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MEDICARE

Inadequate Review of Claims Payments Limits Ability to Control Spending

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The Honorable John D. Dingell
Chairman, Subcommittee on Oversight
and Investigations
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

The federally funded Medicare program is the nation's largest payer of health care benefits. Because Medicare accounts for nearly 15 percent of all money spent on health care in the United States, it is important that those who administer the program—the Health Care Financing Administration (HCFA) and its contractors—curb unnecessary and mistaken payments.

Medicare's program for analyzing paid claims—called postpayment review—is intended to warn Medicare officials of costly payment problems, such as a provider's billing for an improbable number of diagnostic tests, the rapid spending growth of ambulance services and cholesterol tests, or the unexplained high use of foot care and chiropractic services. Postpayment review, typically performed by Medicare's claims processing contractors, is HCFA's primary means for systematically identifying which providers are inappropriately billing the program and why the program spends so much for certain medical services. The purpose of our review was to assess the adequacy of Medicare contractors' postpayment review activities.

Background

In recent years, Medicare's fastest-growing expenditure has been for physician, outpatient, and other health services, such as diagnostic tests and medical supplies. Spending for these services, covered under part B of Medicare, increased from $38.3 billion in 1989 to $50.3 billion in 1992, an average annual increase of almost 10 percent.[1]

Postpayment Review Activities

To constrain rising costs, Medicare's part B claims processing contractors, referred to as carriers, use postpayment review to detect major payment

[1]Medicare part B is administered nationwide by 32 carriers. These are Blue Shield plans and private insurers such as CIGNA, Aetna, and Transamerica. Carriers are responsible for paying Medicare part B claims, implementing controls to safeguard program dollars, and providing information services to beneficiaries and providers.

problems. These problems include a broad range of inappropriate and abusive billing practices, as shown in figure 1.

Figure 1: Examples of Payment Problems Identified Through Postpayment Review

Unnecessary tests	In 1991, the Maryland carrier found, through its review of paid claims for laboratory services, that forms designed by clinical labs for designating tests to be performed encouraged physicians to order blocks of tests rather than specify the individual tests needed. This marketing tactic led physicians to order more tests than necessary. The carrier recovered about $650,000 from providers who had billed for the unnecessary tests.
Miscoding	In 1991, the Louisiana carrier noticed, through an analysis of claims for ambulance services, that its reimbursements for advanced life support ambulance services increased 460 percent over the prior 4 years. The carrier found that over half of the services were simple transports that should have been reimbursed at the basic ambulance service rate or were services that should not have been reimbursed. The carrier identified overpayments to the ambulance companies of an estimated $1,000,000 in 1990.
Loopholes in Payment Policies	In 1991, the Tennessee Medicare carrier found that some ophthalmologists were performing unnecessary laser surgery to correct patients' cloudy vision immediately following cataract extraction. Though such vision problems often correct themselves within a short time, the carrier's payment policies did not stipulate that ophthalmologists wait before providing laser treatment. The carrier changed its policy to require a 60-day waiting period, and, during the first 6 months of 1992, claims for the procedure decreased by 35 percent, or $700,000.
Indicators of Potentially Fraudulent Schemes	In 1990, the Michigan carrier found that suppliers were billing for incontinence kits composed of supply items not covered by Medicare. The carrier denied a total of $3,627,541 in claims for these supplies in 1991 after implementing computerized controls to flag such claims for special review. The carrier also referred the claims of several suppliers to the Department of Health and Human Services (HHS) Office of the Inspector General to investigate for possible billing fraud.

Historically, carriers' postpayment review methods have concentrated on examining the practice patterns of individual physicians or suppliers, an approach known as profiling. The object of profiling is to identify providers who bill for many more services per patient than their peers.

Until recently, carriers' profiling analyses relied on gross measures of individual provider behavior.

In 1993, HCFA developed a new emphasis on data analysis. Calling its approach focused medical review, HCFA required carriers to better focus their profiling efforts and to begin identifying general spending patterns and trends that would allow them to determine the causes for unusually high spending. Carriers are now required to examine spending for specific services or procedures largely by comparing their own spending amounts for certain procedures with these procedures' spending averages across carriers.

Using profiling and focused medical review, as well as leads from beneficiaries and others, carriers identify payment problems and initiate corrective actions, including education letters that notify providers of billing errors, audits of providers' claims, recovery of amounts misbilled, and suspension of flagrant offenders. HCFA prescribes the range of actions carriers can take, but generally does not specify protocols to follow in taking these actions.

If the billing problems appear to be widespread among providers, carriers may also take a combination of steps that include (1) strengthening payment policies or procedures that will disallow or reduce Medicare reimbursement for certain services; (2) developing early detection controls, called prepayment edits, which flag questionable claims for review before payment; and (3) instructing providers about local or national payment policies through education projects.

Scope and Methodology

To examine carriers' postpayment methods, we interviewed officials and reviewed documents both at HCFA and 11 Medicare carriers—Aetna (Arizona), Blue Shield of Florida, Aetna (Georgia), Health Care Service Corporation (Illinois), Associated (Indiana), Blue Shield of Kentucky, Blue Shield of Arkansas (Louisiana), Blue Shield of Maryland, CIGNA (North Carolina and Tennessee), and Transamerica Occidental (Southern California). We also examined postpayment review activities—carriers' data analysis, audits, and recovery actions—and HCFA's oversight of carrier performance, especially its use of performance indicators, to assess results. We conducted our work between May 1992 and February 1994, in accordance with generally accepted government auditing standards.

Results in Brief

HCFA does not pay enough attention to Medicare carriers' analyses of payments made and therefore misses opportunities to identify perhaps millions of dollars in excessive payments. Among other things, Medicare carriers use claims data to identify billing abuses and excessive payments for services. Recent HCFA mandates have tried to enhance carriers' analyses of claims data, but carriers' analysis methods to examine provider billing behavior and Medicare spending trends remain inadequate.

Carriers use inaccurate or incomplete data in compiling statistical reports profiling physicians and other providers; their focused reviews to identify irregular billing patterns and unusual spending trends suffer from HCFA's failure to specify appropriate analysis methods and outcome measures. As a result, HCFA cannot ensure that Medicare carriers are systematically targeting providers or services that most warrant investigation and corrective action. Procedural and legal constraints related to Medicare also hinder carrier efforts to act against abusive providers.

