



Memorandum

AUG 7 1992

Date .
From Bryan B. Mitchell *Bryan Mitchell*
Principal Deputy Inspector General

Subject Corrective Action Review of The Health Care Financing Administration's Medicare Payment Safeguards Program (A-04-92-02037)

To William Toby
Acting Administrator
Health Care Financing Administration

Attached is a copy of our final management advisory report providing you with the results of our corrective action review of the Medicare payment safeguards program which was requested by the Department of Health and Human Services' (HHS) Council on Management Oversight (CMO). In a November 13, 1991 memorandum, we provided the results of our corrective action review to the Chairman of the CMO. We were requested by the CMO to review the payment safeguards program material weakness to determine if the corrective actions were properly completed by the Health Care Financing Administration (HCFA). Payment safeguards had been identified as both a material weakness and a high risk area in the HHS Fiscal Year (FY) 1990 Federal Managers' Financial Integrity Act report.

The premise of the HCFA corrective action plan was to request the redirection of funds from catastrophic health insurance to payment safeguards in FY 1990 and to request adequate funding in future years to maintain consistent levels of payment safeguards activities comparable to FY 1989. By doing so, HCFA believed contractors would be able to maintain well-trained staff and a consistent approach to payment safeguards activities, and thus eliminate the material weakness.

Our objectives were to determine whether HCFA completed their corrective actions, and whether the actions eliminated the material weakness and produced the desired results. To achieve our objectives, we reviewed the amount of funding the contractors received for payment safeguards in FYs 1989 through 1991 and analyzed the effectiveness of Medicare contractors' payment safeguards activities.

We found that HCFA maintained relatively stable payment safeguards funding levels as stated in their corrective action plan. However, we found that these funding levels were not adequate for contractors to maintain consistent staffing

Page 2 - William Toby

and workload activity in the safeguards areas of Medicare secondary payer (MSP) and medical and utilization review.

The review shows that Medicare contractors have not been able to initiate all needed recovery actions on identified potential overpayment claims due to insufficient staffing at MSP units. As a result, backlogs have developed. As of June 30, 1991, contractors have identified a backlog of \$1.1 billion in claims which Medicare paid and where the beneficiary could have other primary insurance coverage. We also found that unless the contractors notified the cognizant insurance company by December 31, 1991, that improper payments had been made, the Medicare program would lose up to \$393 million of the \$1.1 billion of improper payments due to MSP overpayment recovery regulations.

We are concerned that the objectives of the payment safeguards activities to control against fraud, waste, and abuse are not being met. This could adversely impact on the integrity of the Medicare program and result in significant program weaknesses. Based on the funding level and the expansion of the Medicare program, we found that the payment safeguards objectives of preventing, detecting, and recovering overpayments may have been compromised.

Accordingly, we recommend that HCFA review and modify its corrective action plan to assure that the objectives of the payment safeguards program to control against fraud, waste, and abuse are met.

In response to our draft report, HCFA decided not to close the payment safeguards program as a material weakness and developed a new corrective action plan. The HCFA comments are included in their entirety in our report.

We would appreciate being advised, within 60 days, of any actions taken or planned on our recommendations. If you wish to discuss our report, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other Department officials.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CORRECTIVE ACTION REVIEW OF THE
HEALTH CARE FINANCING
ADMINISTRATION'S MEDICARE PAYMENT
SAFEGUARDS PROGRAM**



AUGUST 1992 A-04-92-02037



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Memorandum

Date

Bryan B. Mitchell *Bryan Mitchell*

From

Principal Deputy Inspector/General

Subject

Corrective Action Review of The Health Care Financing Administration's Medicare Payment Safeguards Program (A-04-92-02037)

To

William Toby
Acting Administrator
Health Care Financing Administration

This final management advisory report provides the results of our corrective action review of the Medicare payment safeguards program, relative to its designation as a material weakness/high risk area. The review was requested by the Department of Health and Human Services' (HHS) Council on Management Oversight (CMO). In a November 13, 1991 memorandum, we provided the results of our corrective action review to the Chairman of CMO. We performed an analysis of the effectiveness of Medicare contractors' payment safeguards activities after the Health Care Financing Administration (HCFA) implemented their corrective action plan. Our review showed:

- o Total funding of payment safeguards was relatively stable but the allocation of the funds was not. Funding was decreased in the Medicare secondary payer (MSP) and the medical review/utilization review (MR/UR) areas.
- o The Medicare contractors, due to funding decreases, were not able to maintain adequate, well-trained, and seasoned staff to perform MSP and MR/UR payment safeguards activities.
- o The HCFA's corrective action plan did not consider increased volume in payment safeguards activities based on an expanding Medicare program. As a result, some contractors were not able to meet payment safeguards objectives in accordance with program guidelines.
- o The Medicare contractors have not been able to initiate all needed recovery actions on identified potential overpayment claims. As a result, backlogs have developed. We believe that the backlogs were created primarily as a result of insufficient staffing at contractors'

MSP units. As of June 30, 1991, contractors have identified a backlog of \$1.1 billion in claims that Medicare paid and where the beneficiary could have other primary insurance coverage.

- o Unless the contractors notified the cognizant insurance companies by December 31, 1991 that improper payments had been made, the Medicare program will lose up to \$393 million of the \$1.1 billion of improper payments due to the MSP overpayment recovery regulations (42 CFR 411.24(f)(2)).

The premise of the HCFA corrective action plan was to request adequate funding during the budget periods, Fiscal Year (FY) 1990 through FY 1992, to maintain levels of payment safeguards activities comparable to FY 1989. By doing so, HCFA believed contractors would be able to maintain well-trained staff and a consistent approach to payment safeguards activities. Our analysis of HCFA's corrective action plan showed that although HCFA met the funding goals for payment safeguards established in its corrective action plan, this was not enough to provide stability to some aspects of the payment safeguards program. We found examples of staff and workload resources for the safeguards activities that were adversely effected by FY 1990 and FY 1991 funding levels. We also noted instances where contractual workload goals were reduced or eliminated by HCFA due to inadequate funding in some safeguards areas. These actions may have compromised the payment safeguards program.

We concluded that HCFA met the funding goals established in its corrective action plan. However, we are concerned that the objectives of payment safeguards activities to control against fraud, waste, and abuse are not being met. This could adversely impact on the integrity of the Medicare program and result in significant program weaknesses.

Accordingly, we recommend that HCFA review and modify its corrective action plan to assure that the objectives of the payment safeguards program to control against fraud, waste, and abuse are met.

We received written comments from HCFA that addressed our findings and recommendations. The HCFA decided not to close the payment safeguards program as a material weakness and submitted a new corrective action plan. The HCFA stated that they have taken action to recover the backlog of MSP cases. In this regard, they obtained \$19.9 million in contingency funding, from the Office of Management and Budget (OMB), that will be specifically designated for the MSP backlog. They also stated that payment safeguards funding was less than

requested and that the Office of Inspector General (OIG) report does not highlight their budget request efforts. The HCFA comments are included in their entirety as Appendix II.

BACKGROUND

The Medicare program provides for a hospital insurance program (Part A) and a voluntary supplementary medical insurance program (Part B) for eligible beneficiaries. The Medicare program is administered by HCFA which contracts with intermediaries and carriers (contractors) to assist in the administration of the Part A and Part B services.

The contractors primary function is to process and pay claims for medical services in a geographical area. They also perform payment safeguards activities to control against fraud, waste, and abuse of the Medicare program. These activities include the following functional areas:

- o The MR/UR identifies unnecessary or inappropriate services delivered in other than an inpatient acute care setting. In addition, post-payment reviews identify unusual utilization patterns. Contractors report savings quarterly to HCFA on the "Report of Benefit Savings."
- o Provider audit performs desk reviews and field audits of the cost reports submitted by providers. Providers include hospitals, skilled nursing facilities, and home health agencies. The audits identify unallowable costs to the Medicare reimbursable costs claimed by the providers. Savings based on intermediary adjustments made to cost reports are reported annually to HCFA on the "Contractor Auditing and Settlement Report."
- o The MSP activities recognize other insurers as the primary payer of Medicare claims, including private insurers for automobile medical insurance, no fault insurance, liability insurance, and most employer's group health plan coverage for employed beneficiaries or through coverage for employed spouses. Contractors review claims to ascertain whether the beneficiary has other health or liability insurance coverage. Current claims are either reduced or denied, and paid claims are recovered. These savings are reported to HCFA on the monthly "Report on Medicare Secondary Payer Savings."

The HCFA has concluded that these payment safeguards are cost-effective and serve as an adequate means of identifying potential abuse and preventing improper claim payment. However, according to HCFA, inadequate and/or fluctuating levels of funding for payment safeguards prevent contractors from maintaining adequate, well-trained, and seasoned staff to perform the safeguards functions in accordance with program guidelines. Furthermore, HCFA states, if contractors were unable to staff these management control activities with well-trained personnel on an ongoing basis, the Medicare program would become vulnerable to an increase in incorrect benefit payments.

