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MEDICARE

Adequate Funding and Better Oversight Needed to Protect Benefit Dollars

Statement of Sarah F. Jaggar
Director, Health Financing and Policy Issues
Human Resources Division

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SUMMARY

Medicare's role as the largest payer in the health care industry, which consumes nearly one-seventh of our gross domestic product, underscores the importance of administering the program effectively. In fiscal year 1993 Medicare cost $146 billion, covered about 35 million beneficiaries, and processed about 700 million claims. If current trends continue, Medicare expenditures are expected to increase to $259 billion by 1998. Due to budgeting and management problems, the government pays too little attention to the activities protecting Medicare benefit dollars and is losing opportunities to save many millions of dollars in Medicare payments.

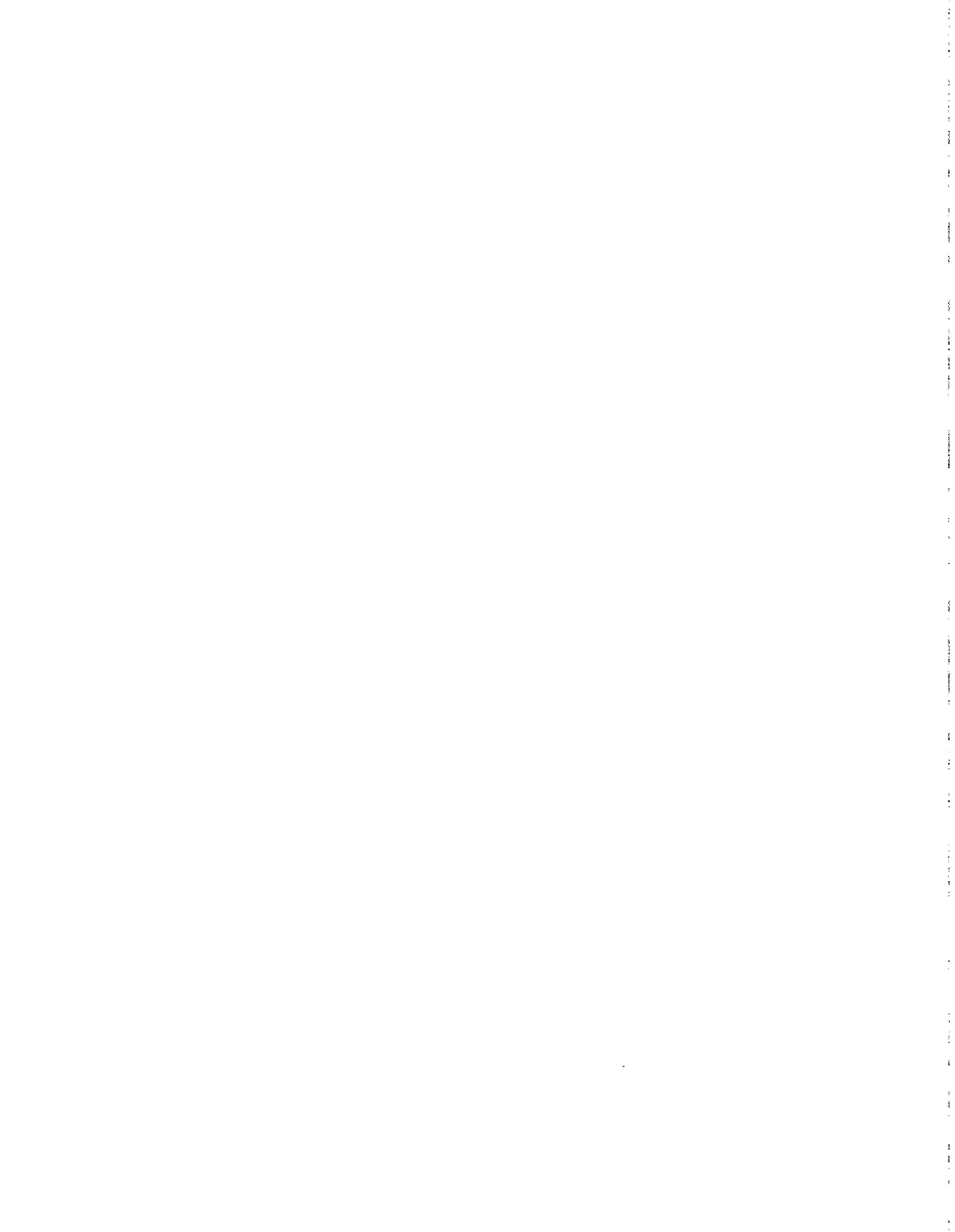
The Health Care Financing Administration (HCFA) administers the Medicare program. It contracts with insurance companies like Blue Cross and Blue Shield, Travelers, and Aetna to process claims and perform payment control activities, called payment safeguards. In performing this work the companies, or contractors, use various controls to avoid making unnecessary or inappropriate payments.

