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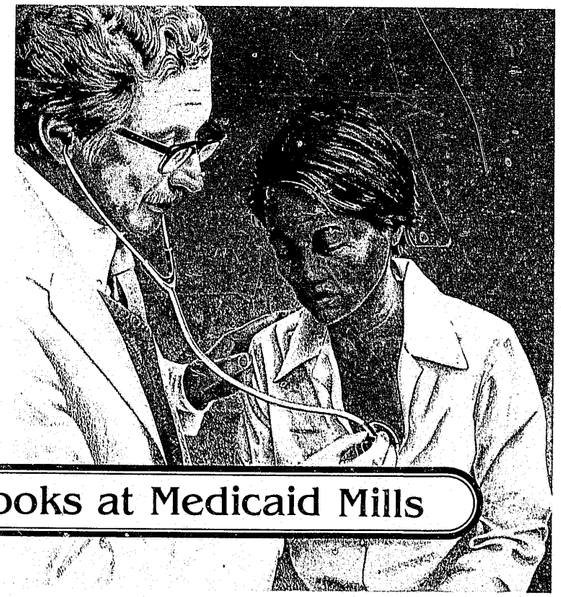

HCFA Looks at Medicaid Mills

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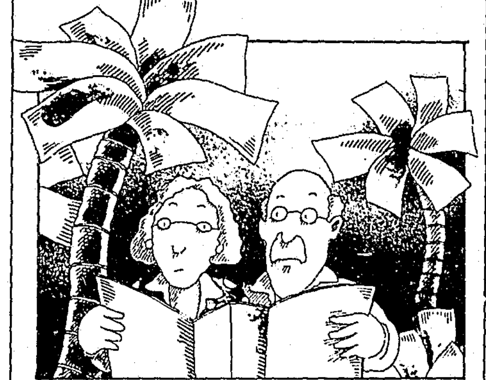
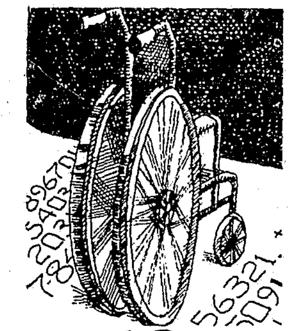
Articles





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Departments

Watching the Reimbursement Dollars

Program validation aims to control waste in Medicare and Medicaid

by Don Nicholson

In just one state, HCFA staff conducting program validation reviews found inappropriate Medicare and Medicaid expenditures of $1.8 million, stemming from improper billing practices by suppliers of durable medical equipment and faulty treatment of claims and cost reports.

Efforts to control abuse and waste in Medicare and Medicaid are not new, but the program validation approach is.

The vast majority of providers of health services and supplies—hospitals, nursing homes, physicians, pharmacists, and the like—conscientiously provide care to patients who truly need it. Most Medicare and Medicaid claims' payers are doing an effective job of getting the money out properly. And most federal operating policies are well developed and have proven effective. Problems of abuse and waste have probably been overstated in the past.

But it cannot be assumed that everything that should be done is happening the way it is supposed to—and that is where program validation comes in.

Program validation is an organized effort by the Health Care Financing Administration to control abuse and waste in these two huge bill-paying programs by reviewing provider performance at the point services are delivered.

HCFA's Office of Program Validation seeks out and attacks problems found in three ways:

- Identifying individual providers who are abusing the programs, either through inappropriate billing or cost reporting practices;
- Working with state Medicaid agencies and Medicare contractors to improve systems for detecting health provider abuse and, once identified, dealing with those problems; and
- Focusing on HCFA policies, particularly in reimbursement, that may be contributing to inappropriate expenditures.

To accomplish these tasks, teams of employees from HCFA's central and ten regional offices perform on-site reviews, visiting hospitals, nursing homes, and other providers of services to Medicare and Medicaid beneficiaries.

New name, old method

As a term, program validation is new, as are some aspects of the current approach (designed in 1978). But much of the total methodology is a packaging of other, earlier initiatives for controlling abuse in the two programs.

The approach is to "validate" Medicare and Medicaid reimbursement policies and procedures to be sure they accomplish what the Congress intended in passing the legislation. (A similar review activity, also called validation, was done in the early 1970s by the Social Security Administration, then responsible for Medicare.)

Depending on the type of provider to be reviewed and the issues on which the review is focused, HCFA employs one of three distinct review approaches. These are labeled aberrant cost studies, systematic abuse reviews, and program implementation reviews.

With an aberrant cost study or a systematic abuse review, the focus is on providers where statistics or other information suggest questionable practices. Not only does HCFA try to determine whether the provider may be engaged in some form of program abuse, but it judges if the state or contractor benefit payment processes are consistent with applicable policy and guidelines. With a program implementation review, although the review includes examination of provider billing practices, the reviewers try to determine whether HCFA needs to improve selected policies governing reimbursement.

