
**MEDICARE CARRIERS'
PERFORMANCE OF PROGRAM
INTEGRITY FUNCTIONS**

**Richard P. Kusserow
INSPECTOR GENERAL**

**MEDICARE CARRIERS'
PERFORMANCE OF PROGRAM
INTEGRITY FUNCTIONS**

**Richard P. Kusserow
INSPECTOR GENERAL**

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to determine: (1) whether existing Health Care Financing Administration (HCFA) policies and procedures are appropriate to ensure adequate program integrity safeguards; (2) whether carriers are performing their program integrity responsibilities in accordance with HCFA operating policies and procedures; (3) whether current funding levels for carrier program integrity activities are adequate; (4) whether carriers are accounting for costs and savings pertaining to program integrity functions in an appropriate manner; and (5) where changes in HCFA policies or procedures are needed.

BACKGROUND

Medicare is a federally-funded program providing health care to the aged and disabled. Within the Federal government, the Medicare program is administered by the Department of Health and Human Services, Health Care Financing Administration. Payments for physician services and medical equipment, such as wheelchairs, are made through private insurance companies acting under contract with HCFA. Currently there are 46 such contractors (known as "carriers"), each with the responsibility for the payment of claims in a designated geographic area.

It is estimated that the Medicare carriers processed over 333.4 million claims in Fiscal Year 1987. In the processing of these claims carriers must ensure that payments are made only for services covered under the Medicare program, medically necessary under recognized standards of medical care, and actually rendered to eligible beneficiaries (Medicare patients). Included within the function carried out by the carriers to meet these responsibilities are functions generally labeled as "program integrity." Operating guidelines promulgated by HCFA for the performance of program integrity functions are contained in the Medicare Carriers Manual (MCM), sections 7500 ("Payment and Postpayment Procedures") and 11000 ("Fraud and Abuse").

The HCFA monitors carriers' performance of their contractual responsibilities, including program integrity, through the Contractor Performance Evaluation Process (CPEP). Under this process, a yearly evaluation of individual facets of the carriers' operations is conducted by HCFA personnel. Carriers must achieve minimum performance levels set by HCFA in order to retain their Medicare contracts.

This inspection was carried out as a joint effort of the three major components of the Office of Inspector General: the Office of Analysis and Inspections (OAI), the Office of Audit (OA), and the Office of Investigations (OI). The data collection process included review and analysis of pertinent HCFA and carrier budget and procedural documents, as well as examination of over 250 individual provider program integrity case files maintained by the carriers. In

addition, 190 persons were interviewed at nine carriers, seven HCFA regional offices, and the Bureau of Program Operations and Bureau of Quality Control in HCFA's central office.

FINDINGS

- **Certain HCFA policies/procedures regarding carriers' program integrity functions are outdated and are not being applied by carriers as intended in all instances.**
- **Funding levels for program integrity functions appear adequate but the trend toward allocation of carrier resources away from traditional program integrity processes is a concern.**
- **Carriers are properly accounting for costs and savings figures attributable to their program integrity functions.**
- **Improvements are needed in the OIG's systems for providing feedback on the status and disposition of fraud cases referred by the carriers.**

It should be noted that several of the above findings have previously been recognized and action is being taken. For example, HCFA has recently tested new guidelines for postpayment review (MCM 7500) on a demonstration basis at seven carriers. Also the CPEP is being modified to place more emphasis on quality versus quantity in evaluation of carrier "program integrity" activities.

RECOMMENDATIONS

The HCFA should:

- **Implement the new MCM 11000 section proposed by the OIG at the earliest possible date. Consultation should be held between HCFA and the OIG to remove any impediment to such implementation, and to consider the necessity of further modification of this section based on the other recommendations contained in this report.**
- **Proceed with the implementation of the new MCM 7500 section, after results of the demonstration project have been thoroughly analyzed.**
- **Designate a Program Integrity Coordinator in each HCFA regional office to act as a liaison with carriers on all program integrity matters.**
- **Separate program integrity costs from prepayment review costs for budget and accounting purposes.**

- Improve the technical knowledge of fraud and abuse issues of persons performing the CPEP review of the carriers' program integrity area.
- Expand the fraud and abuse element of the CPEP to include the review of a more representative sample of fraud and abuse cases handled by the carrier.
- Modify the current measure of the efficiency of the carriers' postpayment review activities to give more credit for innovative approaches developed by the carrier, and for activities that benefit Medicare patients as well as the Medicare program.

The OIG should:

- Undertake a detailed examination of case control systems and other processes involving carrier/OIG interaction and consider the need for altering these systems/processes to improve communications.

HCFA COMMENTS

Excerpts of HCFA's response to the OIG's recommendations are incorporated into the "Recommendations" section of this report.

As reflected by their comments, HCFA agrees with many of the recommendations but disagrees with others. Generally where disagreement occurs, it centers around the issues of availability of HCFA/carrier budget and/or staff to perform the functions addressed in the report.

The HCFA shares a common belief with the OIG that controlling fraud and abuse is essential to the continued well being of the Medicare program and they (HCFA) are willing to work with the OIG to try to resolve any differences in suggested approaches toward achieving this goal. "...We support any positive steps (e.g. cross-training, joint projects, regional HCFA/OIG/carrier meetings to discuss program integrity issues) that will enhance the effectiveness of the process." Already HCFA has invited OIG to participate in two meetings with carrier personnel to discuss implementation of the new MCM 7500 postpayment guidelines. The OIG intends to work closely with HCFA and the carriers on an ongoing basis to facilitate additional opportunities for resolving the issues raised in this report.

TABLE OF CONTENTS

	Page
EXECUTIVE SUMMARY	
INTRODUCTION.....	1
Background	1
Purpose.....	6
Methodology.....	6
FINDINGS	8
Current HCFA policies concerning carriers' program integrity functions are not as effective or efficient as they should be in several key areas	8
Carriers are not applying these policies as intended by HCFA in all instances	9
Funding levels for program integrity functions appear to be adequate but the trend toward allocation of resources away from these functions is a concern	11
Carriers are properly accounting for program integrity costs and savings.....	13
The lack of meaningful monitoring and feedback has a negative effect on carrier performance of program integrity functions	13
RECOMMENDATIONS.....	17

INTRODUCTION

BACKGROUND

Medicare is a federally-funded program established to assure access of the elderly and disabled to quality health care services and supplies by means of payment assistance. The program is divided into two distinct parts: (1) "Part A" - which primarily covers hospital services and supplies, and (2) "Part B" - which covers physician's services and "durable medical equipment" such as wheelchairs. This inspection deals with Part B.

