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MEDICARE MANAGEMENT

CMS Faces Challenges in Safeguarding Payments While Addressing Provider Needs

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Mr. Chairman and Members of the Committee:

We are pleased to be here today as you discuss the administration of the Medicare program and activities undertaken to safeguard the Medicare trust fund. In fiscal year 2000, Medicare made payments of over $220 billion to hundreds of thousands of providers who delivered services to nearly 40 million beneficiaries. Because of Medicare's vast size and complex structure, in 1990 we designated it as a high-risk program—that is, at risk of considerable losses to waste, fraud, abuse, and mismanagement—and it remains so today. Since that time, we have consistently reported on the efforts of the Health Care Financing Administration (HCFA), recently renamed the Centers for Medicare and Medicaid Services (CMS),[1] to safeguard Medicare payments and streamline operations.

Each year improper payments cost Medicare billions of dollars. Therefore, the process of enforcing program payment rules is critical to the viability of the program. My remarks today will focus on the importance of performing activities to protect the integrity of Medicare, while striking a balance of simplicity and responsiveness to the providers that bill the program. My comments are based on our previous and ongoing work and published reports by others.

In brief, at the heart of effectively administering Medicare is CMS' responsibility for protecting the integrity of the program while, at the same time, ensuring that providers are treated fairly. CMS relies on its claims administration contractors to administer Medicare and interact with all of its stakeholders—including providers. As CMS' contractors and others have become more aggressive in identifying and pursuing inappropriate payments, providers have expressed concern that Medicare has become too complex and difficult to navigate. Although CMS monitors the effectiveness of contractors' program management and safeguard activities, the agency's oversight of its contractors has historically been weak. In the last 2 years, however, the agency has made substantial progress. Our ongoing work has identified several areas in which CMS still needs improvement—especially in ensuring that contractors are providing accurate, complete, and timely information to providers about Medicare billing rules and coverage policies.

[1]Our statement will continue to refer to HCFA where our findings apply to the organizational structure and operations associated with that name.

Background

The complexity of the environment in which CMS and its contractors operate the Medicare program cannot be overstated. CMS is an agency within the Department of Health and Human Services (HHS) but has responsibilities over expenditures that are larger than those of most other federal departments.[2] Under the fee-for-service system—which accounts for over 80 percent of program beneficiaries—physicians, hospitals, and other providers submit claims for services they provide to Medicare beneficiaries to receive reimbursement. The providers billing Medicare, whose interests vary widely, create with program beneficiaries and taxpayers a vast universe of stakeholders.

About 50 Medicare claims administration contractors[3] carry out the day-to-day operations of the program and are responsible not only for paying claims but for providing information and education to providers and beneficiaries that participate in Medicare. They periodically issue bulletins that outline changes in national and local Medicare policy, inform providers of billing system changes, and address frequently asked questions. To enhance communications with providers, the agency recently required contractors to maintain toll-free telephone lines to respond to provider inquiries. It also directed them to develop Internet sites to address, among other things, frequently asked questions. In addition, CMS is responsible for monitoring the claims administration contractors to ensure that they appropriately perform their claims processing duties and protect Medicare from fraud and abuse.

In 1996, the Congress enacted the Health Insurance Portability and Accountability Act (HIPAA), in part to provide better stewardship of the program.[4] This act gave HCFA the authority to contract with specialized entities, known as program safeguard contractors (PSC), to combat fraud, waste, and abuse. HCFA initially selected 12 firms to conduct a variety of program safeguard tasks, such as medical reviews of claims and audits of providers' cost reports. Previously, only claims administration contractors performed these activities.

[2]Medicare ranks second only to Social Security in federal expenditures for a single program.

[3]Contractors that process and pay part A claims (i.e. for inpatient hospital, skilled nursing facility, hospice care, and certain home health services) are known as fiscal intermediaries. Contractors paying and processing part B claims (i.e. for physician, outpatient hospital services, laboratory and other services) are known as carriers.

[4]P.L. 104-191.

Inappropriate Payments Underscore The Importance of Integrity Efforts, Raising Provider Concerns

In response to the escalation of improper Medicare payments, Congress and executive branch agencies have focused attention on efforts to safeguard the Medicare Trust Fund. HIPAA earmarked increased funds for the prevention and detection of health care fraud and abuse and increased sanctions for abusive providers. The HHS Office of Inspector General (OIG) and the Department of Justice (DOJ) subsequently became more aggressive in pursuing abusive providers. In response, the medical community has expressed concern about the complexity of the program and the fairness of certain program safeguard activities, such as detailed reviews of claims, and the process for appealing denied claims. Recent actions address some of these concerns.

