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Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities

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Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss our current efforts to assess the vulnerability of the Medicare program to waste, abuse, and mismanagement.

Our work is focusing on the insurance companies that contract with the government to process and pay claims for Medicare-covered services. There are 52 "intermediaries" under part A and 35 "carriers" under part B currently under contract. In recent years, funds available to these Medicare contractors for carrying out claims processing and payment safeguard activities have not kept pace with the growth of the program. As a result, we were concerned about the contractors' ability to perform their responsibilities and ensure the proper expenditures of Medicare funds.

Although we are in the early stages of our evaluation, our information suggests that there has been a serious deterioration in the Medicare contractors' ability to ensure the accuracy of program payments. Largely because of funding shortfalls, contractors are

-- cutting back on medical and utilization reviews of claims that are essential in detecting and preventing erroneous payments,

-- cutting back on the audits of billions of dollars in costs claimed by institutional providers, and

-- unable to pursue hundreds of millions of dollars potentially owed to Medicare by private insurance companies.

GROWTH OF THE MEDICARE PROGRAM

Medicare is the fourth largest category of federal expenditures after defense, social security, and interest payments on the national debt. During fiscal year 1990, Medicare is expected to provide health coverage for over 33 million aged and disabled persons at a total cost of $109 billion. Of this amount, $1.9 billion, or 1.7 percent, represents administrative costs, including those incurred by the Health Care Financing Administration (HCFA) and those paid to the Medicare contractors for processing about 547 million claims.

Throughout Medicare's history, benefit costs have grown faster than both the general inflation rate and the gross national product, as have health expenses in general. Benefit costs increased from $34.6 billion in 1980 to $95.5 billion in 1989, an average annual increase of about 12 percent. A small part of the overall growth is due to an increasing number of beneficiaries. During the period 1980 through 1989, the number of Medicare

beneficiaries increased about 16 percent, from 28.1 million to over 32 million. Another reason has been that, on average, each beneficiary has received more services and more expensive types of services, in part because of the availability of new technology.

IMPORTANCE OF PAYMENT SAFEGUARD ACTIVITIES

Medicare is a complex program with numerous rules about the types of services covered, the conditions under which the services qualify for payment, and the method for determining the amount paid for covered services. These rules are designed to ensure that (1) only medically necessary and appropriate care is provided to beneficiaries, (2) the amount paid for such care is reasonable, and (3) the program is protected from waste and abuse. Most of the money that carriers and intermediaries receive from Medicare is for enforcing these rules.

Carriers and intermediaries perform two functions to assure the accuracy of Medicare payments--claims processing and payment safeguard reviews. The claims processing activity involves a myriad of checks--both automated and manual--to verify that services are covered, that charges are reasonable, that the claim is not a duplicate, and that numerous other payment criteria have been met. Claims processing can result in denying a claim or in identifying claims that need further review through payment safeguard activities.

Contractor payment safeguard activities complement the normal claims processing activities by providing additional means to assure that Medicare payments are appropriate. Payment safeguards include three types of activities. First, the contractors perform medical and utilization review of all submitted claims to determine whether the services furnished were medically necessary and appropriate.[1] Included in the scope of these review activities are evaluations of the amount of services provided and the necessity of the services in treating the patient's condition.

The second major payment safeguard activity is intermediary audits of the cost reports submitted by providers that are reimbursed for services on a cost basis. These include services provided by home health agencies and outpatient services provided by hospitals.

The third safeguard activity is assuring that other insurers, whose coverage is primary to Medicare, pay claims before the Medicare program. This safeguard is called the Medicare Secondary Payer (MSP) program.

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[1]Intermediaries do not review inpatient hospital claims for medical necessity or appropriateness. This function is performed by peer review organizations (PROs), which contract with Medicare specifically for this function.

In total, contractors were paid about $358 million in 1989 to carry out these program safeguard activities that saved the Medicare program about $4 billion--a cost-benefit ratio of about 11 to 1.

HCFA establishes savings goals and/or cost-benefit ratios for each contractor in each of the program safeguard activities as part of the Contractor Performance Evaluation Program. Contractor performance is measured annually against these expectations.

MEDICARE CONTRACTOR BUDGET HAS NOT KEPT PACE WITH PROGRAM GROWTH

From 1984 through 1989 the total amount paid to the Medicare contractors increased from $817 million to about $1.3 billion. At first glance, this increase--about 60 percent--appears to be significant. However, a closer look at these figures, in the context of other changes to the Medicare program during the same period, suggests otherwise.

Medicare's claims volume has been increasing at an annual rate of about 10 percent for the past decade. When the total contractor budget is viewed on a cost-per-claim basis and adjusted for inflation, the amount paid to the contractors actually decreased during that period--from $3.53 per claim in 1984 to about $2.74 per claim in 1989, an average annual decrease of about 5

percent. At the same time, legislative and programmatic changes significantly increased the costs and demands placed on contractor operations.

