 2000. Of the 48 states and 3 territories that reported on the status of their systems in July and August 1998, only 23 states had completed more than 50 percent of their systems renovations. HCFA has begun an independent effort to assess states' compliance.

**HHS Plans Could
More Fully Address
Data Problems**

HHS' summary overview of its performance plan discusses the Department's reliance on its partners and stakeholders for much of the data that will serve to assess the results of HHS programs. The plan also mentions problems stemming from HHS' use of existing data systems that were established to monitor the use of resources and to provide aggregate output data rather than to capture the outcomes of activities. However, most of the plan's discussions of data limitations do not state how HHS or its agencies plan to address these data problems, which could undermine the credibility of performance data. Furthermore, individual agencies did not always provide sufficient information on

**Major Performance and Management
Issues**

data limitations, including some data limitations we had identified in previous work, making it difficult to assess agency progress to overcome them.

Although HHS' strategic plan identifies several information technology initiatives that could help HHS achieve some program objectives, the plan does not discuss how HHS intends to identify and coordinate information technology investments to support departmentwide goals and missions. Nor does the performance plan discuss either HHS-wide information technology resources needed to improve performance or a comprehensive strategy for addressing Year 2000 compliance problems.

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**Program Integrity
Is a Continuing
Challenge for
HHS**

With their broad range of services, large number of grantees and contractors, huge volume of vendor payments, and millions of beneficiaries, HHS programs are attractive targets for fraud, waste, abuse, and mismanagement. Medicare is particularly vulnerable—it pays out about \$200 billion annually and is responsible for financing health services delivered by hundreds of thousands of providers on behalf of tens of

millions of beneficiaries. In the past, we have designated the Medicare program as a high-risk area, and it remains one. HHS' OIG estimated that in fiscal year 1997, HCFA paid about \$20 billion for fee-for-service claims that did not comply with Medicare laws and regulations. While the Congress has given HHS new resources and authorities to improve oversight of Medicare, HCFA's deployment of these tools has lagged, putting on hold potential gains expected from the Medicare Integrity Program, Medicare's prospective payment systems, and Medicare+Choice. Furthermore, efforts to streamline Medicare's claims processing system have stalled, as HCFA has focused its efforts on getting the critical data systems ready for the year 2000. Finally, HHS' fiscal year 1997 financial statements had serious deficiencies.

**HCFA Slow to
Implement New
Authority to Perform
Payment Safeguard
Activities**

The Medicare Integrity Program created under HIPAA was intended to bolster HCFA's flagging efforts to combat fraud and abuse. The insurance companies HCFA contracts with to process, pay, and review Medicare claims are paid to review claims and detect fraudulent and abusive billing practices to prevent mispayments. The Congress increased funding for these and other

payment safeguard activities, appropriated the funding in advance rather than annually, and protected it from potential diversion by placing the funds in a special fraud and abuse account. In addition, the Congress gave HCFA—through HHS—the authority to contract with specialists to perform payment safeguard activities.

However, HCFA has been slow to act. For fiscal year 1998, HCFA did not notify contractors of their annual safeguard funding amounts until a third of the fiscal year had passed. The contractors use these funds, among other things, to hire and retain staff knowledgeable in conducting provider audits, claims reviews, and payment data analyses. The delays, they believed, would make it more difficult to complete their payment safeguard work, thus frustrating the Medicare Integrity Program's intended purpose. Since the time of our review, HCFA stepped up its efforts and set contractors' fiscal year 1999 budgets promptly. However, HCFA has not yet implemented a specialty program safeguard contract owing to various undecided issues, such as which specific safeguard tasks HCFA will ask the contractor to perform and the best geographic location for testing the first contract. Such a contract could be awarded in May 1999, but the scope

will be very limited and will not provide many of the benefits initially envisioned from using a specialty contractor.