Despite the rising volume of Medicare claims, contractors' per claim funding for payment safeguards has declined since 1989 by over 20 percent. Much of this money pays for staff who develop payment controls and review claims. In response to reduced per claim funding, contractors apply fewer or less stringent payment controls to keep the review workload manageable.

The results of a HCFA demonstration project show a positive relationship between investing in payment safeguards and preventing program losses resulting from mistaken payments. In this project, three contractors receiving special funding from HCFA saved 170 percent more, after expenses, than the project's control contractors.

In efforts to protect benefit dollars, HCFA faces management challenges that compound the funding reduction problems. HCFA has little information on such fundamental controls as the computerized edits and payment criteria that contractors use in reviewing claims before making payment. Moreover, HCFA makes little use of data management reports to scrutinize contractor safeguard activities.

GAO believes that with an adequately funded and managed safeguard program, Medicare could avoid many millions of dollars of unnecessary expenditures. Thus, GAO believes the Congress should continue to pursue efforts to modify budget procedures so that Medicare's safeguard funding could be increased without having to cut spending for other government programs. In addition, HCFA needs to better manage contractors' payment safeguard activities. It should establish the infrastructure needed to make identification and correction of payment problems a high agency priority. Such actions could help assure that Medicare has the controls in place to aggressively fight waste and abuse.



Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the importance of efforts to protect Medicare's benefit dollars from waste, abuse, and mismanagement. At other hearings and in reports recently issued,[1] we have made recommendations about Medicare administrative funding and the need to better manage specific functions. Today we would like to reiterate our funding recommendation and discuss management problems from a broader, systemic perspective. In particular, we would like to point out that because of budgeting and management problems, Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. The government pays too little attention to the activities protecting Medicare benefit dollars and is losing opportunities to save hundreds of millions of dollars in Medicare payments.

Medicare's role as the largest payer in an industry that consumes nearly one-seventh of our gross domestic product makes it imperative, in our view, that the program be effectively administered. Under recent health reform proposals, Medicare would continue to have a major economic and policy impact on the health care industry.

In fiscal year 1993 Medicare cost $146 billion, covered about 35 million beneficiaries, and processed about 700 million claims. If current trends continue, Medicare expenditures are expected to increase to $259 billion by 1998. Soaring expenditures for health care underscore the need for the government to fund and manage Medicare judiciously, but budget constraints have resulted in underfunding key program safeguards that control the billions of dollars in benefit payments. What compounds this problem is that the Health Care Financing Administration (HCFA), which is responsible for administering Medicare, faces many challenges in managing its national network of some 80 claims processing and payment contractors to which it delegates program safeguard activities.

We found, for example, through data reported to and sometimes generated by HCFA, that:

-- HCFA did not determine why one of its contractors had a 53-percent drop last year in the amount of money its payment safeguard program saved Medicare.

-- Some contractors have paid many times more per Medicare beneficiary for certain procedures than others, suggesting that some contractors have stiffer payment controls than others. HCFA does little to compile or evaluate information on contractors' payment controls to help

[1]See appendix for a list of reports and testimonies.

explain why certain spending varies so significantly across contractors.

