Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PREPAYMENT REVIEW:

MSP PROCEDURES AT CARRIERS

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INSPECTOR GENERAL

OEI-07-89-01683

EXECUTIVE SUMMARY

PURPOSE

To evaluate the procedures used by Medicare carriers to identify primary payment sources other than Medicare.

BACKGROUND

This inspection is part of an initiative to examine the effectiveness of Medicare carriers' prepayment utilization review processes.

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary is covered by a worker's compensation program or the Veterans Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare (See Appendix A).

These provisions created new functions for Medicare contractors. They are responsible for screening, identifying, and verifying claims for other insurance involvement. In addition, contractors are required to make recoveries when Medicare has paid improperly.

In line with Health Care Financing Administration (HCFA) efforts to reduce program administrative costs, the budget for MSP functions at Medicare Carriers was reduced by approximately 37% from FY 1989 to FY 1990.

METHODOLOGY

We selected a sample of seven Medicare carriers for review based on high and low volumes of claims processed. An inspection team conducted field visits to each carrier. We interviewed the manager and/or supervisor of the MSP units of each carrier in our sample. Additional documentation collected during this review was used to support and verify information gathered during these interviews. This documentation included published materials, claims forms, monthly in-house MSP savings reports, and HCFA-1564 savings reports.

FINDINGS

Carriers' budgets for MSP activities were reduced by 37% for FY 1990.

Carriers made significant staff reductions to cope with the MSP budget reduction.

Most carriers do not recover overpayments following identification of MSP situations.

Representatives from five of seven carriers in this review told the review team that they are conducting no MSP recovery activities. Representatives from the two remaining sample carriers indicated that they are recovering overpayments on a selective basis. These carriers recover those cases that have greatest potential for savings and only do so within their current operating budget.

The HCFA's "required task" list does not include the recovery of MSP overpayments.

Inconsistencies exist in methods used to identify and calculate savings.

RECOMMENDATIONS

The HCFA should continue to pursue additional funding to ensure that carriers restore operations of the MSP units to a level at least equivalent to FY 1989.

The HCFA should consider the development of a legislative proposal that would allow them to conduct demonstration programs to evaluate incentives designed to enhance the identification and recovery of inappropriate MSP payments.

We present several options for how these demonstration programs could be structured. By implementing one of these options we estimate that additional savings could range from $199 million to $361 million.

The HCFA should modify the CPEP standards to evaluate carriers on their MSP identification and recovery efforts.

The HCFA should provide clear and uniform procedures for counting MSP savings.

COMMENTS

The HCFA did not concur with the recommendations presented in the draft report. In response to the first recommendation, the HCFA points out that they will fund the MSP units as much as the current budget allows. Also, previous proposals for legislative changes to allow incentive programs have been unsuccessful, and they feel the CPEP is appropriate for evaluating MSP functions.

We continue to believe a higher level of funding is necessary. However, we have modified the first and second recommendations to encourage HCFA to continue to pursue additional funding and an initiative to test an incentive program. Also, the HCFA should evaluate the carriers' MSP units on more specific criteria.

The HCFA's verbatim comments are included in Appendix E.

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INTRODUCTION

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BACKGROUND

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History of Medicare Secondary Payer (MSP) Provisions

Medicare helps pay medical costs for approximately 28 million people aged 65 and older and approximately 3 million disabled people. Medicare Part A covers inpatient hospital services, home health services, and other institution-based services. Physician, outpatient hospital, and various other health services are covered by Medicare Part B.

The Health Care Financing Administration (HCFA) is responsible for ensuring compliance with Medicare legislation and regulations. Private insurance companies contract with HCFA to process and pay Medicare claims. These contractors are known as fiscal intermediaries (Part A) and carriers (Part B).

Until 1980, Medicare was the primary payer of health care costs for Medicare beneficiaries except when the beneficiary is covered by a worker's compensation program or the Veterans Administration. Congress became concerned about significant increases in the cost of the Medicare program. As a result, between 1980 and 1986 Congress passed a series of statutory provisions requiring certain private insurers to pay medical claims before Medicare.

These provisions require private insurers to pay medical claims primary to Medicare when the beneficiary has other health insurance coverage by an employer group health plan (EGHP), a disabled beneficiary's LGHP, a spouse's EGHP, or automobile, no-fault, or liability insurance (see Appendix A for details of these provisions). After the private insurance company pays up to its coverage limits, Medicare reimburses remaining covered services subject to coinsurance and deductible limits.