HCFA-Administered - Within the Federal government, the Medicare program is administered by the Department of Health and Human Services, Health Care Financing Administration (HCFA). Overall direction is provided by HCFA's central office component located in Baltimore, Maryland. Responsibility for administering the program in specific States is shared among 10 HCFA regional offices located in major cities across the country.

Private Sector Involvement - Payments for services or supplies covered under Part B of the Medicare program are made through private insurance companies acting under contract with HCFA. Currently there are 46 such contractors (known as "carriers"), each with the responsibility for the payment of claims in a designated geographic area. The HCFA provides direction to the carriers on payment matters and is ultimately responsible for assuring that carriers are adhering to applicable program policies and procedures governing such payments.

Administrative Costs - Overseeing the budget process related to administrative costs incurred by the carriers in making program payments is another HCFA function. As the following table indicates, both these costs, and the volume of Part B claims handled by the carriers, have increased significantly in recent years:

Fiscal Year	Administrative Costs (Millions)	Claims Volume (Millions)
1984	\$492.4	213.2
1985	581.1	265.9
1986	589.6	296.4
1987	659.3 (est.)	333.4 (est.)

Program Integrity - With such an enormous number of claims to process, it is imperative that carriers ensure payments are made only for services covered under the Medicare program, medically necessary under recognized standards of medical care, and actually rendered to eligible beneficiaries (Medicare patients). The means by which the carriers fulfill this obligation is known generally as the "program integrity" function.

Although no official policy exists on precisely which carrier processes constitute the program integrity efforts, there is general agreement among carrier personnel that the processes encompass at least the following activities:

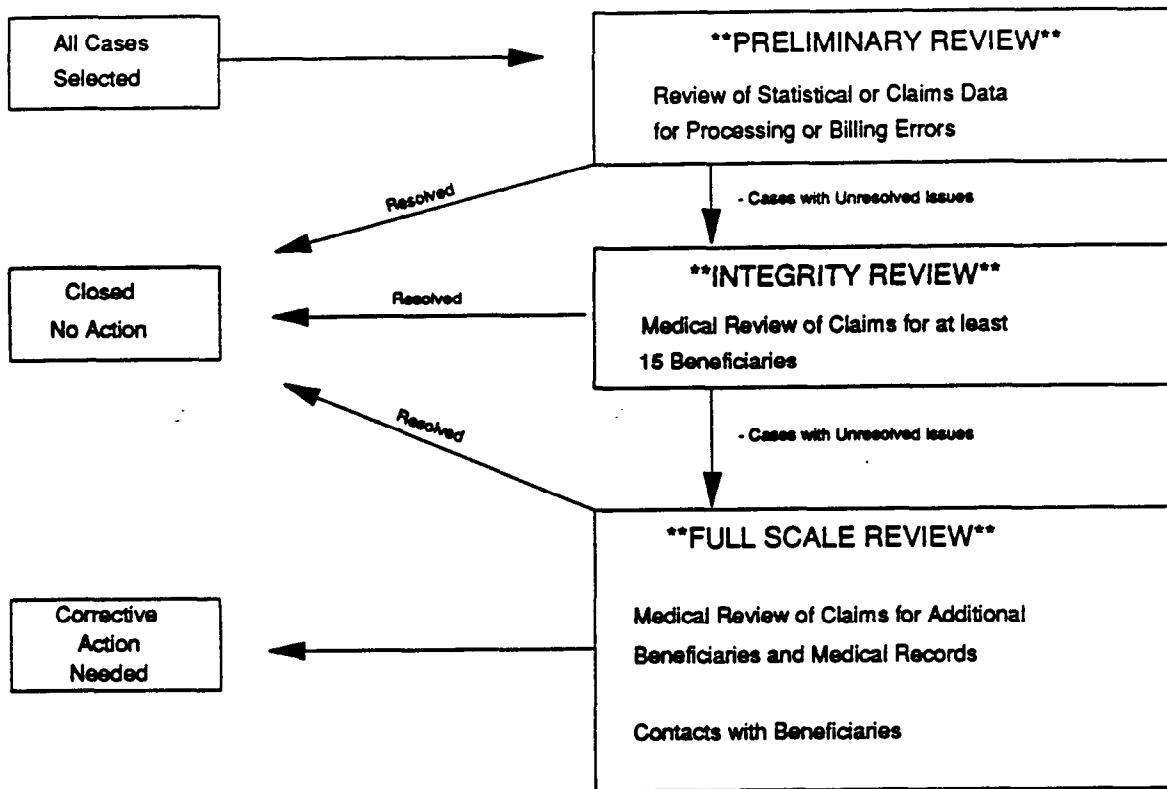
- *prepayment review*--the review of claims submitted by certain providers and suppliers of medical services or equipment, or for certain types of services or equipment, where the carrier has reason to believe that unnecessary or noncovered care is being billed;
- *postpayment review*--the review of paid claims which allows the comparison of service delivery patterns of providers or suppliers over a period of time with those of their peers over the same period; and
- *complaint resolution*--the process undertaken to develop and resolve situations where an allegation or indication of potential fraud or abuse is present.

Other monitoring functions aimed at ensuring proper payments for services could understandably be included in the definition of program integrity as well. However, while many different activities may be important to protect the integrity of the Medicare program, the two most critical to the detection and eventual resolution of significant instances of fraud or abuse are the *postpayment review* and *complaint resolution* areas. Accordingly, for purposes of this inspection, the term "program integrity" relates only to these two areas.

Current Requirements - The guidelines which HCFA has established for conducting the postpayment and complaint resolution functions are contained in the MCM sections 7500 and 11000 respectively. Both prepayment and postpayment review processes are addressed under the general heading of Medical Review/Utilization Review (MR/UR).

Postpayment Review - The principal methodology of the postpayment MR/UR process is the retrospective analysis of paid claims data covering an extended period of time, usually 1 year. This process is currently known as the Initial Three Percent Investigation List (ITPIL) and is mandated by HCFA for use by all carriers. This process begins with the computer generation of the previous calendar year's paid claims data for all providers (physicians or suppliers of medical equipment) in the carrier's service area. This data consists of the comparison of the pattern of practice of individual providers with that of their peers in at least 13 separate categories of services, such as office and hospital visits.

