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Report to the Administrator, Health Care Financing Administration, Department of Health and Human Services

August 1991

MEDICARE

Information Needed to Assess Payments to Providers

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Human Resources Division

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Ms. Gail R. Wilensky, Administrator
Health Care Financing Administration
Department of Health and Human Services

Dear Ms. Wilensky:

As part of our assessment of the management of Medicare payments, we reviewed the accuracy of tentative settlements of cost reports submitted by providers. Medicare providers could receive hundreds of millions of dollars each year above the amounts due them because of excessive tentative settlements made by Medicare contractors. These amounts can remain outstanding for up to 2 years before being recovered. Because Medicare normally earns interest income on its surplus trust fund monies, it loses interest income when it makes excessive payments. These excessive payments could be costing the Medicare trust fund about $40 million in lost interest a year.

The lack of reliable management data affects the Health Care Financing Administration's (HCFA's) ability to monitor the tentative settlement process. Neither of HCFA's main management information systems for tracking payments to hospitals contains a complete accounting of the amounts and dates of tentative settlements. In instances where these systems record tentative settlement data, the data are often inaccurate. Resolving the data reliability problems would provide HCFA the information necessary to determine what corrective actions are needed to improve the tentative settlement process and minimize interest losses for the trust fund.

Background

Medicare, authorized by title XVIII of the Social Security Act, helps pay medical health costs for about 33 million aged and disabled people. HCFA, which administers the Medicare program, contracts with insurance companies, such as Blue Cross/Blue Shield, to process and pay claims. Forty-seven contractors (called intermediaries) service over 25,000 institutional providers under Medicare Part A—hospital insurance.

Reimbursement to institutional providers occurs in several steps. First, HCFA's intermediaries make biweekly payments based on the provider's

historical costs and current cost estimates.[1] These payments help defray the ongoing costs of providing services to Medicare beneficiaries. Second, at the end of each year, after providers submit detailed cost reports to substantiate their Medicare claims for the entire year, intermediaries make tentative settlement payments or recover excessive payments based on the total amount claimed and the amounts already paid in interim payments. Third, the intermediary conducts a more detailed review of the cost reports to determine the appropriate final settlement amounts. Because of the time needed to schedule and conduct audits, intermediaries have up to 2 years to make this review and final settlement.

Tentative settlements that differ substantially from the amount ultimately determined to be due a provider cause underpayments or excessive payments that can remain outstanding for up to 2 years. When excessive payments occur, Medicare loses interest income because it has less surplus trust fund money to invest in government securities.

Objective, Scope, and Methodology

The objective of our review was to measure the accuracy of Medicare payments to institutional providers, based on an analysis of all settlements during fiscal years 1989 and 1990. To accomplish this, we extracted payment information from two HCFA systems that record settlement information on payments to institutional providers. The systems are the Hospital Cost Report Information System (HCRIS), a HCFA maintained system that contains hospital data only, and the System Tracking for Audit and Reimbursement (STAR), an intermediary system that contains data on both hospitals and other institutional providers.

We interviewed and discussed our observations with HCFA headquarters officials from the Office of Financial Operations and the Division of Provider Audit. We visited intermediaries in California, Connecticut, Maryland, Oregon, Virginia, and Washington to discuss their procedures for recording payment information.

We performed our work between July 1990 and March 1991 in accordance with generally accepted government auditing standards.

[1]Hospitals are paid prospectively set rates for their operating costs based on patients' diagnoses. In addition, hospitals receive interim payments for costs not covered by the prospective payment system, such as those for capital, medical education, and certain hospital units exempt from prospective payment.

Tentative Settlements Contribute to Large Excessive Payments

The available information indicates that the tentative settlement process results in excessive payments to providers each year. HCRIS data for fiscal years 1985 to 1987, the most recent years for which substantially complete information was available, show that final cost audits identified net hospital excessive payments totaling about $4 billion.[2] About $3 billion of this amount occurred in fiscal year 1985, over $543 million in fiscal year 1986, and nearly $460 million in fiscal year 1987. Preliminary information for fiscal year 1988 indicates that excessive payments are continuing; with about one-fourth of the final settlements completed, excessive payments totaled about $89 million.

Available data did not permit us to precisely determine the effect of excessive tentative settlements on the Medicare trust fund. However, assuming that the net excessive payments of $460 million in fiscal year 1987 remained outstanding for 18 months, the Medicare trust fund would have lost about $64 million at an interest rate of 9 percent.[3] The following examples illustrate the interest income loss to the trust fund that can result if tentative settlements are excessive. The settlements for two hospitals alone represent interest lost in excess of $1.4 million on excessive tentative settlements totaling about $12.0 million.

- A California hospital received $48.0 million in interim payments throughout its 1986 fiscal year. The hospital submitted a year-end cost report claiming $55.4 million in total Medicare reimbursement. The intermediary accepted most of the claims and made a tentative settlement of $6.6 million, bringing the total amount paid to the hospital to $54.6 million. In October 1988, after the final review was conducted, the intermediary determined that the actual Medicare liability was $47.4 million. Thus, the provider was overpaid a total of $7.2 million, $6.6 million of it in tentative settlement amounts. The interest loss to the Medicare trust fund on the $6.6 million was more than $590,000.