Implementation of MSP Provisions

These provisions created new functions for Medicare contractors. They are responsible for screening, identifying, and verifying claims for other insurance involvement. In addition, contractors are required to make recoveries when Medicare has paid improperly.

The HCFA provides contractors with procedures and instructions to identify primary payment sources. When a Medicare claim is submitted, the contractor searches MSP history files for coverage by another insurer. The most widely used contractor procedures for identifying MSP situations include

- developing leads from HCFA's "Y-trailer" codes;
- screening information included on the claim form;
- querying data in the Regional Data Exchange System (RDES);
- developing the first claim filed by or on behalf of a beneficiary; and
- reviewing all claims containing medical diagnosis codes indicating trauma--to identify injuries related to automobile or work-related accidents.

These procedures helped save approximately $2.2 billion in FY 1989 by identifying primary insurers. However, HCFA actuary estimates, Office of Inspector General (OIG) inspections, and audits by the OIG and the General Accounting Office (see Appendix B for a list of previously published reports) have confirmed that additional savings are possible through improvements to current MSP identification and overpayment recovery systems. The OIG has estimated, based on a random sample of Medicare beneficiaries, that Medicare lost in excess of $600 million in FY 1988 due to unidentified primary payment sources.

The carriers' FY 1990 budgets for MSP activities was significantly reduced from the FY 1989 level. The HCFA actuary estimates that the Medicare program lost approximately $900 million in FY 1990. The current estimate of Medicare program losses due to failure to identify primary payment sources and recover inappropriate Medicare payment has increased to $1.3 billion for FY 1991.

Evaluation of Contractors

The HCFA establishes MSP savings goals for all contractors. The carriers and intermediaries calculate and record all savings resulting from MSP situations. These savings are reported to HCFA on a monthly savings report (HCFA-1564).

Contractors are evaluated on achievement of the MSP savings goals as part of their Contractor Performance Evaluation Program (CPEP).

The HCFA establishes four types of MSP savings.

- Cost avoided MSP claims are those the carrier returns without payment because there is strong evidence that another insurer is the primary payer.

- Full recoveries are defined as savings from claims that were paid by a private insurance company, relieving Medicare of all payment liability.

- Partial recoveries are those situations when the primary payer's payment only covers part of the Medicare allowable charge. In this situation Medicare pays the remaining amount up to what Medicare has allowed.

- Pending claims are those where MSP has been verified but all funds have not been recovered.

METHODOLOGY

We selected a sample of seven Medicare carriers for review based on the volume of claims processed. Six of the sample carriers have high volumes of claims processed and one is considered low volume. The sample carriers include: Blue Shield of Massachusetts-Tri-State; Blue Shield of Florida, Inc; Blue Shield of Indiana; Blue Shield of Texas, Inc.; Blue Shield of Colorado; Arkansas Blue Cross & Blue Shield, Inc.; and Blue Shield of Kansas City.

We visited each carrier to obtain information about the effects of the FY 1990 budget reduction. We obtained data about the effects the reduction had on staff size and numbers of claims processed. In order to learn what procedures the carriers have established to handle MSP claims with reduced resources, we conducted interviews with the manager and/or supervisor of the MSP unit at each carrier. A second interview was conducted with the staff member most familiar with the budget process and budget issues.

In addition, we selected a random sample of 30 claims from the MSP savings log or equivalent computer generated report at each carrier. This sample was selected from the claims processed during the fourth quarter of FY 1989. These claims were analyzed and followed through the MSP development process to the HCFA-1564 monthly savings report. The carriers provided documentation to support the MSP savings claimed on this report.

FINDINGS

THE FY 1990 MSP BUDGET REDUCTION

Carriers' budgets for MSP activities were reduced by 37% for FY 1990.

The carriers' FY 1990 budget for MSP activities was significantly reduced from the FY 1989 level. Table 1 presents a summary of contractors' budgets for the last three fiscal years. The entire budget reduction was applied to carriers. In fact, the intermediaries budget actually increased by 5.7%.

The return on investment (ROI) figures calculated by HCFA represent the ratio of program dollars saved as compared to administrative dollars spent. These figures illustrate that MSP activities are cost effective.

