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Report to Congressional Requesters

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MEDICARE HOME HEALTH AGENCIES

Overpayments Are Hard to Identify and Even Harder to Collect

GAO

Accountability * Integrity * Reliability

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Abbreviations

BBA	Balanced Budget Act of 1997
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
IPS	interim payment system
PIP	periodic interim payment
POR	Provider Overpayment Report
PPS	prospective payment system

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The Honorable Pete Stark
Ranking Minority Member
Committee on Ways and Means
House of Representatives

The Honorable Lloyd Doggett
House of Representatives

Medicare, the nation's largest health care payer, provides insurance coverage to elderly and disabled Americans. Administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS), Medicare covers both inpatient and outpatient services, including services for homebound beneficiaries. Home health care, consisting of skilled nursing, therapy, and related services, was until 1997 one of Medicare's fastest growing benefits. Between 1990 and 1997, spending for home health care more than quadrupled, from $3.7 billion to $17.8 billion. At the same time, the number of Medicare-certified home health agencies (HHA) almost doubled—reaching 10,500—with nearly one in five located in Texas. Since 1997, however, both the rate of growth and the number of HHAs have declined.

The Balanced Budget Act of 1997 (BBA) was particularly important in controlling Medicare's home health spending.[1] This act mandated that HCFA implement a new prospective payment system (PPS). Until this system is implemented, the act requires that agencies be paid under a cost-based interim payment system (IPS). IPS imposes limits on agencies' cost-based payments that are intended to control both cost per visit and the average cost per beneficiary an agency serves.

Following the passage of BBA, a large number of HHAs closed. Between October 1997 and September 1999, more than 2,350 Medicare-certified HHAs left the program. Approximately 650 HHAs closed in Texas alone, or almost one-quarter of all closures nationwide. Before BBA, the number of HHAs in Texas had increased significantly, from 961 in October 1994 to 1,949 in October 1997. Texas was also one of several states where the

[1] P.L. 105-33 §§ 4601-4616

number of visits per user was much higher than the national average and one of the states identified as having higher rates of unnecessary and uncovered home health visits. HCFA initially reported to you that the closed Texas agencies collectively owed Medicare $627 million. HCFA subsequently revised its figure for HHAs with the largest reported overpayment amounts after further reviewing information contained in its reporting and tracking systems.

Because of your concerns about the potentially significant amounts that the HHAs in Texas owed Medicare, you asked us to determine (1) whether HCFA quickly identifies and collects overpayments from closed HHAs, (2) the accuracy of the overpayment amounts HCFA reported for closed Texas HHAs, and (3) whether HCFA can effectively record and track overpayments due from closed agencies. As we discussed with your offices, we conducted work to address your questions as part of a broader review we are conducting of HCFA's processes for identifying and recovering Medicare overpayments.

During the assignment, we reviewed Medicare claims administration contractor procedures for identifying and collecting overpayments from closed HHAs. We interviewed representatives at two contractors that are responsible for processing and paying HHA claims, including the contractor that has primary responsibility for HHAs in Texas. We selected 15 Texas HHAs that this contractor had served and that HCFA reported as owing the largest amounts to Medicare when they closed. From a review of accounting and other records, we prepared an updated estimate of the overpayment amounts the 15 HHAs owed. We asked HCFA officials about their processes for (1) identifying and collecting overpayments from closed HHAs and (2) recording and tracking overpayments for both ongoing and closed HHAs. Finally, we interviewed HCFA officials responsible for initially identifying the amounts closed HHAs in Texas owed. We also used work from our recently issued reports as well as work related to the Chief Financial Officers Act audit of HCFA's financial statements that identified problems with how HCFA records and tracks overpayments. We conducted our work between October 1999 and March 2000 in accordance with generally accepted government auditing standards.

Results in Brief

HCFA is slow to identify amounts closed HHAs owe Medicare and collects little of the overpayments due from such agencies following their closure. Because HHAs receive interim payments based on estimates of what their allowable costs will be, Medicare claims administration contractors must

retrospectively adjust the payments after receiving and reviewing a report of an agency's costs. Agencies have 5 months after they close to submit their final cost report to the contractors; contractors then generally take 18 months to make a final determination of the amount, if any, a closed HHA owes. Contractors have been discouraged from making quicker determinations for closed agencies because doing so would disrupt timely determinations on cost reports from operating agencies. Not surprisingly, we found that little has been collected from the 15 closed Texas HHAs that HCFA reported as owing the most money; closed HHAs typically have few assets or other resources to repay Medicare. Later this year, HCFA plans to implement the home health prospective payment system mandated by BBA, which will involve predetermined payments for home health services. HCFA's proposed home health prospective payment system should reduce the potential for overpayments to HHAs because payment amounts would not be adjusted retrospectively to reflect allowable agency costs.

Our estimate of the overpayments due from the 15 closed HHAs differs significantly from the estimate HCFA initially reported. Using the same definition of an overpayment as HCFA, we estimate that these agencies could owe $68 million—one-third of HCFA's initial $209 million estimate. Two factors accounted for nearly all the difference. First, contractor staff made errors entering data into one of HCFA's overpayment recording and tracking systems, such as a $4.6 million duplicate entry. Second, HCFA's initial query of this overpayment recording and tracking system did not specify that superseded transactions be excluded from the reported overpayments. This type of error, for example, resulted in overstating one agency's overpayments by $4 million. About $43 million of our $68 million overpayment estimate stems primarily from unfiled cost reports. Although it is likely that most of Medicare's payments were allowable, to provide agencies an incentive to file cost reports on time HCFA deems the entire amount paid to an agency during the reporting period to be an overpayment when no cost report is filed.

