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MEDICARE

HCFA Could Do More to Identify and Collect Overpayments

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Contents

Abbreviations

DCIA	Debt Collection Improvement Act of 1996
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HHA	home health agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
IRS	Internal Revenue Service
MIP	Medicare Integrity Program
MSP	Medicare secondary payer
OIG	HHS Office of Inspector General
PRO	peer review organization
PSC	program safeguard contractor
SSA	Social Security Administration

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United States General Accounting Office
Washington, D.C. 20548

Health, Education,
and Human Services Division

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September 7, 2000

The Honorable Dan Burton
Chairman
House Committee on Government Reform
House of Representatives

Dear Mr. Chairman:

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is the nation's largest health insurer. It administers the Medicare program, which paid approximately $200 billion in total benefits and covered nearly 40 million beneficiaries in fiscal year 1999. The vast majority of beneficiaries—about 85 percent—chose to receive their benefits under the traditional fee-for-service program.[1] Although most participating providers comply with Medicare billing rules, the inadvertent errors or intentional misrepresentations that do occur result in overpayments—money owed back to Medicare. In its fiscal year 1999 financial statements, HCFA's overpayments that had not yet been recovered—classified as accounts receivable for accounting purposes—totaled $7.3 billion at the end of the fiscal year.

Recovery auditing is a service conducted by private firms to identify and sometimes collect overpayments for clients such as health insurance companies. In the second session of the 106th Congress, the House of Representatives passed H.R. 1827, the Government Waste Corrections Act of 2000, which you sponsored, requiring use of recovery auditing for federal programs that directly purchase goods and services. Because Medicare's fee-for-service program pays claims to providers and suppliers for goods and services provided to beneficiaries, Medicare is excluded from the bill. Because of your concerns regarding Medicare overpayments, you asked us to answer the following questions: (1) How do HCFA and its contractors identify potential overpayments, and would techniques used by recovery auditors improve overpayment identification? (2) How well do HCFA and its contractors collect overpayments once they are identified, and would the services of recovery auditors improve HCFA's collection efforts?

[1]Most beneficiaries have the option to enroll in managed care—Medicare+Choice—or Medicare's traditional fee-for-service program.

(3) What challenges would HCFA face if it were required to hire recovery auditors to augment its overpayment identification and collection activities?

To address these questions, we reviewed HCFA policies and procedures, and examined its current and planned efforts to identify and collect overpayments. We also met with representatives from four HCFA contractors that process and pay claims and take steps to minimize overpayment losses. We discussed with these contractors how they identified and collected Medicare overpayments. We also obtained and analyzed financial reports from HCFA and the four contractors and examined HCFA's implementation of the Debt Collection Improvement Act of 1996 (DCIA). We also met with representatives of several recovery audit firms and several of their clients to determine if the techniques they use might be applicable to Medicare.

Finally, to determine the implementation challenges HCFA might face if it were to use the services of recovery auditors, we interviewed HCFA officials and contractor, recovery auditor, and medical association representatives. We also reviewed the HHS Office of Inspector General's (OIG) and our prior work. We performed our work from September 1999 to July 2000 in accordance with generally accepted government auditing standards.

Results in Brief

Despite HCFA's efforts to pay claims correctly in its $167 billion fee-for-service Medicare program, several billions of dollars in Medicare overpayments occur each year. It is therefore critical that HCFA undertake effective postpayment activities to identify overpayments expeditiously. HCFA's claims administration contractors use several postpayment techniques to identify overpayments. These include medical review to ensure appropriateness of services, reviews of interim payments and audits of cost reports for providers that are paid on the basis of their costs, and reviews to determine if another entity besides Medicare has primary payment responsibility. The contractors identify and collect billions of dollars through these activities, but how well each contractor performs them is not clear because HCFA currently lacks the information it needs to measure the effectiveness of contractors' overpayment identification activities. While recovery auditors may also save money for clients, such as state Medicaid agencies, by identifying overpayments, the identification techniques they use are generally similar to those already used by HCFA and its contractors. This does not mean that HCFA could not benefit from a

stronger focus on specific postpayment activities. However, doing so may require additional program safeguard funding so as not to shift funds away from HCFA's other efforts, such as prepayment review to prevent overpayments. The Congress has given HCFA assured funding for program safeguard activities; however, the funding level is about one-third less (on a per-claim basis) than it was in 1989 and, although it will increase until 2003, it will only keep pace with expected growth in Medicare expenditures. For fiscal year 1999, based on HCFA estimates, the Medicare Integrity Program saved the Medicare program more than $17 for each dollar spent—about 55 percent from prepayment activities and the rest from postpayment activities. Because these activities can bring a positive return, GAO suggests that the Congress consider increasing HCFA's funding to bolster its postpayment review program.

Overpayment collections, made principally by the claims administration contractors, totaled $8.7 billion during fiscal year 1999, or about 70 percent of the $12.6 billion in overpayments identified during the year. Different factors affect contractors' ability to collect overpayments, including the type of overpayment, the promptness with which it is identified, and the financial condition of the overpaid provider. Contractors transfer overpayments they are unable to collect to HCFA, but HCFA's success in collecting them is limited. HCFA could increase collections if it fully implemented DCIA, which generally requires that debts delinquent over 180 days be transferred to the Department of the Treasury and, in certain cases, a Treasury-designated debt collection center. Treasury and the Treasury-designated debt collection center at HHS conduct varied collection activities, which include contracting with private companies to collect debt, such as certain Medicare overpayments. Treasury's standards require the use of techniques similar to those used by recovery auditors. HCFA has two pilot projects under way to transfer some delinquent overpayments to Treasury's designated debt collection center, but the projects are limited to large-value, aged overpayments, rather than all eligible delinquent debt. HCFA plans to expand its pilot projects from some to all of its claims administration contractors. However, it has established minimum thresholds for referrals for collection that are higher than the Treasury and debt collection center will accept because HCFA says that it does not have the resources needed to pursue collection on the large volume of debt below its thresholds. To promote improved collections, GAO recommends that HCFA fully implement DCIA by immediately referring overpayments as they become over 180 days delinquent to the designated debt collection center to be collected or, where appropriate, to

be referred to Treasury for collection, while continuing efforts to clear its backlog of aged receivables.

HCFA and its contractors are using techniques similar to recovery auditing for identification and collection of overpayments. In addition, HCFA has already recognized that the use of specialized contractors to improve overpayment identification may be beneficial and is currently contracting with such companies. Under authority provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996, HCFA has contracted with 12 firms to assist in its program safeguard efforts. Implementation is progressing as HCFA resolves complex challenges regarding how to compensate the firms, deal with the administrative burdens these firms place on the claims administration contractors, handle coordination and privacy issues, and determine how to oversee the firms' activities—virtually the same challenges HCFA would need to address if it hired recovery auditors. If a particular recovery auditing firm offered postpayment expertise that met HCFA's needs, HCFA could contract with it and gain its expertise within the agency's existing program safeguard contracting structure.

Background

The Medicare program utilizes a variety of payment methods to reimburse providers for the services it covers. Hospital insurance, or Part A, covers inpatient hospital, skilled nursing facility, and hospice care, and certain home health services. Supplemental medical insurance, or Part B, covers physician and outpatient hospital services, diagnostic tests, and other medical services and supplies. Depending on the service, HCFA pays Part A providers based on their costs, or on a prospective payment basis designed to cover the cost of providing a bundle of services related to a particular medical condition. In contrast, Part B providers are typically paid for each individual service, based on a fee schedule. To ensure that only services the statute specifies are covered, Medicare has extensive policies and rules about what constitutes covered services. It is not surprising, therefore, that providers are sometimes overpaid for their services.

Contractors Pay Claims and Identify and Collect Overpayments

Medicare claims are paid by a network of private health insurance companies hired by HCFA, such as Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA. Contractors that process Part A claims are referred to as fiscal intermediaries, while those that process Part B claims are called carriers. In fiscal year 1999, fiscal intermediaries processed about 133 million claims representing $124 billion in payments, while

carriers processed about 721 million claims and paid benefits of about $43 billion. Fiscal intermediaries and carriers also perform activities related to safeguarding Medicare payments. These include using prepayment computer edits to prevent potential overpayments, conducting postpayment medical reviews, determining whether other insurers should pay before Medicare, and auditing reports of providers' costs to determine if any costs are overstated or not allowed by Medicare. HCFA uses specialized contractors to supplement these program safeguard efforts.

Claims administration contractors have principal responsibility for claims processing and administration. Specifically, they contract with HCFA to (1) receive claims; (2) judge their appropriateness; (3) pay appropriate claims promptly; (4) identify potentially incorrect or fraudulent claims or fraudulent providers, and withhold payment if justified; and (5) identify and recover overpayments. The contractors are expected to manage Medicare's funds in a fiscally responsible way, effectively address provider and beneficiary inquiries, and establish a process for handling provider and beneficiary appeals of claims decisions.

Until the HIPAA of 1996 established the Medicare Integrity Program (MIP), only claims administration contractors performed program safeguard activities. Under HIPAA, HCFA has the authority to enter into contracts with a variety of firms—not just insurance companies—to perform certain safeguard-related functions or undertake specific program initiatives to promote Medicare's integrity. For example, one such initiative is aimed at the early detection of fraudulent and abusive billing in three Midwestern states. Under MIP, HCFA has contracted with 12 firms known as program safeguard contractors (PSCs) that compete among themselves to perform program safeguard work detailed in individual task orders. These MIP contractors can subcontract with other companies that may have special expertise to help them perform particular task orders. As of June 2000, HCFA had issued a total of 10 task orders—each for a defined set of program safeguard services provided over a specified time period.

