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Report to the Ranking Minority Member, Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, Committee on Appropriations, U.S. Senate

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MEDICARE

Program Safeguard Activities Expand, but Results Difficult to Measure

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The Honorable Tom Harkin
Ranking Minority Member
Subcommittee on Labor, Health and Human
Services, Education, and Related Agencies
Committee on Appropriations
United States Senate

Dear Senator Harkin:

With its broad range of services, delivered by hundreds of thousands of providers to about 39 million beneficiaries—and payments of about $200 billion in fiscal year 1998—Medicare will always be vulnerable to fraud, waste, and abuse. We designated Medicare as a high-risk program at the inception of our efforts to identify programs most susceptible to fraud and abuse and have issued a number of reports addressing ways to better safeguard the program. Despite the work of several oversight agencies, Medicare's vulnerability continues, as highlighted by a recent Department of Health and Human Services (HHS) Office of the Inspector General (OIG) audit report, which estimated that improper Medicare payments totaled $12.6 billion in 1998.

To help the Health Care Financing Administration (HCFA), which administers Medicare, to combat fraud, waste, and abuse, the Congress enacted title II of the Health Insurance Portability and Accountability Act in 1996 (HIPAA). That title established the Medicare Integrity Program (MIP), which provides HCFA with assured levels of funding for Medicare program safeguard activities. The five main types of program safeguard activities performed by contractors before and after passage of HIPAA are (1) medical reviews of claims; (2) determinations of whether Medicare or other insurance sources have primary responsibility for payment, which is called Medicare Secondary Payer (MSP); (3) audits of cost reports; (4) identification and investigation of potential fraud cases (benefit integrity); and (5) provider education and training (PET).[1] HIPAA also authorized HCFA to hire MIP contractors to perform these program safeguard activities.

Because of your ongoing interest in safeguarding Medicare payments, you asked us to undertake a comprehensive review of HCFA's program

[1]HIPAA also required HCFA, as part of its safeguard activities, to develop a list of the durable medical equipment that will be subject to authorization before payment is made.

safeguard activities. This report responds to your request and provides specific information on (1) how Medicare program safeguard activities have changed from fiscal years 1995 to 1999 and what changes are planned for fiscal year 2000; (2) HCFA's actions to better manage its program safeguard activities, which respond to key findings from our previous audit reports and those of the HHS OIG; and (3) the initial effects of MIP on controlling Medicare fraud and abuse, including the adequacy of HCFA's data for measuring the effectiveness of its program safeguard activities.

To address these issues, we obtained from HCFA program safeguard expenditure and workload data for fiscal years 1995 to 1998 as well as budget data for fiscal years 1999 and 2000. We discussed with HCFA officials reasons for actual or planned changes in program safeguard activities for fiscal years 1995 to 2000 and whether the officials could identify specific effects of MIP on controlling Medicare fraud and abuse. Further, we reviewed pertinent HHS OIG audit reports, including the Chief Financial Officers (CFO) Act audit reports for fiscal years 1996 through 1998, and determined HCFA's actual and planned corrective actions.[2] We also reviewed our reports relating to program safeguard activities and HCFA's responses to our recommendations. Additionally, we met with two Medicare claims processing contractors to determine how MIP implementation affected their program safeguard operations and whether these contractors could identify specific effects of MIP on reducing Medicare fraud and abuse. We did not independently examine the internal and automated data processing controls for systems from which we obtained data used in our analyses. HCFA subjects its data to limited reviews and examinations and relies on the data obtained from these systems as evidence of Medicare expenditures and to support HCFA's management and budgetary decisions. We performed our work from January through June 1999 in accordance with generally accepted government auditing standards, with the one exception we have noted.

Results in Brief

Total program safeguard expenditures began to increase in fiscal year 1998 and will continue to do so through fiscal year 2003. Further, between fiscal years 1995 and 1998 expenditures on four of the five safeguard activities increased, and expenditures for all activities will have increased from fiscal year 1995 levels in fiscal year 2000. Of the five activities, medical review has experienced the largest overall increase. HCFA has taken a number of actions to better protect Medicare and to promote more

[2]We refer to the OIG's fiscal year 1996, 1997, and 1998 Report on the Financial Statement Audit of the Health Care Financing Administration as the CFO Act audits. The CFO Act audit report of 1996 was the first report issued by the OIG that estimated total improper Medicare payments.

efficient and effective contractor safeguard operations. For example, HCFA directed contractors to review more claims before payment because such reviews are consistent with the agency's goal of paying claims correctly and do not involve the "pay and chase" activities associated with postpayment medical reviews. HCFA also recently selected 13 MIP contractors that will initially supplement, rather than take over, the safeguard activities of the contractors that currently process claims.

HCFA is using the results of both our audits and those of the OIG to improve its MIP management. For example, in response to the fiscal year 1996 CFO Act audit, HCFA increased contractor reviews of certain types of claims that the OIG deemed most susceptible to inappropriate payments. HCFA has taken, or plans to take, additional corrective actions that respond to the CFO Act audits from 1996 through 1998 and has also used the results of other OIG audits to better manage its program safeguard activities. Additionally, HCFA has agreed with and implemented many, but not all, of our recommendations related to program safeguards.

Despite HCFA's efforts to improve its safeguard activities, it is both premature and difficult to quantify the effects of MIP on controlling Medicare fraud and abuse. Although MIP started in fiscal year 1997, the first year of increased program safeguard funding under MIP was fiscal year 1998, thus leaving less than 1 year for the effects of this increased funding to occur and to be measured. Perhaps more importantly, HCFA does not have the kind of data needed to measure the effectiveness of its efforts, which also affected our ability to assess MIP's effectiveness. HCFA recognizes the need for this kind of data and has plans for obtaining them in the future; but, in many cases, implementation of data system changes must wait until next year because HCFA is devoting considerable effort to ensuring that its data systems are year-2000 compliant. There are, however, important intangible benefits associated with MIP, such as deterring providers from submitting abusive claims. According to HCFA and its claims administration contractors, other benefits include increased HCFA oversight of contractor safeguard operations and an increased awareness of and focus on combating fraud and abuse by HCFA and its contractors.

Background

Established under the Social Security Amendments of 1965, Medicare consists of two parts: (1) "hospital insurance," or part A, covers inpatient hospital, skilled nursing facility (SNF), hospice, and certain home health services, and (2) "supplemental medical insurance," or part B, covers

physician and outpatient hospital services, diagnostic tests, and other medical services and supplies. Medicare covers an estimated 39 million beneficiaries, the vast majority of whom receive their benefits under the fee-for-service program. Under Medicare fee-for service, physicians, hospitals, and other providers submit claims to Medicare and receive payment for services they have provided to beneficiaries. Claims are processed and paid by a network of about 60 claims administration contractors—such as Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA. Contractors that process part A claims are referred to as intermediaries, while those that process part B claims are called carriers. In fiscal year 1998, contractors processed about 900 million claims.

Before enactment of HIPAA on August 21, 1996, program safeguard activities were funded from the contractors' general program management budget, which also covered contractors' costs for processing claims. Additionally, only these contractors performed safeguard activities. Now, under HIPAA, HCFA is provided dedicated funding for its anti-fraud and -abuse activities as well as the authority to enter into contracts with MIP contractors to promote the integrity of Medicare.

MIP consists of five types of program safeguard activities. First, medical review includes both automated and manual prepayment and postpayment reviews of Medicare claims and is intended to identify claims for noncovered, medically unnecessary, or unreasonable services. The second activity, MSP, seeks to identify primary sources of payment, such as employer-sponsored health insurance, automobile liability insurance, and workers' compensation insurance, that should be paying claims mistakenly billed to Medicare. MSP activities also include recouping Medicare payments made for claims not first identified as the responsibility of other insurers. MSP involves (1) reviewing claims on a prepayment and postpayment basis; (2) matching information from the Internal Revenue Service (IRS) and the Social Security Administration (SSA) with information maintained by HCFA to identify those beneficiaries who have the potential for being covered by employer-sponsored group health insurance; and (3) responding to inquiries from beneficiaries, insurers, and employers. The third MIP activity is the audit process, which involves auditing cost reports submitted by hospitals, community mental health centers, and others to determine if the costs are allowable and reasonable. Fourth, benefit integrity involves contractor fraud units that identify, investigate, and refer potential cases of fraud or abuse to law enforcement agencies that prosecute fraud cases. Finally, MIP-funded PET provides information related to Medicare coverage policies, billing practices, and

issues related to fraud and abuse both to providers identified as being aberrant, abusive, or fraudulent and to the general provider population.

HCFA Has Expanded and Modified Its Safeguard Activities Following MIP Implementation

Program safeguard expenditures in total increased between fiscal years 1995 and 1998 and will continue to increase over the next 4 years because of the assured funding provided by HIPAA. Expenditures for the different program safeguard activities, except for MSP, also increased between fiscal years 1995 and 1998; expenditures for all activities will have increased over 1995 levels by fiscal year 2000. Since the inception of MIP, HCFA has increased the amount of program safeguard money that it administers centrally for projects that support contractors' safeguard activities, such as maintenance and improvement of a database intended to assist contractors in developing local medical review policies. HCFA has also undertaken various actions to increase the efficiency and effectiveness of its contractors' safeguard operations—for example, by emphasizing prepayment claims reviews. Further, HCFA recently hired MIP contractors as authorized by HIPAA.