-- One contractor had many more payment controls and saved Medicare more than twice that of another contractor. HCFA's rating of the two contractors did not reflect the greater accomplishments of the more successful contractor.[2] This lack of emphasis on payment controls is a factor that discourages contractors from making improvements.

Over the past year HCFA has begun efforts to improve its use of Medicare data and has stepped up requirements for contractors to find and correct payment problems. Budget constraints in recent years, however, have compelled HCFA to cut contractor operating costs, which amount to slightly over 1 percent of Medicare's total expenditures. HCFA contractors have a record of saving about $14 for every dollar spent on payment safeguards; nevertheless, funding for Medicare claims review has decreased from 74 cents per claim in 1989 to an expected 52 cents per claim in 1994. These cuts have had a significant effect on how effectively contractors control the billions of dollars of benefit payments. Simply put, fewer dollars spent on contractor operations mean more claims paid without adequate review and increased spending for unnecessary or inappropriate services.

HCFA ADMINISTERS MEDICARE LARGELY THROUGH PRIVATE INSURERS

In 1965, when the Medicare program was enacted, the law called for insurance companies--like Blue Cross and Blue Shield, Travelers, and Aetna--to process and pay claims. Under the law, the insurers, called Medicare contractors, use federal funds to pay health care providers and beneficiaries and are reimbursed for their administrative expenses incurred in performing the work.

Over the years, HCFA has consolidated some of Medicare's operations and the number of contractors has fallen from about 130 to about 80 today. Their duties encompass three major functions: claims processing, provider and beneficiary services, and payment control activities, called payment safeguards. In 1993 the contractor budget is approximately $1.6 billion, with about 26 percent devoted to payment safeguard activities.

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[2]HCFA has a contractor performance evaluation program to rate contractors on various dimensions, such as the accuracy of claims processing and compliance with program safeguard requirements.

CONTROLS OVER MEDICARE PAYMENTS
DETERIORATE DUE TO BUDGET CONSTRAINTS

The importance of contractors' vigilance over payments is growing because of the increasingly complex environment in which contractors operate. In recent years doctors and other providers have been moving more services out of such regulated environments as hospitals to largely unregulated and sometimes unlicensed freestanding facilities. This has contributed in part to an explosion of nonhospital claims that Medicare has to pay. Compared to 116 million claims for inpatient and outpatient hospital services, nonhospital claims are expected to total 630 million claims in 1994. This represents a 55-percent increase in such claims since 1989.

Despite the rising volume of claims, contractors' per-claim funding for payment safeguards has declined since 1989 by over 20 percent. The largest portion of contractor safeguard funding pays for staff who develop payment controls, review claims, and investigate suspect providers. When claims volume increases but the number of safeguard staff remains constant or declines, contractor staff apply fewer or less stringent payment controls.

Payment controls help ensure that Medicare does not pay for unnecessary or inappropriate services. For example, when one contractor found that its spending for foot care services jumped more than threefold--from about $470,000 to about $1.8 million between 1988 and 1991--it developed and implemented a payment control to deny uncovered or inappropriate foot care claims. By fiscal year 1992, the contractor's payments for foot care procedures dropped to about $620,000--about a third of its payments for these procedures in 1991.

At contractors we recently visited, funding constraints have led to less effort spent developing payment controls, some of which are computerized and can flag questionable claims during automated processing. Staff are not available to develop these controls or to investigate the claims that have been suspended for review when such controls are applied. One contractor told us that the suspended claims workload created by existing controls overwhelmed the review staff and, therefore, adding new controls was not a priority. Several contractors even eliminated certain controls because the volume of suspended claims exceeded the capacity of the staff to process them promptly.

Moreover, annual per-claim funding reductions have led HCFA to lower the proportion of claims that contractors must review. In 1989 HCFA set targets for contractors to suspend and review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994. HCFA also reduced by a third the number of audits of providers that contractors are required to perform. In the face of these

significant reductions in claims reviewed, HCFA has encouraged contractors to focus their reviews systematically on the more egregious payment problems.

