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MEDICARE AND MEDICAID

Opportunities to Save Program Dollars by Reducing Fraud and Abuse

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the challenges that face the Congress in seeking health care cost savings. This is an important issue because rooting out fraud and abuse in Medicare and Medicaid can save at least hundreds of millions and perhaps billions of dollars. These two programs account for more than one-fourth of our national health care spending and, in fiscal year 1994, had over $300 billion in federal and state expenditures.

In summary, our work clearly demonstrated that Medicare--serving the elderly and disabled--and Medicaid--serving the poor--are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. For both programs, these include the following:

-- Strong incentives to overprovide services: The programs predominantly pay providers on a fee-for-service basis with relatively little management of care.

-- Weak fraud and abuse controls to detect questionable billing practices: Extraordinarily high volumes of services to individual patients or by individual providers do not necessarily trigger questions by claims reviewers.

-- Few limits on those who can bill: Companies using post office box numbers have qualified to bill the program for virtually unlimited amounts.

-- Little chance of being prosecuted or having to repay fraudulently obtained money: Many cases are settled without conviction, penalties are light, and providers frequently continue in business.

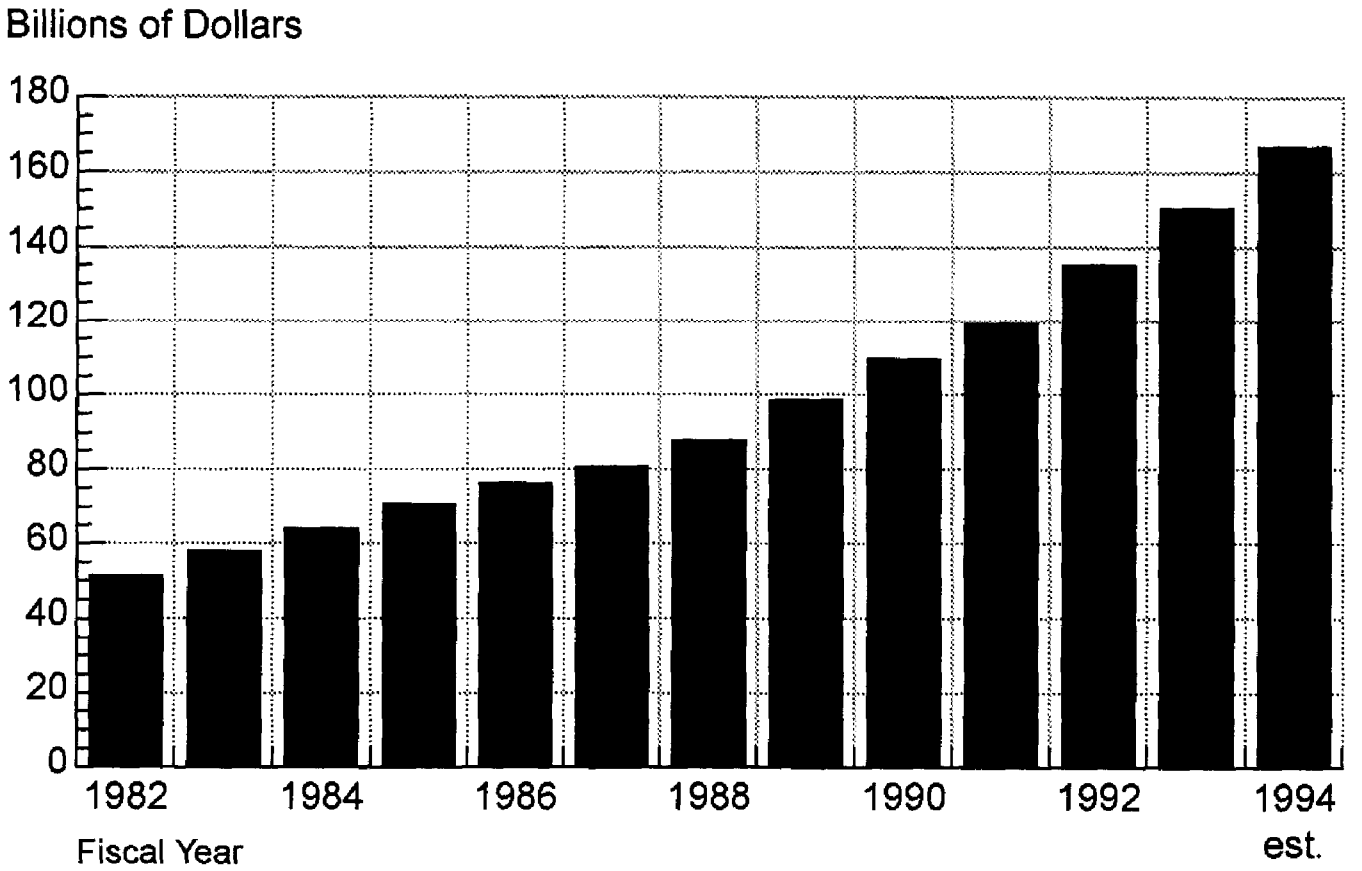
Solving these problems will require exploring options to make greater use of managed care strategies, such as preferred provider networks or health maintenance organizations (HMOs), greater investment in the people and technology needed to ensure that federal dollars are spent appropriately, more demanding standards for gaining authority to bill the federal programs, and exploring administrative reform options proposed in various bills introduced in this and the last Congress to address health care fraud and abuse.