Program Integrity Efforts Have Intensified in Response to Improper Payments

Since 1996, the HHS OIG has repeatedly estimated that Medicare contractors inappropriately paid claims worth billions of dollars annually. The depletion of Medicare's hospital trust fund and the projected growth in Medicare's share of the federal budget have focused attention on program safeguards to prevent and detect health care fraud and abuse. It has also reinforced the importance of having CMS and its contractors develop and implement effective strategies to prevent and detect improper payments.

HIPAA provided the opportunity for HCFA to enhance its program integrity efforts by creating the Medicare Integrity Program (MIP). MIP gave the agency a stable source of funding for its safeguard activities. Beginning in 1997, funding for antifraud-and-abuse activities has increased significantly—by 2003, funding for these activities will have grown about 80 percent. In fiscal year 2000, HCFA used its $630 million in MIP funding to support a wide range of efforts, including audits of provider and managed care organizations and targeted medical review of claims. By concentrating attention on specific provider types or benefits where program dollars are most at risk, HCFA has taken a cost-effective approach to identify overpayments. Based on the agency's estimates, MIP saved the Medicare program more than $16 for each dollar spent in fiscal year 2000.

CMS is only one of several entities responsible for ensuring the integrity of the Medicare program. HIPAA also provided additional resources to both the HHS OIG and DOJ. The HHS OIG has emphasized the importance of safeguarding Medicare by auditing providers and issuing compliance guidance for various types of providers. It also pursues potential fraud brought to its attention by contractors and other sources, such as beneficiaries and whistleblowers. DOJ has placed a high priority on

identifying patterns of improper billing by Medicare providers. DOJ investigates cases that have been referred by the HHS OIG and others to determine if health care providers have engaged in fraudulent activity, and it pursues civil actions or criminal prosecutions, as appropriate.[5] The False Claims Act (31 U.S.C. sec. 3729 to 3733) gives DOJ a powerful enforcement tool as it provides for substantial damages and penalties against providers who knowingly submit false or fraudulent bills to Medicare, Medicaid, or other federal health programs. DOJ has instituted a series of investigations known as national initiatives, which involve examinations of similarly situated providers who may have engaged in common patterns of improper Medicare billing.

Provider Concerns Grow With the Expansion of Safeguard and Enforcement Activities

As safeguard and enforcement actions have increased, so have provider concerns about their interaction with contractors. Individual physicians and representatives of medical associations have made a number of serious charges regarding the following.

- **Inadequate communications from CMS' contractors**. Providers assert that the information they receive is poorly organized, difficult to understand, and not always communicated promptly. As a result, providers are concerned that they may inadvertently violate Medicare billing rules.
- **Inappropriate targeting of claims for review and excessive paperwork demands of the medical review process**.[6] For example, some physicians have complained that the documentation required by some contractors goes beyond what is outlined in agency guidance or what is needed to demonstrate medical necessity.
- **Unfair method used to calculate Medicare overpayments**. Providers expressed concern that repayment amounts calculated through the use of samples that are not statistically representative do not accurately represent actual overpayments.
- **Overzealous enforcement activities by other federal agencies**. For example, providers have charged that DOJ has been overly aggressive in its use of the False Claims Act and has been too accommodating to the

[5]In fiscal year 2000, DOJ filed 233 civil cases and reported recoveries of over $840 million related to civil health care fraud.

[6]Contractors conduct medical reviews—either prior to or after payment—to identify claims that should not be or should not have been paid because services are not covered or are not medically necessary.

OIG's insistence on including corporate integrity agreements in provider settlements.[7]

- **Lengthy process to appeal denied claim**. Related to this issue is that a provider who successfully appeals a claim that was initially denied does not earn interest for the period during which the administrative appeal was pending.

We have studies underway to examine the regulatory environment in which Medicare providers operate. At the request of the House Committee on the Budget and the House Ways and Means Subcommittee on Health, we are reviewing CMS' communications with providers and have confirmed some provider concerns. For example, our review of several information sources, such as bulletins, telephone call centers, and Internet sites, found a disappointing performance record. Specifically, we reviewed recently issued contractor bulletins—newsletters from carriers to physicians outlining changes in national and local Medicare policy—from 10 carriers. Some of these bulletins contained lengthy discussions with overly technical and legalistic language that providers may find difficult to understand. These bulletins also omitted some important information about mandatory billing procedures. Similarly, we found that the calls we placed to telephone call centers this spring were rarely answered appropriately. For example, for 85 percent of our calls, the answers that call center representatives provided were either incomplete or inaccurate. Finally, we recently reviewed 10 Internet sites, which CMS requires carriers to maintain. We found that these sites rarely met all CMS requirements and often lacked user-friendly features such as site maps and search functions. We are continuing our work and formulating recommendations that should help CMS and its contractors improve their communications with providers.