Shortcomings in carriers' claims review activities exist, in part, because HCFA lacks meaningful requirements for—and the data needed to measure—carriers' postpayment review performance. HCFA measures how well carriers adhere to required procedures; it does not assess the extent to which carriers' recovery efforts or payment controls save program dollars or deter future abuse. In addition, shortcomings persist because funds allotted to postpayment review have not kept pace with Medicare's growth in claims or as a percentage of the carriers' total administrative budget.

To ensure that carriers improve their reviews of paid claims, HCFA needs to better direct Medicare's program safeguard efforts. To do this, HCFA should expand guidance and technical assistance for carriers' development of data analysis methods. It should also address constraints on carriers' authority to act against abusive providers. Finally, HCFA should establish relevant measures of effective performance and use these measures to assess carriers' claims review performance.

HCFA Does Not Make Best Use of Claims Data to Explain Spending Irregularities, Contractor Performance

Postpayment review enables carriers to identify billing practices that unnecessarily increase Medicare costs. HCFA does not examine these data, however, for the purpose of addressing excessive spending nationwide or by individual carriers; HCFA staff are responsible for monitoring compliance with reporting requirements that are procedural rather than analytical in nature.

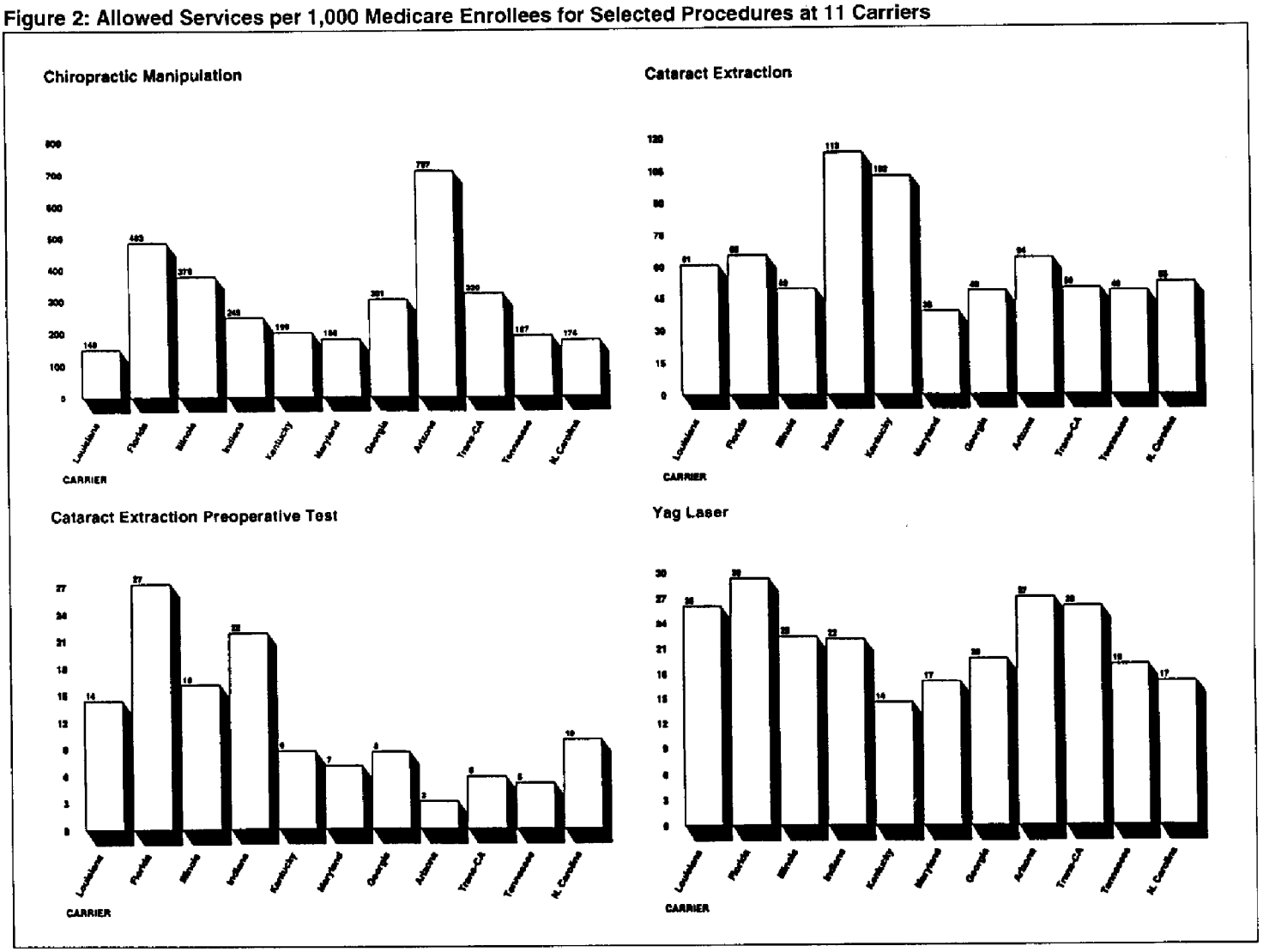
In general, HCFA holds carriers responsible for establishing controls over spending in the Medicare program. Carriers accomplish this through postpayment analyses, which involve automated reviews of paid claims files to highlight questionable claims or suspicious billing patterns. Nurses and claims analysts on the carriers' medical review staffs then review the claims to determine what actions should be taken. Examples from the carriers that we visited demonstrate how postpayment reviews have prompted corrective actions, helping to reduce unnecessary Medicare expenditures:

- A case in Louisiana illustrates the use of postpayment review to identify needed changes in medical policy. By examining spending trends for individual procedures, the carrier found that in 1991 it paid significantly more for foot care services than in prior years. Specifically, the carrier's payment for five foot care services jumped more than threefold—from about $470,000 to about $1.8 million—between 1988 and 1991. The carrier suspected that podiatrists were performing routine foot care but fragmenting their bills to reflect five separate foot care procedures. In 1991, the carrier developed a medical policy delineating the difference between routine foot care and the other procedures. After implementing the policy in fiscal year 1992, the carrier's payments for these five procedures dropped to about $620,000—about a third of its payments for the five procedures in 1991. Without a written medical policy, carriers have little basis for denying a claim.
- A Tennessee case in which the carrier compared payments per beneficiary for selected services to those of other carriers also shows that postpayment review can identify needed policy changes. By comparing payments, carrier officials learned in 1989 that the carrier was paying pathologists for consultations with other doctors when the test results could be interpreted by the requesting physician. The carrier revised its medical policy, and reimbursements for these consultations declined from more than $2,700,000 in 1988 to about $10,650 in 1992.
- An Illinois case shows how physician profiling can identify unnecessary tests. By comparing an individual internist's practice pattern to the average pattern of all internists, the Illinois carrier identified a physician

who was billing for an improbably high number of cholesterol tests, among others. The carrier produced detailed reports that highlighted the billing problem and assessed the physician for nearly $30,000 in claims for unnecessary services.

HCFA could also use postpayment review to assess its contractors' performance in managing Medicare benefit dollars. Through postpayment review analysis of the number of services that carriers reimbursed per Medicare beneficiary, for example, HCFA could get significant information about a carrier's ability to make benefit payments appropriately. As shown in figure 2, some carriers reimbursed several times the number of services per beneficiary reimbursed by other carriers for selected services. Such comparisons would enable HCFA to explore reasons for variations in service use rates and spending, and, with the understanding gained, improve the management of the contractors. HCFA does not use the data, however, for these purposes.

Figure 2: Allowed Services per 1,000 Medicare Enrollees for Selected Procedures at 11 Carriers



Data and Reporting Problems Undermine Carrier Postpayment Review Efforts

HCFA has little assurance that Medicare carriers systematically target providers or services that most warrant investigation and corrective action. Only recently has HCFA begun emphasizing that carriers analyze such factors as spending trends to detect, by procedure, unusual levels or growth of spending. In principle, these new data analysis initiatives can greatly improve Medicare's payment review efforts. The data that carriers use to perform these analyses, however, are often inaccurate or incomplete. Carriers acknowledge these data weaknesses but have little

incentive to correct them. HCFA does not require that data problems be corrected and does not fund carriers to do so.

Incomplete Profile Reports Weaken Efforts to Identify Abusive Billers

Profiling is a technique used by public and private payers to screen providers' practice and billing patterns for overuse of services or billing problems. Private-sector payers commonly use profiling as a means of selecting providers to participate in their medical service networks. In Medicare, the profile reports that carriers generate are intended to target providers that appear to be abusive billers or whose billing patterns are otherwise questionable.[2] Over the years, carriers have acknowledged that their profile reports are generally limited with respect to identifying the billing practices that most warrant audits or other corrective actions.

Carriers consider profiling important in targeting providers with suspect billings, but they have not corrected the problems that limit its usefulness because HCFA has neither required nor funded such actions. Better profiling reports can increase Medicare's savings by making carriers more effective at identifying and correcting their most serious payment problems. Additional Medicare savings, however, do not produce additional revenue for carriers; in fact, carriers generally incur additional costs to achieve savings. Thus, absent specific requirements and reimbursement by HCFA, carriers lack an incentive to improve profiling reports.

HCFA requires that carriers' profiling reports calculate averages for the carriers' use to identify physicians and suppliers who bill, per patient, substantially more services than their peers. The reports are not always reliable, however, because HCFA does not require that carriers adequately account for factors that result in appropriate differences in physicians' practices. Following are particular drawbacks of carriers' profile reports:

- They do not adjust for differences in providers' mix of patients. For example, an internist who treats older, more severely ill patients might appear to be providing too many higher level services when compared to the average internist.

[2]A carrier typically produces profile reports twice a year and uses them as one source of information to identify providers that warrant an audit because they appear to have abusive billing practices. For fiscal year 1993, HCFA required carriers to audit at least 0.5 percent of the providers that billed it. Depending on the carrier's audit findings, possible carrier actions include (1) asking the provider to return amounts that Medicare inappropriately reimbursed; (2) sending an education letter advising the provider of potential billing problems; or (3) referring the case to the carrier fraud unit or HHS Office of Inspector General for further investigation for potential fraud or abuse.

- They do not flag referral patterns that would reveal deceptive billing practices. Medical suppliers and laboratories provide services on the basis of referrals from physicians. Because profile reports do not include data on physicians' referrals, however, carriers cannot screen for physicians who refer unusually high volumes of patients for particular services or supplies. At one carrier we visited, for example, postpayment review staff could not use profiling to detect that a physician had referred an unusually large number of patients for supplies from a particular company.[3]
- They rely on inaccurate classifications of physicians' specialties. Profiling results can be distorted when, for example, a cancer specialist is classified as an internist and measured against other internists on the number of laboratory tests rendered. Since cancer specialists perform a relatively high number of laboratory tests, misclassified internists would appear to have significantly exceeded normal rates for laboratory tests when compared to all internists.[4]

These drawbacks limit the effectiveness of carrier profiling reports for targeting providers to audit. Generally, carriers audit providers that profiling reports suggest as having egregious billing problems. Audits are done to identify and recover inappropriate Medicare payments. An official at one carrier that we visited estimated that more than 95 percent of providers identified by profiling reports do not merit an audit, because the reports do not discriminate between providers committing one-time billing errors and habitual misbillers. Winnowing the list of targeted providers therefore requires a disproportionate amount of time and staff relative to carrier resources. At several carriers, postpayment review staff rely heavily on beneficiary complaints or other referrals for fraud and abuse leads, depending on a fortuitous rather than systematic identification of providers for audit.

Moreover, carriers have had problems using their profile reports to help them educate providers. In 1990, HCFA began instructing carriers to educate providers whose billings looked significantly different from their peers based on the carriers' profiling reports. However, education letters

[3]An anonymous complaint brought this situation to the carrier's attention. The carrier determined that the physician owned the supply company. A subsequent HHS Office of Inspector General investigation found that the physician was part of a fraudulent scheme to bill Medicare and other plans for unnecessary services and supplies.