Table 1

Contractor Budgets and Return on Investment

for MSP Activities

	FY 1988	ROI*	FY 1989	ROI	FY 1990	ROI**
INTERMEDIARIES	$31,508,823	45:1	$32,800,966	50:1	$34,672,890	52:1
CARRIERS	$34,598,000	13:1	$38,300,000	14:1	$28,100,000	22:1
TOTAL	$66,106,823		$71,100,966		$62,772,890	

* ROI = Return on Investment

** The ROI figures for 1990 represent eight months

Carriers made significant staff reductions to cope with the MSP budget reduction.

The most visible result of the reduced MSP budget is that it forced carriers to make significant staff reductions. These reductions made it impossible to maintain all MSP activities at the levels of prior years.

The following graph illustrates the staff reductions at the seven sample carriers for FY 1989 to 1990. These carriers reduced their Medicare-funded full time equivalents (FTEs) for MSP functions by 63%. In order to maintain adequate operating levels,

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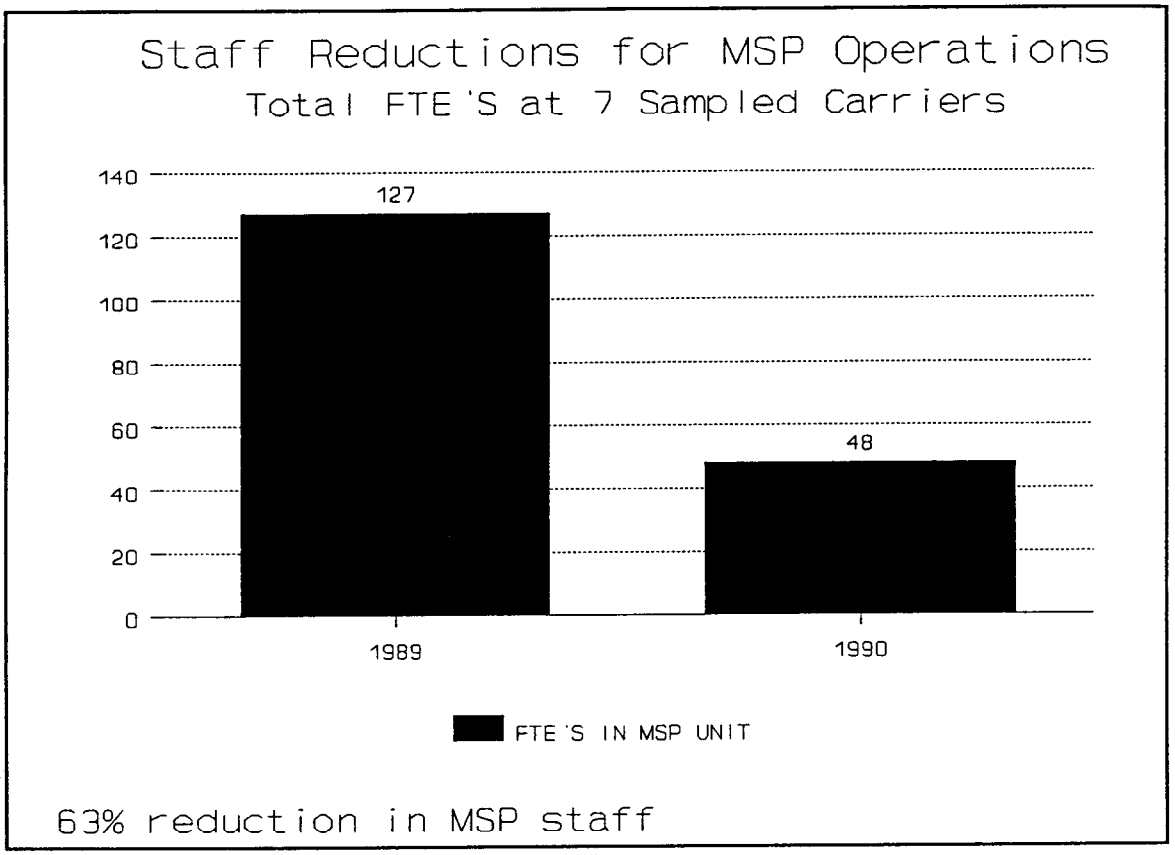
employees from two sampled carriers told us that they were receiving financial support from their private business. The data presented in the graph below does not reflect this support.



The budget reduction in FY 1990 will have long term effects on the operation of the carriers' MSP units. The budget proposal for FY 1991 includes a five million dollar increase for carrier MSP activities. Respondents indicated that this increase will not allow the carrier to "catch up" on a year's backlog created from operating without sufficient personnel. Carriers would use additional funds to recruit and train new personnel.