HCFA's inability to accurately record and track overpayments has been a consistent weakness documented in its financial statement audits from fiscal year 1996 through fiscal year 1999. The fiscal year 1998 audit, for example, reported that HCFA lacked an integrated financial management system to track overpayments and their collection and that its procedures to ensure that overpayments were valid and supported were inadequate. HCFA's contractors record and track overpayment activity for HHAs and other providers using a variety of fragmented and overlapping computer systems but do not always reconcile the data from these various systems.

For example, contractor staff incorrectly keyed data from one of the contractor's systems into a HCFA system, erroneously reporting $77 million in overpayments for one Texas HHA in 1998. No edits are in place to identify such errors. HCFA implemented several interim measures in 1999 to improve the reliability of its overpayment information and is planning additional improvements; however, they could take years to implement.

Background

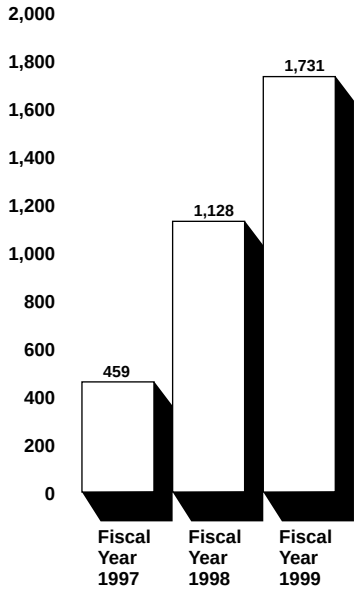
Medicare's home health benefit covers skilled nursing; physical, occupational, and speech therapy; and home health aide services provided in beneficiaries' homes. To qualify for home health services, a beneficiary must be confined to his or her residence; require intermittent skilled nursing, physical therapy, or speech therapy; and be under a written plan of care signed by a physician. Only home health agencies that have been certified as meeting Medicare's conditions of participation are allowed to bill the program.[2]

Medicare home health expenditures increased at an average annual rate of approximately 25 percent between 1990 and 1997—almost three times faster than the rate for the Medicare program overall. During this period, the number of Medicare-certified HHAs almost doubled to 10,524 at the end of fiscal year 1997. However, as shown in figure 1, the number of HHAs that closed has increased each year since fiscal year 1997—the year the Congress passed BBA. By the end of fiscal year 1999, the number of HHAs had declined approximately 20 percent, to 8,172.[3]

[2] HCFA administers its certification process through state survey agencies, usually components of state health departments, that assess whether HHAs deliver quality care and have the appropriate staff, policies and procedures, medical records, and operational practices to deliver quality care.

[3] During the same 3-year period, there were 1,560 new Medicare-certified HHAs.

Figure 1: The Number of Medicare-Certified HHAs That Closed, Fiscal Years 1997-99



Closures are either voluntary, as when an HHA goes out of business, or involuntary, as when the agency fails to meet Medicare's quality of care or financial standards and is terminated from the program. Closure statistics also include agencies that merge with another HHA and continue to serve Medicare beneficiaries. Labeling mergers as "closures" is misleading, but HCFA's data systems cannot distinguish mergers from closures. We reported in May 1999 that agencies that closed after BBA was enacted shared many of the characteristics of agencies that opened in the 1990s.[4] That is, they were disproportionately urban, free standing, and for profit; however, compared with agencies that remained open, the closed agencies tended to be newer, treated fewer beneficiaries, provided more services per user, and had declining numbers of patients. We also reported that despite these closures, beneficiaries' access to services appeared to be unaffected.

[4] *Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired* (GAO/HEHS-99-120, May 26, 1999).

BBA Changed How HHAs Are Paid

To control rapidly rising home health care expenditures while ensuring the appropriate provision of services, PPS, mandated by BBA, is a payment system intended to reward efficient providers and financially penalize inefficient ones. However, in recognition of the time needed to develop PPS, coupled with the need to control spending growth immediately, BBA prescribed IPS. Under IPS, HHAs receive interim payments throughout the year that are based on the projected allowable per-visit costs and, in some cases, the projected volume of services for Medicare beneficiaries.[5] After the HHA's cost reporting year is over, agencies file cost reports specifying their costs of serving Medicare beneficiaries. Under IPS, Medicare pays these costs up to a cost-per-visit cap, which BBA reduced from the prior per-visit cap, and up to an average annual per-beneficiary limit, which BBA added.[6] When the interim payments exceed or fall short of the actual costs Medicare will pay, agencies return or receive the difference. Through the application of the payment limits, IPS attempts to control the costs and amount of services provided to beneficiaries. IPS will be in effect only for several more months; the new PPS is scheduled for implementation at the beginning of fiscal year 2001. As proposed by HCFA, this system will pay HHAs predetermined rates for home health services.[7]

Five Medicare contractors, called regional home health intermediaries, are responsible for paying home health agencies.[8] To help ensure that the interim payments are aligned with what Medicare will ultimately pay, the five contractors periodically conduct interim rate reviews of each agency. During these reviews, which generally take several months to complete, the contractors compare an agency's interim payment rates with cost information submitted by the agency and the agency's audit history. Rates may increase or decrease as a result of the reviews, and the agency may

[5] A small minority of HHAs are paid through a method known as "periodic interim payments," or PIP, in which level payments are made to an HHA every 2 weeks, based on estimated annual visits and Medicare allowable costs. Medicare contractors are responsible for reviewing an HHA's PIP payments every quarter to ensure that the levels are appropriate to the volume of services being provided.