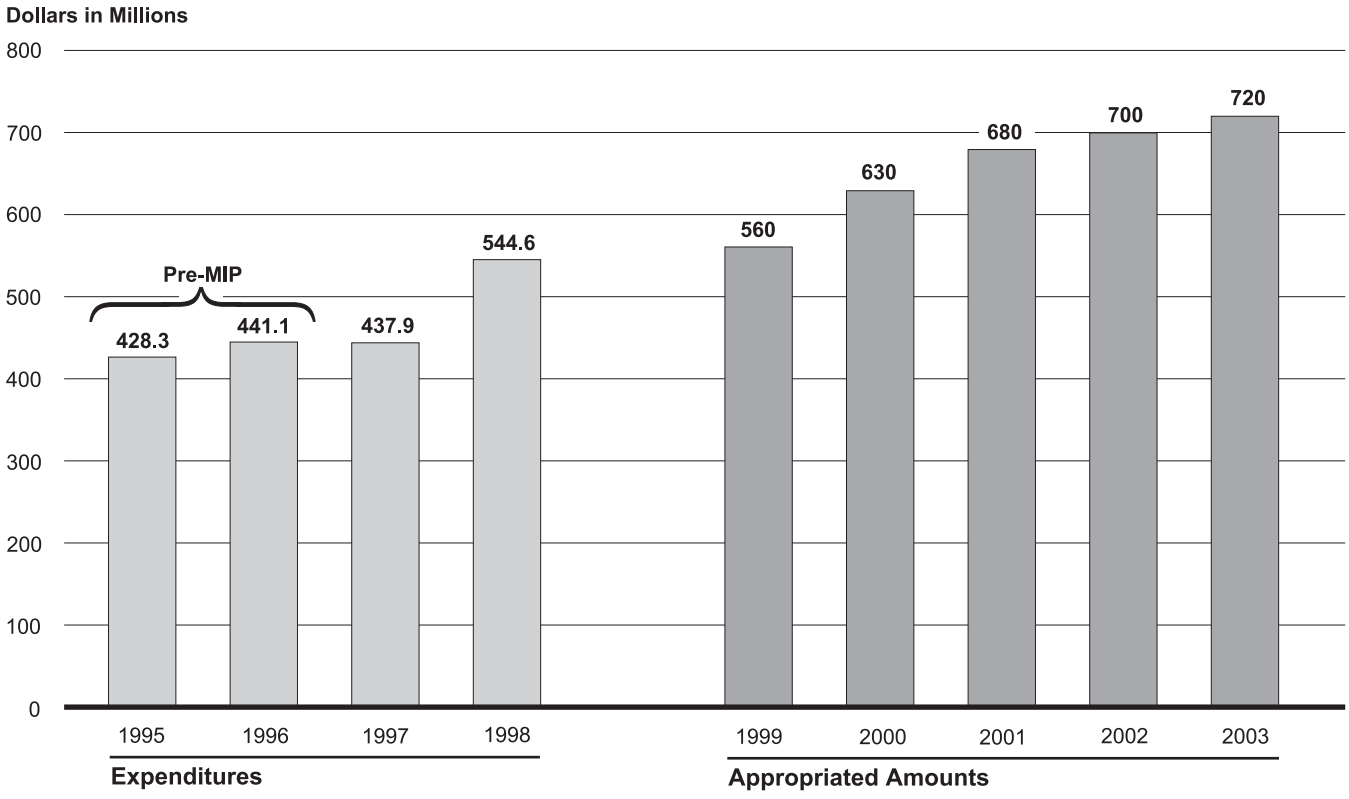
HIPAA's Assured Program Safeguard Funding Has Resulted in Increased Expenditures

HIPAA stipulated, beginning in fiscal year 1997, the amount of funding to carry out program safeguard activities that would be appropriated from the Medicare Trust Fund each year. This change provided HCFA with dedicated, assured funding and represented a departure from the past. Before HIPAA, program safeguard activities were funded as part of the contractors' general program management budget and were subject to funding fluctuations. As we have reported in the past, these fluctuations made it difficult to staff and develop anti-fraud and -abuse efforts by contractors. Further, HCFA officials told us that funding for safeguard activities was often reduced when more program management monies were needed for claims processing.[3]

Figure 1 shows actual program safeguard expenditures for fiscal years 1995 through 1998 and HIPAA-appropriated amounts for fiscal years 1999 through 2003. We included expenditures for fiscal years 1995 and 1996 to provide a comparison between actual expenditures 2 years before and 2 years after MIP implementation.

[3]HCFA can no longer transfer funding between program operations, which are paid for from HCFA's operating budget, and program safeguard activities, which are now paid for from the Medicare Trust Fund, unless HCFA receives specific legislative authority to do so.

Figure 1: Program Safeguard Expenditures for Fiscal Years 1995 Through 1998 and HIPAA-Appropriated Funding for Fiscal Years 1999 Through 2003



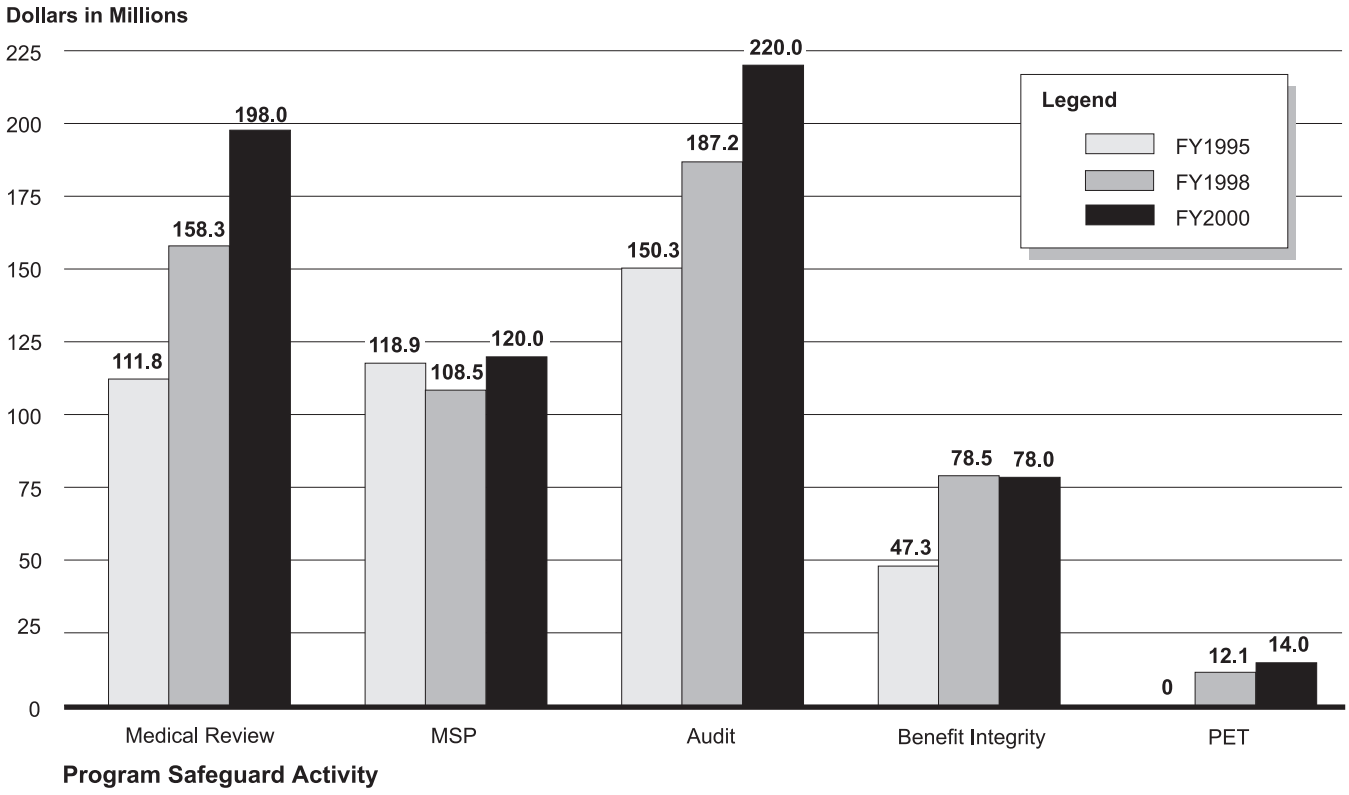
MIP expenditures for fiscal year 1997 were actually less than in fiscal year 1996, the last year before MIP implementation. This occurred because in 1996 HCFA's program safeguard spending benefited from transfers of funds from claims processing operations. Fiscal year 1998 represented the first year of increased program safeguard expenditures following MIP implementation. Not only did the MIP appropriation increase $60 million from the prior year, but HCFA received an additional $50 million in supplemental budget authority for fiscal year 1998 that it expended on program safeguard activities. Program safeguard appropriations are slated to increase between fiscal years 1999 and 2003, with increases of $70 million committed for fiscal year 2000 and another $50 million for fiscal year 2001. By fiscal year 2003, the program safeguard appropriation will total $720 million.

Even when the effects of inflation are considered, program safeguard expenditures grew between fiscal years 1995 and 1998—2 years before and 2 years after MIP implementation. In constant 1998 dollars, program safeguard expenditures increased from 58 cents per claim processed in fiscal year 1995 to 63 cents per claim in fiscal year 1998. However, this 63 cents is still almost one-third less than the amount Medicare expended per claim in fiscal year 1989.

Expenditures on the Various Safeguard Activities Have Also Increased

With the exception of MSP, which experienced a decrease of approximately $10 million, or 9 percent, program safeguard expenditures increased for each of the five main types of safeguard activities between fiscal years 1995 and 1998. Comparing fiscal year 1998 expenditures with budgeted amounts for fiscal year 2000 indicates that funding for all safeguard activities will increase, with the exception of benefit integrity, which will experience a slight reduction. Figure 2 shows these changes.