In 1989, the HHS declared payment safeguards as a material weakness. The intent of this designation was to focus more attention on the shortfalls and fluctuations in funding levels budgeted or projected for future years. The HHS included the material weakness in the FY 1989 Federal Managers' Financial Integrity Act report. In FY 1990, payment safeguards were classified as a high risk area by OMB.

The strategy which HCFA proposed to correct the problem was to request the redirection of funds from catastrophic health insurance to payment safeguards in FY 1990, and to request adequate funding in future years to maintain consistent levels of payment safeguards activities. This was the essence of HCFA's corrective action plan which was implemented during the period from FY 1990 through FY 1991.

In a memorandum dated June 4, 1991, the HCFA Director, Bureau of Program Operations, declared that the corrective action steps for FY 1990 through FY 1991 were completed and that payment safeguards should be declassified as a high risk area and material weakness. The Director, noting that although funding levels were not as high as preferred, concluded that funding for payment safeguards had stabilized over the past three budget cycles, permitting Medicare contractors to maintain well-trained staff and a consistent approach to payment safeguards activities.

The OIG was requested to perform a corrective action review of the Medicare payment safeguards program material weakness by the HHS' CMO. We were requested to determine if HCFA's corrective actions produced the desired results. In a November 13, 1991 memorandum, we provided the results of our corrective action review to the Chairman of CMO.

OBJECTIVE AND METHODOLOGY

Our review was requested by the CMO. We performed an analysis of the effectiveness of Medicare contractors' payment safeguards activities after HCFA implemented their corrective action plan. Our objectives included:

- o determining whether HCFA completed their corrective actions, and whether the actions produced the desired results;
- o determining the amount of funds contractors received for program safeguard activities in FYs 1989 through 1991; and
- o determining the impact of funding levels on the payment safeguards activities.

In order to meet our objectives, we performed an analysis of reported budget, expenditure, and savings data related to payment safeguards activities at Medicare contractors. Also, we examined HCFA management reports and correspondence between HCFA and contractors. We conducted interviews with representatives from HCFA central office, regional offices, and Medicare contractors.

Field work was performed at HCFA central and regional offices and Blue Cross and Blue Shield of Florida. We also contacted a sample of Medicare contractors via telecommunications. The field work was performed in August and September 1991.

RESULTS OF REVIEW

Although HCFA met the funding goals established in its corrective action plan, the plan did not achieve the desired results in the payment safeguards areas of MSP and MR/UR. We found that some contractors did not have adequate resources to examine claims when it was determined that Medicare was to be the secondary payer and that reduced workloads in the medical and utilization review of claims may have resulted in an increased vulnerability to waste and fraud.

We did find that funding for payment safeguards was relatively stable for the 3-year period ending FY 1992. This was the goal established by HCFA in its corrective action plan. Based on its plan, HCFA thought contractors would be able to perform payment safeguards activities at consistent levels, and thus eliminate the material weakness. However, we noted that the allocation of funds in two areas (MSP and MR/UR) decreased. As a result, the resources at some contractors were not adequate to maintain consistent levels of MSP and MR/UR safeguards activities. We found that contractor goals for workload activities were not always accomplished, some tasks defined in the Medicare contractor manuals were not performed, potential savings in some safeguard areas were not realized, and some contractors reported a backlog of unrecovered improper primary Medicare payments totaling an estimated \$1.1 billion.

PAYMENT SAFEGUARDS FUNDING

The HCFA corrective action plan called for adequate funding levels to maintain payment safeguards activities consistent with prior years. We reviewed funding levels for the period FY 1988 through FY 1991 by examining the Notice of Budget Approvals for contractors nationwide. We also reviewed the FY 1992 proposed budget (see Appendix I). We found that funding was relatively stable during these years. Total safeguards funding was decreased by only 4 percent in FY 1990 and FY 1991 over the FY 1989 level. However, we found that HCFA's allocation of these funds was not consistent through the years. The funding in two safeguards areas, Part A MR/UR and Part B MSP, decreased by 32 percent and 36 percent, respectively. The other safeguards areas received increased funding in FY 1990 and FY 1991 at a rate of between 3 percent and 11 percent. We found that the funding reductions had a detrimental impact in Part A MR/UR and Part B MSP.