[4]In 1992, HCFA increased the number of specialty designations it recognized, and carriers sent letters to physicians asking them to reclassify themselves. In commenting on a draft of this report, HCFA specified that 50,000 physicians chose to reclassify—about 11 percent of the total physician population serving Medicare. Over time, therefore, the specialty designation problem will likely be corrected, as carriers make physicians increasingly aware of Medicare's reliance on these designations to profile physician practices.

based on carriers' profiling reports have created confusion, frustration, and a sense of harassment among providers. In fiscal year 1992, for example, when HCFA substantially changed office visit codes, it required carriers to inform selected providers that they appeared to have misbilled for services related to office visits.[5] HCFA asked carriers to select such providers on the basis of their profiling reports, which resulted in the erroneous targeting of many providers. Among those targeted were physicians who only once provided the service under scrutiny, physicians whose billings appeared aberrant because their patients required more intensive services than those of their peer group, and physicians whose specialty classification was inappropriate.

Focused Medical Review Limited in Efforts to Target Service Overutilization

Carriers also have difficulties implementing HCFA's new claims review approach called focused medical review. As a supplement to provider profiling, this approach seeks to focus, or target, spending patterns or trends that pose the greatest risk of unnecessary payments.

Focused reviews are intended to help HCFA and the carriers determine the causes of rapid spending growth for certain services, explain wide variations in spending for certain services within or across states, and identify providers who are driving up expenditures for certain services. Although focused reviews hold promise, they are in an early implementation phase, and poorly defined methods for conducting analyses limit the carriers' ability to address payment problems.

HCFA's focused review requirements direct carriers to target for analysis a set number (40) of procedures showing aberrant billing patterns. Carriers produce their target list from a data report compiled by HCFA that includes the carrier's billing data for more than 2,000 procedure codes and, for comparison, national billing averages for these codes.[6] HCFA requires the carriers to address the targeted aberrancies through actions that include issuing education letters to abusive billers, developing new payment controls, auditing a provider's claims, and assessing repayments from abusive billers. A required minimum (15) of the corrective actions must include revising carrier medical policies or computerized payment edits. Carrier officials charge that HCFA's criteria are not specific enough to determine which procedure codes showing aberrancies carriers should

[5]As part of physician payment reform, HCFA changed the codes physicians use to bill for office, hospital and emergency room visits, and for consultations. HCFA instructed carriers to educate providers whose billings for these codes looked significantly different from their peers.

[6]Carriers can use other data sources, such as internal claims data, to identify aberrant billings.

select for the required 40, what analysis methods carriers should use to determine the causes of aberrancy, or how carriers should determine what constitutes an appropriate response for correcting problems.

Moreover, the reports HCFA provides to carriers for conducting focused reviews are still evolving and include unreliable data. The reports compare a carrier's spending for a service to an average of what other carriers spend for that service. The reports have several problems that will need to be addressed as focused medical review develops. Following are examples:

- The coding of physician specialties is inconsistent across carriers. Since most of the reports provided by HCFA compile the data by physician specialty, the spending rates for services reported by specialty are distorted by differences in carriers' classifications.
- The calculation of spending on the basis of carrier enrollment, rather than on the number of beneficiaries served, distorts carrier spending rates. For example, the Florida carrier, serving a state that attracts many Medicare beneficiaries during the winter, had higher payments per enrolled beneficiary than the other carriers visited.[7] Florida's 1992 payments per enrollee were 91 percent higher than Indiana's, but the per enrollee basis for calculating these rates makes it difficult to determine the root causes of the wide variation. (See app. I showing Medicare payment per enrollee for the carriers visited.)

Program Constraints Reduce Carriers' Recovery of Identified Losses

Even when carriers successfully identify spending irregularities that suggest abusive billing practices, they do not always effectively audit involved providers or make significant recoveries. HCFA does not require that carriers use audit techniques, such as estimating overpayments on the basis of samples, that could help carriers get recoveries commensurate with the losses Medicare incurred. Moreover, procedural and legal constraints also limit carrier audit and recovery efforts.

Audits entail determining which of a provider's services that Medicare paid for were unnecessary or inappropriate by reviewing the medical documentation supporting the provider's claims. Amounts paid for

[7]In many cases, people who vacation in states like Florida continue to maintain their permanent addresses in other states. Thus, though the Florida carrier may process these visitors' claims, the visitors are not counted as Florida residents when HCFA calculates Florida's per enrollee medical expenditures. This would overstate those expenditures and understate the residence states' expenditures.

unnecessary or inappropriate services are considered overpayments to the provider.

One way carriers calculate overpayment amounts—without auditing hundreds or even thousands of claims—is by auditing a sample of a provider's claims. Because of the large volume of claims submitted by the average provider and the time involved in reviewing a claim, many carriers audit a sample of providers' claims for efficiency's sake—they cannot practically examine all of a provider's claims. Most carriers estimate a total overpayment amount by projecting the sampling results. Without projecting, the dollar amounts determined from the sample would generally be nominal compared to the amount likely to be deemed overpaid if the carrier were to audit all the provider's claims.

HCFA does not require that carriers sample and project the sampling results to estimate overpayments. Two carriers that we visited did not use audit samples to develop overpayment projection estimates. One carrier we reviewed that based its overpayment amounts solely on the sample of claims audited assessed an average of less than $2,000 per provider audited; by contrast, another carrier we reviewed that estimated its overpayment amounts on the basis of sample projections assessed an average of more than $20,000 per provider audited.