[6] Under IPS, the per-visit cap was based on 105 percent of the national median per-visit cost. IPS was revised by §§5101 (b) of the Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999 (P.L. 105-277), which increased the per-visit cap to 106 percent of the national median cost.

[7] 64 *Fed. Reg.* 58,133 (Oct. 28, 1999).

[8] Throughout this report, we refer to regional home health intermediaries as contractors.

owe Medicare money or be owed money by Medicare. At the end of its fiscal year, or upon closure, each agency is responsible for submitting a report of its costs to the Medicare contractor. HCFA requires its contractors to conduct several types of cost report reviews to determine whether the agency has been overpaid or underpaid for the reporting period. These reviews also take months to complete. Once a contractor has identified an overpayment, it is responsible for notifying the agency and requesting immediate payment. If payment is not made within 15 days, the contractor can withhold payments to the agency until the overpayment has been repaid; interest also accrues on any balances unpaid longer than 30 days. If a contractor is unable to collect all outstanding overpayments from an HHA, the contractor should refer the debt to HCFA for collection. If HCFA is unable to make the collection, it is required under the Debt Collection Improvement Act of 1996 to transfer debt that is 180 days delinquent to the Department of the Treasury or a designated debt collection center.

Following the BBA Changes, Some HHAs Experienced Large Overpayments

Unless HHAs' interim payment rates were reduced, BBA payment changes created the potential for large overpayments to HHAs in Texas and elsewhere. First, IPS resulted in new payment limits that substantially lowered payments for many HHAs. Agencies in Texas were particularly affected because they provided more visits per user on average than did HHAs in most other states and, thus, were under greater pressure to reduce their per-patient costs. Agencies can take several steps to adjust costs to the new limits. These include balancing their mix of low-cost and high-cost patients, reducing their costs overall, increasing the proportion of low-cost patients treated, or doing some combination of these activities. By not taking such steps, agencies increased their potential to be overpaid following the implementation of the new IPS rates.

Second, information on the new payment limits was not available for months following the effective date of IPS, and HHAs continued to be paid at the earlier, and in some cases higher, interim rates. Specifically, under BBA, HCFA was required to publish the per-visit limits by January 1, 1998, and the new per-beneficiary limits by April 1, 1998, which HCFA did. However, the limits took effect on October 1, 1997. Only after these notices were published could contractors begin recalculating each agency's interim payments and then actually adjust them. Some HHAs incurred large overpayments between October 1997 and the date when the agencies' interim rates were adjusted. Some of these agencies also closed because they were unable to repay their Medicare debt.

Overpayments Are Not Quickly Identified and Are Difficult to Collect

Identifying amounts closed HHAs owe under IPS is a slow process that reduces the potential for collecting overpayments. Contractor overpayment determinations generally depend on the receipt of a cost report, yet HHAs have up to 5 months to file such reports after they close. And it is not until about 18 months following the receipt of the cost report that contractors generally make final determinations of the amounts, if any, that closed HHAs owe. Further, contractors are discouraged from making these final overpayment or underpayment determinations more quickly for closed agencies because doing so would affect their determinations on cost reports from operating agencies. We found that once an HHA closes, little of an overpayment is collected, because closed agencies generally lack cash and other assets to repay the debt. Implementing PPS should virtually eliminate overpayments except in cases of fraud or abuse. As proposed by HCFA, this new payment method will pay a predetermined amount per unit of service, adjusted for patient characteristics that affect the cost of care, and will not involve retrospective reviews of an agency's interim payments and costs. Overpayments should result only from HHAs' improperly claiming payments for patients, not from the amounts of payment per patient.

Overpayments to Closed HHAs Are Not Identified Quickly

Once an agency closes, it has 5 months to submit its final cost report—the same time afforded operating HHAs to submit cost reports for the preceding fiscal year.[9] Contractor representatives told us that after 5 months, responsible officials from closed HHAs are often no longer available to provide contractor staff with access to necessary financial documents or to answer questions. Moreover, during the 5-month period, closed HHAs continue to be paid for services that were provided before they closed, unless the agencies had outstanding overpayments from earlier years' activities. In fact, some Medicare payments received after closure may subsequently be determined to be overpayments. For example, one of the 15 closed Texas HHAs was paid $669,000 after it closed but did not file a cost report covering this payment. When an agency fails to file a cost report, all the payments made to it during the reporting period are deemed an overpayment. As of December 1999, the contractor had recouped $70,000.

[9] Previously, HHAs had 45 days after they closed to submit their final cost reports. A HCFA official told us that HCFA changed this requirement because HHAs complained that 45 days did not give them enough time to make their financial records final and prepare the final cost report.

Once a cost report is received, overpayments can be identified at any of several stages of the contractor's review. For example, the contractor may find that the HHA cost report, as filed, indicates that the agency has been overpaid. Also, cost reports may undergo a desk review by the contractor, generally within 60 days of receipt. During these limited reviews, contractors may identify overpayments from the submitted documentation. Contractors also identify overpayments during cost report audits, but few cost reports from either closed or ongoing HHAs undergo this type of review. In fiscal year 2000, for example, HCFA expects contractors to audit about 12.5 percent of all HHA cost reports.[10] HHAs are selected for audit on the basis of such factors as their total reimbursement and average number of visits per patient. Some are audited randomly. Given HCFA's limited audit resources and closed HHAs' historical inability to repay debt, it is understandable that HCFA has not concentrated its audit efforts on closed agencies.