Review Selection Process (ITPIL) - After the data is generated, an initial review is made by "qualified" carrier personnel, often a registered nurse, to identify 3 percent of the total number of providers whose patterns of practice indicate some potential aberrancy as compared with the patterns of practice of their peers. These 3 percent are then subjected to three distinct, graduated levels of review, as illustrated by the following chart:



Corrective Actions - When a question still remains after all levels of review have been completed (carrier statistics show almost 91 percent of the providers initially selected are dropped out before reaching the final review level), the carrier is required to institute corrective action in one of the following forms:

- referral of the provider to the Office of Inspector General (OIG) for criminal investigation and/or administrative sanction action such as exclusion from the Medicare program;
- educational contacts with the provider;
- referral for peer review by a professional body, such as a State medical society;
- assessment and collection of an overpayment; and/or
- automatic prepayment review of all claims for services rendered by the provider under review.

Periodically, the carriers must conduct follow-up reviews of these providers to ensure that the corrective action taken has brought about the desired effect.

Complaint Resolution - The carriers' postpayment process described above basically represents a proactive approach to detecting and resolving potential fraud and abuse issues. The activities which the carriers perform under complaint resolution are more reactive in nature. Examples of situations that would trigger the complaint resolution process are: (1) a complaint or other report that a claim was submitted for supplies or services which were not provided, or (2) a report from the claims processing area that a physician's bill appears to have been altered.

Investigation - Where such matters involve questionable utilization practices or quality of care issues, the complaint resolution review process followed by the carrier may be very similar to that used in the postpayment area as already described. (In fact, in many carriers, these functions are conducted by the same persons.) However, where potential fraud is suspected, the carrier's role is usually limited to the initial development undertaken to resolve such situations. This may include contacts with personnel in other parts of the carrier's operations, review of medical and other records on hand, and limited contact with Medicare patients of the "suspect provider." Investigation of a potential fraud matter beyond the initial development stages is the responsibility of the Office of Investigations (OI)/Office of Inspector General. Carriers refer such cases directly to the OI regional office which serves their geographic area.

Technical Advisory Groups - To help fulfill its responsibilities to monitor carrier performance and to determine the need for policy or operational reforms, HCFA has formed Technical Advisory Groups (TAGs) for various areas of the carriers' operations, including one for Medical Review/Utilization Review. The TAG membership includes carrier personnel with expertise and experience in the specific area of carrier operations. Central and regional office HCFA staff also serve as members. The MR/UR TAG deals not only with matters involving prepayment and postpayment review, but with the complaint resolution area as well, although the latter is less of a focal point than the other two.

MR/UR Proposed Changes - Several years ago the MR/UR TAG evaluated the carriers' postpayment processes (primarily ITPIL) in response to a growing concern that those processes were not as effective and efficient as they should be. As a result of the TAG's evaluation, a draft for a new MCM 7500 section has been written which significantly alters the current ITPIL process. The principal improvement being proposed is the broadening of the process by which providers are initially selected for review by including the use of other information sources in addition to the computer-generated peer comparison data. This change should allow the carriers to have greater success in identifying "productive" cases initially, without having to spend as much time and effort weeding out the "nonproductive" cases during the subsequent review processes.

The changes the TAG has proposed were recently tested on a demonstration basis at seven carriers during the period October 1, 1987, through March 31, 1988. Following this test, HCFA has been evaluating the results. If no major problems are found, HCFA plans to mandate the changes for implementation by all carriers effective October 1, 1988.

Strengthen Program Integrity Requirement - The OIG has proposed a new MCM 11000 section which would strengthen the carriers' efforts in the fraud and abuse areas in a number of ways. Chief among such improvements are the requirements that carriers: (1) designate specific staff to coordinate or carry out all of the carrier's program integrity functions; (2) establish a training program for all levels of employees to acquaint them with the goals and techniques of fraud and abuse control; and (3) establish a provider and beneficiary educational program on fraud/abuse penalties and administrative sanctions. The HCFA has not yet implemented these revised instructions.

Performance Monitoring - In addition to establishing the policy and guidelines by which the carrier must conduct its program integrity effort, HCFA is responsible for ensuring that carriers are actually performing these functions in accordance with these policies and guidelines. This responsibility is met through HCFA's Contractor Performance Evaluation Program (CPEP). Under CPEP, persons from HCFA's regional offices conduct an annual review of various elements of each aspect of the carriers' operations. Specific criteria, standards, expected level of performance and methods of evaluation for each element are established by HCFA central office on a yearly basis. Point scores are assigned to each element by the reviewers, and carriers must accumulate a minimum number of points in order to retain the Medicare contract. Results of the CPEP are reported in the Annual Carrier Evaluation Report (ACER) which HCFA issues on each carrier.

PURPOSE

The purpose of this inspection is to determine: (1) whether existing HCFA policies and procedures are appropriate to ensure adequate program integrity safeguards; (2) whether carriers are performing their program integrity responsibilities in accordance with HCFA operating policies and procedures; (3) whether current funding levels for carrier program integrity activities are adequate; (4) whether carriers are accounting for costs and savings pertaining to program integrity functions in an appropriate manner; and (5) where changes in HCFA policies or procedures are needed. Among specific questions to be addressed are:

- Are current guidelines covering program integrity sufficient to assure the efficiency and effectiveness of the carriers' processes for identifying and resolving potential fraud and abuse matters?
- Are carriers applying program integrity guidelines as intended by HCFA?
- What is the level of funding budgeted by HCFA for carrier program integrity activities? Is this level adequate?
- Are carriers properly accounting for the costs of program integrity activities? Are cost and savings amounts used by HCFA to evaluate carrier effectiveness properly computed and adequately supported?
- Are there negative/positive influences on carrier performance of program integrity functions?
- What changes can be made in the current policies that would improve the effectiveness and efficiency of the carriers' program integrity efforts?

METHODOLOGY

This inspection was conducted as a joint effort of all three components of the Office of Inspector General: the Office of Audit (OA), the Office of Investigations (OI), and the Office of Analysis and Inspections (OAI). Overall coordination of the project was provided by OAI.

Records Reviewed - The HCFA budget and policy/procedural documents related to the carriers' program integrity function were reviewed and analyzed. An analysis of individual carrier's internal records and procedures, along with various carrier performance reports covering the period of Fiscal Year 1984 through the present, was also performed. Over 250 individual provider program integrity case files maintained by the carriers were examined.