Funding also impacted the payment safeguards program in another way. We believe the HCFA corrective action plan did not sufficiently address the expansion of some safeguards activities through the years. With the annual volume of Medicare claims increasing over 12 percent and the need to identify MSP cases steadily increasing, we expect the workload for payment safeguards to increase accordingly. Therefore, even if contractors had maintained FY 1989 production levels through FY 1992, they would have had difficulty in managing the increased workloads.

ABATEMENT REQUESTS

Our review showed that due to funding reductions in FY 1990, some contractors were not able to maintain consistent staffing for safeguards activities and some safeguards workload goals were not reached. The contractors notified HCFA of these resource problems for performing safeguards activities in abatement letters. An abatement letter is a formal notification by a contractor that, due to a lack of resources, contractual obligations cannot be performed. If HCFA approves an abatement of the targeted activities, the contractor will not suffer a loss in performance of their contractual obligations. Other resolutions of potential abatements include increasing the approved budget, reducing the functions to be performed by the contractor, or a combination of both.

We were informed by HCFA officials that formal requests for abatements have not been common over the years. In FY 1989, they received no abatement letters. However, in FY 1990, HCFA received abatement requests from 26 contractors. In these letters, 20 of the 26 contractors detailed their inability to meet 1 or more payment safeguards contractual obligations due to insufficient funding. In FY 1991, HCFA received seven abatement requests concerning safeguards activities.

We believe that the abatement requests indicated that contractors were hampered in their ability to perform the safeguard activities. Further, these abatement letters indicated that the additional funding allocated to the contractors was not sufficient to meet the required levels of payment safeguards activities.

Our review of eight abatement requests for FY 1990 showed that contractors were reporting that their funding was inadequate to staff their MSP units. For example, a contractor in Region IX reported a shortfall in MSP funding in FY 1990. The HCFA instructed the contractor to continue activities until their funds were exhausted. Further, HCFA stated that FY 1991 funding would not increase and suggested that the contractor should adjust their operations accordingly.

These eight abatement requests also showed that contractors were reporting funding shortfalls in MR/UR that resulted in staff and workload reductions. For example, in mid-1990, a contractor advised that they would discontinue medical review on outpatient bills and skilled nursing facility bills for the remainder of the FY, and all other bill types would be reviewed at reduced levels. The contractor stated that the abatement would result in a reduction of 22 full-time equivalents (FTE) in the medical review area and that any delay beyond June 1, 1990 in implementing abatements would require further cuts to stay within budget. The contractor requested \$445,000 in additional funding to continue MR/UR functions.

The HCFA provided additional funding of \$117,000 and informed the contractor that medical review activities not covered by the additional funding would be abated as proposed.

MEDICARE SECONDARY PAYER

The most significant indicator of a payment safeguards weakness is illustrated by the estimated \$1.1 billion

(Part A and B) backlog of identified improper primary Medicare payments reported by contractors as of June 30, 1991. Also, some contractors are not reporting backlogs; therefore, the \$1.1 billion appears to understate the contractors backlog problems. In a May 1991 request to all Medicare contractors, HCFA stated that "...as a result of budget restrictions, contractors have not been able to initiate recovery action on identified claims. As a result, backlogs have developed." The HCFA requested contractors to establish a system to identify and report activity on these claims. The HCFA stated that the purpose of the report was to identify backlogs of work not processed because of lack of funds. This backlog represents a significant financial impact on the Medicare program, and it developed during the period of HCFA's corrective action plan. We believe that the backlog was created primarily as a result of insufficient staffing at contractors' MSP units. We contacted eight contractors to determine the status of their backlogs. We were informed that the contractors have not received written instructions from HCFA regarding an approach to avoid the expiration of the MSP recovery period. A Region IV contractor, with a reported backlog of \$93 million, stated that on their own initiative, they would notify other insurers that certain claims, with a recovery action deadline of December 31, 1991, may have been improperly paid and that they would be contacted through the normal Medicare recovery process some time in the future. Also, a Region III contractor, with a reported backlog of \$220 million, indicated that even if notification was provided to insurers on these claims, the current funding levels would not be sufficient to develop the actual recovery of improper claims. In another instance, a Region IV contractor reported a backlog of \$58 million that included about \$4 million with a recovery deadline of December 31, 1991. The contractor also reported that as of June 30, 1991, recovery had been initiated on only five claims totaling \$9,500.