In addition to providing HCFA with new contracting authority, HIPAA provided HCFA with predictable increases in program safeguard funding. Before HIPAA, contractor program safeguard activities were funded from contractors' general program management budgets, which also covered contractors' costs for processing claims. This meant that program safeguard activities had to compete for funding with other contractor activities that might have higher priority. For example, funding system improvements to ensure that claims were paid promptly might require a

shift in funding allocations, as would emergencies or new HCFA initiatives. By contrast, HIPAA provides HCFA with assured funding levels for program safeguard activities. Program safeguard expenditures totaled $438 million in fiscal year 1997—the first year of MIP—and HIPAA provides for increased funding in each subsequent year through fiscal year 2003, when the program safeguard appropriation is expected to total $720 million.

Overpayments Occur for Various Reasons

Most of HCFA's accounts receivable are the result of overpayments that have yet to be recovered from providers. Overpayments to providers result from a variety of inadvertent errors or intentional misrepresentations. The following are the four main categories of Medicare overpayments:[2]

- Coverage, medical necessity, or documentation issues—Medicare should pay claims only for services that are medically necessary, meet Medicare coverage requirements, and are properly documented to indicate that the service took place as reflected in the claim. Claims can appear to be correct even though they do not meet these conditions. For example, a home health agency may receive reimbursement for services on behalf of a beneficiary who did not meet the program requirements of being homebound.
- Provider billing errors—Providers make manual or automated billing errors, either of which can lead to overpayments. For example, if a physician's billing clerk enters the wrong procedure code on a claim, the physician may receive a larger reimbursement for a more comprehensive office visit than the visit that actually occurred.
- Cost reporting errors—For services paid on the basis of provider costs, providers receive interim payments based on their projected allowable costs. If costs are later disallowed, providers will have to return these overpayments.

[2]In addition, claims administration contractors can make errors that lead to overpayments. For example, one contractor we visited said that a recent system processing error caused Medicare to pay claims that should have been paid by another federal program.

- Medicare secondary payer (MSP) debt—These debts occur when Medicare pays for a service that subsequently is determined to be the responsibility of another payer.[3] These include certain cases in which beneficiaries (1) have other health insurance coverage provided by their employer or their spouse's employer (2) have occupational injuries or illnesses that would be covered by workers' compensation (3) have injuries which are covered by liability insurance or a settlement arising from an accident; or (4) are receiving care for end-stage renal disease during the first 30 months of their treatment and have other health insurance coverage.

Recovery Audit Firms Also Perform Program Safeguard Activities

Recovery auditing has been used in various industries, including health care, to identify and collect overpayments for about the last 30 years. Recovery audit firms that specialize in health issues contract with private insurance companies, state Medicaid agencies, managed care plans, and employee group health plans. In some cases, clients rely exclusively on recovery audit firms to identify and collect overpayments. In other cases, they supplement their own internal capabilities with the services of recovery audit firms. These firms generally focus on overpayment identification but will also collect identified overpayments. Typically, they are paid a contingency fee based on a percentage of the overpayments that they or their clients collect. Fees vary depending on such factors as the type of overpayment involved and the degree of difficulty associated with identifying and collecting it.

Recovery audit firms employ a variety of techniques to identify overpayments. For example, one firm may use proprietary software to analyze a large database of claims to identify potential overpayments while another may have specially trained staff review medical records for potentially inappropriately billed services. Recovery audit firms may also collect overpayments through such means as issuing demand letters to providers or negotiating an amount to be returned to the client.

[3]MSP debt differs from other types of Medicare program overpayments because the validity of the service itself is not in dispute; the question concerns which payer is responsible for primary coverage. In some cases, contractors may not be aware of the existence of a primary payer. In other cases, contractors make conditional payments when there are indications that another payer has not paid promptly but may ultimately be liable. Later, contractors determine whether other insurance should have paid the claim and, if so, they attempt to recover the Medicare payment.

Expanded Postpayment Activities Could Benefit Overpayment Identification

In the last several years, HCFA has increased its emphasis on prepayment activities that help contractors avoid payment errors. Correct payment involves several prepayment processing steps to determine whether the claim is for covered, medically necessary and reasonable services; is provided to an eligible beneficiary; and contains a valid provider number. All claims go through a variety of computerized prepayment edits designed to ensure they are correct on their face—for example, to ensure that they are not duplicate payments. In addition, many claims go through prepayment medical reviews that are either automated or performed by contractor staff. However, the tremendous volume of Medicare claims processed by each contractor makes it impractical to manually review more than a small fraction of claims prior to payment. For example, in fiscal year 1998, only about 1 in 8 claims were medically reviewed prior to payment and only about 1 in 16 underwent any type of manual prepayment review. As a result, adequate postpayment review is critical to ensuring that overpayments are identified in a timely way.

Identification of Potential Overpayments

In conducting postpayment reviews to identify potential overpayments, contractors primarily focus on three program safeguard activities—postpayment medical review, reviews and audits of cost-based reimbursement payments, and MSP reviews. These activities are described below:

Postpayment medical review. Overpayments due to claims that are medically unnecessary, insufficiently documented, or for noncovered services and that were not identified through prepayment edits must generally be discovered through contractor postpayment medical review. By reviewing paid claims data, contractors identify patterns that could indicate potential abuse. For example, contractor staff may review billing patterns for certain procedure codes and find unusual increases in utilization over time or significant utilization differences among providers. Once a potential problem is identified, contractors typically sample a provider's claims and request documentation from the provider for selected claims to determine if they were paid properly or if overpayments occurred.

Peer review organizations (PROs) are independent physician organizations located in each state that work under contract to HCFA. They conduct postpayment medical review for Medicare claims involving inpatient services.[4] PROs are primarily responsible for ensuring that care provided Medicare beneficiaries is medically necessary, reasonable, is provided in an appropriate setting, and meets professionally accepted standards of quality. If, in the course of their reviews, the PROs discover overpayments, they are supposed to refer the cases to the appropriate fiscal intermediary for payment adjustment.

Interim rate reviews and cost report audits. These activities are performed by fiscal intermediaries to determine whether the payments made to providers paid on the basis of their costs accurately reflect their allowable costs. Interim rate reviews allow contractors to adjust payment rates during the fiscal year after comparing a provider's interim payment rates with its previous cost information, its Medicare payments, and its audit history. These reviews may result in revisions to providers' interim payment rates for the remainder of the year if it is found that the provider was being overpaid or underpaid. Once a provider files its year-end cost report, it is reviewed and may be audited to determine whether there are overpayments or underpayments relating to the costs claimed by the provider.[5]

MSP reviews. HCFA officials estimate that about 8 percent of beneficiaries have medical claims that are potentially the responsibility of another health insurer, liability insurer, or workers' compensation program. MSP reviews seek to identify such primary sources of payment and recoup any primary payments made by the Medicare program. HCFA and its contractors use a variety of techniques to find MSP cases. Contractors send a questionnaire to each new beneficiary 3 months prior to their entitlement to Medicare benefits to determine if the beneficiary or spouse is employed and has group health insurance coverage. Medicare beneficiary information is also matched periodically with Social Security Administration (SSA) and Internal Revenue Service (IRS) data on employment status and earnings. If beneficiaries are identified as employed

[4]By law, the PROs are allowed to conduct postpayment medical review of inpatient hospital claims, including validating the appropriateness of the codes charged for services provided.

[5]In the future, Medicare should have fewer of these overpayments since prospective payment systems are being implemented for home health, hospital outpatient, and rehabilitation hospital services.

and earning less than $10,000 per year, contractors may elect not to send questionnaires to employers asking about the beneficiary's employment and health insurance coverage. In addition, some private insurance companies have agreed (voluntarily or as part of a legal settlement with HCFA) to share information on their policyholders. Finally, if a claim is submitted with certain diagnosis codes indicating traumatic or work-related injury, contractors automatically send the beneficiary a letter requesting information about a potential lawsuit, automobile liability insurance, or workers' compensation coverage. In a recent report, the HHS OIG took steps to identify beneficiaries who had other primary sources of coverage and concluded that HCFA's current MSP questionnaire and data match activities successfully identified most of the beneficiaries with other coverage that the OIG was able to identify. However, it estimated that $56 million had been paid out improperly in 1997 to certain beneficiaries who had other insurance that had not been identified by HCFA's questionnaire and data match activities.[6]

HCFA has contracted with a coordination-of-benefits contractor under MIP to consolidate and improve many of the MSP functions currently performed by the claims administration contractors. In addition, several claims administration contractors have taken lead roles in identifying potential MSP recoveries from nationwide class action lawsuits, such as the product liability case involving breast implants.

Providers themselves are a major source of information on overpayments. Most providers make an honest effort to bill Medicare correctly, but when errors are discovered through their own internal reviews, our work showed that many providers notify their contractor. Often they send payment along with a corrected claim, so the contractor learns of the overpayment at the same time it is recovered.

