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FRAUD AND ABUSE

Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers

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GAO/T-HEHS-96-7

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the challenges that Medicare faces in battling fraud and abuse in the health care system. Medicare, the federal program financing health care for the elderly and disabled, is the nation's largest health payer. In 1994, it spent $162 billion on behalf of about 37 million elderly and disabled people. With this in mind, I would like to describe the ways that unscrupulous providers exploit the program, why it is such an appealing target, and why abusive practices persist despite efforts by program managers and law enforcement agencies.

We have estimated that fraud and abuse may account for as much as 10 percent of health care costs and have pointed out many times that Medicare is vulnerable to such exploitation. We devoted two volumes of our "High-Risk" series to this topic, in 1992 and 1995, and have recently issued two related reports: one focusing on abusive billings for therapy services to nursing home residents, the other on excessive payments for medical supplies. My comments draw heavily from these and other recent reports and testimonies on this subject.[1]

In these documents, we have repeatedly emphasized the importance of "upstream" controls that avoid reimbursement for inappropriate or inflated claims for health care services and supplies. However, these controls will never supplant--though they do reduce--the need for enforcement of laws and regulations targeting abusive and fraudulent providers. These "downstream" activities serve the dual purpose of punishment and deterrence. Both categories share the common objective of curbing Medicare fraud and abuse, both are addressed in our testimony today, and both are targeted by the provisions of bills submitted in this current Congress.

In summary, the vast majority of Medicare providers seek to abide by program rules and strive to meet beneficiaries' needs. Nevertheless, Medicare is overwhelmed in its efforts to keep pace with, much less stay ahead of, those bent on cheating the system. Our recent investigations of Medicare fraud and abuse have implicated home health agencies, medical suppliers, pharmacists, rehabilitation therapy companies, and clinical laboratories, among others. They are attracted by the high reimbursement levels for some supplies and services, and the few barriers to entry into this lucrative marketplace. Once engaged in these profitable activities, exploitative providers too often escape detection because of inadequate claims scrutiny, elude pursuit by law enforcement authorities because of the authorities' limited resources and fragmented responsibilities, and face little risk of speedy or appropriate punishment.

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[1]See appendix I for a list of reports and testimonies addressing this exploitation.

BACKGROUND

Medicare falls within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the federal Department of Health and Human Services (HHS). HCFA establishes regulations and guidance for the program and contracts with about 72 private companies--such as Blue Cross and Aetna--to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted by concerns when the program was established in the mid-1960s that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

FRAUD AND ABUSE ARE FOUND ACROSS THE SPECTRUM OF MEDICARE PROVIDERS

Our studies have identified instances of fraud and abuse in every major category of Medicare provider. A review of recent fraud investigations revealed cases involving psychiatrists, physicians, clinical laboratories, podiatrists, dentists, medical suppliers, and others. And many of these schemes operated in multiple states.

Nursing home residents are often a primary target of provider schemes to bill for unneeded or excessive services or items. Moreover, abusive or fraudulent billing by providers serving nursing home residents is widespread. Table 1 provides typical examples of Medicare fraud that occurs in nursing homes, drawn from completed or active fraud investigations undertaken by Medicare contractors or by the HHS Office of the Inspector General (OIG). Even in this limited context, exploitation can be found across the provider spectrum.

Table 1: Examples of Medicare Fraud in Nursing Homes

Type of provider	Fraudulent behavior
Psychiatrist	Billed for sessions not provided and tests not done; averaged 25.7 45- to 50-minute sessions per day
Physician	Billed for flu shots offered "free" to nursing home residents
Physical lab	Received over $2 million from Medicare for medically unnecessary trans-telephonic electrocardiograms
Clinical lab	Received reimbursement for excessive transportation costs for specimens--corresponding to over 4.2 million miles in 2 years
Medical supplier	Submitted claims for huge quantities of surgical dressings, far exceeding demonstrated need
Podiatrist	Submitted claims for complex procedures, whereas services provided were for routine foot care not covered by Medicare
Dentist	Billed for oral cancer examinations while providing routine dental care not covered by Medicare

Many instances of abusive practices are not pursued as fraud, which requires proof of intentional wrongdoing.