Figure 2: Comparison of Program Safeguard Expenditures for Fiscal Years 1995 and 1998 and Budgeted Amounts for Fiscal Year 2000, by Activity



A HCFA official told us that the agency decreased its MSP funding in past years to provide additional funding for the other safeguard activities because HCFA believed it could sustain the effectiveness of its MSP activities with less money. Funding for MIP-related PET conducted by contractors began in fiscal year 1997. Before that time, contractors used general program management funds to educate and train providers, and they continue to receive such funds for non-MIP-related PET activities.

Although expenditures on benefit integrity activities increased from fiscal years 1995 to 1998, comparing fiscal year 1998 expenditures with the amount budgeted for fiscal year 2000 indicates that benefit integrity expenditures will decrease slightly. However, funding for benefit integrity would have increased had HCFA not reclassified some benefit integrity data

analysis costs as medical review costs. (The same data analysis staff support both of these safeguard activities.) This change resulted in the transfer of $9 million from benefit integrity to medical review in fiscal year 1999.

HCFA Is Centrally Administering More Program Safeguard Money

HCFA is now centrally administering more money for program safeguard projects, resulting in proportionately less money for funding the program safeguard activities performed by the claims administration contractors.[4] These centrally administered projects, however, generally support the safeguard activities performed by the contractors. For example, in fiscal year 1998, HCFA spent $2.8 million on developing the Customer Information System—a database that provides analytical support to the medical review, MSP, audit, and benefit integrity safeguard activities. That same year, HCFA spent $400,000 to maintain and improve a database designed to assist contractors in developing local medical review policies. Funding for some projects is provided on an ongoing basis, such as HCFA's expenditures for the information provided by the IRS and SSA that is matched with HCFA data and used to determine if beneficiaries might have employer-sponsored group health insurance. Funding for other projects is limited to a defined period. For example, last year HCFA entered into a 17-month contract with a consulting and accounting firm. The firm's tasks include identifying contractor "best practices" related to medical review, gathering information on how contractors develop their medical review budgets, and making recommendations to HCFA on ways to improve medical review nationally.

As shown in figures 3 and 4, HCFA centrally administered 1 percent of total safeguard funds in fiscal year 1995, while it administered 9 percent in fiscal year 1998. HCFA's claims administration contractors expended the remaining funds on their program safeguard activities.

[4]For accounting purposes, HCFA refers to these projects as miscellaneous contracts and agreements.

Figure 3: Medicare Expenditures for Program Safeguard Projects Centrally Administered by HCFA and for Activities Carried Out by Contractors, Fiscal Year 1995

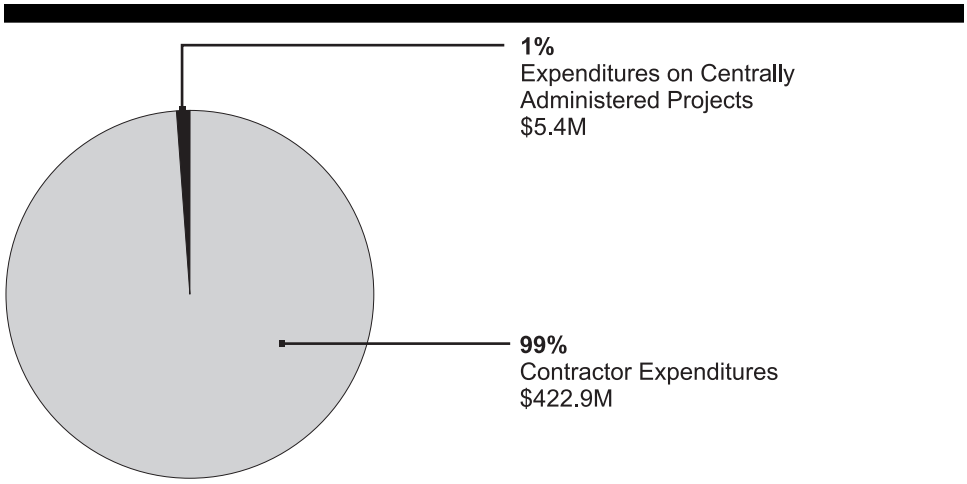
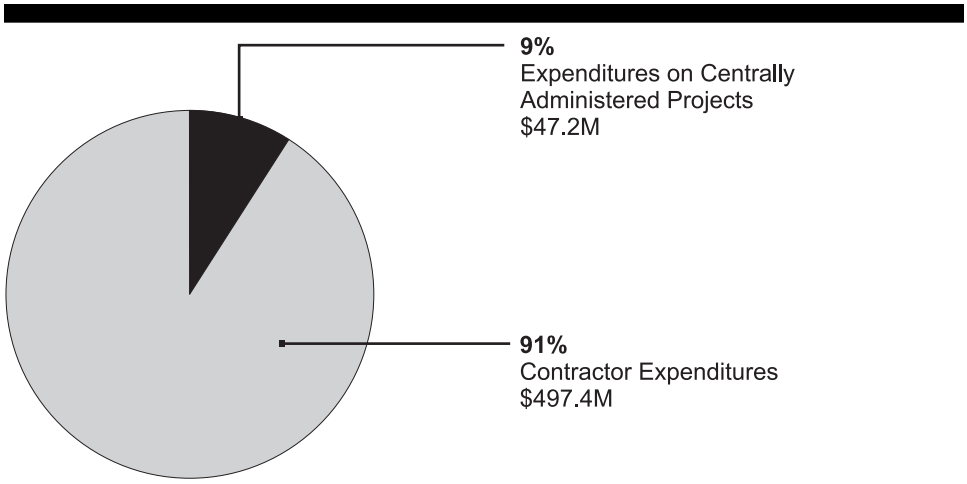


Figure 4: Medicare Expenditures for Program Safeguard Projects Centrally Administered by HCFA and for Activities Carried Out by Contractors, Fiscal Year 1998



HCFA centrally administered 38 projects in fiscal year 1998 costing a total of $47.2 million. The largest project involves HCFA's 2-year licensing of commercial off-the-shelf software edits from a private contractor. Fiscal year 1998 expenditures on this project totaled $7.9 million, with another $8 million budgeted for fiscal year 1999. Savings from the first 6 months of requiring contractors to use a small number of edits totaled $4.6 million; HCFA officials told us that contractors would begin to use more edits in July 1999. The next two largest projects involve audits of cost reports from

health maintenance organizations (HMO) whose payments are based on their costs and a special audit initiative concerning home health agencies (HHA).[5] HCFA spent $4 million and $5.4 million, respectively, on these two projects in fiscal year 1998 and has budgeted $4.8 million for HMO audits this fiscal year. Appendix I provides details on the eight largest projects centrally administered by HCFA in fiscal year 1998, including a brief description of their objectives, status, and amount budgeted for fiscal year 1999.

HCFA officials told us that part of the reason for the increased spending on projects centrally administered by HCFA relates to implementation of MIP. Previously, activities supporting program safeguard and claims processing activities were funded from the general program management budget. For example, before paying claims, carriers and intermediaries submit claims to a system called the Common Working File to validate a beneficiary's entitlement, available benefits, and authorization to pay the claim. This system is operated at nine host sites, with each site supporting the carriers and intermediaries in a defined geographic area. Now, with MIP, HCFA has allocated the costs of these activities to both the MIP and general program management budgets. As a result, some activities that previously were funded exclusively by the program management budget now show up as MIP-funded projects administered by HCFA as well.

Medical Review, MSP, and Audit Activities Are Changing

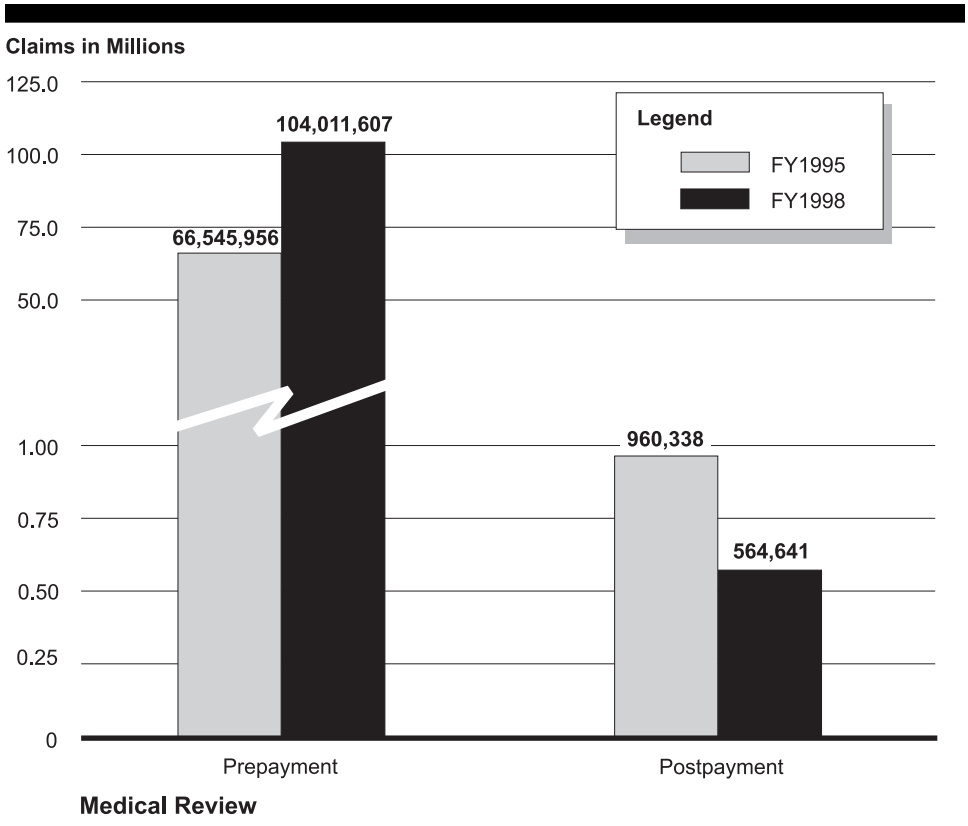
To more effectively protect Medicare from fraud, waste, and abuse and to increase the efficiency and effectiveness of contractor safeguard operations, HCFA has emphasized different types of medical review, MSP, and audit efforts performed by contractors. These are the three safeguard activities that are allocated the most MIP money. Contractors that we visited responded by adjusting their mix of staff skills. The contractors are now (1) using more highly trained nurses to perform medical review and (2) hiring new or additional data analysis specialists who provide support to both medical review and benefit integrity staff. One of the contractors also hired specially trained staff to handle liability insurance cases in which Medicare may be a secondary payer of a beneficiary's health care costs.