HCFA Lacks Information to Measure Effectiveness of Overpayment Identification Activities

HCFA currently has limited information available to measure how effective the contractors are in identifying Medicare overpayments. The HHS OIG's annual estimate of improper payments within the Medicare fee-for-service program provides some indication of national error rates, but is not designed to measure individual contractor performance.

[6]DHHS-OIG, *Unidentified Primary Health Insurance: Medicare Secondary Payer Auxiliary File*, OEI-07-98-00180 (June 2000). The OIG's study included about half of Medicare's beneficiaries.

The HHS OIG's analysis of a sample of Medicare claims for fiscal year 1999 estimates that improper payments totaled about $13.5 billion, or about 8 percent of all Medicare fee-for-service payments.[7] The main reasons for improper payments were insufficient documentation to support a claim and lack of medical necessity for a service or procedure. While the HHS OIG estimates improper payments at the national level, the sample size does not allow HCFA to draw conclusions on contractor-specific performance. The OIG's analysis also does not take into account that an overpayment may have been identified and recovered by the contractor during its postpayment review activities.

HCFA is developing the Comprehensive Error Rate Testing program to better evaluate individual contractor performance. When this program is implemented, an independent firm will periodically review a random sample of claims to determine if the contractors' payment decisions were appropriate. HCFA officials expect that this program will enable the agency to develop error rates specific to each contractor and for different types of benefits and providers. While the program will provide HCFA with additional data on contractor overpayment error rates, it is being designed as a management tool to identify problem areas. It will not identify specific claims beyond claims in the sample that were paid in error during the covered time period. The program will be implemented this fiscal year, beginning with the contractors that process and pay claims for durable medical equipment and supplies, and will include all claims administration contractors by the end of fiscal year 2002. It is too early to determine how the information generated by this program will be used to improve contractor effectiveness by restructuring overpayment identification methods.

Overpayment Identification Efforts Used by Recovery Auditors Mirror HCFA's Current Efforts

We found that the techniques used by recovery auditors were similar to those already employed by HCFA's contractors in their postpayment review, MSP, and other program safeguard activities. While the techniques are similar, the specific application—such as what factors trigger a more extensive review—affect how well overpayments are identified. The recovery auditing techniques most applicable to the Medicare program—data mining, diagnosis-related group (DRG) validation, cost report audits, and third-party liability reviews—are part of current

[7]HHS-OIG, *Improper Fiscal Year 1999 Medicare Fee-for-Service Payments*, A-17-99-01999 (Feb. 2000).

postpayment review activities. HCFA's decision to concentrate its program safeguard resources on prepayment, rather than postpayment, activities in recent years is justified given the cost-effectiveness of error prevention. However, the result is that postpayment review activities have been reduced for some types of claims: only about 565,000 claims were subject to postpayment medical review in fiscal year 1998, compared to approximately 960,000 claims in fiscal year 1995—a drop of over 40 percent. HCFA may be missing opportunities to identify significant overpayments through postpayment activities. However, any increase in these efforts would likely require additional program safeguard funding to ensure that prepayment reviews are not decreased.

Investment in evaluation of the most cost-effective postpayment review activities for identifying overpayments would be worthwhile. HCFA has limited ability to do this kind of evaluation now because it cannot measure the effectiveness of each contractor's program safeguard activities by type of activity.

Data Mining Programs Identify Aberrant Billing Patterns

The large number of computerized claims processed by Medicare lends itself to the application of data mining techniques. Data mining involves specialized software programs that analyze large volumes of claims data to identify potential overpayments. The programs typically contain specific algorithms used to identify billing errors and abusive practices, and are based on the insurer's policies, procedures, and contractual arrangements, as well as common sense. HCFA's claims administration contractors currently use data mining and statistical analysis as part of their postpayment review activities. Since 1993, HCFA also has contracted with a specialized statistical analysis contractor to perform large-scale analysis of durable medical equipment claims. Data mining can identify many potentially inappropriate payments, but determining which ones are actual overpayments takes additional investigation. Currently, the contractors only have the resources to investigate situations in which the data indicate potential large-scale abusive practices.

Several of HCFA's program safeguard contractors also specialize in data mining and the manipulation of large data sets. For example, one program safeguard contractor is preparing algorithms and analyzing national data to identify potential fraud that occurred during the critical months leading to the year 2000. Another program safeguard contractor is conducting data mining activities to support development of medical policies and the early detection of fraudulent and abusive billing in three Midwestern states.

Recovery auditors also use data mining to identify overpayments for their clients. For example, in 1999 a recovery auditor under contract with a state Medicaid program subjected 3 years of paid claims to its data mining edits and identified $52 million in overpayments. These overpayments were approved for collection by an independent state review board. Another recovery auditor found, through its data mining efforts, that a state Medicaid agency was paying 10 times that amount allowed for an asthma inhaler because providers were billing based on the drug's unit dosage—which represents part of a gram—rather than by the gram.

DRG Validation Currently Receives Low Priority

Medicare's payments for hospital inpatient services are determined on the basis of the beneficiary's diagnosis. These diagnoses are grouped for payment, with each DRG designed to reflect the bundle of services and supplies required to treat different medical conditions. Overpayments can result if a DRG reflects a more serious—and expensive—condition than the beneficiary actually had. Some recovery auditors validate DRGs for their clients, such as private insurers who have adopted Medicare's DRG coding system for inpatient claims. According to the representatives of one PRO, while DRG validation was an area of emphasis for PROs in the 1980s and early 1990s, this activity was not a high priority in recent years for the PROs. The PROs, rather than the claims administration contractors, review hospital inpatient DRG-based claims.

DRG validation involves verification that a provider classified a patient within the DRG code that accurately reflects the patient's condition as described in the discharge information. According to recovery auditors, bills are sometimes miscoded because providers base their codes on the patient's medical complaints, rather than on the physician's diagnosis. DRG validation should be based on a patient's principal diagnosis and procedure code information contained in the medical record. The validation is done by staff who have been trained in applying medical coding terminology to medical records information; clinical judgment is not necessarily required. HCFA's Payment Error Prevention Program, which all PROs must undertake, recently has increased the priority they must give to reviewing hospital claims for billing accuracy as well as quality of care.[8] However, two contractors we visited reported that they rarely, if ever, receive reports from the PROs on overpayments that the PROs have identified.

[8]Under this program, which began in fiscal year 2000, the PROs must address two common inpatient problems—unnecessary admissions and miscoded claims—and work with the hospitals to improve their billing accuracy.

Increased Review of Provider Cost Information Could Benefit Medicare

Review of provider cost report financial information is a cost-effective way to identify overpayments. In 1999, cost report reviews and audits of providers not covered by a prospective payment system resulted in disallowing $2.7 billion, or about 10 percent of the total costs claimed by providers. However, as prospective payment systems replace cost-based reimbursement, fewer overpayments of this type will occur.[9] We found that the two intermediaries we visited use cost report audits and rate reviews as the primary means of identifying overpayments for Part A providers. One contractor representative estimated a return of $13 saved for every dollar spent conducting the audits. Although the number of cost reports audited between 1995 and 1998 has increased, a large percentage of cost reports are still never audited by HCFA's contractors. For example, in fiscal year 2000, HCFA expects contractors to audit only about 12 percent of the cost reports submitted by home health agencies and 25 percent of those submitted by single-facility hospitals. It can take up to 2 years after the end of the provider's fiscal year to reach a final settlement on the provider's costs that are allowable by Medicare. So, even though HCFA is changing its payment methods, cost report audits and rate reviews will continue to be important program safeguards for several years. HCFA's financial auditors estimated that if all cost reports submitted by providers not under prospective payment had been fully audited, HCFA might have been able to identify an additional $600 million in fiscal year 1999 overpayments.

It is not necessary to perform a complete audit to identify overpayments. For example, contractors can conduct focused reviews that examine only certain aspects of the cost report. HCFA has encouraged intermediaries to concentrate on these focused reviews. This allows the intermediaries to stretch their audit resources by concentrating on areas yielding the most return, and increases the number of providers whose records are reviewed.

Some fiscal intermediaries have contracted with private firms to augment their cost report audit efforts, albeit with mixed results. For example, one intermediary we visited told us that these firms require substantial up-front training on Medicare's rules and generally had a rate of return lower than with the intermediary's own internal auditors.

[9]The Balanced Budget Act of 1997 required HCFA to design and implement prospective payment for skilled nursing facilities, home health agencies, hospital outpatient surgery, and rehabilitation hospitals.

Some recovery auditing firms specialize in focused reviews of provider financial records, such as credit balance audits. HCFA requires its institutional providers to submit quarterly credit balance reports identifying whether the provider owes Medicare money. However, although these reports are required, HCFA's intermediaries do not routinely conduct credit balance audits outside the context of a full cost report audit. Credit balance audits involve an on-site review of accounting and medical records, and tracing transactions through the accounting system to identify cases in which a provider has been overpaid and not returned the money to the insurer. HCFA is currently developing a statement of work for a contractor to evaluate (1) credit balance reporting policies, procedures, and practices in place at selected Medicare claims administration contractors and (2) HCFA's oversight of those contractors' efforts, so that the contractor can recommend improvements.