Persons Interviewed - The bulk of the information gathered, however, came from interviews with persons most closely involved in the carriers' program integrity processes, both in HCFA and at the carriers themselves. In all, 190 persons were interviewed. These included: 151 at 9 carriers; 27 at 7 HCFA regional offices; and 12 at the Bureau of Program Operations and Bureau of Quality Control in HCFA's central office.

FINDINGS

EFFECTIVENESS OF CURRENT POLICY

Current HCFA policies concerning the carriers' performance of their program integrity functions are not as effective or efficient as they should be. Specific findings of this inspection are:

HCFA Guidelines Not Used

- Carrier staff members involved in the program integrity function generally do not use the current MCM 11000 and 7500 sections as operating guidelines. They rely instead on internal procedures they have developed on their own. Reasons given by carrier personnel interviewed are that the manual sections are outdated, somewhat confusing, and too general to be of practical use.
- Confusion exists among carrier program integrity staff as to whom to contact (HCFA or the OIG) on procedural or policy matters involving the complaint resolution area since the OIG assumed responsibility for investigating Medicare fraud cases. Providing such direction is primarily HCFA's responsibility. However, current guidelines do not make this clear. Many carrier staff members believe that HCFA does not have the technical knowledge of the complaint resolution process necessary to adequately perform this function.

Peer Review Inadequate

- Current HCFA policies do not require carriers to use independent peer review groups for rendering opinions on practice patterns of physicians who chronically abuse the Medicare program. Experience has shown that such peer review is important to support administrative sanction actions taken against problem physicians when other forms of corrective actions have failed. Although some carriers have contracted for peer review with State or local medical societies, others have not sought such service, or have not found it to be satisfactory. These carriers utilize only their own individual medical consultants. Only one of the nine carriers visited made use of the peer review capacity of the peer review organizations (PROs) already under contract with HCFA.

Review Selection Process Ineffective

- Processes historically mandated by HCFA for carriers' use in selecting providers for postpayment review have tended to be ineffective in identifying the worst abusers of the Medicare program. Only a few providers identified on the Initial Three Percent Investigations List eventually prove to be defrauding or abusing the program, and much time and effort is wasted in weeding out nonproductive cases

from those originally selected. This finding is consistent with that made by the MR/UR TAG from its research for development of new postpayment guidelines.

Carrier/State Medicaid Relationships

- Only three of the nine carriers visited have an effective working relationship with the State agencies administering the Medicaid program in their areas. Where such a relationship exists, information being shared on investigative or review methods and on providers suspected of fraud or abuse has significantly enhanced the carrier's overall program integrity effort. One carrier conducts joint reviews of some providers in cooperation with Medicaid staff. Current HCFA policies encourage such relationships but do not require or facilitate them.

CARRIER APPLICATION OF HCFA POLICY

Current HCFA policies regarding the performance of the program integrity function are not being applied as intended by HCFA at the nine carriers visited. (However, since the policies themselves were found to be deficient, failure to properly apply them does not necessarily result in a less effective program integrity effort.) The extent of this problem was found to vary greatly from carrier to carrier, with some carriers apparently doing their best to comply with current requirements while others are making considerably less effort. The following are examples of deficiencies noted at one or more carriers during the course of this inspection which are considered significant enough for comment:

Inappropriate Handling Of Cases

- Seven of the nine carriers visited are closing potential fraud cases prematurely by resolving the initial complaint without expanding the review to determine if the problem is widespread. At one carrier this situation occurred even though the carrier already had evidence in its files that the alleged problem was, in fact, widespread. In this case, the carrier had received 15 separate complaints against a durable medical equipment (DME) supplier over a period of time. Allegations made in these complaints concerned billings for equipment that the patient had never received, and continuing to bill for equipment after it had been returned to the supplier. Each complaint was handled by the carrier as though it were an isolated incident, when the pattern of potential fraud or abuse suggested by the number and similarity of the allegations should have caused the carrier to refer the case to the OIG for further investigation.
- In many instances carriers are not including administrative sanction warning notices in their correspondence to providers as required in MCM 11000. Such omissions make it more difficult for the OIG to initiate stronger action against the provider if the carrier's initial contact fails to resolve the issues.

- Three of the carriers visited have an early screening policy where direct contact is made with the subject of an allegation to request documentation of the service(s) in question. This is done even though the allegation may be that the provider is billing for services not rendered and premature contact with the subject may compromise a potential criminal investigation.
- Carriers are proceeding to identify and recover overpayments without first consulting the OIG in cases which may warrant criminal or administrative sanction actions. Carrier personnel interviewed indicated that pressure to do this arises, in part, from the need for carriers to identify actual dollars saved as a result of their efforts in order to retain their Medicare contracts. (Specific criteria by which the carriers' "program integrity" functions are evaluated by HCFA are discussed later in this report.)
- None of the nine carriers visited are reviewing a full 3 percent of their active providers through the ITPIL process. Some have reduced this figure, with HCFA's permission, by eliminating the review of certain categories of providers or services which have proven unproductive in the past. Others have unilaterally reduced the percentage reviewed simply by selecting fewer providers. In both instances, carriers claim they are attempting to bring the number of providers to be reviewed down to a number they can more realistically handle.

Carriers Behind Schedule

- Despite the reduction of the ITPIL, many carriers are still behind in their review process and are not resolving cases within the 1-year timeframe required. One carrier has an internal goal of resolving cases within 4 years.

Inappropriate Prepayment Review

- Providers whose claims have been placed on special prepayment review, as a result of problems identified in the postpayment process, are often left on prepayment review indefinitely without periodic evaluation to determine whether additional action may be needed. It was noted, for example, that one carrier had a number of providers on special prepayment review at the time of our visit that had been in this status for over 5 years. The carrier had not performed any periodic evaluation of these cases to determine what further action was necessary to resolve these problems so as to remove these providers from the costly prepayment review process.

Training Needed

- Overall program experience and knowledge levels of persons working in the carriers' program integrity area are relatively high, with most persons having spent at least several years in claims processing. However, a lack of expertise in specific methods and techniques for reviewing and processing cases involving potential fraud or abuse was noted at several of the carriers visited. These carriers do not appear to have the capability to correct this deficiency without outside technical assistance.