POTENTIAL SAVINGS ARGUES FOR FUNDING INCREASES FOR CLAIMS REVIEW

The results of a HCFA demonstration project, which we are currently reviewing, help explain how adequate funding of payment safeguards can reduce program losses. In this project, HCFA provided special funding to three contractors and compared the contractors' payment safeguard accomplishments to that of two other contractors that did not receive enhanced funding. The contractors with enhanced funding saved 170 percent more, after expenses, than the other contractors. The enhanced funding permitted them, in comparison to the lower-funded contractors, to

-- employ over twice the number of program safeguard staff,

-- use four times the number of computerized controls to flag questionable claims, and

-- review before making payment nearly four times as many claim items.

In the current budget environment, funding increases appear unlikely, despite the proven record of claims reviews at saving Medicare substantially more than it costs. HCFA's fiscal year 1994 budget for contractor safeguard activities provides for an absolute 6 percent funding decrease; on a per claim basis, this means that contractors are expected to have about 12 percent less than last year for their claims review activities. Continuing declines can be expected as long as payment safeguard activities funded out of Medicare's administrative appropriations are considered part of federal discretionary spending and must compete against program funds for scarce dollars.

In the past we have reported that the Congress should consider modifying budget procedures so that Medicare safeguard funding could be increased without having to cut spending elsewhere.[3] Presently, administrative funding can be increased only if funding for other programs, such as immunizations or job training, is reduced. For example, although an additional $10 spent on program safeguard activities could save $140 in Medicare spending, no credit would be given (or scored) for the savings, while the $10

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[3]Our proposal to amend the Budget Enforcement Act is included in a May 1991 report entitled Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

would be counted as an increase in federal discretionary spending levels.

Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service (IRS) compliance activities without necessitating spending cuts elsewhere. As we reported in 1991, we believe using IRS' method of funding compliance activities as a model would enable the Congress to appropriate the funding needed for Medicare contractors' staffing and performance of payment safeguard activities. The Congress enacted our recommendation in 1992 but the bill was vetoed by the President for other reasons.

HCFA MANAGEMENT CHALLENGES COMPOUND FUNDING PROBLEMS

The Medicare program is also suffering from management weaknesses. HCFA has little information on such fundamental controls as the computerized edits and payment criteria that contractors use in reviewing claims before making payment. Moreover, HCFA makes little use of its management reports to scrutinize contractor safeguard activities. This lack of attention to management reports may help explain why HCFA did not explore the circumstances surrounding a contractor's reported 53-percent drop (amounting to over $26 million) in the 1992 savings it achieved through claims review. In fact, in 1992 HCFA gave the contractor a maximum score for the relevant segment of its program safeguard activities.

Similarly, HCFA does not make effective use of data compiled on contractors' spending for procedures to help explain large disparities in spending between contractors. For example, 1,000 Medicare enrollees in Arizona receive, on average, about 700 chiropractic manipulations per year, while in Louisiana the same number of Medicare enrollees receive only about 150 manipulations. Despite this disparity, HCFA has not assessed whether the differences between contractors serving Arizona and Louisiana are related to payment controls or some other factor that HCFA or the contractors should address. Yet for chiropractic manipulation, Medicare spent over $185 million in 1992.

In the course of several reviews, contractors we visited pointed to instances where Medicare payments were growing rapidly and they had not yet addressed whether payment controls were needed. For example, one contractor:

-- Experienced an annual growth rate in basic ambulance services of about 30 percent over the past 5 years. The contractor believes much of the increase could result from the use of ambulances for routine transportation, a noncovered service. Ambulance services were the fourth largest category of the contractor's expenditures, yet no

computerized controls existed to flag questionable claims. Nationwide, Medicare spent over $1 billion for ambulance services in 1992. Basic emergency ambulance services alone represent the eighth largest amount Medicare spends for a nonhospital service.