Other limitations on carriers' audit and recovery activities include the following:

- Carriers lack the authority to recover overpayments from providers who do not accept Medicare assignment.[8] This sometimes results in substantial Medicare losses. In one case, a carrier audited a cardiologist who billed more than $75,000 in unnecessary services to Medicare beneficiaries in a 6-month period. Most of this amount represented billings for nonassigned claims and could therefore not be recovered from the cardiologist. Given this problem with nonassigned claims, certain offenders are essentially exempt from repayment.
- Carriers lack authority to assess overpayments that involve claims for care that physicians order from suppliers or laboratories. In one case, a carrier could not collect a $123,000 overpayment assessed from a laboratory that

[8]Under Medicare regulations, providers that agree to accept Medicare rates as payment in full are recognized as having been assigned the beneficiary's right to receive Medicare reimbursement. The claims submitted by providers meeting this condition are termed assigned. Claims from providers not accepting assignment are called nonassigned; these providers are not allowed to receive payment directly from Medicare and must obtain reimbursement from their Medicare patients. HCFA believes that in most cases it is neither appropriate nor practical to recover overpayments from beneficiaries.

provided services shown by the carrier to be unnecessary. An administrative law judge ruled that, since the laboratory acted on physicians' orders, the laboratory should not be held liable for the costs billed. Carriers cannot assess overpayments from physicians who make unnecessary referrals because the referring physicians are not the providers that have billed Medicare for the disputed supplies or services.

- HCFA requires carriers to complete provider audits (referred to as comprehensive medical reviews) in 1 year if they are to be counted toward the carrier's performance goals. According to carrier medical review officials, this requirement dissuades carrier staff from doing the complex audits necessary to uncover cases involving extensive billing abuses.

The combined effect of these problems has been to reduce carriers' effectiveness in recovering misspent Medicare dollars. Carriers have voiced these concerns to HCFA for several years, but HCFA has not addressed them adequately.

HCFA Does Not Oversee Carriers' Claims Review Activities Effectively

Carriers have little incentive to strengthen their postpayment review activities. The standards HCFA uses to hold carriers accountable for these activities do not address carrier success in identifying and correcting causes of excessive spending. In addition, declining per-claim budgets over the past several years have deterred carriers from investing in claims review improvements.

Performance Standards Do Not Measure Results

HCFA's fiscal year 1993 Contractor Performance Evaluation Program (CPEP) for postpayment review evaluates carriers' compliance with procedures rather than the achievement of results. CPEP standards therefore give HCFA little information on how well carriers' review methods identify payment problems or to what extent corrective actions prevent future unnecessary spending. CPEP does not score carriers on the outcomes of their postpayment programs, such as whether their efforts result in recovering overpayments or developing effective medical policies and automated controls to flag or deny problem claims. (See app. 2 detailing CPEP requirements governing postpayment review activities.)

Outcomes at two carriers that we visited illustrate HCFA's lack of emphasis on results. In 1992, one carrier recovered less than $40,000 in overpayments and established no new medical policies or automated prepayment controls. Another carrier recovered about $700,000 and established more than 50 new medical policies and prepayment controls.

In CPEP evaluations, both carriers received the maximum score for their postpayment performance.[9]

CPEP standards for postpayment review activities include requirements for profile reports, provider audits, and focused medical review. The requirement for provider profile reports stipulates that carriers produce the reports twice a year and that the reports include averages of provider service utilization. There are no standards for judging the adequacy of the reports' content to prompt carriers' corrective actions. Carrier officials explained that they scarcely use profile reports, though they incur the cost of preparing the reports in order to pass CPEP.

Similarly, the CPEP requirement for provider audits directs the carriers to audit 0.5 percent of active providers in their billing jurisdiction. There are no standards, however, for judging the results of the audit. HCFA's carrier evaluations do not distinguish, for example, between an audit of an abusive biller that results in an education letter to the provider and one that results in large overpayment recoveries—despite the heavy resource investment needed to obtain large recoveries.

The CPEP requirement for focused medical review, among other things, stipulates only that carriers identify 40 aberrant spending patterns and initiate corrective actions. These include developing at least 15 new or revised medical policies or automated prepayment screens.[10] CPEP does not score carriers on their effectiveness in selecting aberrancies or the corrective actions taken.

Carrier officials explained that their claims review activities are geared almost entirely toward passing CPEP because HCFA uses the CPEP scores to determine whether to renew carriers' contracts. The focus on CPEP dissuades carriers from undertaking any projects that, though potentially cost effective, would not improve their CPEP score.

Budget Problems Inhibit Carrier Investment in Payment Safeguards

Declining budgets, coupled with a budgeting process that does not reward carrier performance, create strong disincentives for carriers to initiate improvements independently. From 1989 through 1992, funding for carriers' postpayment activities declined on a per claim basis and as a

[9]In fiscal year 1992, the CPEP requirements did not include a focused medical review criterion requiring carriers to develop 15 new or revised local policies or prepayment screens.

[10]In commenting on a draft of this report, HCFA advised us that carriers are also required to have software in place that supports local data analyses to investigate areas identified for focused medical review.

percentage of the carriers' overall administrative budgets. Specifically, funding for carriers' postpayment-related activities fell

- from 23 cents per processed claim in 1989 to 16 cents per claim in 1992 or
- as a share of the carriers' total administrative budgets, from 10.6 percent in 1989 to 7.9 percent in 1992.

At two carriers that we visited, claims review funding has decreased by more than 40 percent since 1989 on a per claim basis.

Limited funding discourages carriers from developing innovative claims review methods that could help deter billing abuses or correct other payment problems. Effective claims reviews generate the need to develop medical policies, implement prepayment controls, and educate doctors—postpayment activities requiring physicians and nurses. The data analyses involved in focused medical reviews require statisticians and other analysts. The carriers' inability to rely on stable funding, however, precludes hiring, training, and retaining the staff necessary to operate effective postpayment review activities.

Conclusions

HCFA's new emphasis on claims data analysis, which the agency calls focused medical review, is an important and well-intentioned first step toward systematically tracking excessive Medicare payments. HCFA has not, however, paid adequate attention to carriers' data analysis activities to determine whether carriers are conducting appropriately focused reviews. As a result, there is little assurance that Medicare's most significant payment problems are being identified and corrected. Additionally, HCFA has not adequately addressed procedural limitations that carriers have long reported as limiting recovery of program losses. Lastly, HCFA has not held carriers adequately accountable for the timely identification and correction of problems in their claims processing and payment systems. In sum, HCFA must show greater leadership to stimulate the development and continuous improvement of carriers' postpayment review activities. With its access to extensive health care data and experience in operating the nation's largest insurance program, HCFA should be a leader in identifying ways to avoid unnecessary health care expenditures.