Improved Access to Information in MSP Reviews Would Benefit Medicare

HCFA's contractors conduct postpayment MSP reviews by attempting to identify possible alternative sources of health insurance coverage with primary payment responsibility. Contractors' ability to identify MSP debt is hampered by private insurance companies' and employer group health plans' unwillingness to share information about their enrollees with HCFA. GAO has long recognized that private insurance companies and employers are in the best position to routinely identify policyholders and employees who might be eligible for Medicare. Some recovery auditors have developed proprietary databases that contain insurance company enrollment information and other data that could potentially help Medicare identify beneficiaries with other health insurance. However, HCFA might not be able to access this information if the insurance companies involved were unwilling to share beneficiary data.

One recovery audit firm we spoke with that specializes in third-party liability performs its work for 20 state Medicaid agencies. This organization maintains a database containing Medicaid recipient enrollment data along with enrollment data from commercial health insurance plans, Medicare contractors, and Blue Cross and Blue Shield plans. The firm conducts many different types of data matches that involve multiple, successively applied matches, and augments its data match techniques by reviewing employer wage files, credit bureau information, Department of Motor Vehicles data, state vital statistics files and property records to identify possible casualty, tort, and estate sources of payment.

As previously mentioned, HCFA matches Medicare data with employment and earnings data maintained by the IRS and the SSA to identify

beneficiaries who may have health insurance through their employer or their spouse's employer. However, there can be a 2-year time lag between when a beneficiary or spouse is employed and when contractors can confirm the information about employment. Information on employment is reported to IRS after the fact. IRS must then prepare the employment information, which is made available for matching with Medicare beneficiary data. Contractors then confirm it by querying employers. As a result, even with current data match activities, Medicare can have paid for claims long before another liable insurer is identified. Even more time will pass before any funds can be recouped.

Commercial insurers share information with each other on their beneficiaries to determine which beneficiaries have more than one source of insurance. It is advantageous for companies to share this information because, for some beneficiaries, an insurer will be the secondary payer. If firms do not try to coordinate their benefit payments, they may both pay as the primary payer.

Better access to health insurers' beneficiary data could help HCFA identify MSP cases by providing more current data. However, because Medicare is generally the secondary payer to other insurers, it may not be to other insurers' advantage to share beneficiary data with HCFA. At present, insurers are under no obligation to inform HCFA that some of their policyholders are Medicare beneficiaries unless there is a court settlement requiring such data sharing. HCFA has had to pursue certain insurance companies—some with related corporations that are Medicare contractors—in federal civil court for refusing to pay before Medicare when the government contends that Medicare should have been the secondary payer. From 1995 to 1999, HCFA reached settlements that totaled almost $66 million in cases in which a related company was a Medicare carrier or intermediary, including the national Blue Cross Blue Shield Association, Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of Massachusetts, Blue Cross Blue Shield of Michigan, Transamerica, and Travelers. As a result of these legal settlements, some major insurers have agreed to share data, but some of these settlements are about to expire. While insurers can voluntarily share data on their policyholders with HCFA, few have opted to participate, thereby reducing HCFA's ability to identify claims that are the responsibility of another insurer.

If private insurers were required to share information on their policyholders, HCFA could more easily determine which Medicare beneficiaries had other health insurance. In the late 1980s, HCFA proposed—but did not obtain—legislation granting it access to private insurers' policyholder data. Insurer reporting provisions were included in the President's budget proposals for both fiscal years 2000 and 2001, but these provisions were not accepted by the Congress. Without such a requirement, the recovery auditing firm we visited told us that access to some of the private insurer and Medicaid data they used would have to be negotiated with each of the participating insurers before they could be used for Medicare.

Additional Efforts May Require Increased Funding

While Medicare would be likely to benefit from additional efforts to identify overpayments, further efforts may require increased funding. As it has sought to run the program economically, HCFA has been left with fewer and fewer dollars to pay for administering a program that has grown in volume and whose management involves increasingly complex tasks. The Congress has recognized the importance of ensuring that Medicare have adequate program safeguards in place and has developed an assured funding stream for these activities through MIP. For fiscal year 2000, $630 million was appropriated for MIP. The amounts appropriated will grow until fiscal year 2003, when funding will reach $720 million.

However, funding dedicated to program safeguards in fiscal year 2000 is still about one-third less (on a per-claim basis) than it was in 1989. Based on estimates of the growth of trust fund expenditures, our analysis indicates that MIP funding, as a percentage of program dollars, will be less in 2003 than it is today. It will still represent little more than one-quarter of 1 percent of Medicare program expenditures.

With this funding, HCFA and its contractors carry out a range of program safeguard activities, with an emphasis on prepayment reviews designed to prevent overpayments. If HCFA were to increase its overpayment identification activities, it likely would have to do it by curtailing other types of program safeguard activities, such as these prepayment reviews. HCFA has estimated significant returns from both its prepayment and postpayment MIP activities. While it is difficult to isolate the dollar savings attributable to a single year's funding, based on HCFA estimates for fiscal year 1999, MIP saved the Medicare program more than $17 for each dollar spent—about 55 percent from prepayment activities and the rest from postpayment activities.

Additional investment seems likely to yield additional positive returns. However, it is important that both current funding and any additional investment be spent as effectively as possible. In addition, investments in these activities should not be expanded beyond levels likely to yield positive returns. Additional information on the relative effectiveness of these activities could help guide HCFA in its allocation of funds, but precisely measuring the effect of MIP funding efforts is difficult. Savings realized today may result from activities begun several years ago. For example, postpayment activities such as medical review can be used to identify program vulnerabilities that can be addressed in the future through automated prepayment edits and manual reviews. Therefore, while their immediate return on investment can be relatively low, such postpayment activities may lead to future prepayment savings.

Reliable information on the relative value of specific program safeguards could help HCFA target its program integrity efforts. However, at present, HCFA lacks the detailed data that can provide the best estimates of returns from specific program safeguard activities. For example, HCFA does not have information on whether automated or manual prepayment medical reviews generate the most savings. Similarly, HCFA does not know which contractors are realizing the highest return on investment from their program safeguard activities. To remedy this information gap, HCFA will implement a new Program Integrity Management Reporting system for carriers and intermediaries in fiscal year 2001. This system will be used to collect information that HCFA expects will allow it to report savings and provide details by contractor, program activity, and provider type. The system will generate monthly reports, which should allow HCFA to more closely monitor and direct their program integrity activities. HCFA plans to audit the information input into the system to verify its accuracy.

HCFA Needs to Improve Its Collection of Overpayments

HCFA's claims administration contractors are initially responsible for recovering the overpayments they identify. Often they do this by offsetting subsequent payments to providers but this is not possible when, for example, providers leave the program and stop billing Medicare for services. While contractors collect most of the identified overpayments, they still are unable to collect several billion dollars each year. This has resulted in a growing and aging accounts receivable balance that totaled $7.3 billion at the end of fiscal year 1999. If accounts receivable have been delinquent for over 180 days, the contractors must transfer collection responsibility to HCFA's regional offices, which we found typically are unsuccessful in collecting the transferred debt. In addition, HCFA has not

fully implemented DCIA, which generally requires agencies to transfer debt over 180 days delinquent to the Treasury or a Treasury-designated debt collection center. The designated debt collection center for certain Medicare debts—the HHS Program Support Center—contracts with a private debt collection company and uses other collection techniques similar to those used by recovery auditors.[10] Therefore, we do not believe that recovery auditors are necessary to assist HCFA in improving overpayment collections. Instead, our work showed that HCFA could benefit most by accelerating its compliance with DCIA's requirements and referring debt to the Program Support Center.

Large Percentage of Receivables Are Collected but Billions Remain Delinquent

The results of our analysis of HCFA's accounts receivable, shown in tables 1 and 2, indicate that the amount of Medicare's identified overpayments collected increased between fiscal years 1998 and 1999, both in total and separately for parts A and B. Specifically, collections rose from $7.5 billion in fiscal year 1998 to $8.7 billion in fiscal year 1999—a 16 percent increase. At the same time, however, the value of the new accounts receivable identified increased from $10.1 billion to $12.6 billion over the 2 years, or by 25 percent. The difference between the collection and overpayment identification rates resulted in a fiscal year 1999 ending accounts receivable balance of $7.3 billion, as over $3 billion of uncollectable accounts receivable were written off by HCFA under a special initiative to remove old debt from HCFA's accounts receivable. Further, although not shown in the table, a large percentage of the ending accounts receivable balance each year was more than 6 months delinquent—40 percent in fiscal year 1998 and 45 percent in fiscal year 1999.[11] HCFA's claims administration contractors are responsible for nearly all of the collections.

[10]Currently, Treasury's Financial Management Service is the only government-wide debt collection center. Treasury has granted a waiver for HHS to continue to service MSP debt, unfiled cost report debt, and health profession debt, and to be designated as a debt collection center for that purpose.

[11]A non-MSP receivable becomes delinquent if it is not repaid within 30 days of the date of a demand letter and where the provider or supplier has not entered into a satisfactory extended repayment schedule. Generally, MSP debt becomes delinquent if it is not repaid within 60 days of the date of a demand.

Table 1: Medicare Accounts Receivable

(Dollars in Billions)

	Fiscal year 1998			Fiscal year 1999		
	Part A	Part B	Total	Part A	Part B	**Total**
Beginning balance	$3.4	$2.2	$5.5	$4.9	$2.5	**$7.4**
Ending balance	4.9	2.5	7.4	5.4	2.0	**7.3**

Notes: Dollar amounts represent principal amounts only and represent accounts receivable from provider and beneficiary overpayments, civil monetary penalties and other restitutions, fraud and abuse, managed care, Medicare premiums, and audit disallowances. Numbers may not add due to rounding.