Contractors do not review each of the millions of claims they process each year for medical necessity. Instead, contractors review a small percentage of claims, trying to focus on medical procedures that they consider at risk

[5]HMO audits represent an ongoing centrally managed program safeguard project, while the special audit initiative involving HHAs was funded for 1 year.

for excessive use. Figure 5 shows that within medical review, HCFA is now emphasizing prepayment medical review over the "pay and chase" activities associated with postpayment review—an emphasis consistent with HCFA's goal of paying claims correctly the first time.

Figure 5: Number of Claims Reviewed on a Prepayment and Postpayment Basis, Fiscal Years 1995 and 1998



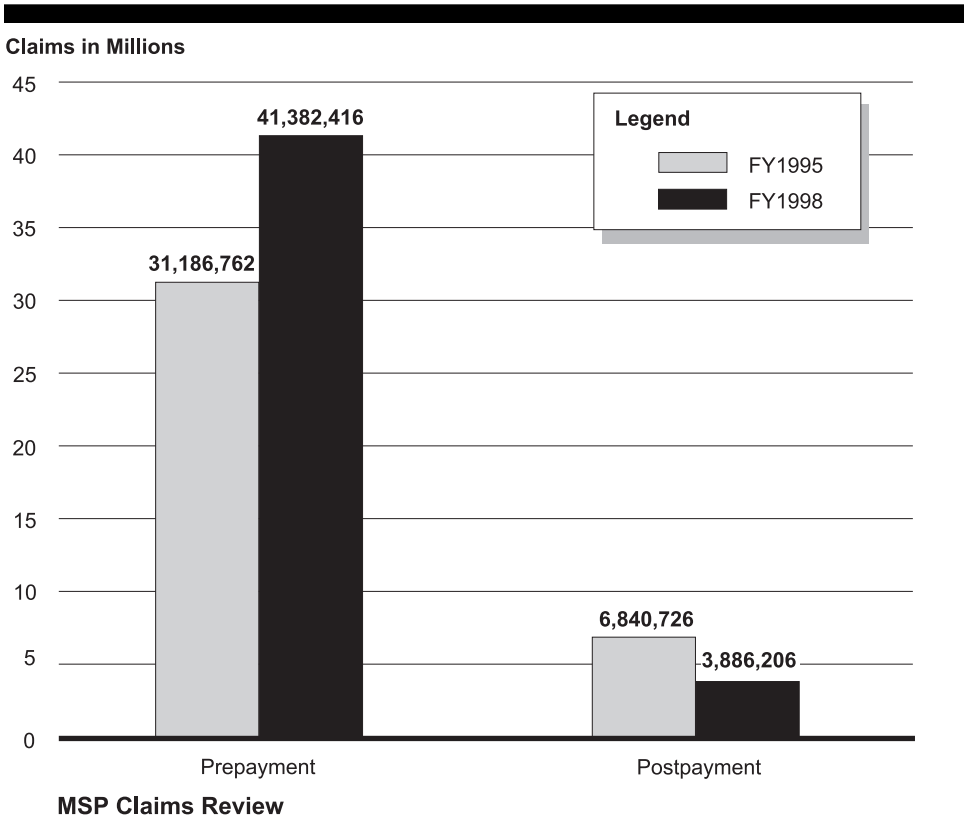
The number of prepayment reviews increased by more than one-half over the 4 years, from 66.5 million claims in fiscal year 1995 to 104 million in fiscal year 1998.[6] At the same time, the number of claims reviewed on a postpayment basis declined from approximately 960,000 to 565,000, or by about 40 percent. In its fiscal years 1999 and 2000 budget and performance

[6]HCFA data for fiscal year 1995 did not distinguish between prepayment and postpayment medical review of part A claims. Because data from fiscal year 1998, the first year that HCFA reported separately on the number of part A claims reviewed on a prepayment and postpayment basis, indicate that nearly all medical reviews of part A claims involve prepayment reviews, we considered all medical reviews of part A claims during fiscal year 1995 to be prepayment reviews.

requirements issued to contractors, HCFA stated that its goal is for contractors to maximize the number of prepayment reviews they conduct and encouraged contractors to develop and implement as many automated edits as possible.[7] HCFA's goal of performing more prepayment reviews to promote the correct payment of claims seems reasonable. However, in those cases in which providers are required to supply documentation in support of their claims before payment, HCFA must balance the expected benefits with the burden placed on providers.

Figure 6 shows that contractors are conducting more MSP prepayment claims reviews and fewer MSP postpayment reviews. This, too, is consistent with HCFA's goal of paying claims correctly.

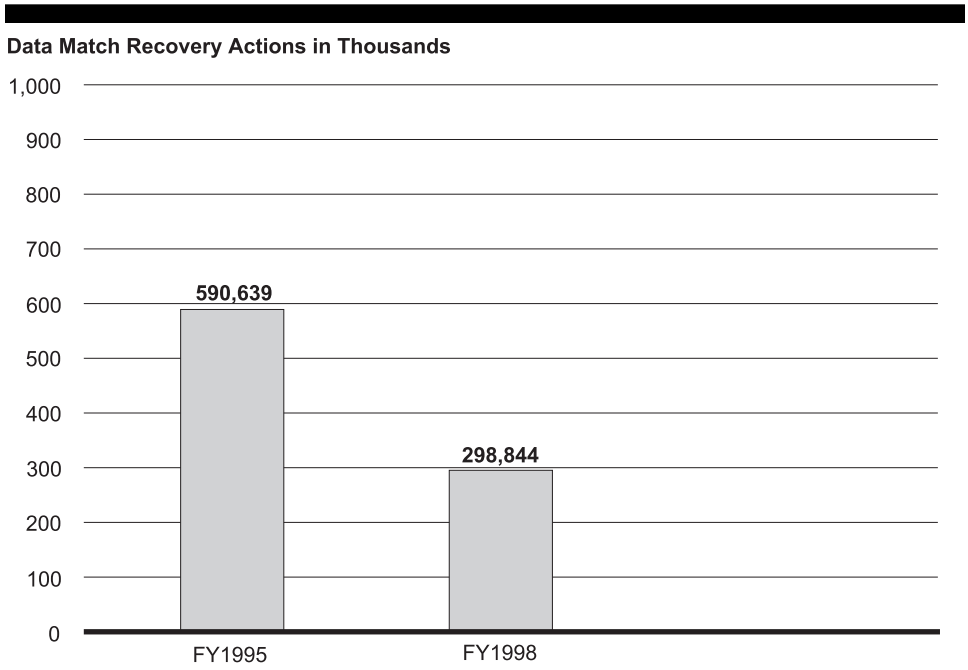
Figure 6: Number of Claims Reviewed for MSP Considerations on a Prepayment and Postpayment Basis, Fiscal Years 1995 and 1998



[7]These edits would automatically deny services that are excluded by statute, are never medically reasonable and necessary, or are not covered on the basis of national or local medical review policies.

Figure 7 shows that fewer MSP IRS/SSA/HCFA data match recovery actions, which primarily involve issuing demand letters seeking payment in MSP cases, are being conducted.[8]

Figure 7: Number of MSP Data Match Recovery Actions, Fiscal Years 1995 and 1998



This reduction in the number of data match recovery actions from approximately 591,000 to about 299,000 over the 4-year period reflects several steps taken by HCFA to increase the efficiency of its contractors' MSP operations. For example, in fiscal year 1996, HCFA raised the threshold of the amount owed Medicare that would trigger a data match recovery action; it also decreased from three to one the number of demand letters issued seeking payment in individual MSP cases. As another example, in 1998, HCFA decided not to send questionnaires to employers if an employee who was identified by Medicare as potentially having group health insurance made less than $10,000. This, too, reduced the number of demand letters issued. A HCFA official told us that it was unlikely that such

[8]Recovery actions also include researching claims but taking no further action because the threshold that would trigger a demand letter has not been reached and determining that there are no claims Medicare has paid as the primary payer.

