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MEDICARE

Funding and Management Problems Result in Unnecessary Expenditures

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SUMMARY

Medicare's soaring expenditures underscore the need for the government to fund and manage the program judiciously. Medicare, the largest of the federal health programs, cost almost $120 billion in 1992; if current trends continue, Medicare expenditures are expected to nearly double by 1998 to $239 billion.

Insurers like Blue Cross/Blue Shield, Travelers, and Aetna--called Medicare contractors--use federal funds to process claims and perform payment control activities, called payment safeguards. In performing this work, contractors use various controls to avoid unnecessary Medicare payments.

Despite a 12-to-1 return on money invested in contractors' payment safeguards, contractors' per claim funding for payment safeguards has declined by over 24 percent since 1989. Most of that funding pays for staff who review claims and investigate suspect providers. When claims volume increases but the number of safeguard staff remains constant or declines, contractor staff review a lower percentage of claims. In fact, several contractors have eliminated certain payment controls because the volume of claims suspended as a result of these controls exceeded the capacity of the staff to process them promptly.

The Medicare program is also suffering from management weaknesses. The Health Care Financing Administration (HCFA), the agency that oversees Medicare, has not compiled information on contractors' payment safeguard controls and cannot systematically identify where important controls may be needed. In addition, the agency has not always provided adequate guidance to contractors on such matters as recovering overpayments and investigating complaints alleging fraud and abuse.

Work we are doing for this committee confirms earlier studies that have established a positive relationship between program savings and more money and management attention for program administration. In a HCFA-run demonstration project to improve payment controls, one contractor more than doubled its savings--from $11 million to $23 million. The contractor had increased its payment safeguard costs by about 7 percent annually during the period of the project.

We believe the Congress should continue to pursue efforts to modify budget procedures so that safeguard funding could be increased without having to cut spending elsewhere. Under current budget procedures, administrative funding can be increased only if funding for other programs is reduced. In addition, we believe that HCFA needs to develop a national strategy to manage the Medicare safeguard program. This would entail assessing the appropriateness and effectiveness of individual contractors' controls and developing methods to assure that controls that have been shown to be effective are implemented across the country.

Mr. Chairman and Members of the Committee:

The need for the government to manage federal health costs effectively is underscored by the fact that federal health programs consumed over 15 percent of the federal budget in 1992. Medicare is the largest of these programs. In 1992 it cost almost $120 billion, enrolled over 35 million beneficiaries, and processed about 700 million claims. If current trends continue, Medicare expenditures are expected to nearly double by 1998 to $239 billion.

Concerned about curbing unnecessary Medicare expenditures, the Congress has asked us to examine numerous Medicare management problems. Two major problems emerge from our work in this area. First, the Health Care Financing Administration (HCFA), the agency that oversees Medicare, does not have an effective, national strategy to protect the program from making erroneous or wasteful payments. Second, budget constraints have led to the underfunding of the types of payment controls that prevent or detect losses due to waste, fraud, and abuse.

Evidence that HCFA has not actively managed these controls and that funding is insufficient is seen in a range of problems that we have reported on over the past several years. We have found, for example, that:

-- Medicare had failed to adequately investigate complaints of fraud and abuse telephoned in by Medicare beneficiaries.[1]

-- Little was done initially to reclaim over $250 million in overpayments owed by hospitals.[2]

-- An estimated $2 billion in claims had been paid by Medicare that may have been the responsibility of other health insurers.[3]

-- Loose controls over who can bill Medicare have allowed profiteers to exploit the program through fraud and abuse.[4]

In other hearings and reports, we have made recommendations aimed at better management of various activities and at adequate funding of safeguard efforts. While HCFA has taken actions to correct many of the specific problems we and others have identified, it has not developed a systematic approach to managing the safeguard program. Developing such a strategy is not an easy task but we believe it is essential to better control unnecessary payments.

