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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

B-210513

MARCH 4, 1983

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Mr. Thomas R. Donnelly
Acting Secretary of Health and
Human Services

Dear Mr. Donnelly:

Subject: Savings Possible by Modifying Medicare's Waiver of Liability Rules (GAO/HRD-83-38)

As part of its 1983 budget-cutting proposals, the administration sought, but did not obtain, legislation to modify Medicare's waiver of liability provision with respect to payments to hospitals, skilled nursing facilities, and home health agencies.[1] According to the President's proposals, this change would have resulted in a net savings of $10 million in fiscal year 1983. We believe that such legislation is not necessary. Savings could be realized by changing the waiver of liability rules.

THE WAIVER OF LIABILITY PROVISION

Medicare's waiver of liability provision, section 1879 of the Social Security Act, protects beneficiaries from having to pay for services they receive that Medicare will not pay for because it determined the services were not medically reasonable or necessary or were custodial in nature. The provision authorizes HHS to indemnify beneficiaries against the costs associated with the claims denied for payment[2] as long as

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[1]Budget material for fiscal year 1984 states that HHS will again request such legislation.

[2]If the provider bills the beneficiary and he or she pays for the denied services, Medicare reimburses him or her at Medicare's normal payment rate for the service in question, less any applicable deductible and coinsurance. The amount reimbursed to the beneficiary is treated as an overpayment to the provider to be withheld from future payments. In fiscal year 1981, Medicare paid 74 indemnification requests totaling $46,577.

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they did not know and could not reasonably have been expected to know that Medicare would not make payment. In administering Medicare, the Health Care Financing Administration (HCFA) presumes that beneficiaries did not know payment would be denied unless there is evidence to the contrary, such as a written notice to the beneficiary (or someone acting in his or her behalf) that claims for a particular service would not be paid.

The waiver of liability provision also protects providers of services who did not know and could not reasonably be expected to know that payment would not be made. As with beneficiaries, HCFA presumes that providers did not know that the services would not be paid for unless there is evidence to the contrary (see 42 CFR 405.332(b)). This includes evidence that Medicare or its utilization review representatives informed the provider that the items or services furnished (or similar or reasonably comparable items or services) were not covered.

While the regulations present several criteria to consider in determining a provider's eligibility for waiver of liability, HCFA has instructed its Medicare intermediaries to base their determination for hospitals, skilled nursing facilities, and home health agencies on how frequently providers submit claims for noncovered services. Waiver status is determined quarterly. If a provider's denial rate for a quarter is less than a fixed percentage of services, a favorable waiver status is granted for all services claimed for reimbursement for the following quarter except where there is evidence the provider knew that a particular service or item would not be covered. Thus, if a provider has obtained a favorable waiver presumption, claims submitted in the following quarter are paid absent a showing of evidence establishing provider knowledge that such services were not reasonable or medically necessary.

The denial rate criteria are set forth in Medicare's Intermediary Manual. The rate for hospitals and home health agencies is 2.5 percent, and the rate for skilled nursing facilities is 5.0 percent.

THE ADMINISTRATION'S PROPOSED MODIFICATION OF THE WAIVER OF LIABILITY PROVISION

In its fiscal year 1983 budget, the administration proposed a legislative change deleting the authorization to waive provider liability for claims for services submitted under

Medicare's Hospital Insurance (part A) program. The provision as it relates to payments for physician and supplier services under the Supplemental Medical Insurance (part B) program would not have been affected. Under the proposal, hospitals, skilled nursing facilities, and home health agencies would no longer be paid when Medicare determines that a service was medically unreasonable or unnecessary or was custodial in nature. The proposal would not affect the protection afforded beneficiaries. According to the administration, the proposal would have saved $10 million in fiscal year 1983; however, it was not enacted.

SAVINGS CAN BE ACHIEVED WITHOUT LEGISLATION

There are several ways to achieve savings without amending Medicare law. All would modify the provider's presumptive status, but the provider would retain the right to appeal for a waiver.

First, the existing Medicare legislation does not require HCFA to presume or establish a presumption that providers did not know or could not reasonably be expected to know that certain services were not covered. Consequently, the presumption could be eliminated, and the applicability of the waiver provision could be determined case by case. Further in this respect, we would expect that Medicare-experienced providers in most cases should know Medicare's coverage requirements.

Another approach--which was used earlier--is to tighten the denial rate criteria used to determine presumed eligibility for waiver of liability. (For example, the acceptable denial rate for hospitals could be reduced.) Before 1978, the criteria were 5 percent for hospitals and home health agencies and 10 percent for skilled nursing facilities. In 1978, the present denial rates were established because about 90 percent of the providers qualified for a waiver under the old rates.

A third way to effect savings would be to change the method for establishing whether a provider is presumed eligible for a waiver. In 1981, HCFA's Office of Direct Reimbursement[3] commented that a provider that has participated in Medicare for an extended time ought to know program rules and

[3]This Office services health care providers who chose to deal directly with the Government rather than with one of Medicare's contractors.

that a determination that it did not should be made only in unusual situations. We believe that after a provider has participated in Medicare for a few years, generally it should know which services are covered. The waiver of liability procedure could be changed to provide that after some period of time there would no longer be a presumption of eligibility.

The Administrator of HCFA has stated:

> "[it] is imprudent for the Federal government to pay for services found to be uncovered or unnecessary simply because the providers were not aware of Medicare coverage rules. * * * making providers liable will give them an incentive to make themselves aware of those rules and better manage admission and treatment policies."

The providers, on the other hand, argue that the reasonableness and medical necessity of services often are not clear cut and therefore providers acting in good faith should not be penalized by having their claims for payment denied.

While legislation would achieve the administration's goal of savings and establish provider incentives, legislation is not needed. Also, the proposed legislation does not take into consideration providers' concerns. We believe that adoption of one of our proposals or some combination thereof would achieve the desired results. Savings could be achieved,[4] incentives would be increased for providers to provide only necessary and covered care, and providers' concerns would be addressed (that is, waiver for providers would be retained in some form).

RECOMMENDATION

We recommend that you direct the Administrator of HCFA to establish more stringent eligibility requirements for the application of waiver of liability for health care providers under part A of Medicare.

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[4]How much savings would depend on the specific changes made.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to examine potential alternatives to the administration's proposal for modifying Medicare's waiver of liability provision for institutional providers. The review was based on an examination of Medicare law, regulations, and implementing instructions and discussions with HCFA officials. Our work was conducted in accordance with generally accepted Government auditing standards.

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As you know, 31 U.S.C. 720 requires the head of a Federal agency to submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report. Under that law, the statement must also be submitted to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen of the four above-mentioned committees and the cognizant legislative committees. A copy is also being sent to the Director, Office of Management and Budget, and other interested parties.

Sincerely yours,

Philip A. Bernstein
Director