The cutbacks have been most noticeable in the funding specifically designated for the three contractor program safeguard activities. For example, program safeguard funds were cut from about $358 million in 1989 to $332 million in 1990, a decrease of $26 million. The administration acknowledges in the 1990 budget that savings from medical and utilization review are expected to drop by $37 million, savings from provider audits by $120 million, and savings from part B MSP by $335 million. The fiscal year 1991 budget requests $335 million for program safeguards.

Because of our concern about the effects of these budget cutbacks on program safeguard activities, we started a broad planning survey in January 1990 to begin assessing the vulnerability of the Medicare program to waste, abuse, and mismanagement. To date, we have performed limited work at intermediaries and carriers in Arizona, California, Maryland, Oregon, Virginia and Washington. Our work indicates that reduced funding for contractors may be seriously hampering their ability to ensure the accuracy of program payments. I will now discuss some of the problems we are seeing in each of the three program safeguard activities.

Medical and Utilization Review

There are two key components to the medical and utilization review process. The first is the complement of automated screens, both HCFA-mandated and contractor-initiated, used by the contractors. These screens are generally based on certain dollar, service volume, or other parameters that are used to identify questionable claims. Next is the human factor, the cadre of trained personnel--generally nurses--who review the questionable claims and other necessary information to determine if payment should be made.

The budget for part A medical review was reduced by 42 percent, from $61 million in fiscal year 1989 to $35.5 million in fiscal year 1990. Because of this cutback, intermediaries that we visited have reduced staffing levels by about 50 percent, including a substantial number of nurses who are essential to the medical utilization review function. Thus, some of the intermediaries are unable to review the large volume of claims rejected daily by various screens and edits and are paying claims that otherwise might be denied.

Others are no longer using optional screens that in prior years identified many questionable claims and resulted in substantial savings to the Medicare program. For example, a California intermediary's funding was reduced from about $7

million in 1989 to $3.3 million in 1990. Because of the budget cuts, the intermediary reduced its staff of nurses from 42 to 22. The intermediary took a number of actions to accommodate the staffing reductions, including recently "turning off" some screens that previously generated about $300,000 a month in savings.

An intermediary in Arizona saw its funding reduced from $465,000 in 1989 to $255,000 in 1990, with a corresponding 50-percent reduction in staff. Intermediary officials stated that screens have not yet been turned off, even though their inventory of questionable claims requiring manual review is now 300 percent above normal. They indicated, however, that many of these claims may have to be paid without being reviewed. In addition, they estimate that the intermediary's medical review savings will drop from $4.5 million in 1989 to about $1 to $2 million in 1990.

An intermediary in Washington told us that it discontinued several cost-effective screens related to hospital outpatient services. An official estimated that discontinuing these screens, which cost less than $100,000 per year, could result in erroneous Medicare payments of about $422,000. The official added that the budget cuts will also prevent the intermediary from adding new, potentially cost-beneficial screens. For example, the medical review staff was concerned about a large number of claims being submitted for certain outpatient diagnostic procedures. During our visit the intermediary reviewed a one-day sample of such claims and

found that one hospital had improperly coded 17 of 18 claims submitted, resulting in about $1,500 in excessive Medicare payments.

In general, contractors are concerned about the weakening medical and utilization review process. Some told us that, because the provider community is aware of which screens are being used, the trend toward eliminating cost-effective screens is making the Medicare program increasingly vulnerable to inappropriate payments.

Provider Audits

The funding level for the intermediary audit function, $131 million, remained the same between 1989 and 1990. However, we are concerned that only a small percentage of Medicare cost reports--generally those of the largest hospitals--are audited before final settlement. As a result, billions of dollars in costs claimed by smaller providers--small hospitals, skilled nursing facilities, and home health agencies--are never audited.

For example, one intermediary official told us that field audits will be done at only 12 of its 190 providers this year. At another intermediary, we were told that the number of field audits has decreased by about 50 percent in 5 years and that only 38 of its 430 providers will be audited in 1990. In the last 3 years,

none of the skilled nursing facilities in Washington or Oregon have been audited.

We are also concerned that shortcomings in the audit process may give providers an incentive to inflate reported costs. As discussed earlier, with the reduction in the number of audits, it is likely a provider's cost report will not be audited. Further, even if the cost report is audited, the actual settlement often is not completed for about 2 years. If the auditors then find that Medicare has overpaid--as they often do--the provider repays only the overpayment amount with no interest. Thus, the provider, in effect, has had a 2-year interest-free loan in the amount of the Medicare overpayment.

Medicare Secondary Payer Program

Over the past several years, we have issued a number of reports related to the MSP program.[2] These reports generally focused on the problem of identifying other insurers that have the responsibility of paying before Medicare. Recent legislative and administrative actions--such as the requirement for an Internal Revenue Service/Social Security data match--should enhance the contractors' ability to identify primary payers. However, we are

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[2]Medicare: More Hospital Costs Should be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988).

concerned that, even if these measures are effective, contractors may not have the staff needed to turn the leads into tangible savings to the Medicare program.