ADEQUACY OF FUNDING LEVELS

Lack of adequate funding for carriers to perform their program integrity functions does not appear to be a serious problem at this time. However, the manner by which such funds are allocated among the carriers' various operations may be gradually eroding the effectiveness of the program integrity effort. Also, as HCFA determines the need for increased monitoring in selected areas of carrier activity, the monitoring functions are often placed with the same staff responsible for the traditional program integrity roles. This in turn diffuses the staff effort in fraud and abuse control.

Program Integrity Costs Not Identifiable

- Under current HCFA budgeting and accounting procedures, costs of the carriers' program integrity functions are included with costs of various prepayment activities in the general category entitled Medical Review/Utilization Review. Costs attributable to the individual functions within this category are not specifically identified. Accordingly, it is not possible to identify the "adequacy" of funding for any particular function by itself.

Funding Increased

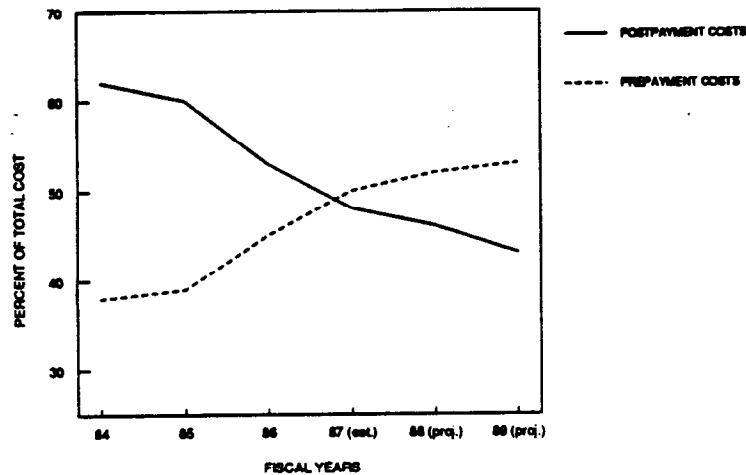
- Funding levels for the MR/UR category have increased during the period covered by this review from \$36.3 million in Fiscal Year 1984 to an estimated \$68.2 million in Fiscal Year 1987. Some of these increases can be attributed to changes in accounting procedures made during this period; however, there has also been an actual increase in funds available for use by the carriers.

Allocation Changed

- Since Fiscal Year 1984, the use of MR/UR funds by carriers has shifted dramatically away from postpayment (including ITPIL and complaint resolution) and toward prepayment activities as a result of a higher rate of measurable savings achieved through the latter. While fiscally prudent on its face, this shift,

in combination with other factors discussed later in this report, has had the unintentional effect of eroding postpayment functions critical to the assurance of quality care and to the detection of providers abusing or defrauding the Medicare program. The following chart illustrates this trend at the nine carriers visited during this inspection:

REPORTED CHANGE IN MR/UR COST AT SELECTED CARRIERS



Functions Added

- Numerous functions generally aimed at cost containment have been added to the postpayment review area in recent years. This has diverted carrier staff away from the more traditional program integrity functions. Staffing levels in the carriers' postpayment area do not appear to have kept pace with these added responsibilities, nor with the additional workloads resulting from the increased claims volume being handled by the carriers (as previously noted in this report).

Some New Functions Ineffective

- According to carrier staff interviewed, some of the functions added to the postpayment area are not effective or efficient in terms of either dollars returned or deterrence. Most frequently mentioned is the Part A and Part B link. This process requires carriers to make medical necessity determinations on the Part B physician's billing for a beneficiary each time the Part A contractor (intermediary) reduces or fully denies the hospital stay of that patient. When the Part B service is also found to be medically unnecessary, usually no overpayment is collected due to waiver of liability provisions of the Medicare law. These provisions state that for a patient to be held financially responsible, he must have known prior to the service being rendered that it would not be covered.

CARRIER ACCOUNTING PROCEDURES

No significant deficiencies were noted in the methodology or procedures by which MR/UR costs (including costs of program integrity) are accounted for at the carriers visited.

Cost/Savings Properly Documented

- Costs directly charged to the MR/UR operational category are adequately supported by source documentation.
- Indirect costs are charged on the basis of reasonable allocation methods applied consistently to applicable carrier cost centers.
- Savings figures attributed to the postpayment process were verified at each of the carriers visited and no major discrepancies were observed.

INFLUENCES ON CARRIER PERFORMANCE

This inspection revealed two factors which influence carrier performance of the program integrity function: (1) the attitude of the carrier's own management regarding the importance of this function; and (2) the perception of carrier staff regarding the importance which HCFA and the OIG attach to the program integrity effort, as reflected by the monitoring and feedback provided in this area. Regarding the first factor, management attitudes differ greatly from carrier to carrier. Regarding the second, some carriers perceive a need for better communications with the OIG concerning case referrals while all carriers visited believe that program integrity is not as high a priority for HCFA as are other areas, such as prepayment and claims processing.

Emphasis On Dollars Saved

- The principal measurement of the *efficiency* of the carriers' postpayment review process utilized by HCFA in its Carrier Performance Evaluation Program (CPEP) is the Cost Benefit Ratio (CBR). This is the ratio of savings attributable to a function to the cost of performing that function. Carriers must achieve a combined CBR of no less than 5 to 1 for their prepayment and postpayment review processes to receive a passing score on the CPEP.

Benefits Of Postpay Not Recognized By CPEP

- Historically, the CBR of the prepayment area has been 7 to 1 or better, while that of postpayment has been 1 to 1 or less. This may be attributed to the fact that the postpayment process is much more labor intensive, and thus more costly than prepayment. Also, much of the benefit achieved by the postpayment effort is in the form of deterring fraud and abuse and protecting Medicare beneficiaries from

harmful or unnecessary services. These benefits are not easily measured in terms of specific dollars saved. The disparity in the CBR's was cited by carrier management as one of the principal reasons for the shift in the percentage of funds allocated from postpayment to prepayment.