When questioned about the effect of the budget cut, one typical manager said, "It will be several years before we rebound from this budget cut. Recruiting and training someone from off the street takes a long time." Another typical manager commented, "We were forced to lay off efficient employees. The work we do in the MSP unit is complicated and the learning curve for these tasks is very large." We heard these and many similar comments at all sample carriers.

Most carriers do not recover overpayments following identification of MSP situations.

When carriers identify and develop potential MSP situations through the usual sources (i.e. first claim development, RDES, "Y-trailer" codes, etc), they deny MSP claims and count the MSP savings from this denial on the HCFA-1564 savings report. However due to the budget and staff reductions for FY 1990, the carriers do not conduct further MSP development or initiate recoveries on claims previously paid by Medicare. These unassessed program losses are in addition to the OIG's current estimate of losses due to the MSP provisions. These new losses have been created by the carriers' inability to continue MSP operations at the same levels prior to the budget reduction.

Representatives from five of seven carriers in this review told the review team that they are conducting no MSP recovery activities. Representatives from the two remaining sample carriers indicated that they are recovering overpayments on a selective basis. These carriers recover those cases that have greatest potential for savings and only do so within their current operating budget.

When asked what development and recovery action is taken on claims that may have been inappropriately paid by Medicare, respondents indicated that they were being stored in boxes and file cabinets. The inspection team observed these claims firsthand at all seven sample carriers. Carrier representatives said that these recoveries will be made when, or if, additional funding and development staff become available.

We asked respondents from the carrier's MSP staff if they knew or could estimate the value of the inappropriately paid claims waiting to be recovered. No one could provide an adequate count or estimate of the number and/or value of these claims. However, all indicated that if this substantial amount was recovered, it would accelerate the carriers' progress toward their MSP savings goal.

A recent audit conducted by the OIG Office of Audit Services has also verified this backlog of claims. Additional inspection work could provide an accurate estimate of the lost savings.

The HCFA's "required task" list does not include the recovery of MSP overpayments.

The aggressive collection of debts due the United States Government is required by statute and regulations, these regulations include the Federal Claims Collection Act and 4 CFR 102.1. Despite these requirements, HCFA has not placed emphasis on the recovery of overpayments resulting from previously unidentified primary payment sources.

In November 1989, correspondence from HCFA provided carriers with MSP claims processing and development priorities for coping with the budget reduction. These priorities are divided into two lists (see Appendix C). The first list contains

"required tasks" and the second includes those tasks that should be undertaken "to the extent that funds are available." Recovery of MSP overpayments is not included on the "required task" list and is the third of four items on the second list. The decision on how much time and effort the carriers expend to make recoveries is left to the carrier's discretion.

The carriers are not directly evaluated on the various methods used to identify and recover overpayments. This is evidenced by the absence of a CPEP performance standard to specifically evaluate the carriers' effectiveness in implementing the various procedures for identifying MSP situations or recovering MSP overpayments. Currently, the only criteria used to evaluate the performance and effectiveness of the MSP units are based on achievement of the pre-established MSP goals.

MSP SAVINGS ISSUES

Inconsistencies exist in methods used to identify and calculate savings.

The HCFA calculates MSP savings goals for all contractors at the beginning of each fiscal year. The HCFA has issued instructions and procedures explaining the methods that should be used to calculate MSP savings. However, carriers are not counting and calculating these savings uniformly, and some of the savings being counted are questionable.

- The HCFA procedures do not require carriers to query for deductible status when calculating savings. This allows carriers to count a deductible amount paid by the beneficiary as MSP savings. The deductible amount is not savings because the beneficiary would pay this amount in any situation. Four sample carriers were not completing such queries but were claiming deductible amounts as savings. Three sample carriers were querying for deductible status but were not counting the deductible as savings.

- The HCFA allows carriers to count savings when an outside source pays a claim as the primary payer and the carrier is informed of this payment by an outside source (i.e. insurance company or physician's office). These savings are counted by some carriers even though no claim is submitted to the carrier. In this situation, savings amounts must be estimated by the carrier because they do not pass through the carrier's system. Four of the sample carriers were counting these situations as savings. Three sample carriers were not counting these situations as savings.

RECOMMENDATIONS

The HCFA should continue to pursue additional funding to ensure that carriers restore operations of the MSP units to a level at least equivalent to FY 1989.