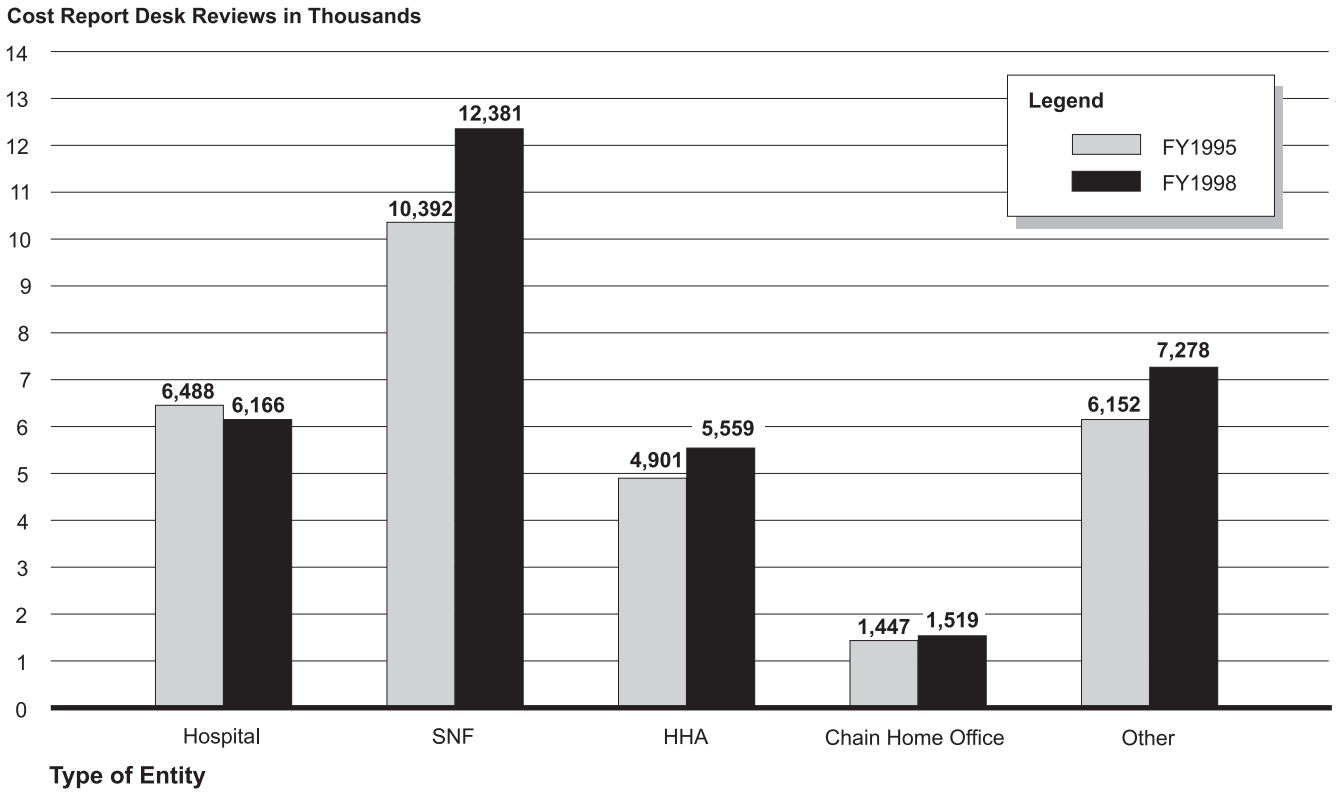
employees had group health insurance that would be responsible for paying their medical claims before Medicare was required to do so.

Cost report audit activity, which includes desk reviews and audits, has increased in an effort to keep up with a growing number of entities submitting cost reports and, in the case of HHAs, to prepare for implementation of a new payment system.[9] As shown in figure 8, desk reviews of cost reports submitted by SNFs, HHAs, and "other" entities increased; desk reviews of hospital cost reports decreased slightly; and desk reviews of chain home office cost reports remained about the same from fiscal years 1995 to 1998.[10]

[9]Desk reviews involve a less intensive review of provider cost reports, while audits involve a more detailed, in-depth review of the reports by auditors.

[10]HCFA defines "other" entities as including community mental health centers, rural health clinics, and end-stage renal dialysis facilities. Chain home offices are the parent sites of organizations that operate health care facilities; home offices can allocate some of their operating costs to their other facilities.

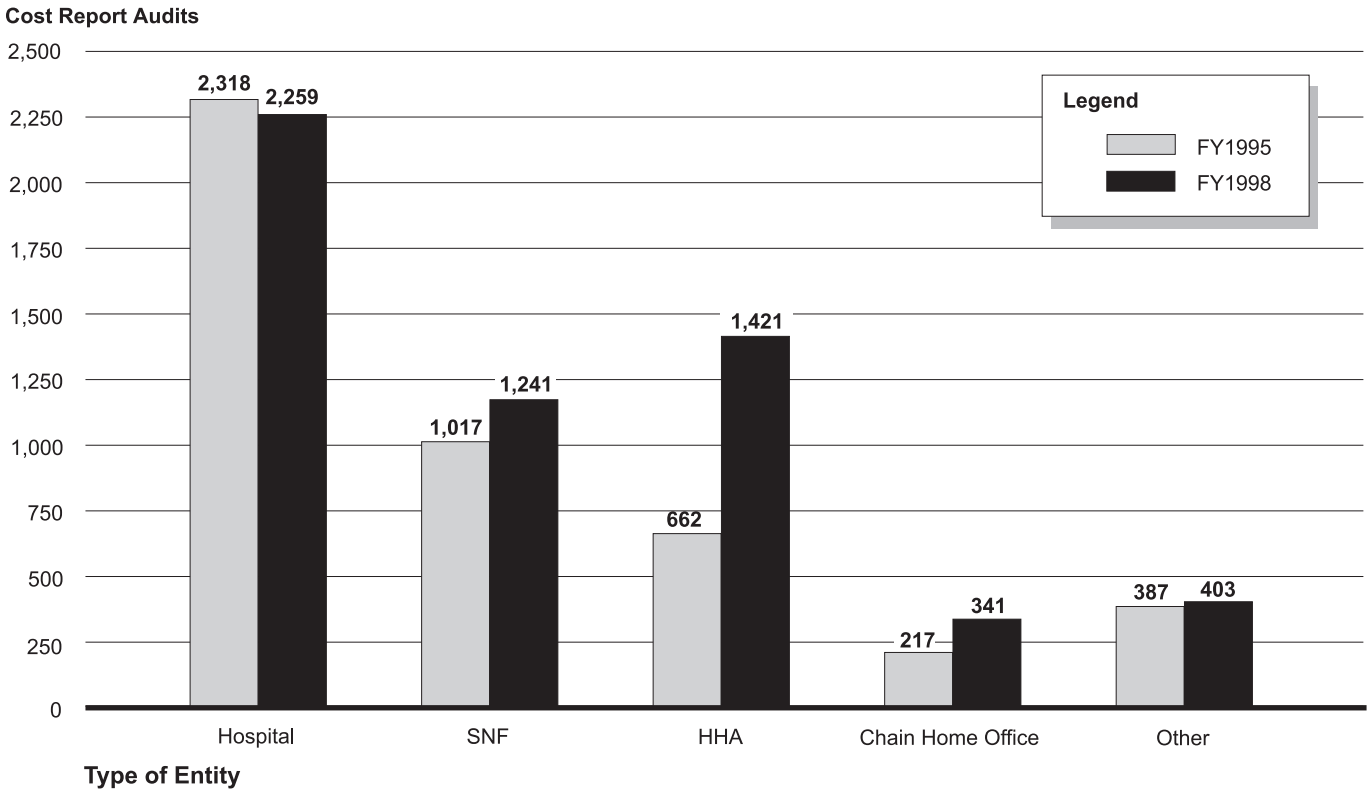
Figure 8: Number of Desk Reviews Performed, by Type of Entity Submitting Cost Reports, Fiscal Years 1995 and 1998



The increasing number of desk reviews of SNF, HHA, and "other" cost reports reflects the growing number of these entities. From fiscal years 1995 to 1998, the number of SNFs grew by 17 percent, HHAs by 20 percent, and "other" entities by 36 percent.

The number of cost report audits of SNFs and HHAs increased as well, as did audits of chain home office cost reports (see fig. 9).

Figure 9: Number of Audits Performed, by Type of Entity Submitting Cost Reports, Fiscal Years 1995 and 1998



The number of cost report audits increased for each type of entity except hospitals from fiscal year 1995 to fiscal year 1998. A HCFA official told us that there is less emphasis on auditing hospitals that have no associated facilities, such as a SNF or an HHA, because HCFA has found relatively few problems with these providers. Regarding HHA audits, HCFA spent about 20 percent of the $50 million in supplemental budget authority it received in fiscal year 1998 on audits of these providers. The results from many of these audits will be used to help develop an HHA prospective payment system that is to take effect in fiscal year 2000.

Although Initial Steps to Hire MIP Contractors Are Complete, Effects Will Take Time

HIPAA provided HCFA with authority to hire MIP contractors, whereas previously HCFA used only its claims administration contractors to perform program safeguard activities. Although HIPAA passed in 1996, it was only recently that HCFA utilized its new authority.

In May 1999, HCFA announced the businesses that have been chosen to serve as program safeguard contractors (PSC)—one type of MIP contractor.[11] The PSCs will perform medical review, audit, benefit integrity, and PET activities. HCFA also announced the first six task orders describing the initial scope of work to be done; the 13 PSCs will compete to perform the work described in the task orders. These task orders are for program safeguard activities that will supplement those currently performed by carriers and intermediaries. For example, one task order calls for the PSCs to identify effective areas to target for national provider education activities in the future. Another task order calls for the PSCs to provide data analysis and other support to the relatively small fraud units at the intermediaries located in New England; these units will continue with their current workload and staffing levels.

HCFA officials said they did not want to take program safeguard activities away from existing contractors this year. They were concerned that doing so could disrupt claims processing activities at a time when HCFA is placing significant emphasis on making its computer systems millennium-compliant. Although HCFA's concerns seem well-founded, this approach will delay HCFA's ability to evaluate some of the intended benefits of the PSCs.