Insufficient Review Of The Effectiveness Of Postpay

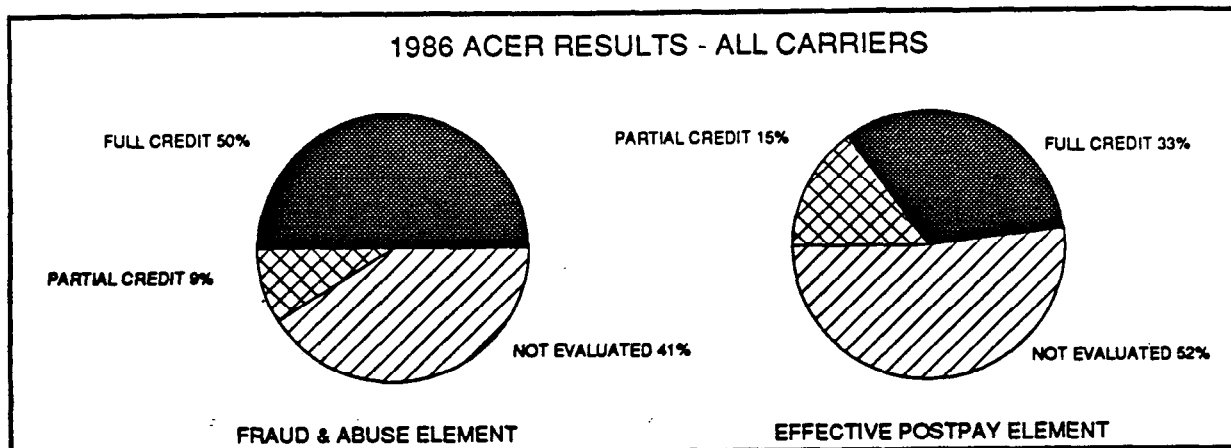
- The *effectiveness* of the carriers' postpayment function is measured primarily by their adherence to HCFA guidelines covering review processes and reporting requirements. Carriers visited in this inspection reported, however, that they have not seen a great deal of attention paid to this particular review element by HCFA in recent years. The CPEP element measuring effectiveness does not carry as much weight in the point score given the carriers as does the element measuring the CBR.

Insufficient Review Of Complaint Resolution

- The HCFA measures carrier performance in the complaint resolution area by reviewing 10 fraud or abuse cases which are opened by the carrier sometime between the beginning of the year and the date the CPEP review is conducted during that year. Both carrier and regional office staffs believe that this is not an adequate measurement of the carriers' total performance in this area. The three principal reasons are said to be: (1) too few cases are reviewed to provide a valid reflection of carrier investigative and review processes; (2) cases "opened" between the beginning of the year and the date of review may only be several weeks/months old and, thus, may have had little or no action taken; and (3) HCFA personnel conducting the case review generally do not have sufficient training or background in fraud and abuse matters to sufficiently assess carrier performance in this area.

Program Integrity Frequently Not Reviewed

- Carriers assert that neither the fraud and abuse nor the effective postpayment elements of the CPEP have received sufficient attention in recent years. Their assertions are supported by the results reported by HCFA in the Annual Carrier Evaluation Reports (ACER's). The following chart reveals that these elements were not reviewed in the Fiscal Year 1986 CPEP at a significant percentage of the 46 carriers under contract that year. Additionally, where these elements were reviewed, the carriers were usually given full credit. This inspection however, found at least some procedural or technical deficiencies at every carrier visited.



Lack Of Feedback

- A comment heard quite frequently during this inspection was that HCFA is not providing meaningful feedback on the carriers' performance of program integrity efforts. Neither the CPEP nor the performance reports submitted periodically by the carriers themselves appear to generate the needed dialog between HCFA and the carriers. For 1985 and 1986, HCFA did not require the carriers to submit their annual management reports. These are the only complete source of information produced on carrier program integrity activities. When these reports were required, carriers indicated that they received little or no response from HCFA on their performance, or on other carriers' activities in the program integrity area.
- Several carriers pointed out that the OIG needs to be more involved with their (carriers') program integrity responsibilities. Timely and consistent handling and feedback on status of suspected cases of fraud referred to the OIG were the principal areas mentioned. Carriers believe better systems are needed to facilitate communications on such referrals.

CONCLUSION

A summary of the findings of this inspection reveals that:

- (1) current HCFA policies concerning carriers' program integrity functions are not as effective or efficient as they should be in several key areas;
- (2) carriers are not applying these policies as HCFA intends in all instances;
- (3) funding levels appear adequate, but allocation of carrier resources away from traditional program integrity processes is a concern;

(4) carriers are properly accounting for costs and savings; and

(5) the lack of meaningful monitoring and feedback has a negative effect on carrier performance.

It should be noted that the extent of the above problems did vary from HCFA regional office to regional office, and from carrier to carrier. Deficiencies observed pertained more to the nature of the policies or processes, rather than to the people performing them, who in general appeared to be making a reasonable effort. Additionally, HCFA is already taking steps to improve carrier performance of program integrity functions through the testing of the MR/UR TAG's revisions of the postpayment guidelines, and by modifying the 1988 CPEP to place more emphasis on quality over quantity. Through the continuation of such efforts and the adoption of the following recommendations, the carriers' performance of their program integrity functions should be enhanced significantly.

RECOMMENDATIONS

The following actions are recommended as a result of the findings of this inspection. Excerpts of HCFA's response to these recommendations are included.

RECOMMENDATION #1 **Implement New MCM 11000 Section**

Finding: Carrier staff members involved in the program integrity function do not often use the current MCM 11000 section as an operating guideline, as they consider it outdated, somewhat confusing, and too general to be of practical use.

Recommendation: The HCFA should adopt and implement the MCM 11000 section proposed by the OIG at the earliest possible date. Consultation should be held between HCFA and the OIG to remove any impediment to such implementation, and to consider the necessity of further modification of this section based on the other recommendations contained in this report.

Impact: This will provide the carrier with a more practical, up-to-date guideline for performing the program integrity functions.

HCFA Comments: "HCFA believes that controlling fraud and abuse is essential to the continued well-being of the Medicare program. To this end, \$5.6 million has been included in our FY 89 funding request to implement the proposed instructions. It must be recognized, however, that considerable time has elapsed since the manual instructions were originally drafted and in the intervening period there have been numerous policy and program changes. It is essential that the proposed manual instructions be reexamined by our respective staffs to assure they are accurate and current before they are finalized and issued to the contractors and regional offices.... We believe these additional requirements (within the new instructions) could cost more than the \$5.6 million requested for FY 1989. As part of a reexamination of the proposed manual instruction, staff from the OIG and HCFA should complete a fiscal analysis of the proposed instructions to determine cost."

RECOMMENDATION #2 **Proceed With Implementation Of New MCM 7500 Section**

Finding: Certain postpayment processes (e.g., ITPIL) described in MCM 7500 are ineffective and are not identifying the worst abusers of the Medicare program.