-- One supplier of surgical dressings regularly billed Medicare for 60 or more transparent films (a type of dressing) per beneficiary per month. For some beneficiaries, the supplier billed for 120 or more films a month.[2] Recommended industry standards suggest the need for no more than 24 films per month.

[2]The Wound Ostomy and Continence Nurses Society's and Health Industry Distributors Association's draft recommendations on utilization levels for surgical dressings call for using up to two transparent films per dressing change. In addition, these types of dressings should be changed no more than two to three times per week.

-- Another supplier billed Medicare an average of 268 units of tape per beneficiary during a 15-month period.[3] The average for all suppliers was 60 units during the 15-month period. Some beneficiaries received between 180 and 720 units of tape in 1 month. Using a 10-yard roll of tape, a common industry length, these beneficiaries would have been wrapped in 60 to 240 yards of tape per day.

-- At least four suppliers regularly billed Medicare for 30 or more drainage bottles a month for each beneficiary. This is 90 times more than the proposed standard of one bottle every 3 months.[4] These four suppliers billed 79 percent of all the drainage bottles billed to this Medicare contractor.

-- One supplier billed Medicare for an average of nine urinary leg bags per beneficiary a month. For some beneficiaries, the supplier billed for one leg bag a day, or 15 times more than proposed standard of two leg bags a month.[5] In total, this supplier billed Medicare for 50,834 leg bags, or 21 percent of all leg bags billed to this Medicare contractor over 15 months.

FACTORS MAKING MEDICARE AN APPEALING TARGET FOR EXPLOITATION

Certain characteristics of the Medicare program and the way it is administered create a climate ripe for abuse by unscrupulous providers. For many supplies and services, Medicare reimbursement far exceeds market rates. And providers are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

Above-Market Rates for Many Services Encourage Oversupply

Unlike more prudent payers, Medicare pays substantially higher than market rates for many services as the following examples show:

-- OIG reported in 1992 that Medicare paid $144 to $211 each for home blood glucose monitors when drug stores across the country

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[3]According to the Health Industry Distributors Association, normal tape usage is no more than two rolls per dressing change.

[4]According to the Medicare contractor's draft payment and coverage policy, drainage bottles are usually changed once every 3 months.

[5]According to the Medicare contractor's draft payment and coverage policy, leg bags are usually replaced twice a month.

sold them for under $50 (or offered them free as a marketing ploy).[6] HCFA took nearly 3 years to reduce the price it pays to $59.

-- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other surgical dressings. Medicare pays more than VA for each of the nine types of dressings purchased by both VA and Medicare. For all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies.[7]

-- Medicare was billed $8,415 for therapy to one nursing home resident, of which over half--$4,580--was for charges added by the billing service for submitting the claim. This bill-padding is permissible because, for institutional providers, Medicare allows almost any patient-related costs that can be documented.

The excessive rates Medicare pays for therapy services are in part responsible for the cost growth in an entire industry that has grown and flourished out of a federal requirement to assess nursing home residents for their need for rehabilitation therapy services. From 1990 to 1993, claims submitted to Medicare for these services tripled to $3 billion. Medicare has been charged rates as high as $600 per hour, though physical, occupational, and speech therapists' salaries, even when fringe benefits are factored in, range from under $20 to $32 per hour. Although Medicare may ultimately pay somewhat under the $600 per hour price, it pays many times more than the average salary range. In one documented Tennessee case, the speech therapist's salary and benefits for 1

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[6]Home blood glucose monitors enable diabetic individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sales of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

[7]42 U.S.C. 1395m(i) required HCFA to establish a fee schedule for surgical dressings based on average historical charges. However, because the benefit was expanded, HCFA did not have such data. Instead, it set fees on the basis of the median price in supply catalogs. The median price is by definition higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule nor can it adjust the schedule if retail prices decrease. While HCFA is authorized to increase payments annually based on the Consumer Price Index, it lacks authority to reduce such payments.