All cost reports go through a settlement process in which contractors make a final determination of how much Medicare reimbursement the HHA has earned and whether Medicare or the agency is owed money. However, it is generally not until about 18 months after contractors receive the cost report that final settlement occurs. HCFA does not require contractors to settle cost reports from closed HHAs more quickly. Moreover, contractors' representatives said that they are discouraged from doing so because it disrupts the order in which reports for other agencies are settled. That is, settling a closed HHA's cost report more quickly delays the settlement of other cost reports, which is inconsistent with HCFA's goals for settling all cost reports in a timely manner.

Contractors may also identify overpayments by conducting an interim rate review after an agency closes. During these reviews, contractors compare the agency's interim reimbursement rates with previous cost information the agency has submitted, Medicare payments, the IPS per-visit and per-beneficiary limits, and the agency's audit history. Decisions on whether to conduct these reviews depend on factors such as the agency's size, dollars at risk, and the time since the contractor's last interim rate review of the agency. The reviews may result in revisions to the agency's interim payments and determinations of underpayments or overpayments. These reviews, too, take time to conduct. We found that the contractor conducted such reviews of 5 of the 15 closed HHAs in Texas that we reviewed and that

[10] The 12.5 percent audit requirement pertains to free-standing HHAs.

they were performed between 3 and 5 months after closure. Overpayments ranged from $20,000 to $362,000.

Contractors' Activities That Impede Identifying Overpayments From Closed HHAs

In addition to the time lags built into the process for identifying overpayments to closed HHAs, we found that the contractor did not always follow the specified procedures, allowing overpayments from the Texas HHAs to remain undetected for years without making efforts to collect them. This also resulted in the agencies owing more to Medicare when they closed. For example, one of the closed HHAs did not file its 1994, 1995, and 1996 cost reports until July 1997. They were 30, 16, and 4 months late, respectively. The agency was overpaid each year, the overpayments for the 3 years totaling $3.5 million. In each case of late cost report filing, the contractor should first have notified the agency that it would suspend payments until it received the cost report. Then, if the agency still did not file its cost report, the contractor should have recorded the entire amount paid to the agency during the reporting period as an overpayment and transferred responsibility for collecting the overpayment to HCFA. In this case, the contractor did neither. It was not until September 1999—more than 6 months after the agency closed—that the contractor settled the three cost reports and asked the HHA to repay Medicare.

We also found several cases in which the contractor did not conduct timely cost report settlements. In one case, for example, a Texas HHA filed its 1995 cost report in January 1996. The contractor should have settled this report in 1997. However, the actual cost report settlement that identified a $171,000 overpayment did not occur until 1999, almost 2 years late and 2 months after the agency closed. In another case, the contractor received an agency's 1995 cost report in May 1996. The settlement that should have occurred by 1998 did not take place until late 1999, by which time the agency had been closed for almost a year. The agency owed Medicare $15,500 from this settlement.

Apparently, the first case discussed was one of the few in which the contractor did not conduct timely cost report settlements in fiscal year 1997. HCFA provided information stating that the contractor was timely in settling nearly 95 percent of the cost reports due for settlement that fiscal year. In fiscal year 1998, however, HCFA did not evaluate the contractor's performance in this area, in part because the contractor's workload nearly doubled from absorbing the workload of a different contractor that left Medicare. In fiscal year 1999, the contractor was timely in settling

approximately 75 percent of the cost reports received; HCFA attributed the reduction to its cuts in the contractor's budget.

Effective HCFA oversight to ensure that its contractors are requiring timely submission of HHA cost reports, and subsequently settling them in a timely way, is critical to sound program management in general and, in particular, to reducing the amounts HHAs owe Medicare when they close. However, as we noted in an earlier report, HCFA's oversight process has weaknesses that impede its review of contractors' performance.[11] Although HCFA requires contractors to certify annually that they have sound internal management controls over all their Medicare operations, we found that it rarely checks to ensure that the controls are working as required.

Once Identified, Few Overpayments Are Collected From Closed HHAs

Once an HHA closes, there is little likelihood of HCFA's collecting all the outstanding overpayments that cost report reviews and interim rate adjustments have identified. Some HHAs rely almost exclusively on Medicare for their revenue and have few assets. Without other revenue streams or assets, HHAs may not have funds available to repay Medicare. For the 15 closed Texas HHAs that we reviewed, we found that the contractor had collected approximately $5.3 million, or just 7 percent of the total overpayments owed. For example, one of the Texas agencies closed in January 1998 and had outstanding overpayments for 1998 of $209,150; none of this debt had been collected by December 1999. Another of the Texas HHAs closed in 1998 with overpayments from earlier years of $3.7 million, of which only about $200,000 had been collected.

Bankruptcy can further complicate overpayment collection efforts and reduce potential collections. Once an HHA has filed for bankruptcy, the contractor's collection activities are subject to the review and approval of the bankruptcy court. Whether any of the bankrupt agency's Medicare overpayments are eventually repaid depends on the results of the bankruptcy proceedings. Of the 15 closed HHAs in Texas, 3 were in bankruptcy as of December 1999.