Recommendations to the Secretary of Health and Human Services

To strengthen carriers' ability to identify and address Medicare losses to waste and abuse, we recommend that the Secretary direct the Administrator of HCFA to

- provide carriers guidance and technical assistance to improve profiling and focused medical reviews;
- identify legal issues that constrain carriers' audit and recovery efforts and make recommendations to the Congress to eliminate such constraints;
- amend Medicare procedures, such as those involving the projection of sample results, to enhance carriers' audit and recovery efforts; and
- revise CPEP evaluation criteria to include outcome measures that better assess carriers' postpayment review performance.

Agency Comments and Our Evaluation

In commenting on a draft of this report, HHS generally agreed with our recommendations. HHS believes that "... focused medical review is the logical alternative when faced with declining payment safeguard funding and increasing claims processing demands." We likewise believe it is a reasonable way to deal with a bad budget situation and minimize losses to Medicare from reduced payment controls. Minimizing the damage of declining budgets, however, does not address our position that HCFA should become a leader in identifying ways to avoid unnecessary health care expenditures. Yet it may be the only acceptable strategy to adopt if the Congress does not identify ways to adequately fund Medicare's program safeguard activities. Following is a summary of HHS's comments on our recommendations and our response.

Regarding our first recommendation, HHS stated that HCFA is well on its way toward providing carriers better guidance and technical assistance. HHS emphasized, however, that focused medical review is in an early stage and that our review took place as carriers were implementing the program. HHS is apparently concerned that our discussion of the limitations we found with focused medical review may be interpreted as criticism of the concept. We have revised the report in several areas to more clearly acknowledge that we believe that focused medical review is a critical first step that could better position HCFA to manage Medicare benefit dollars.

That notwithstanding, focused medical review has a long way to go if the Medicare program is to become a leader in the area of health care claims review approaches. As HHS noted in its technical comments to the report, prior to HCFA's recent initiative, carriers' medical review efforts ". . .

concentrated on very gross measures of individual provider behavior." These measures were initially developed more than a decade ago when HCFA undertook another initiative to require its carriers to develop better ways to use claims data for managing program expenditures. Subsequently, HCFA did little to encourage carriers to enhance their data analysis approaches, and this is why, more than 10 years later, some carriers still have little more in data analysis capabilities than gross measures of provider performance.

Because Medicare is the nation's largest insurer as well as the fourth highest expenditure in the federal budget, the program's lack of sophisticated data analysis capabilities to manage program dollars should be viewed as a serious problem. Focused medical review is HCFA's approach for the future to help resolve this problem. This is why we believe it is important to document current data analysis problems and limitations within HCFA and its contractor network.

HHS also concurred with our recommendation to overcome the obstacles that constrain carriers from acting against abusive providers. HHS explained why carriers currently do not recover from such providers, implying that it foresees difficulties in implementing the recommendation. Carriers, over the years, have frequently asked HCFA to resolve this recovery problem because it allows some providers to bill beneficiaries (and ultimately the program) inappropriately. Continuing to ignore the problem does not seem to us to be a reasonable course of action for HHS and HCFA. Given the agency's discussion of this point, it is not clear whether HHS plans to pursue this action with HCFA.

HHS did not take issue with our recommendation to amend Medicare procedures to enhance carriers' audit and recovery efforts. The agency did, however, express some concern about requiring carriers that use sampling to project their results in calculating overpayments made to providers. Specifically, HHS stated

"Mandating projected overpayment and focusing on savings generated by denying claims on a . . .post-payment basis are not consistent with our emphasis on education to get providers to bill correctly the first time, and our desire to maintain a good relationship with the physician community. . . ."

Education is a key element of any program directed at reducing unnecessary, erroneous, or inappropriate provider billing, and Medicare has an extensive provider education program. It does not follow, however,

that Medicare's emphasis on education is at all inconsistent with efforts (such as projecting) to recover overpayments.

The specific objective of Medicare's postpayment review is to identify and audit providers who appear to have the most abusive billing practices in the areas served by each carrier. Carriers are funded to audit only 5 of every 1,000 providers who bill them each year, and they select for audit those providers most likely to be engaged in abusive billing practices. Thus any provider's chances of being audited are slim. Even when audited, however, a provider has virtually no chance of having to fully reimburse Medicare for overpayments received from carriers that do not project when calculating overpayment estimates. We do not understand how such carriers' routine forgiveness of providers' debts to Medicare can be considered educational in a way that would benefit Medicare. The lesson taught in these situations would appear to be that, even in the unlikely event of a Medicare audit, providers will not be required to repay much of what they owe.

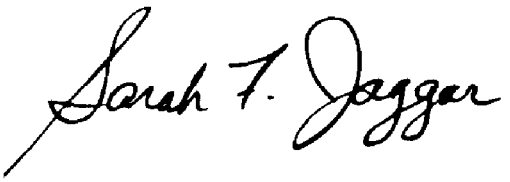
Lastly, HHS generally agreed with our proposal to revise the contractor performance evaluation program to include outcome measures. HHS expressed some concern about developing contractor evaluation standards, noting that if not done carefully, such standards could give contractors ". . . a perverse incentive to just reach savings goals and . . . increase the 'hassle-factor' effect on the providers involved." We agree that it would be inappropriate for HCFA to focus exclusively on savings when assessing a carrier's performance. Ignoring savings, however, is equally inappropriate. The incentives for carriers to be overly aggressive in meeting savings standards could be easily counteracted by setting companion standards for ensuring that savings are not bought at the cost of unwarranted provider hassling. For example, HCFA could also set standards related to the frequency and success that providers experience appealing carrier denials; these measures would be based on the premise that, when carriers' decisions are infrequently appealed and overturned, the carriers are not unduly hassling providers. HHS noted that HCFA recently let a contract to help the agency develop better performance measures. We believe this is a positive, long overdue action.

We have considered other HHS comments and incorporated them as appropriate. (HHS comments appear in app. III.)

As arranged with the subcommittee staff, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies to other congressional committees, the Secretary of Health and Human Services, and other interested parties.

The report was prepared under the direction of Leslie Aronovitz, Associate Director of Health Financing Issues, who can be reached at (202) 512-7104 if you have any questions. Other major contributors are listed in appendix IV.