Sources: *DHHS HCFA Financial Report, Fiscal Year 1998* (Baltimore, Md.: Feb. 1999); and *DHHS Health Care Financing Administration Financial Report, Fiscal Year 1999* (Baltimore, Md.: Feb. 2000).

Table 2: Medicare Claims Administration Contractors' New Accounts Receivable and Collections

(Dollars in Billions)

	Fiscal year 1998			Fiscal year 1999		
	Part A	Part B	Total	Part A	Part B	**Total**
New accounts receivable	$7.5	$2.6	$10.1	$9.3	$3.3	**$12.6**
Collections	5.7	1.8	7.5	6.3	2.4	**8.7**

Notes: Dollar amounts represent principal amounts only. These figures reflect only claims administration contractors' accounts receivable. They do not include accounts receivable from provider and beneficiary overpayments transferred to the HCFA regional offices, HCFA central office, Treasury, or the HHS Program Support Center. The figures also do not include accounts receivable from managed care and Medicare premiums and may not include those associated with civil monetary penalties and other restitutions, such as fraud and abuse cases referred to law enforcement. Therefore, figures in this table cannot be combined with figures in table 1.

Sources: internal HCFA documents—HCFA Form H751 A and B, Status of Accounts Receivable, for Fiscal Years 1998 and 1999.

Contractors are generally able to collect many overpayments immediately, by offsetting them against current payments due. However, contractors' ability to collect Medicare overpayments is affected by a number of different factors, including the type of overpayment, the promptness with which the overpayment was identified, and whether the provider is still in business and participating in Medicare. These factors are discussed below.

Type of overpayment. We found that contractors were much more successful in collecting overpayments identified in cost report audits and medical reviews than those identified through MSP activities. In fiscal year 1998, for example, less than 10 percent of MSP receivables nationally were collected, versus about 62 percent of non-MSP receivables. This low rate of MSP collections is not surprising for several reasons. First, contractors are only required to send one demand letter to the responsible party requesting payment of MSP overpayments, whereas up to three demand letters are sent on other types of receivables. Second, other insurers often dispute that they are responsible for payment. Third, MSP collection rates are also affected by potential conflict of interest or lack of diligence: the claims administration contractors may themselves be responsible for payment and may not be quick to collect on those receivables. For example, in 1999, HCFA hired a private accounting firm to review Medicare accounts receivable at 15 contractors. At one contractor, the firm identified 91 MSP overpayments more than 6 months old totaling $290,000 that the contractor's private operations owed Medicare but had not yet repaid.

Prompt collection of overpayments and provider participation in Medicare. Contractors have not always followed procedures that require prompt efforts to collect overpayments they identify. This affects their ability to collect what becomes aging debt. For example, home health agencies (HHA) are required to submit annual reports of their Medicare costs to the fiscal intermediaries. All cost reports then go through a settlement process that may identify overpayments.[12] At one contractor, we identified several cases in which the contractor did not conduct timely cost report settlements. The contractor was 2 years late in settling one HHA's cost report and, in another case, a cost report settlement that should have occurred in 1996 did not take place until late 1999. Collections are even more difficult when providers terminate their Medicare participation. For example, in a recent GAO report regarding overpayments due from 15 HHAs in Texas that closed between October 1997 and July 1999, we found that HCFA had collected $5.3 million, or about 7 percent of the $73 million due from the closed agencies.[13]

[12]During cost report settlement, contractors make a final determination of how much Medicare reimbursement the HHA has earned and whether Medicare or the agency is owed money.

[13]*Medicare Home Health Agencies: Overpayments Are Hard to Identify and Even Harder to Collect* (GAO/HEHS/AIMD-00-132, Apr. 28, 2000).

Legal proceedings. When a provider has filed for bankruptcy, the contractor's collection activities are subject to review and approval of the bankruptcy court. Whether any of the bankrupt provider's Medicare overpayments are eventually collected depends on the results of the bankruptcy proceedings. Contractors' collection abilities are also affected when providers who owe the program money are under investigation by the HHS OIG or involved in litigation with the Department of Justice. In such cases, contractors must suspend their collection efforts until resolution occurs. A substantial amount of overpayments cannot be collected because the debtors are involved in bankruptcy proceedings or litigation. According to HCFA, $845 million in overpayments cannot be collected because they are protected under bankruptcy proceedings. In addition, $147 million cannot be collected because of litigation.

HCFA's Success in Collecting Delinquent Debt Is Limited

Debt that the contractors cannot collect is referred to HCFA for collection. However, we found that contractors do not always refer debt in a timely way. Even when debt is referred appropriately, we found that the age and type of debt HCFA receives makes it difficult to collect. In addition, HCFA's recording and tracking systems are unreliable, further complicating collection efforts.

HCFA's low rate of collection for transferred debt is attributed in large part to the age and type of debt HCFA receives. HCFA regional office staff informed us that this debt is difficult to collect due to such factors as provider bankruptcy or closure. In addition, it is generally recognized by HCFA and contractor representatives that the longer an overpayment is outstanding, the less likely it is that it will be collected. At one of the intermediaries in our study, accounts receivable transferred to HCFA in fiscal year 1998 totaled $59.8 million; of that amount, HCFA collected $2.1 million as of June 2000—a 3.5 percent collection rate.

When contractors are unable to offset payment or otherwise recover an overpayment from a provider, they are supposed to refer the receivable to their respective HCFA regional offices for review. If regional office staff find that the contractor has taken all appropriate collection actions, the contractor may transfer the receivable to HCFA, which then assumes responsibility for collection through its regional offices. We found that contractors were not always referring receivables appropriately to HCFA regional offices, thus preventing it from initiating its own collection activities.

Although contractors are supposed to refer uncollected debt to HCFA according to time frames set out by HCFA's regional offices, we found that this does not always happen. For example, one contractor we visited told us that referring receivables to its HCFA regional office was a relatively low priority because of the unlikelihood that HCFA would be able to collect them. As a result of untimely referral, the chances that HCFA could collect the debt are substantially reduced because the debt becomes increasingly delinquent.

Another problem related to contractor referrals is inconsistent regional office guidance to contractors. We found that in one HCFA region, contractors were asked to refer receivables less than $1,000 to be written off.[14] At another region, the referral threshold was $50 and the region made the decision whether to write off the debt or pursue collection. Within HCFA, only the regional offices have the authority to authorize the writeoff of government debt. They are allowed to exercise this authority consistent with their judgment regarding the cost-effectiveness and potential for recovery of these debts.

Finally, we found that the various systems HCFA regional offices used to track and report transferred receivables were neither consistent nor reliable. For example, one region provided us with current information on the status of each receivable; however, because many of the overpayments did not exceed $600, they were not included in HCFA's automated tracking system and, as a result, the information had to be compiled for us manually. Another region generated detailed computer data for its Part A receivables, including information on outstanding balances, collection activities, and notes about their collection status. However, this same region could not provide any information on the status of Part B accounts receivable due to problems with its computer files. Because of problems like these, HCFA does not have reliable data on how well it collects debt transferred to it by contractors.

[14]A writeoff occurs when an agency determines that a debt is uncollectable and removes it from its accounting records—that is, it no longer carries it as a receivable. A writeoff does not extinguish the underlying liability for the debt.

Ineffective tracking and reporting systems may also result in receivables being recorded in error. For example, in our report on the identification and collection of overpayments from closed HHAs, we noted that a contractor made a $76.9 million keypunch error when entering overpayment information into one of HCFA's central overpayment recording systems. Further, we noted that ineffective management of Medicare accounts receivable was found to be a consistent problem in HCFA's financial statement audits for fiscal years 1996 through 1999.[15] The fiscal year 1998 audit, for example, disclosed deficiencies in nearly all aspects 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. HCFA's fiscal year 1999 financial statement audit report noted that despite significant improvements, controls over accounts receivable continued to be a material weakness.[16] HCFA has plans to replace its fragmented accounts receivable tracking and reporting systems with a single integrated one, but this will not be implemented until September 2001 at the earliest. In March 2000, we made a number of recommendations to the HCFA Administrator to improve financial management and accountability of the Medicare program, including that HCFA develop a comprehensive financial management improvement strategy.[17]

HCFA agreed with our recommendations and committed itself to aggressively address shortcomings in its financial management of Medicare. For example, in an effort to clean up its financial records in preparation for its fiscal year 1999 financial statement audit, HCFA initiated a one-time project to write down its oldest delinquent receivables. This effort resulted in HCFA's and its contractors' writing off delinquent receivables that were at least 6 years old. Over $3 billion was written off by HCFA and its contractors in fiscal year 1999. Receivables less than 6 years

[15]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 through 1999.

[16]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 the risk that errors or irregularities in the amounts that would be material in relation to the financial statements being audited may occur and not be detected in a timely way.

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

old, however, remain on the financial records; whether they are collectable remains in question.