Recommendation: HCFA should proceed with the implementation of the new MCM 7500 section, recommended by the MR/UR TAG, after completion of the current demonstration process. However, HCFA should ensure that a *thorough* analysis of the demonstration results is carried out to identify and correct any potential weakness prior to mandating the new guidelines for all carriers.

Impact: Implementation of the MR/UR TAG's suggested changes should improve both the effectiveness and efficiency of the carriers' processes for identifying and resolving matters involving abuse of the Medicare program.

HCFA Comments: "We plan to implement revised procedures for all carriers on October 1, 1988 assuming the analysis supports national implementation and providing that funds have been made available. Obviously, fund availability will determine the timing of the implementation of MCM 7500 sections."

RECOMMENDATION #3

Ensure Carriers Have And Maintain Capability To Apply New MCM Sections

Finding: Certain HCFA policies regarding the performance of the program integrity function are outdated and are not being applied as intended in all instances.

Recommendation: In conjunction with the implementation of the new MCM 11000 and 7500 sections, HCFA should ensure that each carrier has the capability to apply the new guidelines as intended. Such an assessment should include: (1) adequacy of resources, including number and qualifications of available staff; (2) training needs; and (3) sufficiency of internal operating procedures. Additionally, the HCFA should conduct annual reviews of the overall program integrity process to assure that expected results are being achieved. Program integrity methods and procedures must keep pace with the rapidly changing manner of delivering health care services, and the increasingly sophisticated methods by which providers are defrauding or abusing the Medicare program. The carriers' annual management reports could be used as one data source for this analysis.

Impact: This will assure that the general foundation needed to achieve the maximum effectiveness of the new guidelines is in place at all carriers, and that the efficiency and effectiveness levels gained by the implementation of the new MCM sections are maintained on an ongoing basis.

HCFA Comments: "The OIG makes the point that HCFA should ensure the capability of each carrier to apply the new guidelines. Measuring contractor capability is one of the major objectives of the CPEP program...."

"While HCFA feels strongly that it should have the sole responsibility for performing CPEP reviews, we do encourage the OIG to conduct training sessions on both the national and regional level as a means of increasing the effectiveness of the CPEP reviews as they relate to program integrity functions. This seems to be a natural and equitable division of responsibilities with respect to the CPEP program. In fact, staff level discussions between HCFA and the OIG have already initiated communications between regional OIG and CPEP staff."

RECOMMENDATION #4

Designate HCFA Regional Office Program Integrity Coordinators

Finding: Carrier staff members are confused as to whom to contact on procedural or policy matters involving the program integrity function. Carrier staff do not feel HCFA has the technical knowledge of fraud or abuse issues necessary to provide adequate guidance in this area.

Recommendation: The HCFA should designate one person in each of its regional offices to act as a Program Integrity Coordinator for all carriers in the region. The functions of this position would include: (1) acting as a liaison with the carriers on all matters involving the program integrity effort; (2) providing a focal point for receipt, analysis, and feedback for reports submitted by the carriers; (3) participating directly (or as a consultant) in the CPEP review process of measuring carrier "program integrity" performance; and, (4) assuring that chronic abusers are not being kept on prepayment review indefinitely when other action is appropriate. The HCFA should ensure that the persons appointed as program integrity coordinators have or receive appropriate training in fraud and abuse matters to enable them to perform their functions adequately.

Impact: Creation of this position would improve communications between HCFA and the carriers and, thus, should improve overall results of the carriers' program integrity functions.

HCFA Comments: "In view of the present staffing shortages and its many other responsibilities, it would be counterproductive for HCFA to designate a PI coordinator in each regional office."

RECOMMENDATION #5

Ensure Adequate Peer Review

Finding: Not all carriers visited during this inspection had the capacity to obtain peer review services necessary to support administrative sanction actions taken against physicians who are abusing the Medicare program by providing excessive or unnecessary services.

Recommendation: The HCFA should explore the possibility of carriers who do not have sufficient peer review capabilities obtaining such services through the appropriate peer review organization (PRO) under contract with HCFA in their States. For those carriers which do have adequate peer review, HCFA should determine whether such services could be supplied by the PRO on a more cost-effective basis, if the same or higher quality level can be achieved.

Impact: This will ensure that all carriers have the peer review capabilities necessary to support administrative sanction actions, which act as an important deterrent against abuse of the Medicare program.

HCFA Comments: "HCFA has increased its budget request to \$50 million for medical review doctors at carrier sites. Assuming this money is forthcoming, we believe this should be adequate funding to provide sufficient peer review capability to each carrier."

RECOMMENDATION #6

Separate Program Integrity Budget

Finding: Carrier program integrity costs are currently included, along with prepayment review costs, in the general budget category known as Medical Review/Utilization Review. Costs for individual functions within this category are not separately identified. The effectiveness and efficiency of postpayment functions are evaluated in terms of how they compare with prepayment functions, rather than on their own merits.

Recommendation: The HCFA should separate the carriers' program integrity costs (e.g., complaint resolution and postpayment review, and whatever other functions HCFA, the OIG, and the carriers agree should be included under the heading of "program integrity") from prepayment MR/UR costs for budget and accounting purposes.

Impact: This will allow for a more accurate assessment of the adequacy of program integrity funding levels and will help to convey to carriers the importance of their program integrity functions.

HCFA Comments: "HCFA believes that some type of a fiscal reporting system could be devised to capture overall PI costs. The main problem would be to devise a suitable definition of PI that would be accurate and acceptable to both HCFA and the OIG. Devising a workable definition (and the costs associated with it) is difficult at best. HCFA would welcome staff input from the OIG as to how a proper reporting mechanism could be devised. The financial staff within HCFA's Bureau of Program Operations (BPO) could work with OIG staff to devise a good fiscal reporting system for PI costs, once agreement had been reached on the definition.

"Another aspect of this recommendation is to separate PI for budget preparation purposes. We cannot support this aspect of the recommendation. It would be difficult to justify such an artificial separation since most of the MR/UR functions are inexorably interwoven. In many cases, the same personnel, computers, etc., are used to do both PI issues as well as normal claims processing. The temptation with a budget line for PI is to argue that this area be funded disproportionately to the other MR/UR functions. This could lead to annual disagreements with OIG for each carrier's budget for PI. We do not wish to encourage distinctions between payment safeguards (including good claims processing) and program integrity (as the OIG thinks of it)."