**Year 2000 and
Design Challenges
Stall Implementation
of Medicare
Prospective Payment
Systems**

Until recently, Medicare used cost reimbursement methods to pay for services such as home health care, skilled nursing facility (SNF) care, and hospital outpatient services. In 1996, spending for these services had reached double-digit spending growth. In an effort to encourage efficient service delivery and discourage rapid spending, BBA mandated the design and implementation of prospective payment systems (PPS), which pay providers—regardless of their costs—fixed, predetermined amounts that vary according to patient need. Specifically, BBA requires HHS—and, by extension, HCFA—to implement (1) a SNF PPS, which became effective in fiscal year 1998; (2) a home health services PPS by fiscal year 1999 and an interim payment system for these services, effective fiscal year 1997; (3) a hospital outpatient services PPS by calendar year 1999; and (4) an inpatient rehabilitation services PPS by fiscal year 2001.

Challenges in developing and implementing these systems pose significant risks:

- Payment design difficulties: Under PPS, HCFA must carefully monitor the accuracy of data used to develop payment levels. It must also develop effective payment adjusters to account for the cost differences in treating patients who are more or less expensive than average to serve. Under a system of fixed payments, inaccurate cost data and the lack of an effective adjuster can result in underpaying or overpaying providers; moreover, if providers serving expensive patients are financially penalized, future access for these beneficiaries is jeopardized. In the case of the SNF PPS, we found that the methodology HCFA used to adjust rates for patient differences is susceptible to manipulation and could raise Medicare outlays rather than improve efficiency and patient care. We also found that, because the data used to set the prospective rates were not adequately audited, overstated costs of providing services were built into the new rates. Therefore, the use of these data may compromise the system's ability to meet the twin objectives of slowing spending growth while promoting the delivery of appropriate beneficiary care.
- Implementation delays: HCFA has announced that the home health PPS and outpatient PPS will not be implemented by the 1999 deadline because of the agency's focused

efforts to ensure that Medicare's multiple automated systems are Year 2000 compliant. The inpatient rehabilitation therapy PPS could face similar delays. To the extent that delays prolong the use of the existing cost-based reimbursement methods or that a rushed implementation builds problems into a new system, Medicare will likely continue to make excessive payments for services in these areas.

**Challenges
Implementing
Medicare+Choice
Threaten Program
Success**

On the premise that managed care plans can save the government unnecessary spending on Medicare services without compromising the provision of covered benefits, BBA established Medicare+Choice. The program is designed to widen beneficiary and health plan participation in Medicare managed care in several ways. First, BBA's guarantee of a minimum payment level can encourage health plans to locate in areas they had not previously served. Second, it expanded the type of plans eligible to contract with Medicare to include—in addition to health maintenance organizations—other models, such as preferred provider organizations and physician-sponsored organizations. Third, BBA requires the development of a nationwide campaign that would disseminate to beneficiaries useful

information on the choices available, thus promoting more effective competition among plans.

However, several key challenges imperil the implementation of the Medicare+Choice program:

- Payment design difficulties: Medicare's payment rates may overcompensate some plans for the beneficiaries they serve because the rates paid for enrolled beneficiaries whose expected use of health services is below average are not adequately adjusted to reflect that lower expected use. Although HCFA is currently working to develop new adjustments, as required by BBA, it is having difficulty collecting the encounter data needed to refine these adjustments.
- Inadequate oversight of allowable profits: The BBA requirement that HCFA audit one-third of all Medicare managed care plans annually could help ensure that plans do not earn excessive profits on their Medicare contracts. However, studies by HHS' OIG and others find HCFA's current oversight in this area inadequate, and HCFA does not plan to begin these audits until 2000.
- Faltering plan participation: Participation by the newly permitted types of managed care

plans has not occurred as intended. To date, only a handful of such plans have submitted applications to HCFA. In addition, some of Medicare's traditional managed care plans are pulling out of certain areas or are reducing covered services and increasing beneficiaries' out-of-pocket costs.

- Information campaign challenges:
Recognizing that consumer information is an essential component of a competitive market, BBA mandated a national information campaign with the objective of promoting informed plan choice. Specifically, BBA requires that comparative information be available to beneficiaries through the Internet, through a toll-free telephone number, and in printed form by mail. Organizing these efforts is an enormous undertaking and is a new HCFA responsibility. The toll-free number and a beneficiary handbook mailing are being piloted in five states. Beginning in 1999, HCFA plans to expand its telephone information efforts nationwide in support of an annual enrollment event in November. The Congress' efforts to encourage the growth of managed care could be thwarted if beneficiaries are confused, instead of enlightened, about their many health care choices.