HCFA Slow to Implement DCIA

DCIA mandates that HCFA and other federal agencies refer all eligible debt over 180 days delinquent to the Treasury or a Treasury-designated debt collection center for collection activities. In 1999, Treasury granted a waiver for HHS to continue to service certain debts including MSP debt and debt related to unfiled cost reports and to be designated as a debt collection center for that purpose.[18] Within HHS, the Program Support Center is the Treasury-designated debt collection center.[19] As such, it is responsible for attempting to collect referred debt related to MSP or unfiled cost reports, and for referring all other types of Medicare debt to the Treasury for collection. At Treasury, collection can be attempted through Treasury's offset program and various other debt collection tools, such as referral to private collection agencies.[20] Although the act is now over 4 years old, HCFA has not fully implemented DCIA and will not be referring all eligible receivables until the end of fiscal year 2002, at the earliest, because of the work involved in certifying that the debt amount is correct and still outstanding.[21]

To improve management of its accounts receivable, HCFA analyzed its debt, performed a one-time writeoff of very old debt, and established two pilot projects to refer eligible debt to the Program Support Center. To address the issue of aging receivables, HCFA wrote off all debt that it determined could not be offset and that was more than 6 years old, and referred the remainder of the 6-year-old (or older) debt to the Program Support Center for collection. This was done in preparation for its annual financial statement audit.

[18]The waiver was granted subject to several conditions, including a provision that HHS refer the remainder of its eligible program and administrative debt to Treasury for collection.

[19]The Program Support Center is an operating division within HHS that provides a variety of financial and administrative support services to federal agencies.

[20]Under Treasury's offset program, delinquent federal debts are collected through offset of certain other federal agency payments including federal income tax refunds. Treasury also contracts with a number of private collection agencies to collect delinquent debt.

[21]For more detail on implementation of DCIA, see *Debt Collection: Treasury Faces Challenges in Implementing Its Cross-Servicing Initiative* (GAO/AIMD-00-234, Aug. 4, 2000).

As mentioned earlier, HCFA's objective for its two pilot projects was to develop a process for contractors to expedite the transfer of eligible Part A debt to the Program Support Center. HCFA concentrated its pilots on older, high-value Part A debt rather than newly eligible delinquent debt. One pilot deals with MSP debt valued at more than $5,000 or more and is up to 6 years old, while the other pilot deals with non-MSP debt, primarily related to cost report audits, of $100,000 or more. Under the pilots, contractors record eligible delinquent debt in a HCFA central office database that is used to transmit the debt to the Program Support Center for collection. Before they refer this debt to the Program Support Center, contractors must validate it by reviewing records and ensuring that the debt is still uncollected and that the debt balance is correct. Validation is necessary because HCFA's systems for recording and tracking overpayments are unreliable. In addition, contractors must seek to collect the receivable by issuing a demand letter that indicates that nonpayment will result in referral to the Program Support Center.

HCFA plans to expand its non-MSP pilot to all of its intermediaries and carriers by October 2000; the time frame for expanding the other pilot is uncertain. However, even under its planned efforts, certain types of eligible debt will be excluded. For example, HCFA has established a $600 threshold for transferring non-MSP debt and tentatively plans to continue with its $5,000 threshold for MSP debt, even though the Program Support Center will accept any eligible debt over $25. This leaves a large amount of debt—almost half of all Part B delinquent debt, for example—with no avenue for collection beyond the contractors' current techniques. This also means that delinquent debt newly eligible for transfer below these thresholds will not qualify for referral. HCFA officials told us that they selected the $600 and $5,000 thresholds in part because they do not have the resources necessary to validate the large volume of aged, delinquent debt below these amounts. However, collection industry statistics as well as Treasury's collection experience to date have shown that collection rates are generally higher on debts with smaller dollar balances and debts that are less delinquent.

The Program Support Center and Treasury use many standard collection techniques in their debt recovery efforts, such as attempting to locate debtors that have ceased operations, issuing demand letters, and reporting information to credit bureaus. They also refer debt to the Department of Justice for litigation, and to Treasury's offset program, where certain federal agency payments can be offset to satisfy claims. To assist them, both the Program Support Center and Treasury contract with private

collection agencies that are paid contingency fees for their collection efforts. For example, for their collection services, the Program Support Center retains 15 percent of the amount collected and the remainder is returned to the Medicare Trust Funds. HCFA is not charged for debt that has been transferred but cannot be collected.

It is too early to evaluate the effectiveness of Treasury and the Program Support Center in collecting Medicare debt transferred to them. However, they have been able to collect some aged, delinquent debt for which HCFA and its contractors had terminated active collection action—in fiscal year 1999, HCFA transferred $341 million in delinquent debt to the Program Support Center of which $1.8 million has been collected.

Contractors and Recovery Auditors Use Similar Collection Techniques

We did not find potential for HCFA to improve collections of Medicare overpayments through the use of recovery auditors. Both the claims administration contractors and the recovery auditors we spoke with use the same basic technique of initiating collections by issuing a demand letter to providers. Demand letters provide details regarding the overpayment, and request prompt payment from the provider. For providers still in the Medicare program, claims administration contractors can simply withhold funds from future payments. Other collections by both the contractors and recovery auditors depend on the debtor's sending a check. The techniques that recovery auditors use would not provide HCFA with collection techniques that differ from those provided by the Treasury and the Program Support Center. Both already use private collection agencies to assist them in collecting delinquent debt. In addition, the Treasury can offset providers' overpayments against certain other federal agency payments—a process not available to recovery auditors.

Implementation Challenges Associated With Using Recovery Auditors

As previously mentioned, recovery audit techniques are, for the most part, no different from the techniques currently being used in Medicare's program safeguard activities. However, there is evidence that HCFA could do more—either in-house, or through its contractors—to identify overpayments, if it had additional resources. The concept of using recovery auditors to help HCFA achieve its program integrity goals has been the subject of controversy. Specific concerns relate to how to compensate recovery auditors, the possible administrative burden that would be placed on the current claims administration contractors and providers, responsibilities to coordinate with law enforcement agencies and to ensure beneficiary privacy, and HCFA's ability to effectively manage this new set of

contractors. These concerns are discussed below. We found that HCFA is already addressing most of these same challenges as it implements its PSC activities under MIP. These contractors, like recovery auditors, are intended to provide HCFA with new tools and capabilities to protect Medicare from overpayments.

Compensating Recovery Auditors

Arguably the most contentious issue regarding Medicare's use of recovery auditing services relates to compensation. Recovery auditors are typically paid a contingency fee by private-sector clients, based on a percentage of the identified overpayments collected. One of the advantages of using recovery auditing services on a contingency fee basis is that additional appropriations are not needed to pay these organizations because the payment comes out of recoveries. However, HCFA and medical associations believe that providers view contingency fees as a "bounty" system that can damage the constructive partnership between Medicare and its providers. The contingency fee is a strong incentive to identify and collect overpayments and may lead to inappropriate identification and collection efforts by recovery auditors. A HCFA official noted that providers have raised a similar concern about the very modest reward available under HIPAA to beneficiaries who uncover fraud.

Instead of paying recovery auditors on a contingency fee basis, HCFA could compensate them in ways similar to the ways it pays PSCs, including firm-fixed-price or cost-plus-award-fee contracts. A firm-fixed-price contract provides for a predetermined payment to the contractor. Payments are not subject to adjustment based on the contractor's costs; in fact, there are strong incentives for the contractor to control costs. A cost-plus-award-fee contract provides for reimbursement of actual costs and can include incentives for efficiency or performance. HCFA is using each type of contract in its PSC task orders. Several of the recovery auditors we met with noted that they would accept other methods of payment besides contingency fees and thus may be agreeable to providing their services under one or more of these different types of contracts.

Administrative Burden Associated With Recovery Auditors

The potential administrative burden that recovery auditors would place on current claims administration contractors and providers has also been raised as a concern similar to the situation HCFA faces as it integrates the PSCs into Medicare's integrity activities. HCFA and claims administration contractor representatives believe recovery auditors would likely generate additional inquiries and appeals due to providers and beneficiaries

challenging overpayment decisions, thereby increasing workload and costs of the claims administration contractors. They also expressed concern that the claims administration contractors would need to divert staff from their normal activities to provide recovery audit staff with information about the claims administration contractors' operations, including local medical policies that define the conditions under which the contractor will pay for certain services. Recovery auditors would need to understand the local medical policies when making determinations on whether the claims were paid properly. Furthermore, the claims administration contractors and recovery auditors would need to share data, requiring development of coordination procedures. Providers, too, are concerned about the potential administrative burden.

Representatives from two medical associations said that they were concerned that recovery auditors working in Medicare would request excessive numbers of medical records from providers, thereby adversely affecting providers'office operations. Recovery auditor representatives told us that they do not believe they place excessive demands on providers for medical records and other information and that they are sensitive to this concern. Representatives from one recovery auditing organization noted that initial identification of physician overpayments often involves computer analysis of claims data, not a review of medical records. As for institutional providers such as hospitals, representatives of a recovery audit firm and a recovery auditor client said these providers routinely allow auditors from private insurance companies to review medical records at their facilities.

Law Enforcement Coordination and Confidentiality of Patient Information

Two other issues associated with hiring recovery auditors are coordination with law enforcement agencies and maintenance of patient information confidentiality. Representatives from some claims administration contractors said that their fraud units closely coordinate their investigations with the HHS OIG and Justice, and that they were concerned that recovery auditors would inadvertently hinder their investigations. Several medical specialty group representatives also raised the issue of confidentiality of patient information, and questioned how HCFA would ensure that recovery auditors did not release such information or use it for unauthorized purposes.