BACKGROUND

Both Medicare and Medicaid fall within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS). Medicare is the nation's largest health payer. HCFA establishes regulations and policy guidance for the program and contracts with insurance companies--such as Blue Cross and Blue Shield, Travelers, and Aetna--to process Medicare claims and perform payment safeguard or

payment control activities to ensure that Medicare dollars are used only to pay claims that are appropriate. These safeguards and controls are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. The computer automatically holds the claim until the data are corrected. The development and implementation of these safeguards and controls are generally the responsibility of Medicare's contractors. In fiscal year 1994, Medicare contractors paid almost 700 million claims for about 36 million elderly and disabled Americans, totaling $162 billion.

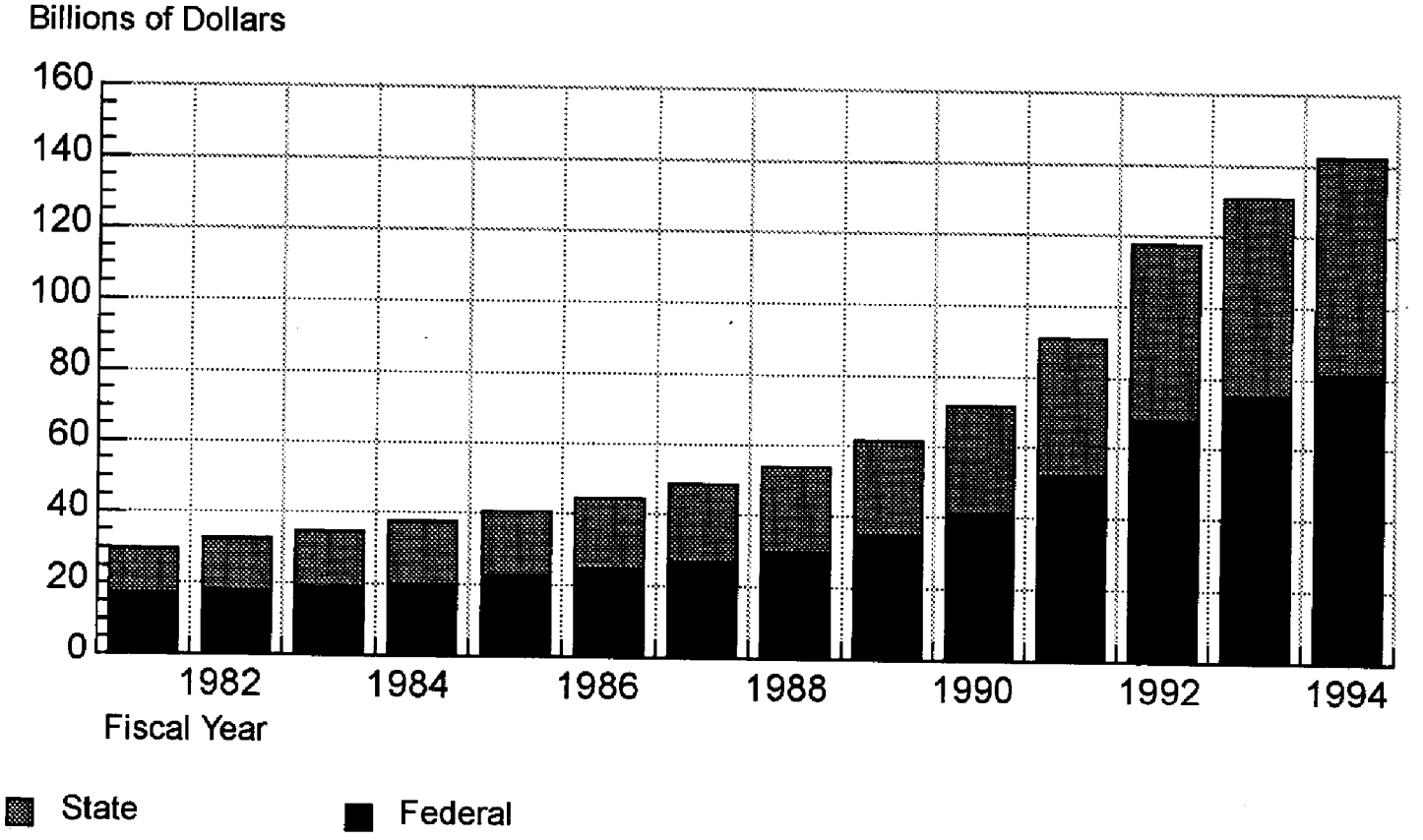
Figure 1: Medicare Spending 1982-94



Medicaid--the largest government health program for the poor--is a federally aided, state-administered medical assistance program. The federal government provides a share of each state's payment for services--between 50 and 83 percent--depending on the state's per-capita income. Each state administers the program through its own Medicaid agency. Each agency is responsible for ensuring that program dollars are spent appropriately in much the same way that Medicare holds its contractors responsible for payment control activities.

Medicaid spent about $143 billion (of which $81 billion was federal aid) on behalf of 34 million recipients during fiscal year 1994. Its size, structure, target population, and state-by-state variations render the program especially vulnerable to false billings and other fraudulent activities.

Figure 2: Medicaid Spending 1981-94



The introduction of managed care for Medicare beneficiaries and Medicaid recipients offers some promise of decreasing fraud related to overbilling or to providing unnecessary services. Though the consequences of fraud and abuse are similar--wasteful spending and inappropriate patient care--the forms it takes and the approaches used to address it are generally different for fee-for-service and prepaid health care providers.

In the fee-for-service reimbursement system, providers have the incentive to enhance their income by ordering too many services. Because fee-for-service providers bear little financial risk for the costs of services they prescribe, providers can inflate fees, services provided, or services billed. Fraudulent or abusive practices in the fee-for-service reimbursement system include overcharging for services provided, charging for services not provided, accepting bribes or kickbacks for referring patients, and rendering inappropriate or unnecessary services.