Here is a brief description of each review approach and the methodology used:

- *Aberrant cost study*—This is a review of institutional providers who are reimbursed on a cost basis. The review focuses on specific elements of costs which, on the basis of analysis and comparison with like facilities, appear aberrant. In addition to targeting the audit on the appropriateness of specific costs, the reviewers also examine the medical necessity of the services rendered to the Medicare or Medicaid beneficiary.

  A hospital was automatically placing all Medicare patients in wards, because its staff assumed that "old people want to be together," a hospital administrator told federal reviewers checking to see how Medicare patients were treated in hospitals. This was contrary to federal regulations, which state that Medicare patients should be given semi-private accommodations whenever possible.

- *Systematic abuse review*—This audit is specific to ambulatory care providers who are reimbursed on a charge or fee basis. Basd on statistical or other information, the reviewers may decide that there is reason to question the appropriateness of a par-

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ticular form of ambulatory care services in a given geographical area. Having identified the area, HCFA then selects such providers, usually 10 to 20, whose practice patterns appear irregular. After looking at the Medicare and Medicaid claims' payment processes to see if the way that claims are being paid offers at least a partial explanation, HCFA reviewers go on-site to the provider's location. There they examine medical records and review with the physician or other health care supplier his or her Medicare/Medicaid billing practices. Overutilization is often a problem area.

• *Program implementation review* —In these reviews, HCFA examines a particular facet of program operations to determine if monies related to the activity are being appropriately expended, selecting an area typically related to some potentially troublesome aspect of reimbursement policy. A preliminary survey, consisting of a review of the statute, regulations, and guidelines specific to the area is conducted. HCFA tries to learn whether the area was previously selected for review by the Government Accounting Office or the audit staff of HHS' Office of the Inspector General. Then HCFA prepares a report and decides whether the topic is suitable for a full review. For the latter, a review protocol must be developed. This often involves the use of computers and special programming, which are provided by the Office of Systems Analysis in HCFA's Bureau of Quality Control.

Following the book

In conducting any form of program validation review, HCFA follows five distinct steps: preliminary review, onsite review, desk review and report writing, communication of findings and recommendations, and follow up.

A home health agency being audited by HCFA reduced its patient load by one-third just one month after the reviewers had gone in. This raised serious questions as to whether many of the patients receiving home health care really needed it. HCFA is now monitoring the agency carefully to guard against abuse of Medicare funds.

The decision to conduct a validation review may be based on a statistical aberrancy discovered in the records of a provider or supplier. A problem is suspected, but HCFA staff may not be sure exactly what it is or its extent.

Thus an objective, professional approach is critical to the success of the effort. Reviewers are careful not to alienate the provider community through actions in person or in writing. They make it clear that, when an individual or organization is selected for review, no guilt or wrongdoing should be inferred; the review is performed to verify the propriety of program expenditures, as a necessary function of HCFA program administration.

To facilitate the review effort, HCFA is writing an operations' manual for program validation. Draft portions of the manual were used this spring to train some 60 regional and central office professional staff involved in performing validation. An automated control system is being developed to catalog current and completed reviews, as well as findings by type of issue and provider.

Just as important to HCFA as finding errors is learning who is most effectively controlling program dollars and making that knowledge available to others in the system who need help. HCFA does this by circulating planning documents and results of reviews. Available from the Office of Program Validation is a validation audit plan for fiscal year 1980 that details the review process and the level of validation activity anticipated by the regions and central office. Compendium reports that highlight results of completed reviews are circulated to Medicare contractors and state Medicaid agencies.

Who's involved

Controlling waste and abuse that lead to dollar losses is the business of everyone connected with administering Medicare and Medicaid. No one office has a monopoly on discovering cracks in the system. The Office of Program Validation forms partnerships with other HHS and HCFA components and state/contractor personnel to accomplish validation goals.

Indeed, the 172 Medicare contractors and state Medicaid agencies are responsible for a number of tasks comparable to the validation process and quite often assist HCFA in conducting field reviews. These claims' payers perform audits to verify the accuracy of reported provider costs (the basis for institutional reimbursement). Through post-payment reviews, they identify ambulatory providers who have demonstrated questionable practice patterns and perform reviews to detect instances of over-utilization or erroneous billing. HCFA conducts reviews to be sure that states and contractors are performing these roles well. In addition, HCFA collects quarterly statistics on provider abuse cases worked and dollar results from case adjudication.

A hospital entered into a $22,500 per year contract with a firm owned and operated by a physician on the hospital staff. The sole purpose: so that the hospital administrator could have the benefit of consultation with the staff physician. When HCFA reviewers questioned this arrangement, it was explained that the hospital administrator did not get along with his chief of staff and wanted someone else to talk to when medical issues were raised. This service was disallowed as not being a reasonable cost.