We also found that a Region IV contractor had no staff assigned to MSP post payment activities in FY 1990. This resulted in a backlog of MSP correspondence that went unanswered and retroactive recoveries that were not initiated. A subsequent OIG audit of this contractor disclosed a backlog of identified improper Medicare payments that totaled about \$26 million. The report recommended that the contractor should recover the overpayment amounts.

The above examples reported by contractors indicate that the Medicare program may be in danger of not recovering significant amounts of identified overpayments and indicates that a weakness may exist in the MSP safeguard activity.

Further, an MSP recovery regulation, 42 CFR 411.24(f)(2), now precludes the recovery of as much as \$393 million of the \$1.1 billion. The regulation, effective November 13, 1989, states that contractors must initiate recovery action within 15 to 27 months after identifying another insurer as being primary or the insurer will no longer be liable for the amount mistakenly paid by Medicare. Contractors had until December 31, 1991 to notify other insurance companies that these improper payments were made, otherwise, the \$393 million cannot be recovered.

Additionally, the contractors have reported that claims for an additional 400,000 confirmed MSP beneficiaries are also at risk. Contractors have not had the resources to research claims history for any primary payments related to these confirmed MSP beneficiaries. These claims are in addition to the \$1.1 billion.

In addition to the current backlog, recent legislative and administrative MSP initiatives (i.e., Internal Revenue Service/Social Security Administration/HCFAs match) have provided contractors with increased capabilities to identify additional primary payers. We believe that with the predictable increase in identified MSP cases, coupled with current funding levels, that HCFA could be faced with an increased backlog of Medicare overpayments. Although HCFA has provided some contingency funds for the backlog situation, some contractors reported that the additional funding was insufficient to accomplish the recoveries. Therefore, the ability of Medicare contractors to meet their obligation to recover overpayments will be increasingly compromised.

MEDICAL AND UTILIZATION REVIEWS

Medical and utilization reviews of claims are an integral ingredient in denying claims that should not be paid and in identifying providers that submit claims in a wasteful or fraudulent manner. We found indications that contractors' MR/UR units were not sufficiently staffed to provide a consistent presence as a medical review agent. We were informed by a Region IV contractor that MR/UR funding shortfalls decreased their ability to influence providers with respect to improving providers' billing procedures. Their funding reduction resulted in FTE reduction for medical review of 18.8 staff to 10.4 staff from FY 1989 to 1990. The contractor stated that their administrative dollars were directed toward performing necessary medical reviews

and that they had little resources to evaluate trends in billing or in detecting problem areas where savings had once been quite large.

We also found that HCFA has granted some contractors workload adjustments, due to insufficient funding. For example, in May 1990, the HCFA Region IV office responded to a contractor's request for relief in workload requirements. The contractor was notified by the HCFA regional office that they should "...immediately start taking the necessary actions to reduce staff in these areas (MR/UR) to meet anticipated FY 1990 funding." The HCFA regional office recommended that the workload be reduced because the contractor was unable to perform the required levels of MR/UR during the first 6 months of the FY due to "...staffing shortage that was created by the 50 percent reduction in their FY 1990 Part A MR/UR funds."

Due to the limited resources for MR/UR, HCFA, in FY 1991, has allowed contractors to establish focused medical review programs. This medical review methodology provides leeway to contractors in identifying procedures and providers to review. Previously, contractors were provided more mandated areas to review. As a result of the more focused reviews, greater savings could be reported. However, we believe that this method of review also limits the scope of claims that receive attention and, thereby, weakens the vital deterrence of this safeguard activity.

Based on our review, we believe that due to limited resources, contractors are paying claims that otherwise would be denied and that the sentinel effect of this safeguard activity has to some extent been compromised.

CONTRACTOR PERFORMANCE EVALUATION PROGRAM

The major vehicle for HCFA to

evaluate contractor performance is the Contractor Performance Evaluation Program (CPEP) review. Included in these reviews are evaluations of the payment safeguards activities. We believe that the implications of diminished contractor resources for payment safeguards is not reflected in the CPEP reviews. We found examples where previously established safeguards criteria for contractor performance was revised to mirror current contractor capabilities. This procedure allowed contractors to meet CPEP standards in spite of reduced safeguards coverage. Therefore, we question whether CPEP evaluations adequately reflect the effectiveness and completeness of payment safeguards objectives.