Sincerely yours,



Sarah F. Jaggar
Director, Health Financing
and Policy Issues

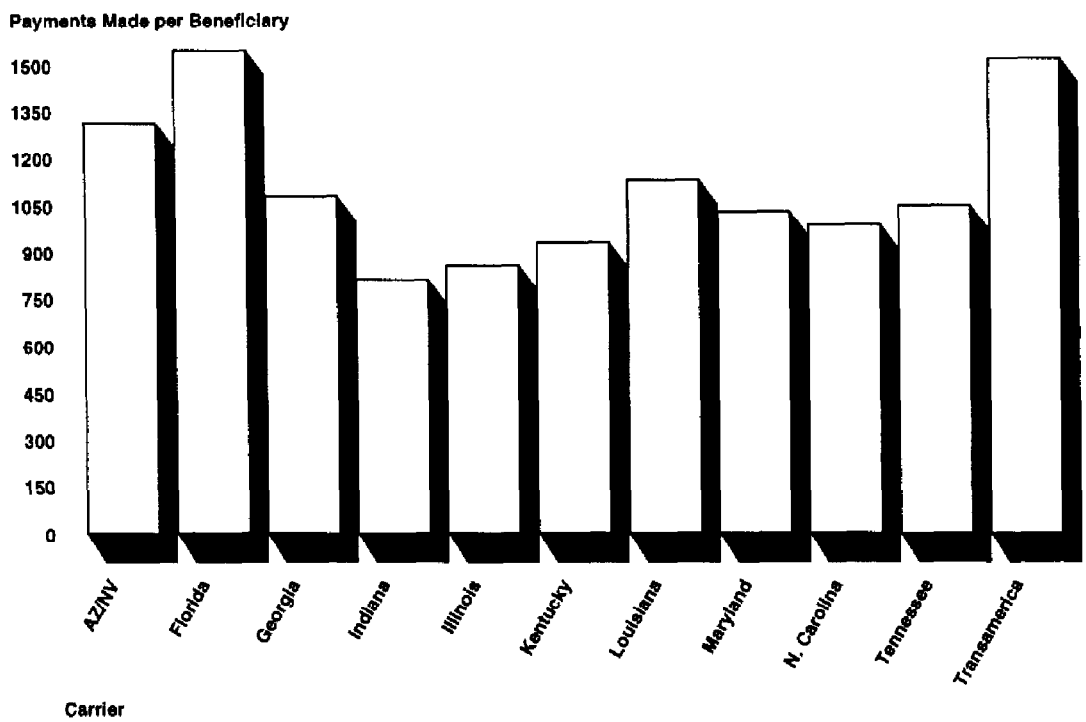
Contents

Abbreviations

CPEP	Contractor Performance Evaluation Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

Payment per Enrolled Beneficiary at 11 Carriers Visited

Figure I.1: Payment per Enrolled Beneficiary at 11 Carriers Visited



Payments made have been adjusted for geographic variation using the geographic consumer price index.

Benefits do not include those paid for beneficiaries in HMO programs.

HCFA's Fiscal Year 1993 CPEP Standards for Postpayment and Focused Medical Review

Focused Medical Review

To receive full credit for this criterion, the carrier is required to

- address 40 or more payment aberrancies in the national data or other data sources by initiating appropriate corrective actions including educational activities of an individual or group, prepayment edits, and identification of local medical policies to be developed or revised, and
- document that 15 of the corrective actions taken involve developing new or revised local medical policies or prepayment screens.

Postpayment Review

To receive full credit for this criterion, the carrier is required to

- profile provider practices by running comparative reports every 6 months,
- select 0.5 percent of their active physician and supplier population for audits which must be completed within 1 year, examine a provider's billing practices for a period of at least 6 months, and include a review of at least 15 beneficiaries,
- submit a timely postpayment annual report and a special study, and
- document postpayment actions, including the reasons providers were chosen for audit.

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 1 1994

Ms. Leslie Aronovitz
Associate Director
Health Financing Issues
United States General
Accounting Office
Washington, D.C. 20548

Dear Ms. Aronovitz:

Enclosed are the Department's comments on your draft report, "Medicare: HCFA Needs to Better Direct Contractors' Use of Data to Safeguard Benefit Dollars." The comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

June Gibbs Brown
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office (GAO) Draft Report, "Medicare: HCFA Needs to Better Direct Contractors' Use of Data to Safeguard Benefit Dollars"

Overview

The GAO study took place between May 1992 and June 1993. Carriers were not required to have the hardware, software, and personnel in place to conduct focused medical review until the end of Fiscal Year 1993 (i.e., by Septmeber 30, 1993). During Fiscal Year 1993 Health Care Financing Administration (HCFA) provided the funding and technical guidance for carriers to make the transition to focused medical review.

Focused medical review requires carriers to focus their medical review activities on those areas with the highest probability of medically unnecessary services through the utilization of data analysis, policy development, and focused screens. Beginning with Fiscal Year 1993, carriers were provided with additional funding in order to develop or purchase software, and to hire the additional capacity needed to implement focused medical review.

Under focused medical review, carrier medical review emphasizes not only elimination of waste through detection of medically unnecessary or unreasonable services claimed for Medicare payment, but also the education of providers. This education is to eliminate the provision of wasteful services and to prevent upcoding, and other such billing practices. The elimination of the program evaluation standard measuring a carrier's achievement in generating savings or in achieving a specific cost-benefit ratio from medical review activities was based on the Health Care Financing Administration's (HCFA's) concern that it could create a perverse incentive affecting the carriers' medical review activities. Demanding a pre-set and prescribed recovery quota of savings caused the carriers to focus on generating savings, at the expense of performing appropriate reviews and educating providers. This former standard also generated considerable administrative costs and burden in the areas of inquiries, hearings, and appeals of denied services.

Additionally, we would note that case mix adjustment methods are sophisticated analysis techniques that would lack consensus and are quickly criticized. We did not feel it was an appropriate requirement to place on carriers at this time. In Fiscal Year 1994 we do require carriers to have the ability to profile ordering/referring physicians. HCFA has decided to pilot the use of this information before directing carriers to take action on findings. Carriers must have the capability to

perform profiling by the ordering and referring physician. We are not sure that this information will provide better identification of problems than profiling by performing physician, so this will be tested this year in a small number of carriers.