hour's therapy (rounded) amounted to $19. Yet the total bill was $172--$34 for the patient's copayment and $138 billed to Medicare (of which auditors allowed $110 as a reimbursable cost--almost 6 times what the therapist was paid).[8]

In response to such instances of inappropriate billings for therapy services, HCFA is developing guidelines to limit reimbursement rates. However, HCFA contacts told us that resources are not available to routinely check market prices for all items covered by Medicare. Yet such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse. Furthermore, our work has shown that HCFA's inability to systematically review payment rates as technologies mature and become more widely used, and as providers' costs per service decline, can support the proliferation of costly technology. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.[9] High Medicare payments for MRI scans supported a proliferation of MRI machines in some states. In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various covered benefits, such as overpriced procedures, selected durable medical equipment items, clinical lab tests, intraocular lenses, computerized tomography (CT) scans, and MRIs.

Medicare Does Not Adequately Screen Providers for Credibility

For certain provider types, Medicare's requirements to obtain authorization to bill the program are so superficial that these providers' credibility cannot be assumed. The result is that too often Medicare loses large sums to providers and suppliers that never should have been authorized to serve program beneficiaries. This problem has become more acute as providers that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples from our work and the OIG's show instances in which wrongdoers obtained Medicare provider numbers and billed the program extensively over the past several years:

-- Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation

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[8]For further information on abuses related to rehabilitation therapy, see Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

[9]Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

-- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

-- A Georgia Medicare contractor reported that the program authorized a company to bill for therapy services even though it had no salaried therapists and was essentially a storefront office operated by one clerical employee. The shell company billed Medicare for services provided to nursing home residents through two therapy agencies with which it subcontracted. The company's contractual relationship with the nursing home entitled it to add to its claims an 80-percent markup over what the company paid the therapy agencies. As a result, a company that appeared to exist solely for the purpose of billing Medicare added in 1 fiscal year about $135,000 in administrative charges to the costs of the therapy services.

-- Another shell company we identified had no staff. Simply by creating a "paper organization," with no office space or employees, an entrepreneur added $170,000 to his Medicare reimbursements over a 6-month period. The entrepreneur simply reorganized his nursing home and therapy businesses so that a large portion of his total administrative costs flowed through the shell therapy company and could thus be allocated directly to Medicare.

HCFA's Program Integrity Group is examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. The group is concerned, however, about the reporting burden and costs that new requirements may pose for honest providers.

ABUSES PERSIST BECAUSE OF INADEQUATE DETECTION, PURSUIT, AND PUNISHMENT OF OFFENDERS

A number of factors combine to produce an environment in which opportunities persist to overbill Medicare by billions of dollars. Monitoring of claims may fail to detect overpriced or overutilized services. Even where controls exist to signal aberrancies, many cases are not investigated. And the few offenders convicted of fraud face minimal and much delayed sanctions.

In the current fiscal environment, limited resources contribute to these inadequacies. Although payment of claims is the program's chief administrative function, claims processing and

activities to prevent inappropriate payments constitute slightly more than 1 percent of total Medicare spending. Less than one-quarter of 1 percent goes toward checking for erroneous or unnecessary payments.

Evidence of Abusive Billing Suggests Medicare's Checks on Claims Payments Are Inadequate

Medicare's claims processing contractors employ a number of automated controls to prevent or remedy inappropriate payments.[10] Although these measures are effective in some instances, abusive claims costing billions of dollars escape detection. For example, contractors that process claims for medical equipment and supplies do not necessarily review high-dollar claims for newly covered surgical dressings. In consequence, one such contractor paid $23,000 when the appropriate payment was $1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. Automated controls failed to identify either of these abuses.