HCFA has made some provisions for both of these concerns as it implements its program safeguard contracts. PSCs are required to provide the OIG, Justice, and the Federal Bureau of Investigation with information

related to potential fraud cases and may also periodically meet with law enforcement agencies to coordinate ongoing work. In regard to privacy concerns, the Statement of Work requires the PSCs to comply with the Privacy Act of 1974 and applicable HHS regulations relating to information security.

HCFA's Ability to Effectively Oversee Recovery Auditor Activities

A final issue regarding Medicare's use of recovery auditors concerns HCFA's ability to effectively manage and oversee these organizations, given its other oversight responsibilities. We have reported numerous problems with HCFA's ability to effectively manage and oversee its current claims administration contractors. Medical association representatives note that HCFA has a number of other program safeguard projects under way and have suggested that HCFA evaluate these results before undertaking any new initiatives.

HCFA acknowledges that its oversight of the claims administration contractors can be improved and is taking various steps toward that goal. To ensure continual oversight of its PSCs, HCFA has already established a performance evaluation program. Because the PSCs have been operating for less than a year, HCFA has not formally evaluated any of them, but plans to assess the PSCs' performance annually against the statement of work and applicable task order requirements.

Instead of establishing a new contracting structure for recovery auditors, if their expertise is needed, HCFA could contract with them in the context of its PSC initiative. In fact, a PSC teamed with a recovery auditor we met with to bid on one of HCFA's task orders; HCFA, however, selected another PSC to perform this work.

Conclusions

Although Medicare's claims administration contractors already have extensive prepayment safeguards in place to help ensure that claims are paid correctly, Medicare continues to make overpayments totaling billions of dollars annually. With its recent emphasis on prepayment review, HCFA is justifiably spending much of its limited program safeguard funds on identifying erroneous or improper claims before they are paid. However, thousands of these claims are paid nonetheless, and if not identified during postpayment reviews, they ultimately are lost in a program that can ill afford the financial drain on the trust funds. In an effort to tackle its outstanding overpayment problem, some have suggested that HCFA use

the services of recovery auditors to supplement its program integrity activities.

We attempted to identify any techniques or tools used by recovery auditors that could also benefit HCFA. While recovery audit firms we met with have achieved results on behalf of their private insurance and Medicaid clients, their techniques are similar to HCFA's current postpayment tools. That is not to say that Medicare could not benefit from a stronger focus on postpayment activities to identify additional overpayments. While we believe that HCFA's effort to balance prepayment and postpayment activities is sound, more could be done to safeguard Medicare if additional resources were available.

Since its enactment, HIPAA has provided HCFA with increased and assured funding for program safeguards, but funding is still less than what was available in 1989 on a per-claim basis. While this funding is due to increase in the next several years, it will only keep pace with expected growth in program expenditures and amounts to little more than one-quarter of 1 percent of program expenditures. According to HCFA estimates, more than $17 is saved for every $1 invested in safeguarding Medicare through MIP. We believe that HCFA must target any new resources to the activities most likely to result in the greatest payoff. We understand that HCFA is developing a process to determine the return on its prepayment and postpayment activities broken down by contractor and activity which, when completed, should give it greater ability to perform this targeting.

For its MSP activities, HCFA could more effectively identify beneficiaries who have other primary insurance coverage if insurers were required to share information on their enrollees. HCFA has had difficulty gaining insurers' cooperation and has had to sue a number of them to enforce MSP requirements. If insurers were required to share enrollee information with HCFA, HCFA could match more current data, and in a more efficient manner, than its present data matches. However, such a step would require congressional action.

In regard to collecting overpayments once they have been identified, we found that HCFA's claims administration contractors do a fairly good job when providers' current payments can be offset to collect previous overpayments. However, HCFA's delinquent receivables are a continuing problem. The longer debt ages, the more difficult it is to collect. HCFA's practice of offsetting overpayments with future payments gives it leverage that accounts for much of its collection success, but this option is typically

not available on older debt, because the provider may no longer be in business, be participating in Medicare, or even be located.

We believe HCFA could collect more of its older debt if it fully implemented the DCIA. HCFA is not transferring all its eligible debt to HHS' Program Support Center in a timely manner. Under its two pilot projects, HCFA is focusing on transferring some Part A debt of significant value that may be as old as 6 years; its plans to expand the pilots to all contractors will still exclude debt that falls below HCFA's minimum thresholds. While in some cases the cost of validating debt may exceed the amount collected, this may be more applicable to very old debt that requires more extensive validation efforts than to newly eligible debt. It does not seem reasonable to wait until the end of fiscal year 2002 at the earliest to transfer all eligible debt, as HCFA plans. Rather, transferring delinquent debt as soon as it becomes eligible could result in a greater payback to Medicare; the sooner it is transferred, the more likely that Treasury or the Program Support Center will be able to collect. Treasury and the Program Support Center use collection techniques that are similar to, and may be better than, those available from recovery auditors. As a result, we did not identify any additional role for recovery auditors in Medicare's overpayment collection activities.

We do not believe that recovery auditors offer unique benefits to either identify or collect overpayments that are not available from HCFA's current contractors and contracting arrangements. Recovery audit firms whose postpayment expertise coincides with HCFA's needs presumably could perform their work on specific PSC task orders or for a specified contract. HCFA could gain the benefit of their expertise without changing its existing and accepted payment safeguard contracting structure. In regard to contracting with recovery auditors, providers and others have raised concerns about issues such as compensation, administrative burden, coordination with law enforcement, privacy protection, and contractor oversight. HCFA is working on addressing these same issues as it implements its PSC initiative.

Matters for Congressional Consideration

The Congress should consider increasing HCFA's MIP funds to allow an expansion of postpayment and other effective program safeguard activities, and require HCFA to report on the financial returns from these and other program safeguard investments.

Because HCFA has had difficulties gaining the cooperation of health insurers in identifying beneficiaries covered by other insurance under the Medicare Secondary Payer Program, the Congress should consider requiring all private health insurers to comply with HCFA requests for the names and identifying information of their enrolled beneficiaries.

Recommendations

To improve overpayment identification and collection, we recommend that the Administrator of HCFA require that the effectiveness of prepayment and postpayment activities be evaluated to determine the relative benefits of various prepayment and postpayment safeguards.

In addition, the Administrator should require that all debt be transferred to HHS' Program Support Center for collection or referral to Treasury for collection as soon as it becomes delinquent and is determined to be eligible for transfer. For its current backlog of debt that is determined to be eligible, HCFA should validate and refer such debt to HHS' Program Support Center as quickly as possible.

Agency Comments and Our Response

In commenting on this report, HCFA agreed with our matters for consideration by the Congress and our recommendations to the agency (see app. I). HCFA noted that it has taken many actions to address program safeguard and management weaknesses reported by GAO and the HHS OIG. It outlined a number of activities under way to better prevent overpayments from occurring and to identify those that have occurred.

In response to our matters for consideration of the Congress, HCFA stated that having additional funding under MIP would allow HCFA and its contractors to expand their range of program safeguard activities. In addition, HCFA stated that requiring insurers to comply with its requests for names and identifying information on enrolled beneficiaries would help the agency more effectively identify beneficiaries with other primary insurance coverage.

In regard to our recommendations to HCFA, the agency agreed with our recommendation that it should evaluate the relative benefits and effectiveness of specific prepayment and postpayment tools, and indicated that a PSC contractor will begin to assist HCFA with this activity soon. Further, HCFA agreed with our recommendation to transfer all debt to the HHS Program Support Center for collection or referral to Treasury for

collection as soon as it becomes delinquent and is determined to be eligible. The agency noted that it had begun the process of transferring its debt nearly 18 months ago and has hired additional staff in both its central and regional offices to focus on debt referral activities. We acknowledge HCFA's efforts, but believe that it should broaden its focus to transferring debt as it becomes delinquent, rather than solely clearing out its backlog of aged receivables, because debt that has only recently become delinquent should be simpler to validate and is generally easier to collect. HCFA also suggested technical changes to the report, which we incorporated where appropriate.

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of the Health Care Financing Administration, appropriate congressional committees and subcommittees, and other interested parties. We will also make copies available to others on request.

If you have any questions regarding this report, or if we can be of further assistance, please call me at (312) 220-7600 or Sheila Avruch at (202) 512-7277. Other major contributors to this report are listed in app. II.

Sincerely yours,

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 Administratio

The Administrator
Washington, D.C. 20201

DATE: AUG 29 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: HCFA Could Do More to Identify and Collect Overpayments" (GAO/HEHS/AIMD-00-304)

We appreciate the effort that went into the drafting of the above-mentioned report, and GAO's acknowledgment of the significant work we have invested in improving our identification and collection of overpayments. We concur with all of the GAO's recommendations. Furthermore, we appreciate GAO's comments that Congress should consider increasing HCFA's Medicare Integrity Program (MIP) funds to allow an expansion of post-payment and other effective safeguard activities, which would allow us and our contractors to expand a range of program safeguard activities.

The Health Care Financing Administration (HCFA) takes its financial management responsibilities very seriously. Working closely with the auditors of our financial statement – the HHS Office of Inspector General (IG) and independent public accounting firms – we have a more accurate picture of Medicare's financial status and clearer understanding of the many actions we must take toward stronger financial management of HCFA's many programs. Indeed, an ambitious array of aggressive actions is underway to address many of the issues reported by the GAO and the IG.