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

HCFA Overstated Amounts Owed From Closed HHAs in Texas

HCFA reported that 642 Medicare-certified HHAs in Texas closed between October 1997 and July 1999 and that these agencies collectively owed Medicare $627 million.[12] HCFA generated its overpayment amounts from its Provider Overpayment Report (POR) system, which records and tracks overpayments from HHAs and other types of providers, both ongoing and closed. Our analysis showed that HCFA significantly overstated the amounts that the 15 closed Texas HHAs with the largest reported overpayments owed. Additionally, we found that almost two-thirds of the overpayments resulted from unfiled cost reports. To provide an incentive for HHAs to file timely cost reports, HCFA deems the entire amount paid to the agency during the reporting period to be an overpayment when cost reports are overdue. HCFA knows that it is likely that at least some of the payments were appropriate and allowable.

As is shown in table 1, HCFA reported that the 15 closed Texas agencies owed Medicare about $209 million, or one-third of the overpayments due from all the closed Texas HHAs.[13] However, we estimate that these HHAs owed $68 million, or one-third what HCFA originally reported.

[12] This figure includes interest accrued on unpaid overpayments.

[13] Most of the 15 terminated agencies were new entrants to the home health industry. Only two were Medicare providers before 1991. Medicare payments to the 15 HHAs for fiscal year 1997 ranged from $1.4 million to $12.8 million.

Table 1: Overpayment Amounts for 15 Closed HHAs in Texas With the Largest HFCA-Reported Overpayments

HHA	HCFA's reported overpayment	GAO's estimated overpayment	Primary reason for difference
1	$21,939,652	$18,341,695	HCFA amount includes contractor data entry error
2	6,145,572	1,381,737	HCFA extracted POR data incorrectly
3	9,533,916	1,494,121	HCFA extracted POR data incorrectly
4	5,749,580	3,688,232	HCFA extracted POR data incorrectly
5	5,983,577	563,908	HCFA extracted POR data incorrectly
6	5,053,679	599,598	HCFA extracted POR data incorrectly
7	79,247,220	2,365,262	HCFA amount includes contractor data entry error
8	16,853,645	2,356,325	HCFA extracted POR data incorrectly
9	8,473,051	2,738,402	HCFA amount includes contractor data entry error
10	9,567,131	126,379	HCFA extracted POR data incorrectly
11	8,077,040	5,943,379	HCFA overpayment amount exceeds Medicare payment to HHA for the year
12	6,697,425	5,334,822	HCFA amount includes contractor data entry error
13	6,722,368	9,139,407	HCFA amount includes contractor data entry error
14	6,404,648	7,319,658	HCFA amount includes contractor data entry error
15	12,319,664	6,555,153	HCFA extracted POR data incorrectly
Total	**$208,768,168**	**$67,948,078**	

Most of these overpayments are for services provided in 1996, 1997, and 1998; however, some are for the costs of home health services provided as far back as 1994. For example, HHA 12 did not file its 1994 and 1995 cost reports until July 1997. In September 1999, the contractor settled the 1994 cost report and determined that the agency was overpaid approximately $474,000 and that it owed an additional $158,000 in penalties.[14] The contractor also settled the 1995 cost report in September 1999 and identified a $955,000 overpayment plus $169,000 in penalties. This same agency had additional overpayments of approximately $3.5 million, including penalties and interest, related to its fiscal year 1996, 1997, and 1998 activities. This amount included $1.7 million related to overpayments

[14] HCFA imposes a penalty for each month that a cost report is filed late.

from a September 1999 desk review of the agency's 1996 cost report and $1.6 million related to unfiled cost reports for 1997 and 1998.

We found that three primary types of errors explain nearly all the difference between our overpayment estimate of approximately $68 million and the approximately $209 million that HCFA reported.[15]

- Contractors' errors entering data into the POR system, such as keypunch errors, failure to enter appropriate data, and duplicate entries, totaled about $100 million. One keypunch mistake alone for HHA 7 resulted in an erroneous reporting of a $76.9 million overpayment for 1998. In another case, the contractor entered a $4.6 million overpayment amount twice for the same HHA.
- How HCFA extracted data from the POR system accounted for another $50 million in errors. The POR system consists of two parts. One is the Master File that contains current outstanding overpayment activity for a provider. For example, the Master File shows that HHA 10 has an outstanding overpayment of approximately $145,000 due from the settlement of its 1998 cost report. The other is the History File that contains information on all overpayment transactions associated with the provider and thus serves as an audit trail. For example, this file shows that HHA 10 initially failed to file its 1998 cost report, resulting in an overpayment of approximately $4 million. Because HCFA extracted both Master File and History File information for each of the closed Texas HHAs, it overstated the amounts due Medicare by including information from the History File that had been superseded. In the case of HHA 10, HCFA overstated the agency's fiscal year 1998 overpayments by $4 million.
- A third type of error relates to the data contained in the POR system. POR data are not reconciled against information contained in other HCFA data systems, such as the System Tracking for Audit and Reimbursement that reports information on Medicare's total annual payments to a provider. Because there is no reconciliation among the different systems, the POR system may indicate that an HHA's overpayments for a year, exclusive of penalties and interest, exceeded its Medicare payments—an impossibility. For example, HHA 11 received $2.8 million in total Medicare payments during its fiscal year 1998. Yet

[15] These errors resulted in both increases and decreases to HCFA's original overpayment amount. Because of this, the total value of the errors—approximately $159 million—exceeds the $141 difference between our overpayment estimate and what HCFA reported.

HCFA reported that the HHA's overpayments that year totaled $5.1 million. HCFA's overpayment figure included $2.3 million because of an interim rate adjustment and $2.8 million because of an unfiled cost report.[16] We found $7 million in these types of errors.