Medicare's controls against fraud have not kept pace with today's health care environment in which the number of claims processed has risen dramatically--from 484 million in 1989 to almost 800 million (estimated) in 1995. Existing controls rely on data that may identify potential fraud but are derived from systems designed primarily for other purposes. New antifraud systems are available and are used today by private insurers, some of whom are also Medicare contractors. In addition, almost 200 private insurers, including 13 of the 20 largest, now use commercial systems to detect code manipulation--a type of billing abuse that affects all insurers--whereas Medicare's abilities to do so are limited. In testimony earlier this year, we reported the results of our study on private sector computer software controls used to detect such coding abuses.[11] We compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect

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[10]Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Other controls automatically deny claims or recalculate payment amounts. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

[11]See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

miscoded claims.[12] We invited each firm to reprocess over 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that had Medicare used this commercial software, the government would have saved hundreds of millions of dollars by detecting these billing abuses.

Enhancement of payment controls is problematic in the current fiscal environment. Contractor resources are a major factor here. On a per claim basis, funding for contractors has declined in recent years, as shown in table 2. As a consequence, we have found instances where automated controls that flag claims for further review have been turned off for lack of staff to follow up.

Table 2: Per Claim Funding of Medicare Contractors for Selected Activities

Activity	1989 budget (actual)	1995 budget (estimated)	Percentage decrease	
			Not adjusted for inflation	Adjusted for inflation
Medical review of claim	$0.32	$0.15	54.4	61.8
All payment safeguards	0.74	0.50	32.7	43.6
Total contractor budget	2.74	2.05	25.1	37.2

Although heavier reliance on automated controls that do not require manual review would help, automation alone will not solve the problem of decreasing resources because many decisions require the judgment of trained medical personnel. Noting that every dollar spent on Medicare safeguard activities returns at least $11, we and others have proposed that additional funds be provided to at least keep pace with the growth in claims processed. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity for increased control over Medicare program costs.

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[12]Providers bill their charges to Medicare according to the American Medical Society's Current Procedural Terminology Handbook, which contains codes for almost every medical procedure. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit.

Penalties for Wrongdoing:
Too Little, Too Late

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or of having to repay fraudulently obtained money. Few cases are pursued as fraud. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white-collar crime in general) and are not confined to Medicare. They are variously attributed to the complexity of cases, lack of resources, necessity for interagency coordination, and uncertainty of outcome. In recent testimony, the Special Counsel for Health Care Fraud at the Department of Justice noted that health care fraud cases are extremely resource-intensive and are among the most document-intensive of all white-collar crime.[13]

Potentially fraudulent activities are investigated by Medicare's claims processing contractors, OIG's headquarters and regional offices, and law enforcement agencies at all levels. The lack of resources hampers investigations for each group and leads to extended delays in case resolution. For example, our recent investigation of inappropriate therapy billings for Medicare beneficiaries in nursing homes traced one case from the initial beneficiary complaint through OIG's close-out. This case took almost 3 years, and even then the resolution was inconclusive.

The contractors are the first line of defense. Fraud units at each contractor site investigate leads from beneficiaries and other sources and refer persuasive cases to OIG, whose regional and headquarters offices decide whether to become further involved and whether to seek civil or administrative sanctions. Criminal action is the province of the Department of Justice, which can also initiate civil actions in federal court. In Medicare cases, OIG investigators provide the information on which the Department of Justice bases its decision. OIG may also refer cases declined by the Department of Justice to local or state law enforcement agencies.

Many fraud cases are negotiated among the various parties involved before conviction to explore possible plea bargains. While the cases are developed at regional OIG offices, they must be reviewed and approved by headquarters, where delays result because there are only three qualified and available negotiators for the entire country. Cases settled through such negotiation offer

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[13]Statement by Gerald M. Stern, Special Counsel, Health Care Fraud, Department of Justice, before the House of Representatives, Committee on Government Reform and Oversight, Human Resources and Intergovernmental Relations Subcommittee, concerning Medicare and Medicaid fraud and abuse (June 15, 1995).

providers an opportunity to avoid being "excluded" from (prohibited from billing) Medicare.[14] Ninety percent of cases OIG judges to have merit are settled through negotiation.

In some instances, as a result of negotiation, corporate providers can continue their program participation despite egregious Medicare fraud. Recently, a clinical laboratory company operating nationwide acknowledged over $100 million in fraud committed against Medicare, Medicaid, and CHAMPUS[15] over a 4-year period. The lab was allowed to negotiate a civil settlement including language that specifically permitted its continued participation in all three programs.