HCFA also plans to hire a coordination of benefits contractor—a second type of MIP contractor—by the end of the fiscal year that will be responsible for many MSP functions currently performed by existing contractors. These responsibilities include the IRS/SSA/HCFA data match now performed by a claims administration contractor and administration of the initial enrollment questionnaire sent to soon-to-be beneficiaries before they become Medicare-eligible. This work is now conducted by a nonclaims administration contractor hired by HCFA.

[11]Initially, HCFA announced 12 PSCs. However, one business that was not chosen objected to HCFA's selection of contractors and, as a result, that business was added to the list of PSCs.

HCFA Is Using Results of OIG and Our Audits to Manage Its Program Safeguard Operations

HCFA's policy is to utilize our findings and those of HHS' OIG to help it administer and manage its program safeguard activities, and we found that this is generally happening. As required, HCFA has prepared, and is implementing, corrective action plans that respond to program safeguard recommendations contained in the OIG's CFO Act audit reports from 1996, 1997, and 1998. HCFA has also taken, or is planning, actions responding to virtually all of the findings from other OIG reports we reviewed to guide HCFA's MIP management. Further, HCFA has responded positively to many of our recommendations for program safeguard improvements. In some cases, however, HCFA did not agree with our recommendations or has yet to take corrective actions.

HCFA Is Responding to CFO Act Audits

The CFO Act of 1990 imposed important requirements on federal agencies relating to the development of annual financial statements. Under the act, HCFA is required to prepare financial statements that report its financial position and the results of its operations. In the OIG's first CFO Act audit of HCFA covering fiscal year 1996, HCFA was cited for two issues directly relating to program safeguards. First, the OIG reported that HCFA did not have a process for estimating a national error rate for improper Medicare payments. The OIG noted that such a process would enable HCFA to measure its performance in reducing erroneous payments. The OIG developed its own error rate estimate for fiscal year 1996 of 14 percent of total Medicare fee-for-service payments, or $23.2 billion. Second, the OIG reported that it was unable to determine whether the cost report settlement payments made by HCFA as part of its audits of provider cost reports were accurate.[12] Because HCFA's audits primarily target providers deemed to have the greatest potential for overpayments, the OIG did not have a statistically valid sample to draw upon to validate HCFA's settlement results.

National Error Rate for Improper Medicare Payments

The fiscal year 1997 CFO Act audit again reported that HCFA did not have a process for establishing a national claims payment error rate—the first of the OIG's fiscal year 1996 program safeguard findings. (The fiscal year 1998 CFO Act audit report also mentioned this issue but did not cite it as a material weakness as in prior years.) To address this issue, HCFA signed a

[12]Each cost report must be settled. That is, HCFA determines the amount of the allowed costs to be paid by Medicare to the provider. Because of the limited scope of the audit work conducted by contractors, the OIG was unable to determine what adjustments, if any, were necessary to the $3 billion in cost settlements from prior years as well as any settlements that might be required for the cost reports filed for fiscal year 1996.

contract with the OIG in August 1998.[13] Under the contract, the OIG was to spend $4.7 million in fiscal year 1999 to develop a national Medicare payment error rate for HCFA and estimate the amount of improper payments for that year. The OIG was also to develop an error rate and estimate the amount of improper payments for fiscal years 2000 and 2001, at an additional cost to HCFA.

In February 1999, the OIG reported that HCFA had made improvements in reducing improper Medicare payments.[14] The OIG found that improper Medicare payments in fiscal year 1998 totaled $12.6 billion, $7.7 billion less than in fiscal year 1997. The OIG attributed this reduction, in part, to HCFA's efforts under MIP to expand contractor safeguard activities and to HCFA's corrective action plans in response to CFO Act audits. For example, HCFA targeted medical reviews in fiscal year 1998 at certain types of services the OIG deemed most susceptible to improper payments, such as office visit services provided by physicians. However, despite these HCFA efforts noted by the OIG, approximately 80 percent of the reduction in improper payments from fiscal year 1997 to 1998 resulted from improved provider documentation given to auditors rather than from a substantive reduction in improper payments in categories such as lack of medical necessity, incorrect coding of claims, and noncovered services.[15] In fiscal year 1997, documentation problems accounted for $9 billion, or 44 percent of the $20.3 billion in improper payments, while in fiscal year 1998, documentation problems accounted for $2.1 billion, or 17 percent of the improper payments estimated by the OIG.

HCFA's corrective action plan responding to the fiscal year 1998 CFO Act audit contains a number of steps intended to reduce improper Medicare payments in future years. These steps include (1) improving the effectiveness and efficiency of medical reviews by identifying contractors' best practices, (2) implementing and then further expanding upon the use of commercial off-the-shelf computer edits for medical review, (3) expanding upon HCFA's initiative to ensure that claims contain correct codes for the services provided, and (4) educating physicians with billing problems about proper Medicare billing. Although these efforts to reduce

[13]According to the contract, the OIG's work is comparable to management advisory services provided by independent public accounting firms.

[14]HHS, OIG, Improper Fiscal Year 1998 Medicare Fee-for-Service Payments (A-17-99-00099) (Washington, D.C.: HHS, Feb. 9, 1999).

[15]Medicare requires providers to maintain sufficient documentation to justify the claims submitted for payment. Documentation errors found by the OIG included (1) insufficient documentation to determine the patient's overall condition, diagnosis, and extent of services performed and (2) no documentation to support the services provided.

improper payments are noteworthy, HCFA needs to consider other alternatives for spending its scarce resources as well. For example, calculating an error rate for each contractor may be more important than calculating a national claims payment error rate because error rates will likely vary by contractor, and this process could lead to identification of best practices at some contractors. Additionally, HCFA would have a better basis for targeting its safeguard monies.[16]

Accuracy of Cost Report Settlement Payments

The 1997 CFO Act audit report again cited the OIG's inability to determine whether cost report settlement payments made by HCFA during the year were accurate—the second of the OIG's 1996 program safeguard findings. While the fiscal year 1998 report did not specifically cite this same problem, a HCFA official told us that HCFA continues to audit insufficient numbers of cost reports, with the result that the OIG cannot take obtain a statistically valid sample. The HCFA official attributed this problem to a lack of audit funds.

MSP Accounts Receivable

The OIG's fiscal year 1998 CFO Act audit report cited problems related to MSP accounts receivable that had not been cited in earlier CFO Act audits. The OIG reported deficiencies in nearly all facets of MSP activity at the contractors tested. For example, some contractors could not reconcile their MSP accounting records with the amounts that they reported to HCFA. The OIG also could not verify the allowance for uncollectible MSP accounts receivable that HCFA calculated.[17] Further, the OIG noted that HCFA had executed settlement agreements with several insurance companies for MSP overpayments. However, at fiscal year end, HCFA had not adjusted its MSP accounts receivable balance to reflect either the collections from the settlement agreements or the amounts to be settled. A HCFA official told us that HCFA has not yet finalized its corrective action plan that will respond to these findings, but that the agency was in the process of doing so.

[16]In commenting on a draft of this report, HCFA said that it had established a goal for 2001 of developing error rates at the contractor level, as well as error rates for the different categories of Medicare benefits. HCFA also said that it is completing work at one contractor to test a methodology for developing these error rates.

[17]Not all MSP accounts receivable are collectible; HCFA therefore estimates the amount to be written off as uncollectible.

HCFA Is Also Responding to Other OIG Findings Related to Program Safeguards

As part of our work, we judgmentally sampled seven other OIG audit reports issued since 1995 pertaining to program safeguards and reviewed how HCFA responded to them.[18] We found that HCFA agreed to, and had taken or planned to take corrective actions on, virtually all OIG recommendations contained in the seven reports. Several examples follow.

In November 1998, the OIG reported on intermediary fraud control units. Among its findings were that fraud control units differed substantially in the number of complaints and cases handled and that some units produced few, if any, significant results. The OIG also found that key words and terms related to fraud unit work varied in meaning, thereby hindering HCFA's ability to interpret fraud control unit data and to measure units' performance. The OIG made five recommendations, and HCFA agreed with each. Among the actions taken or planned by HCFA in response to the OIG's recommendations were (1) establishing a set of measures in order to evaluate contractors' performance in meeting national objectives and (2) clarifying definitions of key words relating to fraud and abuse.

Another example concerns a second November 1998 OIG audit report regarding clinical laboratory tests performed by hospital outpatient department laboratories. The OIG found that intermediaries did not always have adequate controls to detect and prevent inappropriate payment for laboratory tests. The OIG recommended several actions, including that intermediaries (1) implement additional procedures and controls to ensure that all clinical laboratory tests performed by hospital outpatient department laboratories are appropriately grouped together and not billed separately and (2) collect overpayments that the OIG estimated at $43.6 million for a 2-year period ending December 1995. HCFA agreed with these recommendations and took several actions, including requiring its contractors to have the detection capabilities in place to ensure that no inappropriate payments are made.

In a third case, the OIG reported on questionable Medicare payments for wound care supplies—such as dressings, adhesive tape, and roll gauze—in October 1995. The report made two recommendations, to which HCFA agreed, on ways that HCFA and its contractors could reduce unnecessary payments. In a related report issued in June 1998, the OIG noted that there had been a significant reduction in Medicare payments for wound care

[18]The OIG has issued hundreds of reports since 1995 dealing with many different Medicare issues. We did not attempt to review all of these reports to determine if they addressed program safeguard issues; rather, we reviewed a list of the OIG's reports and identified seven that, in our opinion, dealt with major safeguard issues and related to the activities at multiple Medicare contractors.

supplies—from $143 million in 1995 to $74 million in 1996. The OIG attributed this reduction, in part, to measures taken by contractors, including their use of edits to screen for unnecessary supplies, as the OIG had recommended in its October 1995 report.