**Efforts to Streamline
Medicare Claims
Processing System
Have Stalled**

A continuing challenge to HCFA's ability to maintain the integrity of Medicare is its effort to streamline the Medicare claims processing system. HCFA undertook this effort to increase the efficiency of its claims process, better manage contractors, improve customer service, and help reduce fraud and abuse.

The streamlining involves reducing the number of claims processing software systems from eight to three, one of which would process only durable medical equipment claims. However, HCFA halted this consolidation effort because it needed to focus resources on critical Year 2000 work, dealing a major setback to the effort in the short term.

**HHS' Financial
Statement Audits
Continue to Have
Problems**

An area of HHS vulnerability on which HHS' OIG has reported is HHS' difficulty in complying with the requirements of the Chief Financial Officers Act, as expanded by the Government Management Reform Act of 1994. HHS received a qualified opinion from the OIG on its fiscal year 1997 financial statements, primarily because of (1) a lack of adequate supporting documentation for \$2.5 billion in net Medicare accounts receivable; (2) difficulty in determining what, if any,

adjustments needed to be made to the Medicare cost settlements as reported in the fiscal year 1997 financial statements; (3) insufficient evidence to support \$2.7 billion in grant accrual expenses and a potential net misstatement of \$386 million in grant expenses; and (4) lack of supporting documentation for intraagency transactions. These serious deficiencies indicate that reliable financial management data are not readily available to permit HHS managers to make informed decisions. In this regard, the OIG reported material weaknesses in internal controls and a material instance of noncompliance with the Federal Financial Management Improvement Act of 1996.

Specifically, HHS' OIG reported serious control weaknesses affecting the reliability, confidentiality, and availability of data throughout the Department. It reported that the six primary accounting systems are not electronically linked; depend on external sources, such as Medicare contractors, for essential information; and cannot automatically generate financial statements. In addition, Medicare contractors were not adequately protecting confidential personal and medical information associated with claims. As a result, contractor employees could potentially browse data on individuals,

search out information on acquaintances or others, and possibly sell or otherwise use this information for personal gain or malicious purposes. Furthermore, although HCFA had corrected weaknesses found in the previous year, it was still possible to gain access to HCFA's database and modify managed care files.

HHS has recognized the need to protect the security of information technology systems and the data contained in them. Starting in 1997, HHS began to revise security policies and guidance and required each major operating division to develop and implement corrective action plans to address each major weakness identified by the OIG. However, due to its decision to focus on Year 2000 modifications, HCFA will probably not address many of these electronic data processing control weaknesses in the near future. Therefore, concerns related to the integrity of claims paid and the confidentiality of medical records will continue.

In addition, the fiscal year 1997 financial statement audit again reported HCFA's inadequate oversight of the Medicare program as a material weakness—one that hampers HHS' fiduciary responsibilities. For

example, HCFA had not developed its own process for estimating the national error rate for improper Medicare fee-for-service payments. For fiscal year 1997, HHS' Inspector General estimated that about 11 percent of all Medicare fee-for-service payments for claims, or about \$20 billion, did not comply with Medicare laws and regulations. Similarly, we reported in our first audit of the federal government that problems exist in estimating improper payments for major programs, and among these were programs administered by HHS.

While HHS' strategic plan recognizes the importance of improving the Department's financial management information, it does not specify the corrective actions and timetables needed to obtain an unqualified or clean opinion on its financial statements. When financial management issues are closely related to accomplishing an agency's mission, the agency's performance plan should include goals related to improving the reliability and timeliness of financial data. HCFA and IHS included such goals in their plans. The plans of other operating divisions—such as ACF, whose fiscal year 1997 financial statement audit found several financial accountability deficiencies—could

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also have benefited from financial-related goals.

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