Even when exclusion is imposed, this information can be slow to reach contractors and other affected parties despite recent improvements in the process of notification. Providers who continue to bill after exclusion are not always caught right away; indeed, providers who move from state to state or who use more than one provider number may continue to obtain Medicare reimbursement indefinitely.

OIG is working with HCFA in seeking a nationwide uniform provider agreement that prohibits paying excluded individuals. They are also seeking expanded authority to act against culpable owners of excluded companies. Currently, the owner of such a company is free to reincorporate or start another business without fear of exclusion.

RECENT INITIATIVES TARGETING HEALTH CARE FRAUD AND ABUSE

In the past, HCFA generally placed more emphasis on program safeguards--designed to curb fraud, waste, and abuse--than did private insurers. That is true no longer. Response to the problems of inappropriate and excessive billings noted in our recent reports has been slow. The delay may be in part due to

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[14]The Secretary of HHS has the authority to exclude health care providers from Medicare for a number of reasons and has delegated these various authorities to OIG. Program exclusion is mandatory following convictions for Medicare or Medicaid program-related crimes or for patient abuse and neglect. Under other conditions, OIG can exercise judgment as to whether exclusion is appropriate. According to OIG, very few companies or other entities are excluded from the program: over the past 10 years, 90 percent of the exclusions have targeted individuals.

[15]CHAMPUS--the Civilian Health and Medical Program of the Uniformed Services--is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

limited resources. More significantly, though, as a public program, Medicare changes require public input and hence can be cumbersome and time-consuming. As we reported last month, past experience suggests that changes made by HCFA will typically be contested.[16] In considering cost-saving initiatives, HCFA must therefore weigh the resulting expense and disruption as well as the risk of ultimate failure against anticipated savings.

Recently, HHS has initiated several efforts, alone and in conjunction with other agencies, to address long-standing problems with inappropriate payments. First, HCFA let a contract to design a single automated claims processing system--called the Medicare Transaction System (MTS)--that promises greater efficiency and effectiveness. By replacing the 10 different claims processing systems now used by Medicare contractors with a single system, MTS is expected to serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. However, full implementation is not scheduled until September 1999.

HCFA's second initiative involves giving greater prominence to fraud and abuse activities in Medicare. One individual now serves as a focal point for health care fraud and abuse activities, reporting directly to the Administrator of HCFA. In addition, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. Before the development of these units, following up on fraud allegations and developing cases for referral to OIG were often seen as collateral duties and given low priority.

HHS also recently announced a new antifraud effort, Operation Restore Trust, to be run jointly by OIG, HCFA, and the Administration on Aging. The project is focusing on home health agencies, nursing homes, and durable medical equipment companies in five states: California, Florida, Illinois, New York, and Texas.

In August, responding to a draft of our September report cited previously, a HCFA official told us of additional measures:

-- HCFA has asked all contractors to regularly screen claims that represent unusually high dollars or volume of services and is compiling a comprehensive collection of "common sense" edits to be installed in the contractors' processing systems.

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[16]Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

-- HCFA is also pursuing a Provider/Supplier Enrollment Initiative to enhance HCFA's control over entry into the Medicare program and thus better safeguard the program against fraud and abuse. In a related effort, HCFA is participating in a joint federal and state initiative to develop unique provider identifiers.

-- Medicare contractors are piloting the use of commercial databases that compile information on the stability and business histories of providers and suppliers as one way of screening out high-risk providers and suppliers.

CURRENT PROPOSALS FOR CURBING FRAUD AND ABUSE

Bills introduced in the current Congress to address fraud and abuse have focused on both prevention and enforcement activities. On the enforcement side, key features common to several of these proposals, including your own, respond to issues we have identified here.

-- Coordination among federal, state, and local law enforcement programs. As we pointed out earlier in this testimony, fragmentation of responsibility significantly hinders enforcement activities.