We are also in the preliminary stages of examining how claims are reviewed and how overpayments are detected to assess the actions of contractors as they perform their program safeguard activities. Although we have not yet formulated our conclusions, agency actions may address some provider concerns. For example, HCFA clarified the conditions under which contractors should conduct medical reviews of providers. In August 2000, the agency issued guidance to contractors regarding the

[7]A corporate integrity agreement is an obligation imposed on a provider by the HHS OIG as part of a settlement of a potential fraud matter. It requires the provider to improve compliance and to report periodically to the OIG.

selection of providers for medical reviews, noting, among other things, that a provider's claims should only be reviewed when data suggest a pattern of billing problems. Although providers may be wary of the prospect of medical reviews, the extent to which they are subjected to such reviews is largely unknown. Last year, HCFA conducted a one-time limited survey of contractors to determine the number of physicians subject to complex medical reviews in fiscal year 2000. It found that only 1,891, or 0.3 percent, of all physicians who billed the Medicare program that year were selected for complex medical reviews—examinations by clinically trained staff of medical records.[8]

In regard to physician complaints about sampling methodologies, HCFA outlined procedures to give providers several options to determine overpayment amounts. Contractors would initially review a small sample (probe sample) of a provider's claims and determine the amount of the overpayment.[9] A provider could then (1) enter into a consent settlement, whereby the provider accepts the results of this probe review and agrees to an extrapolated "potential" overpayment amount based on the small sample, (2) accept the settlement but submit additional documentation on specific claims in the probe sample to potentially adjust downward the amount of the projected overpayment, or (3) require the contractor to review a larger statistically valid random sample of claims to extrapolate the overpayment amount. According to agency officials, although providers can select any of these options, consent settlements are usually chosen when offered because they are less burdensome for providers, as fewer claims have to be documented and reviewed.

In response to concerns regarding its use of the False Claims Act, DOJ issued guidance in June 1998 to all of its attorneys that emphasized the fair and responsible use of the act in civil health care matters, including national initiatives. In 1999, we reviewed DOJ's compliance with its False Claims Act guidance and found that implementation of this guidance varied among U.S. Attorneys' Offices.[10] However, the next year we

[8] *Regulatory Issues for Medicare Providers* (GAO-01-802R, June 11, 2001).

[9] To identify improper billing by a provider, CMS requires contractors to conduct a "probe" review of roughly 20 to 40 claims. If the probe sample indicates improper billing, the contractors determine the provider's overpayment amount by either selecting a statistically valid random sample of claims or basing the amount on a small sample that is not statistically representative.

[10] *Medicare Fraud and Abuse: DOJ's Implementation of False Claims Act Guidance in National Initiatives Varies* (GAO/HEHS-99-170, August 6, 1999).

reported that DOJ had made progress in incorporating the guidance into its ongoing investigations and had also developed a meaningful assessment of compliance in its periodic evaluations of U.S. Attorneys' Offices.[11] Regarding corporate integrity agreements, we noted in our March 2001 report that these agreements were not always a standard feature of DOJ settlements.[12] For example, 4 of 11 recent settlements that we reviewed were resolved without the imposition of such agreements.

Finally, some providers' concerns about the timeliness of the appeals process could be addressed by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), which imposes deadlines at each step of the appeals process. For example, initial determination of a claim must be concluded within 45 days from the date of the claim, and redetermination must be completed within 30 days of receipt of the request. These revisions are scheduled to take effect on October 1, 2002.

CMS' Oversight of Contractors Is Key to Balancing Program Safeguards and Provider Concerns

CMS' oversight of its contractors is essential to ensuring that the Medicare program is administered efficiently and effectively. CMS is faced with the challenge of protecting program dollars and treating providers fairly. However, to accomplish these goals, contractors must implement CMS' policies fully and consistently. Historically, the agency's oversight of contractors has been weak, although it has made substantial improvements in the past 2 years. Continued vigilance in this area is critical as CMS tries to cope with known weaknesses and begins to rely on new specialty contractors for some of its payment safeguard activities.

Various Factors Have Contributed to Weak Contractor Oversight

Medicare's claims administration contractors are responsible for all aspects of claims administration, conduct particular safeguard activities, and are the primary source of Medicare communications to providers. However, oversight of Medicare contractors has historically been weak, leaving the agency without assurance that contractors are implementing program safeguards or paying providers appropriately. For years, HCFA's contractor performance and evaluation program (CPE)—its principal tool

[11] *Medicare Fraud and Abuse: DOJ Has Made Progress in Implementing False Claims Act Guidance* (GAO/HEHS-00-73, March 31, 2000).

[12] *Medicare Fraud and Abuse: DOJ Has Improved Oversight of False Claims Act Guidance* (GAO-01-506, March 30, 2001).

used to evaluate contractor performance—lacked the consistency that agency reviewers need to make comparable assessments of contractor performance. HCFA reviewers had few measurable performance standards and little direction on monitoring contractors' payment safeguard activities. The reviewers in HCFA's 10 regional offices, who were responsible for conducting these evaluations, had broad discretion to decide what and how much to review as well as what disciplinary actions to take against contractors with performance problems.