  In the previous year, the same provider had received a $3.7 million excessive payment, $3.4 million in tentative settlement amounts. Interest income loss associated with this tentative settlement was about $508,000.

[2]The summary data do not distinguish between cases where tentative settlements occurred and those where final settlements were made without a tentative settlement. These data are limited to hospital settlements and exclude thousands of smaller providers, such as skilled nursing facilities and home health agencies.

[3]For purposes of illustration, we applied an interest rate of 9.0 percent in our calculations of lost interest. Medicare Trust Fund investments earned between 8.75 percent and 10.2 percent in 1989.

- Another hospital in California received $13.1 million in interim payments for its 1987 fiscal year. After the hospital submitted its annual cost report, the intermediary paid an additional $3.2 million as a tentative settlement, bringing the total paid to $16.3 million. Two years later, intermediary auditors determined that the actual Medicare liability was $14.3 million. Thus, the tentative settlement resulted in a $2.0 million excessive payment that existed for almost 2 years. The interest loss to Medicare was over $325,000.

Database Problems Prevent Accurate Analysis of Tentative Settlements

The Secretary of Health and Human Services identified the management of Medicare program data as a high-risk area in his 1990 Federal Managers' Financial Integrity Act Report. The report cites a need for more accurate and timely data, including ". . . data systems to record actual program costs on a timely basis." Tentative settlements are a critical element in overall Medicare program costs, and, as such, need to be properly recorded in HCFA's information systems. At present, however, HCFA's two systems—HCRIS and STAR—are not effectively capturing this information.

HCRIS and STAR Data Are Incomplete

The vast majority of hospitals receive tentative settlements, HCFA officials told us. However, our review of HCRIS data on over 21,000 final settlements to Medicare hospitals during fiscal years 1987 to 1990 showed that only 25 percent of the tentative settlements were recorded. According to HCFA's Chief of the Data Reporting Policy Branch, intermediaries should have recorded tentative settlement information into HCRIS when they entered final settlement information. Although HCFA has instructed intermediaries to enter summary tentative settlement information into HCRIS, the HCRIS data we examined showed that most tentative settlement fields were left blank.

Most intermediaries indicated that they did not record tentative settlements in their STAR databases. According to the Chief of HCFA's Expenditure Development and Analysis Branch, recording tentative settlements into STAR is optional.

Data Reliability Problems Hamper Data Analysis

When HCRIS entries did contain information about tentative settlements, we found the information was often inaccurate. In the HCRIS format, total Medicare liability should equal the sum of interim payments, tentative settlements, and final adjustments. However, of the 5,500 final settlements in HCRIS with complete payment data, over half did not meet

this test. We also found problems with the reliability of STAR data. For example:

- One intermediary frequently entered percentages in a field that should contain dollar amounts. This could dramatically misstate the actual amount of tentative settlements. If the intermediary paid a $500,000 tentative settlement and recorded it as 100 percent paid, for example, the database would show 100 dollars, a $499,900 error.
- Another intermediary inadvertently recorded a $30 million settlement as a $3 million settlement.
- A third intermediary told us that the final settlement field had been left blank for some providers. Other data problems at this intermediary included erroneous dates and amounts for tentative settlements and interim payments.

HCFA Officials Believe Data Problems Can Be Corrected

HCFA officials from the Office of Financial Operations and the Division of Provider Audit told us that they share our concern about inaccurate data in the databases and agree that better information is needed on tentative settlements. Further, they said that they could begin to collect complete tentative settlement data by instructing all intermediaries to enter tentative settlement information into the existing STAR databases and reminding them of the requirement to record tentative settlement data in HCRIS.

Conclusion

The accuracy of Medicare payments made to institutional providers in tentative settlements is of considerable importance to the government. Although excessive payments are recovered through final settlements, the interest income the Medicare Trust Fund loses while this money remains with the providers cannot be recovered. Given the size of payments to institutions and the substantial time between tentative and final settlements, the potential for substantial loss to the trust fund is present.

Knowledge of the full extent of excessive tentative settlements and associated interest costs is limited by the incompleteness and inaccuracies in the data in HCFA's information systems. We believe that a first step in addressing the need for changes in the tentative settlement process is to improve the completeness and accuracy of information entered into these systems. HCFA could then analyze these data to identify the problems that consistently result in excessive tentative settlements. Also, HCFA could then make more informed decisions on what type of

corrective action is needed and use HCRIS data to monitor tentative settlements on a broad basis. If such monitoring found indications of a problem, HCFA could use the detailed STAR data for an in-depth analysis.

Recommendations

To improve the completeness and accuracy of Medicare information databases we recommend that you

- instruct intermediaries to record data on all tentative settlements in STAR,
- reemphasize to intermediaries the requirement to record tentative settlement data accurately and promptly in HCRIS, and
- improve monitoring of HCRIS and STAR to ensure the integrity of the data in both systems.

Once these improvements are made, we recommend that you analyze the data to determine the reasons for inaccurate tentative settlements and, if warranted, initiate corrective measures to minimize the problems.

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. Such a written 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.

Please call me on (202) 275-5451 if you or your staff have any questions concerning this report. Other major contributors to this report are listed in appendix I.

Sincerely yours,

Janet L. Shikles

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Director, Health Financing and
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