In the formal HCFA response to the above mentioned abatement requests, we found that a frequently suggested remedy to contractors was to request relief from CPEP scoring levels. Also, as stated above, HCFA regional offices also have the authority to adjust contractor workloads. We were told that workload adjustments were legitimately granted to contractors only for unusual circumstances beyond their control. However, each FY HCFA and contractors enter into agreements that outline performance criteria and funding levels. We believe that the established criteria should be the measurement of contractor performance, not the adjusted levels. We believe this would lend more credibility to the evaluation process.

CONCLUSIONS AND RECOMMENDATIONS

We found that HCFA maintained safeguards funding levels as stated in their corrective action plan. However, we found indications that these funding levels were not adequate to maintain consistent staffing and workload activity in the safeguards areas of MSP and MR/UR. We noted instances where contractual workload goals were reduced or eliminated by HCFA due to inadequate funding in some safeguards areas. The staff and workload reductions in safeguards activities typify the adverse effect of the FY 1990 and FY 1991 funding levels.

We are concerned that the objectives of the payment safeguards activities to control against fraud, waste, and abuse are not being met. This could adversely impact on the integrity of the Medicare program and result in significant program weaknesses. Based on the funding level and the expansion of the Medicare program, we found that the payment safeguards objectives of preventing, detecting, and recovering overpayments may have been compromised. Further, as evidenced by the \$1.1 billion MSP backlog, we believe that the safeguards weaknesses disclosed in this review could continue to hamper the Medicare program.

Accordingly, we recommend that HCFA review and modify its corrective action plan to assure that the objectives of the payment safeguards program to control against fraud, waste, and abuse are met. Specifically, we recommend that HCFA:

- o instruct contractors to recover the improper primary payments identified in the MSP backlog report and notify other insurance companies of improper payments within the time frames of the recovery regulations;

- o ensure that contractors have sufficient resources to perform adequate medical and utilization reviews so that the sentinel effect of this safeguard activity is not compromised; and
- o evaluate its internal controls to assure contractors have adequate payment safeguards programs that control against fraud, waste, and abuse.

AUDITEE'S COMMENTS AND OIG'S RESPONSE

The HCFA responded to our findings and recommendations in a

memorandum dated April 14, 1992. Their comments and our responses are summarized below.

The HCFA agreed with our recommendation to modify its corrective action plan to ensure that the objectives of the payment safeguards program are met. They submitted a new corrective action plan to the President and the Congress in December 1991.

The HCFA agreed with our recommendation that contractors should be instructed to recover improper primary payments in accordance with the time frames of the recovery regulation. They instructed contractors to make MSP backlog reduction their first priority. Further, HCFA obtained \$19.9 million in contingency funding from OMB, specifically for recovery action on backlog cases.

The HCFA generally agreed with our recommendation that contractors should have sufficient resources for medical and utilization review to ensure that the sentinel effect of the safeguard activity is not compromised. Also, HCFA stated that contractors will move from claim-specific reviews to identification and analysis of specific aberrant utilization patterns and practices. We agree with HCFA that analysis of utilization patterns is an appropriate safeguard function. However, HCFA's proposed review methodology could limit the scope of claims that receive attention and, therefore, dilute the sentinel effect of this safeguard activity.

The HCFA disagreed with our recommendation that internal controls be evaluated to ensure that contractors have adequate safeguards programs. The HCFA stated that it would not be appropriate to evaluate the contractor performance of an activity that had been abated. We do not concur with the HCFA response. We believe there would be more credibility to the evaluation process of payment safeguards if the contractors' performance, relative to the abatement, was

assessed. For example, the need to abate an activity may be due to more than insufficient HCFA funding. If a contractor performed inefficiently and exhausted their funding, they should not be excused from the programmatic effect of not having the resources to complete the contractual safeguards functions.

Finally, HCFA provided additional general comments on the draft report. The HCFA stated that we did not recognize their efforts at requesting increased payment safeguards funding, but rather, focused on receiving reduced amounts. We agree that HCFA's budget requests exceeded program appropriations. This report acknowledges that HCFA met the overall funding goals established in their corrective action plan. It also recognizes that the funding for payment safeguards had stabilized over the past three budget cycles. However, we conclude that reduced safeguards budgets resulted in reduced contractor performance and increased the Medicare program vulnerability to fraud, waste, and abuse. The HCFA and HHS apparently agreed with our concerns because they decided not to remove payment safeguards as a material weakness.