The FY 1990 budget reduction for MSP activities has affected carriers' ability to handle the MSP workload. Carriers face a huge backlog of potential MSP recovery cases with reduced staffing and funding. In order to effectively identify and recover all possible MSP situations, the carriers must use all procedures available to them. Restoring the MSP unit's operational efforts to the levels of the prior year will help carriers utilize current procedures to identify and recover as many MSP savings as possible.

To accomplish this, it might be necessary to restore appropriations to previous levels. An alternative would be to provide the funding out of savings captured by each contractor. The next recommendation provides details of this option.

The HCFA should consider the development of a legislative proposal that would allow them to conduct demonstration programs to evaluate incentives designed to enhance the identification and recovery of inappropriate MSP payments.

Many sources have established that Medicare funds continue to be lost due to unidentified primary payment sources. An incentive program would provide the carriers an opportunity to increase Medicare savings while supplementing their operating budget. This incentive program should not supercede current MSP requirements and procedures. Carriers would be required to maintain all educational efforts at the current level.

For implementation of this type of program, a legislative change is necessary. Sections 1814 (b) (1) and 1814 (b) (3) (A) of the Social Security Act require contractors be reimbursed only for the "reasonable cost" or "customary charge" for the services rendered. If an incentive program is implemented as a demonstration project, it might be necessary to modify this law.

Current MSP procedures are cost effective. This is illustrated by the data presented in Table 1 on page 4 of this report. Medicare is currently saving 13 to 22 dollars for every dollar spent for operations at the carriers' MSP units. As long as these return on investment figures remain positive, an incentive program will be cost effective for the Medicare program.

The following options describe some of the many possibilities for this incentive program. By implementing one of these options, we estimate that additional savings could range from $199 million to $361 million. We suggest that HCFA evaluate

these options for demonstration programs and determine appropriate reimbursement percentages for these incentives.

OPTION A: The HCFA could allow participating carriers to use five percent of all savings they identify during the year to increase their ability to identify MSP situations. These payments would not be included as part of the carriers' contract budgets.

OPTION B: The HCFA could allow participating carriers to use five percent of all savings identified during the year plus an additional two percent of all savings from recoveries made on claims that were previously paid inappropriately. As in Option A, these payments would be used by the carrier's MSP unit to finance part of their activities. This option would provide additional funding to aggressively collect inappropriate payments.

OPTION C: The HCFA could allow participating carriers to keep a total of five percent of identified savings. Three percent would be used by the carrier's MSP unit to finance collection efforts. The remaining two percent could be an incentive payment used in any area of the Medicare operation or be retained as profit. This option could provide an even greater incentive to the carriers because they would have more flexibility in utilizing these incentive payments.

OPTION D: The HCFA could allow participating carriers to keep twenty-five percent of the savings carriers identify and/or collect above their established MSP savings goal. This option provides an incentive for carriers to continue to aggressively pursue all potential MSP cases even after the yearly MSP savings goal is achieved. As in Option C, 60 percent of these payments would be used to finance collection efforts, the remaining 40% would be an incentive payment.

[See Appendix D for an estimate of potential savings to the Medicare program should one of these incentive options be implemented.]

In order for any of these incentive systems to be effective, the method of measuring achieved savings must be reliable. The next two recommendations address this problem.

The HCFA should modify the CPEP standards to evaluate carriers on their MSP identification, recovery, and educational efforts.

The only criteria for the MSP portion of the CPEP evaluation is the achievement of their MSP savings goal. If the carriers achieve 90 percent of their savings goal, they receive 100 points toward their CPEP evaluation. However, the carriers are not evaluated on their compliance and efficiency in conducting MSP identification and recovery activities.

The recovery of overpayments created by not properly identifying primary payment sources other than Medicare is not a priority for the carriers. This results in a substantial loss to the Medicare program. The CPEP standards should be modified to emphasize the importance of identifying and recovering these overpayments.

The HCFA should provide clear and uniform procedures for counting MSP savings.

We found inconsistencies in the methods used to identify, count, and report MSP savings. We recommend that HCFA clarify the procedures currently used to count and report these savings.

We are not recommending a specific method, but we do recommend that the procedures used by all carriers be consistent.

AGENCY COMMENTS

The HCFA did not concur with the recommendations presented in this report. The HCFA's verbatim comments can be found in Appendix E.