Our $68 million overpayment estimate is net of about $5.3 million—7 percent—collected by withholding payments to the agencies or by extended repayment arrangements.[17] More could have been recouped had the contractor not made mistakes. For example, HHA 15 had agreed to a 12-month extended repayment plan related to a $251,500 1996 overpayment but defaulted after about 6 months. The contractor should have put the agency on 100 percent withholding 2 months after the agency stopped making payments. In this case, however, the contractor did not begin withholding until 5 months after the agency's payments stopped. During this delay, the agency received more than $800,000 from Medicare, part of which could have been used to repay the remaining $83,800 due from the agency's outstanding 1996 overpayment.

We found that about $43 million of our $68 million estimate was the result of documentation problems, primarily unfiled cost reports. In these cases, it is likely that at least some of, or potentially all, Medicare's payments were appropriate and allowable; this would result in reducing the amounts the 15 agencies owed. However, while HCFA could likely estimate whether an agency was overpaid or underpaid for the reporting period, given the agency's past history, without a cost report the entire amount paid to an HHA during the year is deemed an overpayment. The remaining $25 million in estimated overpayments reflects amounts determined through settlement of cost reports, interim payment adjustments, or other audit activities.

[16] While an agency's overpayments for a year cannot exceed its total Medicare payments for that year, POR data represent valid Medicare overpayments. In the case of HHA 11, it is appropriate for POR to record both types of overpayments for fiscal year 1998.

[17] HCFA's $209 million overpayment estimate is also net of collections.

HCFA Lacks a Reliable Integrated System for Recording and Tracking Overpayments

It is not surprising that HCFA reported inaccurate overpayment information on closed HHAs in Texas, given its longstanding and systemic problems accounting for overpayments—its accounts receivable.[18] Inaccurate accounts receivable prevented HCFA from obtaining an unqualified opinion on the accuracy of its annual financial statements until 1999.[19] Contractors track and report overpayment activity for HHAs and other providers by means of a variety of fragmented and overlapping systems but are unable to reconcile the data in these systems—resulting in reporting errors. While HCFA implemented several interim measures in 1999 to improve the reliability and completeness of its accounts receivable information, permanent solutions, such as an integrated accounts receivable tracking and reporting system, will not be fully implemented until 2001 at the earliest.

Ineffective management of Medicare accounts receivable has been noted as a consistent problem in HCFA's financial statement audits for fiscal years 1996 through 1999.[20] These audits identified numerous recurring control weaknesses and systems problems with Medicare's accounts receivable. The fiscal year 1998 audit, for example, disclosed deficiencies in nearly all facets of HCFA's accounts receivable activity, including the lack of an integrated financial management system to track overpayments and their collections as well as inadequate procedures for ensuring that receivables were valid and supported. In 1999, auditors found that despite significant improvements in contractors' recordkeeping, controls over accounts receivable continued to be a material weakness.[21]

[18] Overpayments are classified for accounting purposes as accounts receivable.

[19] In 1997 and 1998, HCFA received a qualified opinion on its financial statements, in part because of deficiencies in accounts receivable activities at Medicare contractors. Auditors did not express an opinion on HCFA's 1996 financial statements for several reasons, including contractors' inability to support their accounts receivable.

[20] The Government Management Reform Act of 1994 requires annual financial statements for the 24 major federal agencies and the U.S. government as a whole. HCFA has issued audited financial statements for fiscal years 1996-99.

[21] A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level of risk the errors or irregularities in the amounts that would be material in relation to the financial statements being audited.

Because HCFA does not have a single integrated system for tracking and reporting receivables, HCFA and its contractors use several fragmented and overlapping systems to track overpayment activity. For example, contractors track HHA overpayments on manual ledger records and in their claims processing systems and must manually enter information into HCFA's POR system. Using different, nonintegrated systems increases the risk of errors and misstatements as we found with overpayments HCFA reported on the 15 closed Texas HHAs. In earlier audits of HCFA's financial statements, auditors found that reconciliations among the recording and tracking systems were not always done or were not done properly. In some cases, the different systems could not be reconciled, either with one another or with the contractors' quarterly activity reports. During our review, for example, we found that the contractor did not reconcile its records with the POR system. This allowed an erroneous report of a $76.9 million overpayment to remain in POR even though the contractor's own records contained the correct overpayment amount due from the HHA.

Likewise, HCFA does not reconcile the POR system with other HCFA reporting systems, such as the System Tracking for Audit and Reimbursement, as an additional quality control check. We found several instances in which, because the two systems were not reconciled, HCFA reported an HHA's overpayment to be greater than the HHA's total Medicare payments for a year. In one case, for example, HCFA reported that the agency owed $12 million for its fiscal year 1996 activities. However, Medicare payments to the agency that year totaled $7 million.

In 1999, HCFA initiated several actions to improve the accuracy and reliability of the receivable activity and balances reported by its contractors, including HHA receivables. First, during 1999, HCFA entered into a reimbursable interagency agreement with the HHS Office of Inspector General to perform detailed reviews of Medicare receivable balances and activity at HCFA's central and regional offices. Second, HCFA contracted with outside consultants to review internal controls and accounts receivable activity at its 15 largest contractors. Third, HCFA issued new instructions to its regional offices requiring detailed reviews of receivable balances at all contractors that were not included in the consultant study. Fourth, HCFA contracted with other outside consultants to review internal controls at 26 contractors and recommend any needed improvements. And last, HCFA directed contractors to review their Medicare receivables and recommend items for possible write-off.