RECOMMENDATION #7
Assess Benefits Of Current Postpayment Functions

Finding: Numerous functions have been added to the carriers' postpayment processes in recent years. Carrier staff interviewed indicated that not all of the functions added are effective or efficient in terms of either dollars returned or deterrence.

Recommendation: The HCFA should analyze each function of the postpayment area to determine the extent of the benefit to the program integrity effort derived from that activity. Non-productive processes should be modified or eliminated.

Impact: This will assure that limited resources are being utilized in the most productive manner possible.

HCFA Comments: "We agree with this recommendation. HCFA recognizes the value of effective postpayment reviews to avoid inappropriate program expenditures. Thus, we would welcome any suggestions the OIG may have on processes which they consider to be productive or nonproductive."

RECOMMENDATION #8
Review Program Integrity CPEP Elements Annually

Finding: The fraud and abuse, and effective postpayment process elements of the Carrier Performance Evaluation Process have not been given adequate attention in recent years. For Fiscal Year 1986, the fraud element was not reviewed at 41 percent of all carriers, and the effective postpayment element was not reviewed at 52 percent of the carriers.

Recommendation: The HCFA should ensure that *all* elements of the CPEP pertaining to the program integrity function are reviewed at all carriers *yearly*.

Impact: This will assure identification of carriers with performance deficiencies so that corrective action may be implemented and will also convey to the carriers the importance of the program integrity area.

HCFA Comments: "FY 1986 was the only year that fraud and abuse standards were not reviewed at all contractors and this was instituted as an optional element only because of regional office (RO) resources limitations. In FY 1987, when the standards were deemed critical, reviews were required to be conducted at all contractors. For FY 1988 and FY 1989, HCFA determined that all standards will be reviewed at all contractor sites."

RECOMMENDATION #9

Improve Technical Knowledge Of CPEP Reviewers

Finding: Carrier staff interviewed believe that, in general, HCFA personnel conducting the case reviews for the fraud and abuse CPEP element do not have sufficient training or background in fraud and abuse matters to adequately assess carrier performance in this area. This opinion was echoed by several HCFA reviewers.

Recommendation: The HCFA should assure that regional office staff reviewing the program integrity CPEP elements have sufficient training and knowledge in fraud and abuse matters to enable them to conduct such reviews adequately.

Impact: This should improve the effectiveness of the CPEP process which, in turn, should lead to more effective performance of the program integrity function by the carriers.

HCFA Comments: "To do the most thorough evaluation of PI-related CPEP standards, RO staff would have to be more than just familiar with fraud and abuse matters. Such staff would have to be conversant with the role of pre-pay and post-pay MR/UR in uncovering fraud and abuse.... We suggest that the OIG provide guidelines to the HCFA RO CPEP staff that could be used in evaluating carrier PI functions. Again, we feel OIG training at both the national and regional level will do much to alleviate this problem."

RECOMMENDATION #10

Expand Fraud And Abuse CPEP Element

Finding: The CPEP element concerning carrier performance in the complaint resolution area consists of a review of only 10 cases of alleged provider fraud or abuse opened by the carrier during the review period. Carrier and HCFA personnel interviewed believe this is an inadequate number of cases at larger carriers and that many of the cases opened during the review period may have had little or no action taken on them at the time of the CPEP review.

Recommendation: The HCFA should expand the number of cases to be reviewed for the fraud and abuse element to a sample size more representative of the carrier's claims volume or program integrity workload. Additionally, the review should include cases "closed" by the carrier, not just those "opened," in order to provide a broader reflection of the carrier's total activities related to this area.

Impact: This will improve the effectiveness of the fraud and abuse CPEP element as a true measurement of carrier performance.

HCFA Comments: "This present method of evaluation (MOE) is based on "small samples" in recognition of limited RO resources. In the absence of updated instructions, an expanded review was not an efficient way to use limited resources. The MOE can be expanded to a full sample, but this is contingent upon the release of updated instructions, including timeframes, as

well as the availability of sufficient RO resources to conduct additional reviews. In spirit, HCFA agrees with the recommendation, but with the limited staff resources now available for this activity, it will be difficult to implement. We have however, revised the FY 1989 CPEP standards to explicitly include for sample review those fraud and abuse cases received in FY 1989 or closed in FY 1989."

RECOMMENDATION #11 Modify Measure Of Efficiency

Finding: The CPEP measures the efficiency of the carriers' postpayment activities by means of the cost-benefit ratio of the prepayment and postpayment areas combined. The CBR of the postpayment area has historically been far less than that of the prepayment area. This is because postpayment is more labor-intensive than prepayment, and much of the benefit of the postpayment process is in the form of deterrence, which is not easily quantified.

Recommendation: The HCFA should separate the postpayment and prepayment areas for purposes of assessing the efficiency of the postpayment process. The minimum CBR acceptable for the postpayment area should be reduced to a more practical level. Carriers should be given "credit" in the measurement process for monies saved beneficiaries as a result of their actions on assignment violations, and for carriers' innovative approaches of detecting or deterring fraud or abuse.

Impact: This will provide a more accurate reflection of the benefits derived from the postpayment process, encourage carriers to develop innovative review methods (possibly already being used in their private business), and eliminate the pressure to concentrate resources on the prepayment side due to the higher CBR of that area.

HCFA Comments: "Conceptually, this recommendation has merit. We have been examining the prepayment and postpayment areas very closely for some time and will continue to do so. However, our studies reveal that it is a very complex and involved area with no easy solutions. We would welcome any suggestions the OIG might have on how best to equitably treat carriers in the measurement process. We would also be interested in any suggestions the OIG might have on a minimum cost benefit ratio acceptable for the postpayment area."

RECOMMENDATION #12 Improve Systems For Carrier/OIG Feedback And Communications

Finding: Carriers were uneven in voicing concern or praise regarding their relationship with OIG regional staffs. Some noted that OIG failed to acknowledge receipt of cases of suspected fraud, and noted their need for feedback on status and disposition.

Recommendation: The OIG should undertake a detailed examination of case control systems and other processes involving carrier/OIG interaction and consider the need for altering these systems/processes to improve communications.

Impact: Carriers, in general, would be more likely to refer cases, and to more closely follow sound investigative techniques, with the prior knowledge that the OIG would give periodic and timely feedback on such referrals.

OIG Comments: The OIG has initiated an internal review to address this issue.