-- Establishment of a central funding source--intended to increase and not supplant regular agency appropriations--to support health care anti-fraud and abuse activities. Again, we identified lack of resources as a factor contributing to delayed and inadequate sanctions.

-- Establishment of a national data collection program for reporting of final adverse actions against health care providers, suppliers, or practitioners, with access by federal and state government agencies and health plans. Such a provision could also contribute to the enhancement of interagency coordination.

-- Making health care fraud a federal crime. Representatives of the law enforcement community have repeatedly called for such a measure to simplify their task.

There have been related proposals for more severe monetary penalties and tightening of provisions barring program participation for providers violating program restrictions, including--but not limited to--the submission of fraudulent or abusive billings. However, the deterrent effect of these measures may well be offset by proposed changes to the Medicare Anti-Kickback Law and the Civil Monetary Penalties Law that would make it much harder to prosecute both criminal and civil penalty cases. As we told you in earlier correspondence, the result would be a greater potential for fraud, with a consequent negative financial effect on Medicare.

Moreover, other proposals would place a number of additional responsibilities on HHS, HCFA, and OIG--for example, the requirement to provide advisory opinions concerning potential "safe harbors" from anti-kickback restrictions. If no resources are provided to accomplish these tasks, however laudable the intent, the result could be that anti-fraud and abuse staff are spread too thinly.

Further strains upon scarce resources could result from suggestions to reward individuals reporting abusive or fraudulent behavior on the part of Medicare providers, potentially leading to an even greater backlog of pending investigations. A related measure already exists in the form of "qui tam" provisions of the False Claims Act, which allow private individuals to share in monetary recoveries from convicted offenders.

With regard to prepayment detection of inappropriate claims, your own bill, Mr. Chairman, requires Medicare carriers to acquire commercial automatic data processing software to process part B claims for the purpose of identifying billing code abuse, which we identified as a significant problem earlier in this testimony. However, only one proposal, to our knowledge, addresses another major issue we raised--the lack of adequate screening for credibility before allowing providers to bill Medicare--and even this focuses only on financial solvency and fiscal integrity.

CONCLUSIONS

Enhancing the capability to introduce and enforce strict rules regarding fraud and abuse against Medicare likely requires Congressional action. Meanwhile, however, as the nation's largest health payer, HCFA's unique federal role confers the responsibility to lead in the development of effective ways to manage health care expenditures. This would entail such pre-enforcement measures as

-- exploring opportunities to improve care management in settings such as nursing homes where fraud and abuse have been a recurring problem;

-- seeking ways to strengthen requirements for providers that request authorization to bill the program;

-- identifying for its contractors, and helping to implement, those leading-edge technologies that can best flag questionable claims or providers; and

-- facilitating the prompt reduction of obviously inflated prices for Medicare supplies and services.

It is encouraging to learn of the various HCFA initiatives along these lines. However, we are all too aware of the urgency of expediting changes that could lead to substantial savings and of

HCFA's historical pattern of slow response absent specific statutory authority. In the meantime, the dollars lost to fraud, waste, and abuse place a continuing drain upon an already overburdened Medicare program.

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Mr. Chairman and Members of the Committee, I want to thank you for the opportunity to speak before you today. This concludes my prepared statement. I would be pleased to answer any questions.

For more information on this testimony, please call Jonathan Ratner, Associate Director, or Audrey Clayton at (202) 512-7119.

RELATED GAO PRODUCTS

Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995).

Medicare: Antifraud Technology Offers Significant Opportunity to Reduce Health Care Fraud (GAO/AIMD-95-77, Aug. 11, 1995).

Medicare: Modern Management Strategies Could Curb Fraud, Waste, and Abuse (GAO/T-HEHS-95-227, July 31, 1995).

Medicare: Adapting Private Sector Techniques Could Curb Losses to Fraud and Abuse (GAO/T-HEHS-95-211, July 19, 1995).

Medicare: Allegations Against ABC Home Health Care (GAO/OSI-95-17, July 19, 1995).

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Shared System Conversion Led to Disruptions in Processing Maryland Claims (GAO/HEHS-94-66, May 23, 1994).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

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

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

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