Program validation fits nicely into HCFA's total strategy for quality control. According to Martin Kappert, director of the agency's Bureau of Quality Control:

"HCFA wants to be sure that what we are doing and the benefits we are paying are consistent with the intent of the law and in accordance with sound management principles. Through program validation, we assess the ways the programs operate directly at the provider level. If we find problems, we document the reasons and assure that corrective actions are taken."

Other units of HCFA are involved in the quality control effort. For instance, where medical expertise is required to judge the appropriateness of treatment for which reimbursement sought (such as in a systematic abuse review), the Office of Program Validation may turn to a local professional standards review organization (PSRO). If program abuse is found in this context, the PSRO has authority to recommend that some form of action be taken to correct the problem.(PSROs are part of a nationwide program relating to utilization and quality of care that is administered by HCFA.) Elsewhere within HHS, the Office of the Inspector General performs further investigation of any cases of suspected fraud referred to it by HCFA. (Prosecution is handled by the Department of Justice.)

As the Office of Program Validation gains experience and other HCFA components, states, and contractors become more familiar with validation goals and processes, effective cooperation in their accomplishment will increase.

In addition to validation activities, which occupy about half of the professional staff time in the Office of Program Validation, the office has other responsibilities. Among the more prominent functions is the exercise of the Secretary's sanction authority. Under law, any health care provider convicted of Medicare or Medicaid fraud must be suspended from the program. Also, health providers who have filed false claims or who have engaged in program abuse may be expelled from the program at the Secretary's discretion. Validation staff in the central and regional offices are required to identify these situations and prepare case files for action. As of July, action had been taken on 167 such cases.

A medical equipment company was found to be filling physician orders for rental of oxygen tanks ($17 per month) with much more expensive oxygen concentrators ($190 per month) and billing Medicaid for the higher rate. When contacted, most of the prescribing physicians told HCFA reviewers that they had not intended provision of the more expensive equipment and promised to review more closely the forms they signed in the future to be sure their patients got only the equipment needed and prescribed.

The bottom line

What are the results of program validation, and can we yet report dollar savings to federal and state governments and the taxpayers?

For most of fiscal year 1979, the effort was still experimental. The concept had been developed, review guides were assembled by provider type, and each region as well as the central office began performing reviews. Last fall, HCFA's central office staff held meetings with each region to share results and plan for the future. From these meetings evolved the 1980 audit plan and a structured validation process.

A facility's administrative costs were being inflated by inclusion of the administrator's weekly commuting costs, a HCFA review team found. The administrator lived 2,000 miles from his job. This was not considered to be a reasonable cost.

Relating costs to benefits, HCFA has set a goal of at least four dollars saved for each dollar spent. Projected dollar results of validation reviews fall into one of four categories:

• Overpayments related to a particular provider and subject to collection;

• Dollar savings related to specific provider practices, but not established as overpayments;

• Savings that result from correcting operational deficiencies in contractor or state agency operations;

• Savings that result from recommended changes in HCFA policies that were contributing to erroneous payments or wasteful practices.

By now, some early returns are in and they are encouraging. Against annual validation-related expenses of about $4.5 million, HCFA has already projected some $44 million in savings through March 1980. (Of this, $12 million is shown in final reports already completed on 28 validation reviews done by central and regional office staff, to which can be added $32.5 million estimated in 79 more draft reports written, but still undergoing clearance.) Savings estimates are not yet available from 78 reviews still underway.

Although a major goal of program validation is to ferret out errors and abuse in dollar terms, positive findings are significant as well. In many reviews, even though problems were suspected, HCFA is unable to detect dollar losses. It is, of course, valuable to test and find program areas operating appropriately. HCFA resources can then be concentrated on program deficiencies.

Looking ahead

For the current fiscal year, HCFA's validation audit plan calls for a total of 185 reviews, 31 to be performed by central office staff and 154 by regional personnel.

Planning has already begun for the fiscal 1981 audit plan. A draft is being developed and circulated to the various HCFA components for comment.

With federal expenditures under Medicare and Medicaid estimated to total 45 billion dollars this fiscal year, it is critical that HCFA have the capacity to critically evaluate how benefits are expended. Such large benefit programs will probably always be characterized by some degree of waste and abuse, and a few unscrupulous health providers will take illegal advantage, when large sums of money are potentially available.

Program validation cannot erradicate all these problems. But especially in these days of budget restraint, there must be a sound, systematic assessment to be as sure as possible that program expenditures are appropriate. Unlimited tax dollars are not available. Conserving scarce dollars through program validation and other quality control measures helps assure beneficiaries that money for services will be available when needed.

We owe it to our beneficiaries and the taxpayer as well that efficiency and economy characterize HCFA's role and the part played by the states and contractors in paying for health services. This is the purpose of validation review and the goal of the staff devoted to conducting such reviews. ■

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