We believe it is necessary that carriers operate at a level at least equivalent to FY 1989. We understand that this requires additional funding and that this decision is not completely in HCFA's control. However, we feel the HCFA should continue to actively and aggressively pursue this additional funding. We have modified the first recommendation to clarify our position.

We believe that an incentive program would enhance the carrier's motivation to aggressively identify MSP situations and recover overpayments. We recognize the legislative implications for establishing a program such as this, but feel the potential benefits in the form of savings to the Medicare program would justify the efforts in this area. We have modified the second recommendation to encourage HCFA to pursue the necessary legislative changes to make such a demonstration program possible.

We realize that 10 percent of the carriers' CPEP evaluation is devoted to MSP functions. However, the only criteria for this evaluation is the percentage of the savings goal that is achieved by the carrier. The carriers are not evaluated on the efficiency and/or compliance with the MSP procedures described in the carriers' manual. We continue to believe that a percentage of the CPEP evaluation should be devoted to areas other than simply achieving their MSP savings goals.

The fifth finding in this report discusses inconsistencies in methods of counting and reporting savings. These inconsistencies are partially due to differing interpretations of the procedures. The HCFA should assure that all procedures are conducted uniformly among the carriers.

The report has been modified to agree with HCFA's FY 1989 and 1990 budget figures for MSP activities.

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APPENDIX A

MEDICARE SECONDARY PAYER LEGISLATION

TITLE OF LAW	PUBLIC LAW	ENACTMENT DATE	EFFECTIVE DATE	DESCRIPTION
Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)	97-248	09-03-82	01-01-83	TEFRA made Medicare benefits secondary if the employee or spouse is age 65 through 69 covered by an EGHP and the employer has at least 20 employees.
Deficit Reduction Act of 1984 (DEFRA)	98-369	07-18-84	01-01-85	DEFRA broadened the definition of working spouse by including spouses age 65-69 of employed individuals under age 65, thereby removing the lower age limit.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)	98-272	04-06-86	05-01-86	COBRA further broadened the definition of working aged by removing the limitation of age 70 and older.
Omnibus Budget Reconciliation Act of 1986 (OBRA)	99-509	10-21-86	01-01-87	OBRA made Medicare items and services secondary for payment if the disabled beneficiary or spouse is working and covered under an EGHP.

APPENDIX B

PREVIOUSLY PUBLISHED REPORTS

1. Priority Audit Memorandum - Survey of the Tax Equity and Fiscal Responsibility Act of 1982 - March 7, 1984, Control Number: ACN-03-42009

2. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - August 24, 1984, Control Number: 1-07-4001-14

3. Medicare Secondary Payer Provision End-Stage Renal Disease - South Dakota - November 20, 1984, Control Number: 1-08-4009-14

4. Medicare Secondary Payer Provision End-Stage Renal Disease - Colorado - December 4, 1984, Control Number: 1-08-4001-14

5. Medicare Secondary Payer Provision End-Stage Renal Disease - Program Inspection Report - April 3, 1985, Control Number: 1-07/08-4002-14

6. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - North Dakota - May 1, 1985, Inspection Control Number: 03-08-5001-14

7. Program Inspection of Medicare as a Secondary Payment Source for Beneficiaries with End-Stage Renal Disease in the State of Oregon - May 10, 1985, Inspection Control Number: 3-10-4008-14

8. Medicare as Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts -June 1985, Control Number: 1-01-4105-31

9. Medicare as a Secondary Payer for Medical Services Related to Automobile Accidents in Massachusetts - Boston - June 1985, Control Number: 1-01-4105-32

10. Report by the Comptroller General of the United States. The Congress Should Consider Amending the Medicare Secondary Payer Provisions to Include Disability Beneficiaries - September 30, 1985, Control Number: GAO/HRD-85-102

11. Medicare Secondary Payer Provision Automobile Liability and Medical Insurance - State of Missouri -Program Inspection Report - December 1985, Control Number: 3-07-5001-32

12. Medicare Secondary Payer Provision Automobile Medical and No-Fault Insurance - State of Colorado - Program Inspection Report - December 1985, Control Number: 3-08-5002-14

13. Medicare Secondary Payer Provision Credit Balances in Medicare Beneficiary Hospital Accounts, Control Number: OPI-85-070-040