In contrast, prepaid health care providers, typically HMOs, are both insurers and providers of care. They bear the financial risk for their members' care in exchange for a fixed, predetermined fee per member. HMOs can, however, enhance their profits by minimizing spending on patient care; that is, by underserving their members. Consistent with this incentive, fraudulent or abusive practices found among some prepaid health plans in the Medicare and Medicaid programs tend to involve avoiding expensive treatments, underfinancing health plan operations, disregarding member complaints, providing poor-quality care, or using deceptive marketing practices, such as failing to reveal significant plan restrictions to consumers.

Although there has been a considerable shift from fee-for-service to managed care in Medicaid (now about 24 percent of enrollees, up from 10 percent in 1991) and to a lesser extent in Medicare (about 9 percent, compared with 6 percent in 1991), most care is still provided on a fee-for-service basis. For the foreseeable future, a significant though lower share of services is likely to continue on a fee-for-service basis, especially for Medicare beneficiaries.

MANY FRAUDULENT SCHEMES COMMON TO BOTH PROGRAMS

Our recent and ongoing work has shown that medical professionals or businesses that engage in fraudulent and abusive practices have targeted both programs, resulting in unnecessary Medicare or Medicaid expenditures.[1] Opportunities for fraud exist in both Medicare and Medicaid because each incorporates incentives to submit claims for services that are not needed, not provided, or

[1]See the related GAO products section at the end of this testimony for a listing of reports and testimonies addressing this issue.

overpriced. Moreover, each program has control weaknesses that result in paying providers' claims for improbably high levels of service or cost. The following are examples of abuses that have come to light through whistleblowers or some other fortuitous circumstance, not because program safeguard controls detected them.

-- Over 16 months, a van service billed Medicare $62,000 for ambulance trips to transport one beneficiary 240 times.

-- For one recipient, Medicaid paid for more than 142 lab tests--mostly duplicative--and 85 prescriptions during an 18-day period. One lab involved in this example billed Medicaid for more than $80 million in 2 years.

-- In 1994, five individuals pleaded guilty to defrauding Medicare and Medicaid of approximately $4 million by using illegally obtained beneficiary identification numbers and billing the programs for large quantities of diagnostic services not provided.

Medicare contractors acknowledge that they have difficulty controlling widespread billing abuses for claims submitted for such things as medical supplies and home health, psychiatric, diagnostic, or rehabilitation therapy services. In addition, because the population served by Medicaid is relatively more transient and less likely to form a stable relationship with providers, additional opportunities for fraud result from the difficulty of verifying that patients are in fact eligible for Medicaid. Our recent investigations of Medicaid fraud have implicated psychiatrists, pharmacists, family practitioners, and clinical laboratories, among others.

Table 1 provides typical examples of fraud in both programs, drawn from completed or active fraud investigations.

Table 1: Examples of Medicare and Medicaid Fraud Investigations

	Fraudulent Behavior	
Provider	Medicare	Medicaid
Psychiatrist	Billed Medicare and was reimbursed for sessions that would have required nonstop counseling in excess of 24 hours per day.	Billed Medicaid for 4,800 hours a year or almost 24 hours each workday.
Physician	Billed Medicare for flu shots offered "free" to nursing home residents.	Billed Medicaid for abortions on women not pregnant, including one who had a hysterectomy. In 48 separate instances, he billed for 2 abortions within 1 month on the same patient.
Ophthalmologist		Performed unneeded cataract operations on Medicaid patients. In 5 years, he obtained $1 million from Medicaid, often telling patients that cataracts were contagious.
Physiological lab	Received over $2 million from Medicare for medically unnecessary trans-telephonic EKGs.	
Clinical lab	Received Medicare reimbursement for transporting laboratory specimens--corresponding to driving over 4.2 million miles in 2 years or almost 6,000 miles every day.	Bought massive quantities of blood from the poor; billed Medicaid $3.6 million for expensive, unordered, and unnecessary blood tests.
Medical supplier	Submitted claims for huge quantities of surgical dressings, far exceeding demonstrated need.	
Podiatrist	Submitted claims for surgical procedures, but services provided were for routine foot care--usually not covered by Medicare.	Billed Medicaid for high-priced custom-made orthotics while providing cheap stock goods.
Dentist	Billed and reimbursed for oral cancer examinations while providing routine dental care that was not covered by Medicare.	Billed Medicaid for treatments to nursing home residents already deceased.