Further, focused medical review is the logical alternative when faced with declining payment safeguard funding and increasing claims processing demands. We are in complete agreement with GAO when it states that declining budgets inhibit carrier investment in payment safeguards. We are currently pursuing alternative methods to fund payment safeguard activities.

Focused medical review also represents a new approach in that the concepts of continuous quality improvement are built into the medical review process. For example, a problem identified through focused medical review should lead to the development of a local medical review policy. Such a policy can be enforced through prepayment screens. At a later time, data may demonstrate that provider behavior has changed, and new policies and screens will replace those that are no longer needed.

We also find it noteworthy that throughout the GAO report there are examples of postpayment review activities that illustrate that carriers are performing postpayment review quite well. Beginning on page 3 and again on page 8, GAO provides several examples of payment problems that were identified through postpayment review activities and for which the carriers took appropriate action.

GAO Recommendation

To increase carrier incentives for strengthening their capabilities to identify and address Medicare losses to waste and abuse, we recommend that the Secretary direct the Administrator of HCFA to:

-- provide carriers the guidance and technical assistance to improve profiling and focused medical reviews;

Department Comment

While we agree with this part of GAO's recommendation, we believe that we are well on the way to doing it already.

In Fiscal Year 1993, carriers were funded and required to establish an infrastructure (i.e. personnel, hardware, and software) to implement focused medical review. During implementation, carriers were expected to develop computer

systems with the ability to analyze claims data, identify patterns of practice, decide whether patterns are appropriate, and then find the most effective course for resolving problems which result from inappropriate practice patterns.

We expect carriers to have systems in place that employ analytical methods to identify potential problems. These methods could include:

- trend analysis to identify significant changes over time;
- analysis to profile providers, procedures, diagnoses codes, and beneficiaries in order to identify unusual patterns of care or billing; and,
- comparative analyses to explore variation.

We expect that through the use of focused medical review methods, carriers will be able to target medical review efforts on patterns/trends which have the greatest potential for being over-utilized. It is our goal that carriers utilize their focused medical review data analysis capabilities to look at trends in utilization and charges to ensure that dramatic variation, as in the example cited, does not go undetected and unaddressed.

Implementation of focused medical review is in the beginning stages. As GAO notes in its report, the study began just prior to the fiscal year in which carriers were to begin implementation of focused medical review. Specifically, GAO began its review in May 1992. As we noted on our overview, carriers were to begin putting the hardware, software, and personnel required to conduct focused medical review in place during Fiscal Year 1993 (10/01/92 - 09/30/93). During Fiscal Year 1993, HCFA provided funding and technical guidance to the carriers to help them in their transition to focused medical review.

As part of the focused medical review initiative, carriers were required to use the systems developed for focused medical review to identify 40 areas they targeted for medical review. From these 40 areas, carriers are to develop 15 new or revised local medical review policies. Carriers are required to report on this via the Medicare focused medical review Status Report. In this report, the carrier must indicate the corrective actions taken to correct over-utilization problems and, for those areas identified because of national/local utilization comparisons, the carriers are to report the change in utilization resulting from corrective actions.

GAO Recommendation

-- identify legal issues that constrain carriers' audit and recovery efforts and make recommendations to the Congress to amend constraining legislation;

Department Comment

We concur. In the course of implementing the recommendation, GAO should recognize certain operational issues which will affect implementation.

For audits of non-assigned claims, GAO recommends that HCFA should be able to recover any overpayment on a medical necessity denial on a physician's service directly from the physician. There are several problems with the approach, not the least of which is the fact that the physician never received any payment from the program. This scenario occurs when the beneficiary chooses to utilize the services of a physician who does not accept Medicare assignment. In this case, the beneficiary pays the physician directly, and the physician, on behalf of the beneficiary, submits a bill to the Medicare program. The bill, though, is for beneficiary reimbursement. The physician never receives reimbursement directly from the program.

GAO acknowledges in its footnote 8 on page 23 that "In most cases it is neither appropriate nor practical to recover overpayments from beneficiaries."

GAO Recommendation

-- amend Medicare procedures, such as those involving the projection of sample results, to enhance carriers' audit and recovery efforts; and,

Department Comment

Currently, carriers have the option to collect actual overpayment, projected overpayment based on a statistically valid random sample (SVRS), or a consent settlement which is projected overpayment based on a non-statistically valid random sample. Mandating projected overpayment and focusing on savings generated by denying claims on a pre-payment or post-payment basis are not consistent with our emphasis on education to get providers to bill correctly the first time, and our desire to maintain a good relationship with the physician community, and, to limit provider hassle.

On the other hand, we do agree that we should emphasize collection of actual overpayments or other types of overpayments where we believe the provider is abusive, or where we can set an appropriate example for all providers.

GAO Recommendation

-- revise the contractor performance evaluation program (CPEP) evaluation criteria to include outcome measures that better assess the carriers' postpayment review performance.

Department Comment

CPEP is currently designed to measure carrier performance in meeting HCFA program requirements. In the area of medical review, HCFA established standards to assure that carriers are accurately making medical review decisions, focusing medical review resources on aberrant and unnecessary services and providers, and the postpayment analysis of paid services.

We believe the use of "outcome measures" is of value in measuring carrier performance activities in conducting an effective medical review program, but we believe that it must be carefully designed or it could create a perverse incentive to just reach savings goals (without regard to the appropriateness of the review) and increase the "hassle-factor" effect on the providers involved. To better understand the idea and use of outcome measures, HCFA is planning to meet with staff from GAO, the Inspector General, and the Office of the Actuary. Based on comments from those meetings, along with comments from our regional offices, we will develop "outcome measures" for Fiscal Year 1995.

Finally, we note that HCFA has awarded a contract to develop methodologies for assessing the effectiveness of medical review (including focused medical review). The purpose is to develop alternative methodologies for measuring the effectiveness of medical review, and predicting outcomes that may result from these activities. We expect to receive the results of this award before the 1995 CPEP is developed.

Major Contributors to This Report

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Hannah Fein

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