14. Medicare Secondary Payer Provision Working Aged in Missouri - July 1986, Control Number P-07-86-00079

15. Medicare Secondary Payer Provision Working Aged in Colorado - July 1986, Control Number: P-07-86-00071

16. OIG Audit Report - Medicare Overpayments for Services Provided to Beneficiaries with End-Stage Renal Disease - April 28, 1987, Control Number: A-10-86-62003

17. OIG Audit Report - Retirees of Exempt State and Local Governments Could Cost Medicare $12.8 Billion over the Next 5 Years - September 10, 1987, Control Number: CIN A-09-86-62050

18. Amending the Medicare Secondary Payer Provision for ESRD Beneficiaries Could Save the Medicare Program $3 Billion Over the Next 5 Years - December 1, 1987, Control Number: CIN-A-10-86-62016

19. Medicare as a Secondary Payment Source - End-Stage Renal Disease - January 1988, Control Number: OAI-07-86-00092

20. Medicare as a Secondary Payment Source - January 1988, Control Number: OAI-07-86-00017

21. Medicare as a Secondary Payment Source: Medicare Beneficiaries Covered By Employer Group Health Plans - February 1988, Control Number: OAI-07-86-00091

22. Nationwide Review of Medicare as Secondary Payer for the Period September 1, 1983 through November 30, 1985, Control Number: CIN A-10-86-62005

23. Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare - November 1988, Control Number: GAO/HRD-89-191

24. Management Advisory Report: Medicare as Secondary Payer -- A Restitution Proposal, Control Number: AO-12-89-00002

25. Management Advisory Report: More Complete Employer Group Health Plan Information is Needed to Administer the Medicare Secondary Payer Program, Control Number: A-09-89-00100

26. Draft Management Advisory Report: MSP Survey - Contractors Questionnaire, Control Number: A-09-89-00151

27. Management Advisory Report: Medicare Secondary Payer: Unrecovered Funds (OEI-07-90-00764)

APPENDIX C

PRIORITY LISTS FOR CARRIERS' MSP ACTIVITIES*

Required tasks

1. Process prepayment recoveries. These recoveries should be processed for ongoing operations such as Working Aged, Workers' Compensation, Automobile Medical, Liability and No-fault, End Stage Renal Disease, and disabled.

2. Develop first claims submitted by a disabled individual and the first claim submitted by individuals ages 65 and 66. The results of the development must be incorporated into the regional data exchange system (RDES).

3. Operate and maintain the standardized software systems, and participate fully and completely in the RDES.

Tasks that should be complete to the extent that funds are available

1. Develop any new leads in any MSP area.

2. Process suspected cost avoidance claims (claims with "Y" trailers or indications of other insurance coverage from the RDES).

3. Recover mistaken prior payments or provide recovery information to lead contractor as appropriate.

4. Maintain outreach activities at the FY 1989 level.

* These priorities were communicated to HCFA regional offices in November 1989. Carriers were often notified verbally of these priorities but written notification was not uniform. Some carriers were never provided with these priority lists.

APPENDIX D

INCENTIVE PROGRAM OPTIONS

The following example represents potential savings to the Medicare program if an incentive program is established. All calculations are based on national figures for FY 1989 (the most recent fiscal year).

Return on Investment (ROI) for carriers (prior to FY 1990 reductions) = 14:1

Total Savings by carriers = $554,920,413

OPTION A:

Total Savings X Reimbursement Rate = Payment to Carriers

$554,920,413 X .05 (5%) = $27,746,020

The savings of over $27 million would be used by the carriers to supplement their MSP activities. The following calculation illustrates total Medicare program savings that could be achieved if this program is implemented.

Incentive payments to Carriers X ROI - Payment to Carriers = Potential Medicare Program Savings

($27,746,020 X 14) - $27,746,020 = $360,698,269

Even if the ROI decreased with increased expenditures, as long as it remains positive the program will remain cost effective.

OPTION B:

This option would provide additional funding to encourage carriers to make recoveries on the backlog of claims created by the FY 1990 budget reduction.

Savings for this option would equal the savings in Option A plus recoveries made on claims that were previously paid inappropriately. This potential savings is unknown because there is no accurate count or estimate of these potential recoveries.

OPTION C:

This option provides an added incentive to the carriers to use a portion of the funds in any area of the corporate operation.