MEDICARE PROGRAM MANAGED LARGELY THROUGH PRIVATE INSURERS

In 1965, when the Medicare program was enacted, the law provided for insurance companies--like Blue Cross/Blue Shield,

Travelers, and Aetna, to name a few--to process and pay claims. Under the law, the insurers, called Medicare contractors, used federal funds to pay health care providers and beneficiaries and were reimbursed for their administrative expenses incurred in performing the work. This arrangement was pragmatic in that the insurance companies had both claims-processing experience and an understanding of the medical practices of their communities.

Over the years, HCFA has consolidated some of Medicare's operations and the number of contractors has fallen from about 130 to about 80 today. Their duties encompass three major functions: claims processing, provider and beneficiary services, and payment control activities, called payment safeguards. In 1993 the contractor budget is approximately $1.6 billion, with about 25 percent devoted to payment safeguard activities.

PAYMENT CONTROLS HAVE SAVED $12 FOR EVERY $1 SPENT

I want to focus today's testimony on the contractors' payment safeguard activities which in recent years have returned over $12 for every $1 dollar invested. These activities consist of various controls that occur throughout the process of paying and reviewing claims. Some controls, called prepayment screens, are computerized edits that are in place when a claim is entered into the contractor's automated claims processing system. The screens detect certain irregularities that result in automatic denials or suspensions of claims for further review before payment. For example, contractors limit the number of chiropractic visits per month for which they will pay. Similarly, contractors require a physician's certificate stipulating the need for a wheelchair before they will make this payment. Prepayment screens, therefore, are programmed to suspend claims that exceed a specified limit on chiropractic visits and for claims for wheelchairs that have not been adequately documented for medical necessity.

Other controls occur after the payments are made. Contractors use a technique called profiling to identify physicians and other providers who bill for many more services, such as diagnostic scans, than their peers. Profiling can lead to reviews or audits used to examine providers' billing abuses, such as upcoding (that is, upgrading a procedure to one that is reimbursed at a higher rate) and unbundling (splitting one procedure into several to increase the reimbursement total).

Prepayment screens and postpayment reviews are shaped in large measure by the contractors' medical policies. These policies embody the criteria used to establish the conditions under which Medicare will pay claims for certain medical services or procedures. Using medical policies, contractors develop the computer screens that suspend or deny claims for exceeding specified limits. Contractors determine which services will be

covered by medical policies generally at their own discretion. In the absence of a medical policy for a given service, claims for those services, if otherwise complete, are paid and are not likely to be reviewed for appropriateness.

One example illustrates the importance of establishing medical policies to help assure that Medicare does not pay for unnecessary or inappropriate services. A contractor we recently visited identified over a 15-fold increase in expenditures, from about $580,000 to $10 million between 1989 and 1991, for echocardiograms (a procedure that allows doctors to view an image of the heart). The contractor had no medical policy regarding this test and thus no basis for questioning the appropriateness of the claims.

Echocardiograms are illustrative of the types of services that are candidates for close scrutiny at a national level. For one kind of echocardiogram, for example, Medicare spent nationwide $366 million in 1992.[a] The rapid growth in medical expenditures for services like echocardiograms emphasizes the importance of contractors' vigilance over the appropriateness of payments for these services and the need for ongoing development of medical policies and new screens.

CONTROLS OVER MEDICARE PAYMENTS DETERIORATE DUE TO BUDGET CONSTRAINTS

The importance of contractor vigilance over Medicare claims is in fact growing because the environment in which contractors operate is becoming increasingly complex. In recent years doctors and other providers have been moving more services out of relatively regulated environments such as hospitals, to largely unregulated and sometimes unlicensed freestanding facilities. Physicians are also increasingly becoming owners of the facilities to which they refer patients, which can increase incentives to overuse services and add to Medicare's costs.

These trends complicate what has always been a difficult task of identifying and preventing or recovering losses from those who inappropriately bill the program. Accompanying these trends has been an explosion in nonhospital claims that Medicare has to pay. Compared to 107 million claims for inpatient and outpatient hospital services, nonhospital claims are expected to soar to 630 million claims in 1993. This represents a 55-percent increase in such claims since 1989.