HCFA Is Using Our Findings in Its MIP Management but Has Not Always Agreed With Our Recommendations

According to four of our key reports issued since fiscal year 1995 that related to HCFA's program safeguard activities, HCFA has often, but not always, agreed with our findings and implemented our recommendations for improving program safeguard operations. Three examples follow.

In June 1998, we reported that while HIPAA provided HCFA with assured funding levels for program safeguards, HCFA had not administered that funding in a way that provided contractors with increased funding stability.[19] Specifically, we reported that HCFA did not notify contractors of their fiscal year 1998 program safeguard funding until one-third of the way through the fiscal year, hindering contractors' ability to expand their program safeguard activities. HCFA addressed this finding by issuing contractors their fiscal year 1999 program safeguard funds at the beginning of the fiscal year.

As another example, our January 1996 report concerning medical review made several recommendations, including one that HCFA establish computerized prepayment controls that would suspend the most aberrant claims for further review.[20] HCFA subsequently strengthened its instructions to contractors, directing them to implement prepayment screens to prevent payment of billings for egregious amounts or patterns of medically unnecessary services or items. HCFA also authorized its contractors to deny automatically the entire amount for any services that exceeded certain service limits.

In a third example, we reported on problems associated with Medicare's payments for surgical dressings in August 1995.[21] One of our recommendations was that HCFA develop and implement prepayment review policies as part of its process for implementing any new or expanded Medicare coverage. In October 1995, HCFA implemented a

[19]Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS-98-160, June 1, 1998).

[20]Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

[21]Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

regional medical review policy covering the expansion of the surgical dressing benefit that had occurred in March 1994.[22] Also, specialized contractors that process and pay claims for durable medical equipment and supplies began using prepayment edits following the policy's implementation. As discussed above, the OIG's June 1998 report on wound care dressings noted a significant reduction in Medicare's payments for surgical dressings following these and other actions by HCFA.

While HCFA's policy is to use our findings to help it administer and manage program safeguard activities, HCFA has not always agreed with, or implemented, our program safeguard recommendations. For example, our August 1995 report concerning Medicare's payments for surgical dressings recommended that providers be required to itemize supplies they bill to Medicare. This would provide contractors with more detailed information for determining whether the supplies were covered by Medicare and were medically necessary. HCFA disagreed with our recommendation, saying that the additional cost and burden on providers and Medicare contractors outweighed the value of itemization. In May 1998, we again reported on Medicare's payment system for medical equipment and supplies and recommended that HCFA require providers to identify the specific supplies and equipment they bill Medicare by including the universal product numbers on their claims.[23] We explained that the universal product numbers would provide HCFA with better information to determine exactly what it is paying for. While HCFA did not specifically disagree with our recommendation, HCFA cited several problems associated with using universal product numbers. According to a HCFA official, the agency is currently studying the issues related to implementing universal product numbers for supplies billed to Medicare.

Although Effects of MIP Are Difficult to Determine, Certain Benefits Have Resulted

Although HIPAA provided HCFA with important new tools and resources for fighting fraud and abuse, precisely measuring the effects of MIP on saving Medicare funds is difficult. The period of time since MIP implementation is relatively short, and it is not known what would have occurred in the absence of MIP. Further, we identified inconsistencies, inaccuracies, and other problems with HCFA's data and data systems that could lead HCFA to draw incorrect conclusions about the effectiveness of its safeguard activities. These same limitations also affected our reporting on the

[22]In March 1994, HCFA had greatly expanded the surgical dressing benefit by broadening the types of dressings covered and the conditions under which they would be covered.

[23]Medicare: Need to Overhaul Costly Payment System for Medical Equipment and Supplies (GAO/HEHS-98-102, May 12, 1998).

effectiveness of MIP. HCFA officials told us that they recognize the need for better data but that HCFA's emphasis on ensuring that its computer systems are year-2000 compliant takes precedence over other necessary data systems changes. Even with better data, however, HCFA officials said that some of the most important benefits of MIP are not directly measurable, such as increased HCFA oversight of its contractor program safeguard activities.

Several Factors Make It Difficult to Determine Effects of MIP

Although MIP began in fiscal year 1997, the first year of funding increases for program safeguard activities was fiscal year 1998, when the MIP budget increased from $440 million to $550 million.[24] As a result, not enough time has passed since HCFA directed additional money toward safeguard activities to measure the effects of that funding. For example, in fiscal year 1998, HCFA encouraged its contractors to develop greater numbers of local medical policies. Contractor staff that we met with explained that it often takes months to draft new policies, submit them for review by medical societies within the states where they will apply, and finalize them. Further, claims processing edits to enforce the policies must be developed and installed in the claims processing system, and providers must be educated about the policies. Thus, the full effects of policies developed in fiscal year 1998 in response to HCFA's directions are not likely to be known for several years.

There are several other reasons why it is hard to measure the effects of MIP on reducing or deterring Medicare fraud and abuse. First, it is difficult to quantify the incremental effects of MIP from ongoing program safeguard activities performed by Medicare contractors. For example, it is unknown whether a contractor would have identified and developed a potential fraud case in the absence of the program. Second, it commonly takes many years to develop and prosecute fraud cases, and there has been insufficient time since MIP implementation for cases to be settled and recoveries made. Moreover, it will be difficult to associate Medicare savings to MIP even in future years because different agencies use different funding sources to identify, develop, and prosecute fraud cases. For example, Medicare contractors may use MIP funds to identify a potential fraud case, while the Department of Justice may use its own funds to develop and prosecute the case.

[24]This included an additional $50 million in supplemental program safeguard funds made available by the HHS fiscal year 1998 appropriation.

Data limitations also hamper effective measurement of HCFA's program safeguards. HCFA needs consistent, detailed data to effectively monitor and evaluate the various program safeguard activities. However, we identified data limitations that hinder HCFA's ability to make the most informed decisions, as illustrated by the following examples.

- HCFA's medical review savings data are not sufficiently detailed for HCFA to determine which types of reviews are most effective. Medical review involves decisions on whether claims are for covered services that are medically necessary and reasonable. Decisions can be made by contractors either before a claim is paid (prepayment medical review) or after a claim is paid (postpayment medical review). There are three types of prepayment review: automated reviews that are based on computerized edits within the contractor's claims processing system, routine manual reviews that involve decisions by contractor staff based on the claim and any attachments to it, and complex manual reviews that require staff to request and evaluate medical records and other documentation from the provider. There are two types of postpayment review: routine postpayment medical review of individual claims and comprehensive medical review of all, or certain types of, claims by an individual provider.

  Under Medicare part B, HCFA can identify whether medical review savings stem from prepayment or postpayment reviews, but it cannot identify whether prepayment savings result from automated, routine manual, or complex manual reviews. On a more fundamental level, HCFA cannot identify whether part A medical review savings originate from prepayment or postpayment activities and can therefore only report medical review savings in total for part A.

- Limitations of HCFA's cost and savings data related to cost report audits also hinder HCFA's ability to determine which cost report audit activities are most effective. Medicare's cost report audit process includes both desk reviews and audits. Currently, there are two types of desk reviews—limited and full—and two types of audits—focused audit reviews and field audits.[25] HCFA's information systems do not separately identify costs and savings by the types of desk reviews or audits conducted. Rather, HCFA reports the total cost of desk reviews and the total cost of

[25]During limited desk reviews of cost reports, auditors examine the reports, compare specific provider characteristics with thresholds set by HCFA, and decide if the cost reports should be reviewed in more depth. Full desk reviews involve a more complete examination of the cost reports, a determination of whether they should be audited, and a decision on the scope of the audit to be conducted. Focused audit reviews address preselected cost report issues and are conducted on-site. Field audits involve a complete, on-site audit of cost reports.

audits and reports savings in two broad categories. As a result of such reporting, HCFA cannot calculate either savings or a return on investment—costs divided by savings—for the different types of desk reviews and audits contractors perform.

- Because contractors sequence their medical review and MSP edits differently, part A medical review and MSP savings data, along with the return on investment for each activity, are inaccurate. Seven fiscal intermediaries currently use a claims processing system called the Arkansas Shared System. This system first subjects claims to MSP edits to determine if the claims should be paid by Medicare as the primary payer or as secondary payer to the beneficiary's other insurance. Once this MSP determination is made, the claims are then subjected to medical review edits. However, other fiscal intermediaries use the Fiscal Intermediary Shared System—the system that all fiscal intermediaries will eventually use. This system first edits claims for medical review and then edits them for MSP considerations. Since the priority in which claims are edited affects how savings are recorded, contractors using the Arkansas Shared System report MSP savings for claims while those on the Fiscal Intermediary Shared System claim medical review savings for the same claims.[26] Because of these inconsistencies, both medical review and MSP part A savings data reported by HCFA are inaccurate; so, too, are the return on investment calculations. We do not know, however, the extent to which savings are over- or underreported for each of these two program safeguard activities.
- Finally, HCFA does not know which contractors are realizing the highest return on investment from their program safeguard activities. As we learned from our work on HCFA's oversight of contractors, HCFA has few outcomes standards or performance measures to ensure that contractors adequately perform their program safeguard activities.[27] Further, HCFA relies primarily on contractors to self-report the results of their operations and does little in the way of validating the accuracy of the reported data. Moreover, HCFA recognizes that there may be inaccurate data in its various databases because of policy and procedural inconsistencies among its contractors. As a result of these problems, HCFA does not know which contractors are saving Medicare the most money from their safeguard activities and, therefore, cannot calculate an accurate return on investment for individual contractors' program safeguard activities.

[26]This assumes that the claims reviewed had both MSP and medical review problems.

[27]Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity (GAO/HEHS-99-115, July 14, 1999).