-- Saw over a 15-fold increase, from about $580,000 to $10 million between 1989 and 1991, for echocardiograms (a procedure that allows doctors to view an image of the heart). In 1992 Medicare's spending nationwide for one kind of echocardiogram--$366 million--ranked ninth largest in amounts spent on a nonhospital service.

HCFA REDUCES AUDITS OF HOSPITALS AND OTHER FACILITIES

Providers such as hospitals, home health agencies, and nursing homes are reimbursed, at least in part, on the basis of their costs of providing services. Between 1989 and 1993, funding for HCFA's auditing of these facilities has decreased from 27 cents to 22 cents per claim and in 1994 is expected to drop to 19 cents per claim.

Our recent review of the general and administrative expenses of a large hospital chain--Hospital Corporation of America (HCA)--illustrates why it is necessary to periodically review the submitted costs of hospitals and other institutions.[4] Of the $2.6 million of HCA's general and administrative expenses that we examined, we identified $1.1 million that we consider to be either unallowable, questionable, or unsupported. This amount includes:

-- $17,755 for alcoholic beverages at various employee meetings and functions,

-- $51,013 for entertainment at employee meetings and other functions, and

-- $233,547 for scholarships and related expenses for children of HCA employees.

HCFA BEGINS EFFORTS TO IMPROVE MANAGEMENT OF PROGRAM SAFEGUARDS

Over the past year, HCFA implemented a new data analysis approach, referred to as focused medical review, that requires contractors to begin systematically addressing payment problems. Specifically, HCFA now requires the contractors to identify

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[4]Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD-94-13, Oct. 15, 1993).

services or procedures that have inappropriately high utilization and take action to reduce that utilization. Though HCFA's new approach can significantly improve Medicare contractor payment controls, funding reductions have seriously limited the potential of focused medical review to achieve control of Medicare expenditures. Program safeguard activities require staff to review records and assess medical necessity. Thus, staffing will continue to be a major constraint as long as safeguard funding continues to lag behind the growth in Medicare claims.

HCFA is also planning to consolidate its multiple automated systems for claims processing into a single automated system as part of an overall strategy to improve the efficiency and effectiveness of Medicare operations. HCFA believes the proposed consolidation has the potential to enhance contractor management. A single system would format claims data uniformly and would enhance HCFA's ability to compare data on contractors' workload, savings resulting from payment controls, and other performance indicators. In addition, HCFA believes that a single claims processing system would allow it to designate contractors specifically to focus on activities exclusive of claims processing, such as program safeguards. HCFA expects to award a contract to begin developing the system in early 1994 and have the system developed and tested by late 1996.

CONCLUSIONS

Currently, the administrative budgets of federal programs are facing cuts. In our view, given the condition of the Medicare safeguard program, reductions in Medicare's administrative budgets should not be made without careful consideration of the likely effect on benefit payments. Over the past 5 years, Medicare's program safeguards budget, on a per claim basis, has declined appreciably. As a result, opportunities to curb unnecessary Medicare expenditures are being lost. Strong evidence suggests that with an adequately funded and managed safeguard program, Medicare could avoid many millions of dollars of unnecessary expenditures. Consequently, we believe the Congress should continue to pursue efforts to modify budget procedures so that Medicare's safeguard funding could be increased without having to cut spending elsewhere.

In addition, we believe that HCFA needs to develop an effective strategy to manage contractors' payment safeguard activities. This would entail establishing the infrastructure needed to make identification and correction of payment problems a high agency priority. Such a strategy could help ensure that Medicare has the controls in place to aggressively fight waste and abuse.

* * * *

Mr. Chairman, this concludes my testimony. I would be pleased to answer any questions.

Medicare: Better Guidance Is Needed to Preclude Inappropriate General and Administrative Charges (GAO/NSIAD-94-13, Oct. 15, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

Medicare: Funding and Management Problems Result in Unnecessary Expenditures (GAO/T-HRD-93-4, Feb. 17, 1993).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

Medicare: One Scheme Illustrates Vulnerabilities To Fraud (GAO/HRD-92-76, Aug. 26, 1992).

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (GAO/HRD-92-64, June 12, 1992).