In our current survey, for example, we are seeing that contractors have backlogs of claims in which a potential primary insurer has been identified after Medicare paid the claim. Due in part to the budget cutbacks, contractors do not have the staff to develop these cases and pursue recovery from private insurers. This is particularly true in part B, where the funds for MSP were cut from about $36 million in fiscal year 1989 to about $15 million in 1990, a reduction of 60 percent.

The situation at the Medicare contractor in Maryland, responsible for processing claims under both part A and part B, illustrates this problem. Through its MSP investigative efforts, the contractor developed information--including policy numbers--which showed that other insurers were probably responsible for thousands of claims paid by Medicare. These claims dated from 1983 to 1989.

Our analysis of a sample of about 3,300 of these claims showed that the potential erroneous Medicare payments totalled at least $8.7 million. The contractor's records identified its parent company, Blue Cross/Blue Shield of Maryland, as the

commercial insurer potentially responsible for about $4.5 million (55 percent) of the total amount in question.

Currently, the contractor has one half of a full-time-equivalent staff person assigned to pursuing the recovery of these overpayments from private insurers. Contractor personnel estimate that three to six additional staff, at an annual salary cost of less than $200,000, would be able to work this backlog in less than 1 year. In a March 1990 letter to HCFA, the contractor requested additional resources for this effort, but the request was denied.

We found a similar condition at contractors in Arizona and California. Because of funding cutbacks, the contractors reduced their MSP staffs by about 50 percent, and they estimate that about $13 million in potential erroneous payments will not be recovered from private insurers.

HCFA agrees with our preliminary estimate that, nationwide, these potential overpayments could be as much as $200 million, or about 60 percent of the estimated $335 million that will be lost due to cutbacks in part B MSP funds. The proposed MSP budget for fiscal year 1991 is virtually the same as that for 1990; thus, improvements are not likely in the near future.

The probability that some of these potential overpayments will ever be collected from private insurers is reduced further by

Department of Health and Human Services (HHS) regulations issued in October 1989. These regulations state that unless contractors initiate recovery action within 15 to 27 months after identifying another insurer as being primary, the insurer will no longer be considered liable for the amount paid erroneously by Medicare. Thus, the clock may have started on thousands of claims in which a primary payer has already been identified, but resources are not available to pursue recovery. The combined effect of these two factors--the regulations and the budget cuts--could be to excuse private insurers from a liability of hundreds of millions of dollars owed to Medicare.

Growth in the "Contingency Fund"
in the Medicare Contractor Budget

While funding for the cost effective program safeguard activities has been decreasing, another part of the Medicare contractor budget has grown significantly over the past several years. Historically, the contractor budget has contained an amount designated as a "contingency fund." The purpose of this reserve account is to provide for unanticipated administrative costs, such as those due to an unexpected growth in the claims workload.

HCFA monitors contractor expenditures and workload throughout the year, and can request the release of contingency funds if needed. Such requests go through HHS, and must be

approved ultimately by the Office of Management and Budget(OMB). Unused contingency funds are not carried over from year to year and remain in the Medicare trust fund.

The contingency fund, as a line item in the budget, has grown significantly--increasing from $20 million, or 2 percent of the fiscal year 1985 Medicare contractor budget, to $100 million, or 6.7 percent of the 1990 contractor budget. The 1991 budget proposes a $173 million contingency fund, which represents 12.3 percent of the contractor budget.

Although the contingency fund has grown rapidly, none of the money has been used since fiscal year 1988, when about $47 million was released. About $11.8 million, 25 percent, of the amount released was used for contractor claims processing and payment safeguard activities. HCFA's 1989 request for release of over $90 million, including $47 million for claims processing activities and $10 million for payment safeguard activities, was denied by OMB. HCFA currently has no plans to request release of any of the 1990 contingency fund even though a number of Medicare contractors have requested additional funds.

SUMMARY

The fact that we have identified weaknesses in each of the safeguard activities suggests that the funding cutbacks have

caused a deterioration in the Medicare contractors' ability to insure the accuracy of program payments. Attempting to save administrative costs by reducing funding for payment safeguard activities is penny-wise and pound-foolish because safeguards, on average, save the Medicare trust fund $11 for every $1 spent.

In the past, we have recommended a number of actions to improve the effectiveness of program safeguards, and our ongoing work is likely to identify additional opportunities for improvement. However, we believe that the more immediate solution to the problem lies in adequate funding of these important safeguard functions. Increasing funding for program safeguard activities, and thereby cutting inappropriate program payments, could help lessen the need for the difficult across-the-board cuts to all providers that this Subcommittee is faced with annually. Two options for increasing funding are appropriating additional funds for these budget line items and thus increasing the overall contractor budget, or using contingency funds.

This concludes my prepared statement. I will be happy to answer any questions you may have.