Total Savings X Reimbursement Rate = Payment to Carriers

$554,920,413 X .03 (3%) = $16,647,612 (to supplement MSP unit activities)

$554,920,413 X .02 (2%) = $11,098,408 (incentive payment)

Payment to Carrier X ROI - Payment to Carriers = Total Medicare Savings due to Incentives

($16,647,612 X 14) - ($16,647,612 + $11,098,408) = $205,320,548

OPTION D:

Total Savings - FY 1989 Savings Goal = Amount Saved Above Goal

$554,920,413 - $447,109,000 = $107,811,413

Amt. Saved Above Goal X Reimbursement Rate = Payment to Carrier

$107,811,413 X .15 (15%) = $16,171,712 (to supplement MSP unit activities)

$107,811,413 X .10 (10%) = $10,781,141 (incentive payment)

Payment to Carrier X ROI - Payment to Carrier = Total Medicare Savings due to Incentives

($16,171,712 X 14) - ($16,171,712 + $10,781,141) = $199,451,115

APPENDIX E

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date MAR 18 1991

From Gail R. Wilensky, Ph.D.
Administrator

Subject OIG Draft Report - "Medicare Prepayment Review: MSP Procedures at Carriers", OEI-07-89-01683

To The Inspector General
Office of the Secretary

We have reviewed the subject draft report which concerns the effectiveness of Medicare carriers' prepayment utilization review processes used to identify Medicare Secondary Payer (MSP) situations. The report focused mainly on the Fiscal Year (FY) 1990 MSP budget reduction for Medicare carriers.

OIG recommends that HCFA ensure that carriers restore operations of MSP units to a level equivalent to FY 1989, conduct exploratory demonstration projects to evaluate incentives to enhance carrier identification and recovery efforts, modify the Contractor Performance Evaluation Program (CPEP) standards to evaluate carriers on their MSP efforts, and modify HCFA procedures for counting MSP savings. HCFA does not concur with OIG's recommendations. Our specific comments on the report's recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Report - "Medicare Prepayment Review: MSP Procedures at Carriers", OEI-07-89-01683

Recommendation 1

HCFA should ensure that carriers restore operations of the MSP units to a level at least equivalent to FY 1989.

Response

HCFA does not concur. Part B MSP funding was $38.3 million for FY 1989. FY 1990 Part B MSP funding was increased to $28.1 million from $22.3 million when funds were allocated from HCFA's contingency fund. However, Part B MSP funding for FY 1991 is $26.8 million. The MSP funding level reflects the budgetary constraints faced by HCFA and the entire Federal government. HCFA is hoping to be able to more adequately fund the carrier MSP function in FY 1992 and 1993, but cannot ensure that this will happen.

Recommendation 2

HCFA should conduct demonstration programs evaluating incentives to enhance the identification and recovery of inappropriate MSP payments.

Response

HCFA does not concur. The report included several suggestions for demonstrations, and all the suggestions proposed that carriers keep a portion of the recovered funds. OIG correctly noted that the primary obstacle to offering cash incentives is that this is contrary to current law. HCFA's past attempts to obtain the necessary legislative change to implement this recommendation have been unsuccessful.

Recommendation 3

HCFA should modify the Contractor Performance Evaluation Program (CPEP) standards to evaluate carriers on their MSP identification, recovery, and educational efforts.

Response

HCFA does not concur. HCFA already evaluates carriers' procedures for identifying MSP situations. There is a total of 1000 points in CPEP. Of this total, 100 points of CPEP are devoted solely to evaluating the contractors' performance of their MSP functions. HCFA believes that to allocate more than 10 percent of CPEP to MSP would not be appropriate. The current criteria used in the CPEP review include the essence of all of the elements OIG has recommended be included in CPEP. We also wish to note that we plan to use the Common Working File reports to evaluate carrier identification of MSP situations.

Recommendation 4

HCFA should provide clear and uniform procedures for counting MSP savings.

Response

HCFA already provides uniform procedures for counting MSP savings. The instructions are found in Section 13450 of the Medicare Carrier Manual, and in Section 3899 of the Intermediary Manual. Savings are validated during the annual performance of CPEP. If contractors are found to be reporting savings incorrectly, the CPEP scores are adjusted. Then, corrective action steps are outlined and controlled by HCFA regional offices.

Technical Comment

In Table 1 of page 4 of the report, OIG states that the carriers' MSP budget for FY 1989 was $37,579,565. Our figures show that $38.3 million was budgeted for the carriers' MSP function for FY 1989. Also the carriers' MSP budget for FY 1990 was $28.1 million, not $21,271,700.