Despite these growing complications and rising claims volume, over the past 5 years, budgetary constraints have led to a reduction in Medicare's program safeguard activities. Since 1989,

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[a]See Appendix I for a listing of the top 30 nonhospital procedures that Medicare spent the most on in 1992.

contractors' per claim funding for payment safeguards has declined by over 24 percent. The largest portion of contractor safeguard funding pays for staff who review claims and investigate suspect providers. When claims volume increases but the number of safeguard staff remains constant or declines, contractor staff review a lower percentage of claims.

Not surprisingly, as a result of per claim funding reductions contractors are currently reviewing fewer claims and fewer providers. For example, in 1992 HCFA set targets for contractors to suspend and review 12 percent of all claims. The agency has now reduced this target to 9 percent in 1993. HCFA also reduced the number of provider reviews required by a third.

At some contractors we recently visited, funding constraints have led to less effort spent developing medical policies and screens, simply because the staff is not available to develop screens or to investigate the claims that have been suspended for review. One contractor told us that the workload created by existing medical policies and screens overwhelmed the staff; adding new medical policies and screens was not a priority. In fact, several contractors eliminated some screens because the volume of suspended claims exceeded the capacity of the staff to process them promptly.

WEAK HCFA MANAGEMENT EXACERBATES MEDICARE CONTROL PROBLEMS

As well as inadequate funding for payment safeguard activities, the Medicare program is also suffering from management weaknesses. HCFA has poor management information on such fundamental contractor controls as medical policies and screens. Thus, HCFA is not in a position to actively manage Medicare's overall program safeguards. In addition, the agency has not always provided adequate guidance to contractors on such matters as recovering overpayments and investigating complaints alleging fraud and abuse.

Management Information System Weaknesses

In our ongoing work, for example, we find that HCFA cannot rely on management information to compare contractor performance in payment safeguard areas. Moreover, HCFA has not compiled information on contractors' controls and cannot systematically identify where important controls may be needed. Consequently, it is not uncommon for HCFA to be unaware of problems until they become widespread.

This was the situation when the durable medical equipment (DME) scandals were documented by this committee last year. Several contractors had medical policies and screens that allowed for nearly unconditional reimbursement and favorable payment rates

for supplies and equipment. Unscrupulous suppliers took advantage by billing the contractors with liberal medical policies and high payment rates.

Weak controls can have dramatic effects on Medicare expenditures. For example, inadequate controls on seat-lift chairs at one contractor we reviewed allowed a five-fold increase in expenditures to occur over a 1-year period. During this time suppliers were mass-marketing the chairs in the contractor's area. Strengthening its controls and claims reviews resulted in the contractor reducing these expenditures from about $3.5 million in 1986 to about $50,000 by 1990.

Many examples of serious payment problems are documented in the DME area, and steps are now being taken to close some of the loopholes in policies and procedures that allowed these problems to flourish. HCFA is also in the process of reducing the number of contractors who will process DME claims to four. Our work is showing, however, that serious payment problems are not unique to DME suppliers.

Contractors we recently visited in the course of several ongoing reviews pointed to instances where Medicare payments were growing dramatically and needed to be investigated. In some cases the problems stem from the lack of effective medical policies or screens; in others, resources simply were not available or adequate to address the problems. The following examples illustrate the problems contractors face in controlling the outflow of Medicare payments:

-- Several contractors reported problems detecting and avoiding unnecessary clinical laboratory tests. A sense of the scope of this problem can be seen in a recently settled fraud case against a national laboratory. The laboratory pled guilty to submitting false claims to the government and agreed to repay more than $110 million in settlements and fines. The laboratory led doctors to believe it could perform additional blood tests, though medically unnecessary, at little or no cost when doctors ordered a routine battery of chemistry tests. In fact, the laboratory billed Medicare and other public insurers for the tests. Contractors policies and screens were not effective in stopping such payments.