While HCFA's recent write-off efforts have made receivable balances more reliable in the short term, they do not address the underlying causes for the weaknesses found in past audits. More permanent solutions to HCFA's accounts receivable problems could take years to implement. HCFA has long recognized that it needs to replace its fragmented accounts receivable tracking and reporting systems with a single integrated system. However, efforts to develop new systems were delayed by more immediate needs, such as fixing potential year 2000 computer glitches. HCFA officials told us that developing new financial management systems is now one of the agency's highest priorities.

One proposed system, called the Medicare Accounts Receivable System, would replace the POR system. According to HCFA officials, the new receivables system will be fully automated and will take overpayment information directly from the contractors' claims processing systems. It will also interact with other new financial management systems being developed, including an automated Medicare general ledger system to better track and report contractors' financial activity. HCFA hopes to begin implementing the new Medicare Accounts Receivable System in 2001.

Conclusions

Under IPS, HHAs receive interim cost-based payments that contractors must adjust retrospectively through activities such as interim rate adjustments, desk reviews, audits, and final settlements. These activities may or may not identify overpayments but are usually not performed for months after an agency closes. There is little likelihood of collecting significant portions of a closed agency's overpayments because closed agencies have few, if any, non-Medicare resources or other assets with which to repay their Medicare debts. The fact that HCFA has collected only about 7 percent of the overpayments due from the 15 closed Texas HHAs we reviewed attests to this. It is important to note, however, that the large overpayments to some HHAs under IPS is a one-time situation related to the change in Medicare's payment method; overpayment problems for the same reasons and of this magnitude are unlikely under PPS as proposed by HCFA.

HCFA's initial calculation of what closed HHAs in Texas owed was significantly overstated because HCFA's POR system for tracking and reporting overpayments is unreliable and inaccurate. Not only does the POR system lack edits to check for data entry errors but HCFA does not reconcile POR data with other HCFA data systems, such as the System Tracking for Audit and Reimbursement. This has resulted in HCFA's

reporting that some providers owed more money than Medicare actually paid them in a year. While we estimate that the 15 closed Texas HHAs owe $68 million, two-thirds of this amount, or $43 million, stems primarily from unfiled cost reports. It is likely that at least some of the $43 million is allowable and therefore not an overpayment, but without the cost reports, the entire amount paid to the agency during the cost report period is deemed an overpayment.

Weaknesses with the POR system reflect HCFA's longstanding and systemic accounts receivable problems. HCFA has taken interim steps to address these issues and plans to begin phasing in a single, integrated accounting system to report and track overpayments in 2001. While this system should help overcome the problems HCFA has with recording and tracking overpayments, its effectiveness will not be known until it is operational.

Agency Comments and Our Evaluation

HCFA commented on a draft of this report and generally agreed with its contents and conclusions.[22] (HCFA's letter is printed in appendix I.) In its comments, HCFA emphasized its commitment to strengthening Medicare's financial controls and systems and to bringing the agency into accord with standard government accounting practices. HCFA acknowledged weaknesses in the POR system that limit its effectiveness as a managerial tool and outlined both current and future steps to correct these weaknesses. Chief among these steps is its planned implementation of the Medicare Accounts Receivable System in 2001. HCFA also noted that it is considering using a commercial off-the-shelf product as a short-term remedy to some of the problems with the POR system. The steps HCFA outlined, if properly implemented, would improve its current accounts receivable systems and could help manage and safeguard HCFA's programs.

HCFA agreed with our portrayal of the difficulties contractors face in trying to quickly identify and collect overpayments from closed HHAs. In its comments, HCFA stated that when HCFA does receive notice of an agency's intent to leave the program, the contractors determine quickly whether a provider has outstanding overpayments or the potential for overpayments and begin withholding any future payments to recover the money. This is a more positive picture than we found. As our report indicates, the contractor generally did not make final determinations of the

[22] HCFA also provided technical comments that we incorporated where appropriate.

amounts owed until almost 2 years after HHAs closed, and HCFA does not require contractors to settle cost reports from closed HHAs more quickly than from operating HHAs. While contractors can conduct interim reviews to estimate any underpayments or overpayments, for only 5 of the 15 cases we reviewed was an interim review conducted—all from 3 to 5 months after closure.

HCFA emphasized in its comments that moving to a prospective payment system for HHAs would help resolve HHA overpayment issues currently confronting HCFA and its contractors. Strengthening financial controls and modernizing Medicare's accounting systems would also help resolve financial management problems. Finally, HCFA affirmed its commitment to protecting the home health benefit for persons who qualify for it while protecting the financial integrity of the Medicare program.

As we arranged with your offices, unless you publicly announce the report's contents earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies of the report to the Secretary of Health and Human Services, the Administrator of HCFA, appropriate congressional committees, and others who are interested. We will also make copies available to others on request.

If you or your staff have any questions, please call me at (312) 220-7767 or Sheila Avruch, Assistant Director, at (202) 512-7277. Other major contributors to this report include Robert Dee, Anna Kelley, Wayne Marsh, Frank Putallaz, and Suzanne Rubins.

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

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: APR - 4 2000

TO: Leslie G. Aronovitz
Associate Director
Health Financing and Public Health Issues
General Accounting Office (GAO)

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: GAO Draft Report, "Medicare Home Health Agencies: Overpayments are Difficult to Identify and Even Harder to Collect and Track" (GAO/HEHS/AIMD-00-132)

Thank you for the opportunity to review this draft report concerning the Health Care Financing Administration's ability to collect overpayments from certain home health agencies.