APPENDICES

**NATIONWIDE
PAYMENT SAFEGUARDS
BUDGET AND COST DATA
FY 1988 THROUGH FY 1991
(In million dollars)**

<u>PART</u>	<u>PAYMENT SAFEGUARD</u>	<u>FY 1988</u>	<u>% chg</u>	<u>FY 1989</u>	<u>% chg</u>	<u>FY 1990</u>	<u>% chg</u>	<u>FY 1991</u>	<u>% chg</u>	<u>FY 1992</u>
A	Provider Audit									
	NOBA	\$117.9	10.26	\$130.0	3.77	5134.9	1.78	\$137.3	-6.70	\$128.1
	FACP	\$118.9		\$130.3		\$135.3		\$102.3		
A	MSP									
	NOBA	31.1	5.14	32.7	10.09	36.0	1.67	36.6	2.73	37.6
	FACP	31.1		32.7		36.1		27.9		
A	MWUR									
	NOBA	50.1	21.96	61.1	-36.00	39.1	-11.50	34.6	-7.51	32.0
	FACP	50.2		61.3		39.2		26.8		
B	MSP									
	NOBA	34.6	8.96	37.7	-32.10	25.6	2.73	26.3	23.19	32.4
	FACP	35.1		39.4		26.2		21.4		
B	MR/UR									
	NOBA	67.0	37.91	92.4	11.80	193.3	.58	163.9	-10.49	93.0
	FACP	67.4		94.5		105.1		77.5		
B	FRAUD AND ABUSE									
	NOBA	0		0		0		0		10.0
	TOTAL									
	NOBA	\$300.7	17.69	\$353.9	-4.24	\$338.9	-.06	\$338.7	-16.53	\$333.1
	FACP	\$302.7		\$358.2		\$341.9		\$255.9		

NOBA=Notice of Budgetary Approval
FACP=Final Administrative Cost Report
(FACP 1991 represents activity through June 1991)
(NOBA 1992 represents President's budget)



Memorandum

APR 14 1992

D a t e Acting Administrator

From Health Care Financing Administration

Subject Draft Management Advisory Report: "Corrective Action Review of the Health Care Financing Administration's [HCFA] Medicare Payment Safeguards Program"
(A-04-92-02037)

T O

Inspector General
Office of the Secretary

We have reviewed the above-referenced draft report which presents the results of **OIG's** corrective action review of the Medicare payment safeguards program. The payment safeguards program was identified as both a material weakness and a high risk area in the Department's Fiscal **Year** (FY) 1990 Federal Managers' Financial Integrity Act report. This review was requested by the Department's Council on Management Oversight.

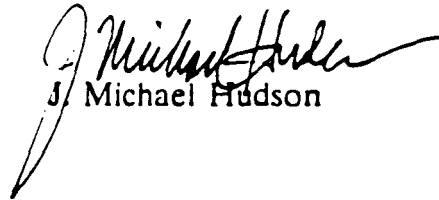
OIG found that, while relatively stable levels of payment safeguard funding were maintained, the funding levels were not adequate for contractors to maintain consistent staffing and workload activity in the areas of Medicare secondary payer (MSP) and medical and utilization review.

OIG has presented valuable information about some of the current vulnerabilities in the area of MSP. However, we are concerned that this report does not reflect relevant facts regarding the payment safeguards program and the funding situation during FYs 1989-91.

We believe recent developments will address many of the concerns raised by **OIG**. In addition to the \$324.3 million allocated for payment safeguards in the President's FY 1992 budget, HCFA requested and the Office of Management and Budget approved \$19.9 million from the contractor contingency fund specifically to support MSP recovery activity. In addition, the President's FY 1993 budget includes an allocation of **\$404** million for payment safeguards, which is a substantial increase over the FY 1992 funding level. Attached are our detailed comments on the report and its recommendations.

Page 2- Inspector General

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



J. Michael Hudson

Attachment

Comments of the Health Care Financing Administration (HCFA)
on OIG's Draft Management Advisory Report:
"Corrective Action Review of [HCFA's]
Medicare Payment Safeguards Program"
(A-04-92-02037)

General Comments

OIG notes that the "cornerstone" of HCFA's corrective action plan was to request "adequate funding levels" for payment safeguards activities. OIG also states that HCFA completed the steps in its corrective action plan; that is, HCFA's budget requests met its "funding goals established in the plan." However, on page 6 of the report, OIG states:

- "Although overall funding levels were "relatively stable," HCFA Increased funding for some activities while it cut funding sharply in Part A medical review (MR) and Part B Medicare as Secondary Payer (MSP), and
- HCFA's corrective action plan did not take into account increases in claims workload, inflation, etc."