-- One contractor experienced an annual growth rate in basic ambulance service expenditures of about 30 percent over the past 5 years. The contractor believes much of the increase could result from the use of ambulances for routine transportation, a noncovered service. Basic ambulance services were the fourth largest category of the contractor's expenditures, yet no computerized screens existed to flag questionable claims. This is potentially a

problem for other contractors. Nationwide Medicare has spent over $1 billion for ambulance services in 1992.

Consequences of Weak HCFA Guidance

Limited HCFA direction to Medicare contractors is another factor that has contributed to a breakdown in program protections. Our recent work has addressed the investigation and referral of beneficiary complaints and contractors' failure to recover millions of dollars in Medicare overpayments. HCFA has begun implementing corrective actions for these problems, and early results show that substantial savings can be achieved when contractors take concerted actions.

For example, in one recent study we found that HCFA provided virtually no program guidance to Medicare contractors regarding the investigation of beneficiary complaints--a primary source of fraud, waste, and abuse leads. Inadequate investigation of these complaints can result in missed opportunities to recover overpayments and to send a message that fraudulent or abusive behavior will not be tolerated. In one instance, a provider was initially pursued for billing irregularities because of beneficiary complaints. Upon further investigation, 100 apparently similar complaints surfaced, encompassing about 300 fraudulent claims. The provider involved agreed to refund over $2.5 million to the federal government.

In another study, we reported that HCFA was not giving adequate program guidance to Medicare contractors regarding the recovery of hospital overpayments. At last count, the refundable amounts exceeded $250 million, $180 million of which has been recovered. Many of the hospitals had amounts outstanding for several years though contractors were doing little, and in many cases nothing, to recover amounts owed to Medicare.

We found similar problems with contractor efforts to recover claims that Medicare mistakenly paid that may have been the responsibility of other insurers to pay. Specifically, contractors were doing little to recover what we estimated to be about $2 billion in such claims. Some progress has been made in recovering these amounts over the past year. However, the problem remains particularly severe at one contractor which currently is behind in collecting $425 million in mistaken payments.

IMPROVED PROGRAM SAFEGUARDS PROMISE HIGH RETURNS

Work we are doing for this committee suggests that better management coupled with more funding for program safeguard activities can lower the program's exposure to overpayments. We are examining the results of a recently completed HCFA demonstration project to assess the effects of funding and greater

management emphasis on contractors' payment safeguard programs. We are finding that the demonstration contractors that improved their medical policies and added screens enhanced their ability to avoid making inappropriate payments. During the study period one contractor developed 56 new medical policies. From 1988 to 1991 the contractor more than doubled its savings from $10.8 million to $23.4 million. The contractor achieved these savings with an increase in payment safeguard costs of about 7 percent annually. This contractor's performance confirms earlier studies that have established a positive relationship between program savings and more money and management attention for program administration.

CONCLUSIONS

Currently, budget constraints are more severe than ever and the administrative budgets of all federal programs are in jeopardy of being cut. However, in our view, given the condition of the Medicare safeguard program, reductions in Medicare's administrative budgets should not be made without careful consideration of the likely effect on program safeguards. Over the past 5 years Medicare's program safeguards have declined appreciably. As a result, opportunities to curb unnecessary Medicare expenditures are being lost.

We believe the Congress should continue to pursue efforts to modify budget procedures so that safeguard funding could be increased without having to cut spending elsewhere. Under current budget procedures, administrative funding can be increased only if funding for other programs, such as immunizations or job training, is reduced. For example, although $10 dollars spent on program safeguard activities could save $120 in Medicare entitlement spending, no credit would be given (or scored) for the savings, while the $10 would be counted as an increase in federal discretionary spending levels. The fact that payment safeguard expenditures are part of the domestic discretionary budget means that they must compete against programmatic funding.

Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service (IRS) compliance activities without necessitating spending cuts elsewhere.[5] As we reported in 1991, we believe using IRS' method of funding compliance activities as a potential model would enable the Congress to appropriate the funding needed for Medicare contractors' staffing and performance of payment safeguard activities.