As you know, HCFA has worked aggressively in recent years to strengthen Medicare's financial controls and systems to increase the efficiency and accuracy of its financial statements. These efforts will bring us in accordance with standard government accounting practices. Since the Inspector General conducted its first comprehensive audit of HCFA's financial statements for Fiscal Year 1996, we have taken many steps to modernize Medicare's accounting systems, strengthen oversight of the private insurance companies that process claims, and ensure proper payment for Medicare services. We are attacking financial management problems with the same focus and energy that we deployed to meet the Year 2000 computer challenge, and we intend to be as successful in this effort.

One sign of the progress that we have made so far is the clean opinion that HCFA received from independent auditors for its Fiscal Year 1999 financial statements. Assuring that Medicare's financial status is accurately portrayed has been an essential first step as we – and the private contractors that pay claims – take additional actions to strengthen day-to-day management.

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Your report focuses on concerns that we ourselves identified in response to a Congressional request last year. We would like to take this opportunity to clarify and elaborate on the issues that prompted your review.

Collecting Overpayments from Closed HHAs

Unfortunately, it is difficult for intermediaries to quickly identify and collect overpayments from closed HHAs. As a practical matter, agencies that decide to terminate from Medicare do not notify HCFA of their intentions until it is too late for HCFA to act. When HCFA does receive notice of an agency's intent to leave the program, in general, the intermediary will quickly determine if a provider has outstanding overpayments or the potential for outstanding overpayments, and will begin withholding any future payments to recover the money.

Reporting of Overpayment Amounts

As the GAO report notes, the overpayment amount originally reported was inflated by figures associated with overdue cost reports. The Medicare Accounts Receivable System (MARS) system, which we plan to implement in 2001, should address the inflated figures identified in the report.

Until a cost report is received, contractors are required to conclude that all payments made during the fiscal year are overpayments. When the cost report is submitted, overpayment data regarding the unfiled cost report should be deleted or modified based on the receipt of the cost report. However, HCFA's current system, the Provider Overpayment Report (POR) system, does not prompt or correct the user to delete or account for previous entries regarding unfiled cost reports. In short, the $209 million resulted from data extracted from an outdated POR system where there are no edits to flag errors in reporting. The MARs system will include such edits and lead to more accurate overpayment reporting.

Tracking Overpayments from Closed Agencies

The POR system limitations hamper HCFA's ability to use the data, and impedes recording and tracking of the data. However, each contractor is required to maintain accurate records and data. Each contractor has an internal system that details overpayment activity. HCFA uses this information to refer uncollectible overpayments to the Department of Treasury for further collection activity. As required by the Debt Collection Act, we are examining each of the terminated providers for referral to the Department of Treasury for further collection efforts or to the Department of Justice for

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filing claims in bankruptcy litigation, if appropriate.

The status of the Health Care Financing Administration's accounts receivable system is an important issue. There are two accounts receivable systems under development – the MARS and the Recovery Management for Medicare Secondary Payer System (REMAS). MARS is scheduled for implementation in September 2001 and will replace the current POR system. We are currently exploring the use of a commercial off-the-shelf product (one certified by the Joint Federal Management Improvement Program) to remedy some of the problems with the POR.

We also appreciate your acknowledgment that the home health prospective payment system (which will be implemented October 1 this year) will resolve most overpayment issues. Under cost reimbursement, cost reports must be filed, audited and settled before a final determination of overpayment or underpayment can be made. Moving to a prospective payment system should eliminate the time delays associated with a cost-reimbursement system and will increase certainty regarding Medicare payments.

Home health care enables seniors and disabled Americans, including the frailest beneficiaries, to receive many services in their homes as covered under Medicare law. We are committed to protecting the benefit for those who qualify for it, while preventing the waste, fraud and abuse that have threatened it in the past. As a result of these efforts, the HHS Inspector General recently found that we had cut Medicare's improper payment rate for home health services in half since 1997.

By introducing a home health prospective payment system, curtailing fraud, waste, and abuse, strengthening financial controls, and modernizing Medicare's accounting systems, we believe we will reduce home health overpayments while protecting the financial integrity of the Medicare program for beneficiaries and taxpayers alike. We appreciate the efforts of the GAO to inform and guide these important efforts.

Attachment

Related GAO Products

Medicare Financial Management: Further Improvements Needed to Establish Adequate Financial Control and Accountability (GAO/AIMD-00-66, Mar. 15, 2000).

Medicare Home Health Agencies: Closures Continue, With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

Medicare Home Health Agencies: Role of Surety Bonds in Increasing Scrutiny and Reducing Overpayments (GAO/HEHS-99-23, Jan. 29, 1999).

Medicare Home Health Benefit: Impact of Interim Payment System and Agency Closures on Access to Services (GAO/HEHS-98-238, Sept. 9, 1998).

Medicare: Interim Payment System for Home Health Agencies (GAO/T-HEHS-98-234, Aug. 6, 1998).

Medicare Home Health Benefit: Congressional and HCFA Actions Begin to Address Chronic Oversight Weaknesses (GAO/T-HEHS-98-117, Mar. 19, 1998).

Medicare: Improper Activities by Med-Delta Home Health (GAO/T-OSI-98-6, Mar. 19, 1998; GAO/OSI-98-5, Mar. 12, 1998).

Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation (GAO/T-HEHS-98-41, Oct. 29, 1997).

Medicare Fraud and Abuse: Summary and Analysis of Reforms in the Health Insurance Portability and Accountability Act of 1996 and the Balanced Budget Act of 1997 (GAO/HEHS-98-18R, Oct. 9, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare: Home Health Cost Growth and Administration's Proposal for Prospective Payment (GAO/T-HEHS-97-92, Mar. 5, 1997).

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

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