This highly discretionary evaluation process allowed key program safeguards to go unchecked and led to the inconsistent treatment of contractors with similar performance problems. Dispersed responsibility for contractor activities across many central office components, limited information about how many resources are used or needed for contractor oversight, and late and outdated guidance provided to regional offices have also weakened contractor oversight.[13]

Over the years, we have made several recommendations to improve HCFA's oversight of its claims administration contractors. For example, we recommended that the agency strengthen accountability for evaluating contractor performance. In response to our recommendations, HCFA has established an executive-level position at its central office with ultimate responsibility for contractor oversight, instituted national review teams to conduct contractor evaluations, and provided more direction to its regional offices through standardized review protocols and detailed instructions for CPE reviews.

Although the agency has taken a number of steps to improve its oversight efforts, our ongoing work suggests that opportunities for additional improvement exist. Last month, we joined CMS representatives as they conducted a CPE review at a contractor's telephone center. Although providers' ability to appropriately bill Medicare is dependent on their obtaining accurate and complete answers to their questions, the review focused primarily on adherence to call center procedures and the timeliness of responses to provider questions. Moreover, the CMS

[13]The weak oversight of contractors helped create an environment in which a number of HCFA contractors committed fraud. The fraud was not detected through the agency's oversight efforts but instead was reported by whistleblowers and resulted in settlements for millions of dollars. HCFA failed to uncover the contractors' fraudulent practices, in part, because it relied on contractor self-reporting of management controls and seldom independently validated contractor-provided information.

reviewer selected a small number of cases to evaluate—only 4 of the roughly 140,000 provider calls this center receives each year.

While CMS' management of claims administration contractors suffers from weak oversight, its contracting practices for selecting fiscal intermediaries and carriers may contribute to these difficulties. Unlike most of the federal government, the agency was exempted from conducting full and open competitions by the Social Security Act. Thus, for decades, HCFA has relied on many of the same contractors to perform program management activities, and has been at a considerable disadvantage in attracting new entities to perform these functions.

New Contracting Authority Provides Opportunity for Improving Safeguard Performance

Congress included provisions in HIPAA that provided HCFA with more flexibility in contracting for program safeguard activities. It allowed the agency to contract with any entity that was capable of performing certain antifraud activities. In May 1999, HCFA implemented its new contracting authority by selecting 12 program safeguard contractors—PSCs—using a competitive bidding process.[14] These entities represent a mix of health insurance companies, information technology businesses, and several other types of firms.

In May of this year, we reported on the opportunities and challenges that the agency faces as it integrates its PSCs into its overall program safeguard strategy.[15] The PSCs represent a new means of promoting program integrity and enable CMS to test a multitude of options. CMS is currently experimenting with these options to identify how PSCs can be most effectively utilized. For example, some PSCs are performing narrowly focused tasks that are related to a specific service considered to be particularly vulnerable to fraud and abuse. Others are conducting more broadly based work that may have national implications for the way program safeguard activities are conducted in the future or which may result in the identification of best practices.

[14]Almost all of the PSCs have had experience as Medicare contractors: as of May 2001, six were Medicare claims administration contractors and an additional five had other types of contracts with CMS. Two of the six PSCs with claims administration contracts have established new entities to perform PSC work.

[15]*Medicare: Opportunities and Challenges in Contracting for Program Safeguards* (GAO-01-616, May 18, 2001).

In our report, we recommended that the agency define the strategic directions for future use of the PSCs, including the establishment of long-term goals and objectives. We also recommended that clear, quantifiable performance measures and standards be established and related to well defined outcomes in order to lay the groundwork for meaningful future performance evaluations. We recognize that it will take some time for the agency to develop appropriate performance criteria, but believe it is important to start experimenting with different approaches, such as using performance-based contracts, and refine them as time goes on. This need for better performance measures, standards, and outcomes will become especially critical if CMS awards contracts that are performance-based and contain financial incentives and penalties.

Concluding Observations

Medicare is a popular program that millions of Americans depend on for covering their essential health needs. However, the management of the program has fallen short of expectations because it has not always appropriately balanced or satisfied beneficiaries', providers', and taxpayers' needs. Although the agency has taken some positive steps, weaknesses in its communications with providers and its oversight of contractors still exist. CMS' ability to successfully address these and other shortcomings will ultimately enhance its program safeguard activities and improve Medicare program operations.

This concludes my statement. I would be happy to answer any questions that you may have.

GAO Contact And Staff Acknowledgments

For further information regarding this testimony, please contact me at (312) 220-7767. Susan Anthony and Geraldine Redican-Bigott also made key contributions to this statement.

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