In addition, we believe that HCFA needs to develop an national strategy to manage the Medicare safeguard program. This would entail

-- assessing the appropriateness and effectiveness of the whole range of individual contractors' controls, including

medical policies, screens, and other controls for curbing unnecessary expenditures, and

-- developing methods to assure that controls that have been shown to be effective are implemented across the country.

Such a strategy could help assure that HCFA monitors its decentralized contractor operations more effectively and that Medicare has the controls in place to aggressively fight fraud and abuse.

ENDNOTES

1. Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991). Testimony on same topic (GAO/T-HRD-92-2, Oct. 2, 1991).

2. Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

3. Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1991).

4. Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

5. Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

APPENDIX I

1992 Part B Expenditures: Top 30 Procedures

Ranking	Procedure Code Description	Allowed Charges	Allowed Services	Charge Per Service
1	Office/Outpatient Visit: Established Patient (RVU=1)	$1,913,779,707	67,137,128	$28.51
2	Extracapsular Cataract Removal with Insertion	$1,809,610,575	1,989,494	$909.58
3	Subsequent Hospital Care (RVU=1.45)	$1,070,038,022	27,602,983	$38.77
4	Office/Outpatient Visit: Established Patient (RVU=1.52)	$989,408,217	22,931,380	$43.15
5	Subsequent Hospital Care (RVU=1.01)	$863,824,956	29,746,970	$29.04
6	Office/Outpatient Visit: Established Patient (RVU=.72)	$610,189,860	29,363,821	$20.78
7	Subsequent Hospital Care (RVU=1.95)	$429,481,092	8,059,841	$53.29
8	Ambulance Service, Basic Life Support	$374,031,655	3,063,214	$122.10
9	Echocardiography, Real Time w/ Image Documentation	$366,289,396	2,837,143	$129.11
10	Office/Outpatient Visit: Established Patient (RVU=2.34)	$333,807,933	5,159,409	$64.70
11	Level IV--Surgical Pathology: Gross/Microscopic Exam	$330,787,893	6,053,901	$54.64
12	Initial Hospital Care (RVU=3.83)	$321,809,238	3,271,457	$98.37
13	Discission of Secondary Membraneous Cataract	$317,650,225	735,493	$431.89
14	Initial Inpatient Consultation (RVU=3.69)	$300,439,226	2,758,813	$108.90
15	Radiologic Examination, Chest, Two Views	$297,790,197	16,313,973	$18.25
16	Ambulance Service, Advanced Life Support	$283,230,220	1,262,042	$224.42
17	Individual Psychotherapy by a Physician 45-50 Minutes	$251,130,799	3,906,814	$64.28
18	Ophthalmological Services: Medical Examination	$245,455,827	5,300,257	$46.31
19	Arthroplasty, Knee, Condyle and Plateau	$235,118,695	167,202	$1,406.20
20	Initial Hospital Care (RVU=3.03)	$230,041,749	2,762,751	$83.27
21	Hospital Discharge Day Management	$216,088,664	5,009,078	$43.14
22	Oxygen Concentrator	$215,915,858	840,676	$256.84
23	Combined Left Heart Catheterization	$214,975,055	335,915	$639.97
24	Automated Multichannel Test	$211,357,501	16,639,160	$12.70
25	Office Consultation (RVU=3.66)	$200,094,620	1,882,615	$106.29
26	Leuprolide Acetate, For Depot Suspension, 7 5 Mg	$191,706,591	2,371,613	$80.83
27	Electrocardiogram, Routine ECG	$188,196,772	9,043,975	$20.81
28	Manipulation of Spine by Chiropractor	$185,757,880	10,157,771	$18.29
29	Weekly Radiation Therapy Management	$180,655,364	1,971,635	$91.63
30	Enteral Formulae	$178,870,206	286,966,123	$0.62

Source: HCFA BMAD data