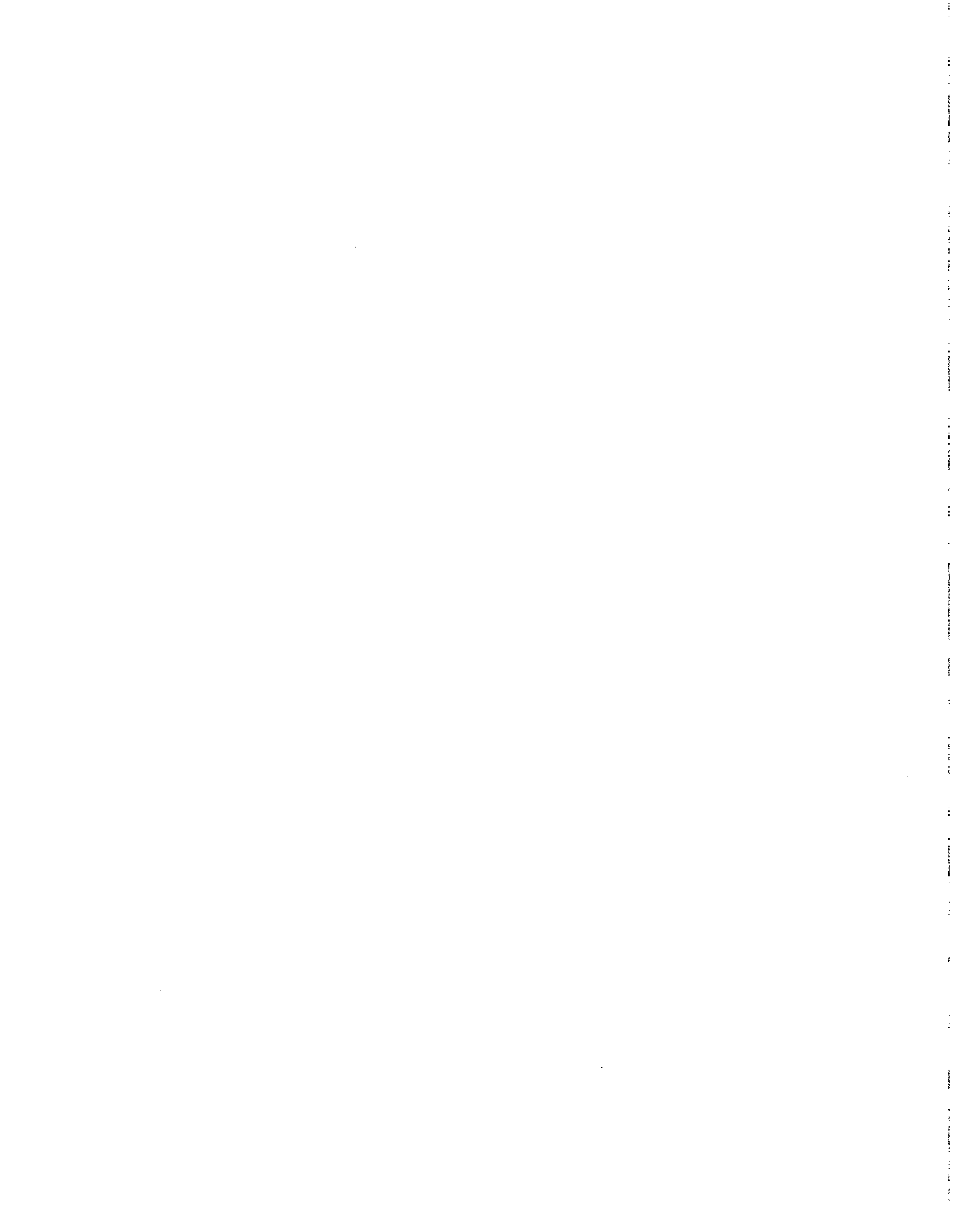
Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992). Testimony on same topic (GAO/T-HRD-92-29, May 7, 1992).

Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991).



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