Because of the limitations identified above, we could not determine the savings associated with medical review, MSP, or cost report audit activities. Neither could we determine return on investment for these three safeguard activities.[28]

HCFA is taking several steps to address its data limitations, but most of these improvements will not be implemented until the year 2000. For example, HCFA is now developing a program integrity management reporting system that will provide HCFA with more detailed medical review savings, workload, and cost data. According to a HCFA official, this system is expected to be tested and sent to contractors for their use in 2000. Another HCFA official told us that the agency plans to develop more detailed cost and savings data related to cost report audits in the coming months through changes to one of its reporting systems. HCFA officials also told us that they recognize the MSP and medical review edit sequencing problem caused by intermediaries' using both the Arkansas Shared System and the Fiscal Intermediary Shared System and that they intend to fix this problem. However, again, because HCFA's ongoing efforts to ensure that its data systems are year-2000 compliant take precedence, HCFA will not be able to implement corrections until next year.

Important Intangible Benefits Are Associated With MIP

We identified several important intangible benefits of MIP. HCFA officials told us that, perhaps most importantly, MIP has resulted in increased agency oversight of contractor program safeguard activities. Our related work shows this to be true; HCFA is moving toward a more structured evaluation process of its contractors and is reorganizing its contractor activities at headquarters. HCFA officials and contractor representatives we contacted also pointed to an increased awareness of and focus on Medicare fraud during the past several years that they believe has translated into a more determined effort to combat improper Medicare payments. Further, contractor representatives pointed to increased collaboration among HCFA, contractors, and law enforcement agencies since MIP implementation and noted that the OIG and other law enforcement agencies are more frequently seeking data and assistance from them. Representatives from one contractor also said that the contractor is referring greater numbers of potential fraud and abuse cases to the OIG since implementation of MIP; we did not, however, verify this information.

[28]HCFA does not report savings associated with either benefit integrity or PET because the effects of these activities on Medicare savings cannot be directly identified.

Conclusions

Implementation of MIP has positively affected HCFA's program safeguard activities. Now that it has predictable, assured program safeguard funding, HCFA and its contractors can better plan and implement their safeguard strategy and efforts. A number of the centrally managed projects administered by HCFA should be able to assist contractors in performing more effective safeguard activities and better protect Medicare from fraud, waste, and abuse. Appropriately, HCFA is emphasizing prepayment claims reviews to promote correct claims payment, thereby avoiding the difficulties of seeking repayment from providers when claims are paid in error. Recent hiring of the MIP contractors is an important first step in HCFA's use of its new contracting authority.

The CFO Act audit reports have identified important areas for improvement in managing MIP, and HCFA has taken, or plans to take, appropriate corrective actions. HCFA's responses to other OIG audit report recommendations, as well as recommendations that we have made, also indicate that HCFA takes seriously its responsibilities for improving its program safeguard operations.

Additional time and improved data will enable HCFA to better measure the effects of MIP. Better safeguard data in many cases, however, will not be available for another year, because HCFA is first addressing the larger issue of ensuring that its data systems are millennium-compliant. Perhaps the most important effects of MIP so far have been those that are intangible. In the longer term, greater HCFA oversight of its contractors' safeguard activities and closer collaboration among HCFA, its contractors, and law enforcement agencies could lead to substantial reductions in Medicare fraud, waste, and abuse.

Agency Comments and Our Response

In commenting on a draft of this report, HCFA said that it agreed that measuring the impact of program safeguard activities undertaken as a result of MIP is a difficult and challenging task. HCFA suggested we recognize that, as part of its MIP activities, it is required to develop a list of durable medical equipment that will be subject to prior authorization. The report now notes the need for HCFA to develop such a list. A copy of HCFA's comments appears in appendix II. HCFA's comments also suggested technical changes to the draft, which we have incorporated as appropriate.

We are sending copies of this report to the Honorable Donna E. Shalala, Secretary of HHS; the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; interested congressional committees; and others. We will also make copies available upon request.

If you or your staff have any questions about this report, please contact me at (312) 220-7600. Robert Dee, Anna Kelley, and Lisa Stein made major contributions to this report.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health Financing
and Public Health Issues

Contents

Abbreviations

CFO	Chief Financial Officers
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
IRS	Internal Revenue Service
MIP	Medicare Integrity Program
MSP	Medicare Secondary Payer
OIG	Office of the Inspector General
PET	provider education and training
PSC	program safeguard contractor
SNF	skilled nursing facility
SSA	Social Security Administration

Major Program Safeguard Projects Centrally Administered by HCFA, Fiscal Year 1998

The following table lists the eight largest program safeguard projects centrally administered by the Health Care Financing Administration (HCFA) in fiscal year 1998; collectively, they represent 70 percent of the $47.2 million spent by HCFA that year on such projects.

Table I.1: The Eight Largest Program Safeguard Projects Centrally Administered by HCFA, Fiscal Year 1998

Project	Description	Status	Fiscal year 1999 budget (in millions)
Medicare summary notices	These notices inform beneficiaries of actions taken by contractors on their claims and standardize the many Medicare notices that beneficiaries have previously received.	Ongoing; some, but not all, contractors have already begun using the notices; others are scheduled to begin this fiscal year.	$6.4
Common Working File host operations	The Common Working File database is a major component of the Medicare claims processing function. It is used by contractors to validate Medicare claims payments and is operated at nine host locations. Medicare Integrity Program (MIP) funds are used to support the work of the host sites.	Ongoing	2.9
Customer Information System	This HCFA database provides analytical support to the medical review, Medicare Secondary Payer (MSP), audit, and benefit integrity safeguard activities. The system has been in development since 1994 and continues to be expanded.	Ongoing	2.4
Local medical review policy analysis contractor	HCFA hired a private firm to analyze and report on various issues associated with local medical review policies,[a] including the sufficiency of local medical review policies at contractors' sites and the need for national coverage policies.	Ongoing	0 (Project was totally funded in fiscal year 1998.)
Commercial off-the-shelf software edits	HCFA has a 2-year license with a private firm to use its off-the-shelf prepayment medical review software edits.	Ongoing	8.0
Health maintenance organization (HMO) audits	This activity involves audits and settlements of HMO cost reports. HCFA hires private accounting firms to conduct the audits.	Ongoing, yearly activity	4.8
Special audit initiative	This initiative was part of HCFA's special initiative to utilize prepayment and postpayment strategies to prevent home health agency fraud and abuse. It involved coordination of the medical review, benefit integrity, and audit program safeguard activities.	This was part of a 1-year special initiative.	0
Medical review verification and validation contractor	HCFA hired a private firm to identify best practices in contractors' medical review activities, assess the accuracy of medical review decisions, and make recommendations to improve medical review nationwide.	Ongoing	0 (Project was totally funded in fiscal year 1998.)

[a]Local medical review policies describe whether Medicare covers an item or service and under what circumstances it is considered to be reasonable, necessary, and appropriate.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

JUL 28 1999

FROM: Mike Hash
Deputy Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare: Program Safeguards Activities Expand But Results Difficult to Measure"

TO: Leslie G. Aronovitz, Associate Director
Health Financing and Public Health Issues, GAO

We very much appreciate the opportunity to review your draft report to Congress concerning HCFA's program safeguard activities. We agree with the GAO that measuring the impact of our program safeguard activities is a difficult assignment. We appreciate the GAO's recognition of HCFA's efforts to improve these activities and stress that these efforts will continue.

I have attached HCFA's specific comments to the report. We look forward to working with the GAO on this issue and remain committed to working with the Congress, providers and all of our partners in improving our program safeguard activities.

Comments of the Health Care Financing Administration (HCFA) on the General Accounting Office (GAO) Draft Report: "Medicare: Program Safeguards Activities Expand But Results Difficult to Measure"

Since the Clinton Administration took office, the Department of Health and Human Services has taken a number of steps to implement a "zero tolerance" policy for fraud, waste, and abuse. To do this, we must assure that Medicare pays the right amount, to a legitimate provider, for covered, reasonable, and necessary services for an entitled beneficiary. Achieving this goal is one of our top priorities at HCFA. With help from Congress, our contractors, providers, beneficiaries, and our many other partners, we have achieved record success in assuring proper payments. We also have made considerable progress in fighting fraud by increasing investigations, indictments, convictions, fines, penalties, and restitutions.

To this end, we developed a Comprehensive Plan for Program Integrity, which was released in March 1999. Its development began a year earlier when we sponsored an unprecedented national conference on waste, fraud, and abuse in Washington, D.C., with broad representation from our many partners in this effort. One of the ten key areas included in this plan is the implementation of the Medicare Integrity Program.

In May, HCFA named 12 businesses with expertise in conducting audits, medical reviews, and other program integrity activities, to be the first-ever Medicare Integrity Program (MIP) contractors. MIP, as authorized under the Health Insurance Portability and Accountability Act, allows us to hire special contractors whose sole responsibility is ensuring Medicare program integrity. Until now, only the insurance companies who process Medicare claims have been able to conduct audits, medical reviews, and other program integrity activities. Under this new authority, we are contracting with these 12 firms to bring new energy and ideas to this essential task.

We completely agree that measuring the impact of program safeguard activities undertaken as a result of the Medicare Integrity Program (MIP) is a difficult and challenging task. That is why, as the GAO notes, we are working to improve our program integrity reporting and measurement systems. We believe, in addition, that this GAO report should include, as part of our MIP activities, the development of the list of durable medical equipment which will be subject to prior authorization as mandated in the statute.

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We look forward to continued partnership with the GAO and their feedback on our efforts as they continue. We appreciate the professionalism of the GAO staff who conducted the study and the collaborative efforts put forth by the agency in their review of these activities.

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