In FY 1999, our fiscal intermediaries and carriers processed a total of 850 million claims representing $167 billion in benefit payments. Your report notes that overpayment collections totaled $8.8 billion during FY 1999, or about 70 percent of the $12.6 billion in overpayments. The amount of uncollected FY 1999 overpayments represents approximately 2.27 percent of total benefit payments made by our contractors during the year. As discussed in our response below, there are several reasons why these overpayments exist, however, we are continually improving our overpayment prevention and collection efforts.

An indication of the significant progress we have made so far is the unqualified audit opinion we received on our fiscal year 1999 financial statements. Since the first audit of HCFA's 1996 financial statements, we systematically worked to eliminate the audit

qualifications. We improved our audit opinion from a disclaimer in fiscal year 1996 to a qualified opinion in fiscal year 1997, and finally to an unqualified opinion in FY 1999.

We appreciate GAO's recognition of HCFA's pre and post-payment safeguard activities. HCFA has a host of initiatives underway that harness technology to keep pace with questionable billing practices. These activities include the use of:

- The Correct Coding Initiative (CCI)
  Implemented in 1996, CCI contains nearly 100,000 computer edits to detect claims with codes for services that cannot or should not be performed together or for services that should be grouped together and paid as one item at a lower rate than if billed separately. CCI produces almost $300 million in savings per year.

- Statistical Analysis Contractor (SAC)
  Under contracting authority derived from the Medicare Integrity Program, HCFA recently awarded a contract to conduct trend studies of Medicare claims. The statistical analysis contractor (SAC) will review Medicare claims data from three States, perform analyses of utilization and payment to determine areas where HCFA should focus additional resources. If, during the course of its work, the SAC identifies aberrant pattern(s) representing significant risk to the Medicare Trust Fund, HCFA may allow the SAC to analyze data from additional States.

- Comprehensive Error Rate Testing (CERT)
  CERT will begin this summer with the four Durable Medical Equipment regional carriers. Statistically valid random sample of claims from each contractor will be reviewed to determine whether health care providers were underpaid or overpaid for the sampled claims. These results will reflect not just the individual contractor's performance, but also the billing practices of the healthcare providers in their region. Much as the IG's audits have helped guide efforts to reduce payment errors in a national scope, the contractor-specific error rates will be tracked to promote improvement. Contractors will develop targeted corrective action plans to reduce payment errors through provider education, claims review, and other activities.

- Benefit Integrity Support Center
  Under this recently awarded PSC task order, the contractor will supplement current Part A Medicare fraud and abuse detection activities in the New England States.

- Electronic Fraud, Waste and Abuse Detection Product Study Survey
  In January 1999, HCFA received the final report from a project that catalogued the functions of 10 widely used electronic fraud, waste, and abuse (FWA) detection products and outlined the FWA detection technologies currently used by Medicare contractors. The same contractor who performed the technology study will also conduct a market survey on commercially available FWA detection products. The survey will shortly be posted to HCFA's internet website, and will ask respondents to highlight the functions of the FWA tools they are using, evaluate the product's performance, and complete customer satisfaction questions.

- Fraud and Abuse Technology Conference
  In June 2000, HCFA cosponsored with the Department of Justice a conference on using electronic tools to combat fraud and abuse. The conference brought together both law enforcement and federal and state health care officials to (a) identify new and emerging technologies that may be applied to detecting health care fraud, waste, or abuse; (b) discuss the benefits and drawbacks of technologies currently on the market; and (c) provide a networking forum for the various consumers of fraud, waste and abuse technology. HCFA plans to follow up on this conference by producing a report of proceedings with recommendations for future steps, including the possibility of regional or national technology user groups.

In addition to these efforts, HCFA has had great success by cooperating with providers to help them document and file claims properly to prevent improper payments. Most providers do not intentionally make billing errors, they simply make honest mistakes, and therefore, we want to ensure that providers understand our coding and documentation rules. We are meeting with physicians around the country to explore ways we might be able to make it easier for them to understand and comply with Medicare rules and regulations. In all these activities, it is essential that we maintain a constructive partnership with providers to prevent overpayments.

With regard to the collection of overpayments, the report states that HCFA could collect more of its older debt if it fully implemented the Debt Collection Improvement Act and that HCFA is not transferring all eligible debts in a timely manner. Over the last 18 months HCFA has had a renewed focus on all aspects of financial management, including the appropriate referral of debts as mandated by the DCIA. HCFA's goal is to have referred all eligible debt for collection by the end of FY 2002. This means only debt that cannot be referred, i.e., bankruptcies, debt subject to litigation, debt under extended repayment plans or debt less than 180 days old, would remain in the HCFA accounts receivable. This is an ambitious plan that HCFA has committed to meet with the goal of clearing out the backlog of old debt while remaining timely on the transfer of current debts.

Our records to date indicate that $845 million of overpayments cannot be collected due to protection under bankruptcy and $147 million of overpayments cannot be collected due to issues under litigation. However, the report should also provide some context that: (1) in the majority of cases, overpayments are collected immediately by offsetting against current payments due; (2) the accounts receivable is not a static number, but is constantly changing as contractors continue to both report and collect receivables; and (3) a large amount of debt is not eligible for collection or referral due to its protected status under the bankruptcy provisions or litigation.

Prepayment and Postpayment Activities/Recovery Auditors

We agree with the GAO's recommendation that we consider the relative benefits and effectiveness of prepayment and postpayment activities. The PSC contractor that was awarded the Comprehensive Error Rate Testing (CERT) task order will be looking at postpayment activities to determine where we need to focus our attention. As we continue to incrementally implement the Medicare Integrity Program, we will look at various safeguard activities, including prepayment and postpayment medical review, to determine their effectiveness and relative benefits.

The report notes that the GAO does not believe that recovery auditors offer unique benefits not available from HCFA's current contractors and current contracting arrangements; however, if recovery audit firm's expertise met HCFA's needs, they could perform their work on specific PSC task orders or for a specified contract. Recovery auditors do have access to the Medicare program through the PSCs. The GAO mentioned an occasion where a recovery auditor teamed with a PSC to bid on one of our PSC task orders but was not selected for award. In that instance, the proposal was evaluated in accordance with the same evaluation criteria that were applied to every proposal submitted for that procurement.

We note that under current law, HCFA is prohibited from paying recovery auditors on a contingency fee basis out of recoveries. 31 USC 3302 mandates all recoveries on behalf of the United States be immediately deposited to Treasury without deduction. 31 USC 3718 provides for an exception to that requirement, but this provision does not apply to Medicare recoveries, as provided in 31 USC 3701(d).

We appreciate GAO's comments that Congress should consider increasing HCFA's Medicare Integrity Program (MIP) funds to allow an expansion of post-payment and other effective safeguard activities. Additional funding under MIP would allow HCFA and its contractors to expand a range of program safeguard activities.

Transfer of Debt for Collection

We agree with GAO's recommendation to require contractors to transfer all debt to Treasury or its designated collection center, the Program Support Center, as soon as it becomes delinquent and is determined to be eligible for transfer. HCFA began implementing this recommendation nearly 18 months ago. To date, we referred over $1.2 billion of delinquent debt to Treasury for collection. We expect to refer another $300 million by the end of this fiscal year. We have hired additional staff in both our Central Office and Regional Offices to focus on debt referral activities. Further, we have specific, measurable plans to have all delinquent debt referred to Treasury by the end of FY 2002. While HCFA has made efforts to secure additional funding to increase its resources applied to the referral of delinquent debt, we have been unsuccessful in securing the necessary funds.

Medicare Secondary Payer

We agree with GAO's comment that HCFA could more effectively identify beneficiaries with other primary insurance coverage if all private health insurers were required to comply with HCFA requests for the names and identifying information of their enrolled beneficiaries. In fact, this Administration has repeatedly asked Congress to pass legislation requiring insurers to report Medicare Secondary Payer (MSP) information to HCFA. Insurer reporting legislation was part of the President's budget for both 2000 and 2001; however, Congress did not accept these proposals.

HCFA has a Government Performance and Results Act (GPRA) goal for FY 2000 of increasing liability, automobile and no-fault MSP recoveries by 5 percent. To increase our success in our MSP activities, in the fall of 1999 HCFA awarded a contract for a Coordination of Benefits Contractor to consolidate and improve HCFA efforts in identifying other insurers and reduce the number of mistaken payments. Beginning in January 2000, HCFA initiated a pilot to transfer delinquent MSP debt for further collection. Based on its success, we will expand the pilot in FY 2001 to require all contractors to begin referring delinquent debt. In addition, we recently issued a Program Memorandum (PM) (AB-00-27) reminding contractors of their responsibilities for identifying and collecting MSP debt. The PM focuses on the outreach that contractors must establish to remind providers, beneficiaries and the legal community of their obligations for providing MSP data to the Medicare program.

Thank you for your consideration of these comments and the opportunity to work with you to ensure that your report reflects our continued focus in the financial management of the Medicare program.

Enclosure

GAO Contacts and Staff Acknowledgments

GAO Contacts

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Staff Acknowledgments

In addition to those listed above, Kay Daly, Robert Dee, Anna Kelley, James Kernen, Wayne Marsh, Frank Putallaz, and Suzanne Rubins made key contributions to this report.

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