We disagree with OIG's explanations for the funding shortfalls. OIG failed to acknowledge that, in Fiscal Years (FYs) 1990 and 1991, the amount that HCFA initially requested for these activities far exceeded the appropriation that HCFA ultimately received. HCFA's budget requests for payment safeguards funding did take into account the workload growth and inflation. Unfortunately, our actual spending authority did not. We have already supplied OIG with documentation on this point.

While the FYs 1990-91 funding situation was "relatively stable" in terms of current dollars, HCFA was receiving fewer real dollars for payment safeguards. In view of declining resources and increased workloads, HCFA changed the allocation of spending among activities that we believed would yield the greatest return. For this reason, we emphasized spending on Part A MSP at the expense of Part B MSP. We also instructed the Medicare contractors to seek out more efficient ways of conducting their operations.

We believe OIG has not brought forward any evidence in this report that calls into question our allocation of funding, given the difficult budget situation. OIG did not include savings data for the FYs 1990-91 period in the report: the data would show that the rate of return actually increased for many line items.

Page 2

HCFA will continue to request adequate levels of funding for its payment safeguards activities. We are also exploring alternative methods of financing payment safeguards. However, given the budgetary restrictions under which HCFA must operate, we believe that our ongoing efforts to target for funding those activities which yield the greatest return on investment should not be overlooked.

OIG Recommendation

HCFA review and modify its corrective action plan to assure that the **objectives** of the payment safeguards program to control against fraud, waste, and abuse are met.

HCFA Response

We agree and action has already been taken on this matter. HCFA and the Department decided not to close the payment safeguards material weakness in November 1991, and a new corrective action plan was developed at that time. This plan was submitted by the Department to the President and Congress in December 1991.

OIG Recommendation

HCFA should instruct contractors to recover the improper primary payments identified in the MSP backlog report and notify other insurance companies of improper payments within the timeframes of the recovery regulations.

HCFA Response

We agree and action has already been taken on this matter. When the MSP backlog report was implemented, HCFA took immediate action to fund those contractors who reported backlogs with a recovery deadline of December 31, 1991. Also, HCFA instructed the contractors in October 1991 to make backlog reduction their first priority. Finally, the \$19.9 million in contingency funding recently approved by the Office of Management and Budget for MSP activities is specifically designated for recovery action on backlogged cases. We expect to save **\$3** billion as a result of this effort and our other MSP activities.

Page 3

OIG Recommendation

HCFA should ensure that contractors have sufficient resources to perform adequate medical and utilization reviews so that the sentinel effect of this safeguard activity is not compromised.

HCFA Resuonse

As noted above, HCFA has consistently requested adequate funding for payment safeguards. In FY 1993, by targeting MR, identifying the most effective MR criteria, and increasing automation, HCFA expects to save \$1.1 billion in program dollars as a result of MR and utilization review activities. By FY 1993, HCFA will have collected and analyzed a considerable amount of data on provider patterns of practice, utilization norms, and trends. The contractors will use the data to move from claim-specific reviews to identification and analysis of specific aberrant utilization patterns and practices.

OIG Recommendation

HCFA should evaluate its internal controls to assure contractors have adequate payment safeguards programs that control against fraud, waste, and abuse.

HCFA Response

We are unsure of the intent of this recommendation. If OIG is referring to its findings regarding the Contractor Performance Evaluation Program on page 11, we disagree. When HCFA abates a contractor activity, the contractor is not obligated to perform the activity. It would not be appropriate for HCFA to then evaluate the contractor's performance of the activity.

If OIG is referring to specific controls against fraud and abuse, we agree. The President's FY 1993 budget, for the first time, requests \$24 million targeted for efforts to detect and investigate fraud and abuse. In FY 1993, HCFA will expand the contractors' Medicare Program Integrity Units, which are dedicated to the investigation of allegations of Medicare fraud. HCFA also will increase outreach and educational programs. As a result, we expect an increase in the number and quality of referrals to OIG and a program savings of \$360 million.

Page 4

In addition, HCFX will emphasize desk reviews rather than complete provider audits, in FY1993. By concentrating on limited reviews, we expect to improve the efficiency of audit expenditures. HCFA will continue to give priority to known problem areas, such as prospective payment system multi-facility hospitals and chain-affiliated providers and home offices. We expect to realize \$1.8 billion in savings as a result of these efforts.