Moreover, federal and state fraud investigators concur that those involved in these violations rarely confine themselves to a single

program, but rather submit inappropriate claims to Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),[2] the Department of Veteran's Affairs, private insurers, workers' compensation programs--whatever is convenient.

MANAGEMENT ILLS LEAVE MEDICARE CLAIMS SYSTEM VULNERABLE

Medicare is not managing care more effectively by using its substantial claims data to identify problem areas and implement corrective actions. Nursing homes, for example, provide HCFA an opportunity to reduce costs by adopting basic managed care concepts--identifying high-cost sites and encouraging providers to reduce costs. Nursing home residents are often a primary target of provider schemes to bill for unneeded or excessive services or items; abusive or fraudulent billing by providers serving nursing home residents is widespread. Providers that have recently been prosecuted or are currently under investigation for fraud by Medicare contractors and the HHS Office of Inspector General (OIG) include ambulance companies, suppliers of medical equipment and supplies, podiatrists, psychiatrists, and laboratories, some of which operate in multiple states.

HCFA could identify such schemes by compiling data on Medicare reimbursements per patient per day by nursing home. Identification of high-cost homes would be the first of various analyses to isolate problem nursing homes or services within homes. This approach would serve to pinpoint for HCFA the locations that require attention and the providers that serve those sites. The approach would also allow HCFA to establish benchmarks against which to measure the success of any corrective actions that it stipulates.

HCFA also does relatively little to check contractor controls to spot questionable providers or the overprovision of services. For example, even companies that have used post office box numbers as billing addresses or have little, if any, business history have qualified to bill the program. Further, there are no limits on the volume of bills that a new provider can submit. This makes obtaining a Medicare provider number easy for unscrupulous providers. They can then bill the program extensively and receive large payments over a brief period and disappear before (or soon after) Medicare begins to ask questions. For example, five clinical labs (that Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the possible submission of false claims. The labs' mode of operation was to

[2]CHAMPUS is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

bill Medicare large sums over 6 to 9 months, and when they would receive inquiries from Medicare, they go out of business.

Moreover, for most services Medicare contractors do not have sufficient computerized checks to flag unusually high volumes of a service or supply item to a beneficiary or to the beneficiaries at a particular care site, such as a nursing home. These weaknesses explain why Medicare contractors processed, without questioning

-- over $1.2 million in claims over 12 months from a supplier of body jackets to nursing home residents when the supplier had previously been paid about $8,500 for the previous year for the same item or

-- almost $1 million in claims over 12 months for therapy services from a small nursing home that previously had only nominal therapy claims.

HCFA Initiatives

HCFA has begun two major initiatives to address longstanding problems with inappropriate payments. First, HCFA contracted for the design of 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. Full implementation is at least 3 years away, however.

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. Further, 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 the OIG were often seen as collateral duties and given low priority. HCFA has also taken several steps that make obtaining authorization to bill the program more difficult for fly-by-night providers.

SYSTEMIC PROBLEMS INCREASE MEDICAID'S VULNERABILITY

Medicaid also is intrinsically vulnerable to fraud. First, the program is large, with costs increasing at more than 10 percent a year. By the year 2000, the Congressional Budget Office anticipates that, without major changes, the federal share alone will approach $150 billion, surpassing the current total spent by

federal and state governments combined. Medicaid generates a correspondingly large number of claims: approximately 800 million a year. This volume makes examining claims closely for abusive or fraudulent practices difficult.

Second, because Medicaid has traditionally paid providers on a fee-for-service basis and has nominal if any copayments, Medicaid offers no financial disincentives to heavy use by honest recipients, much less those who may participate in dubious schemes.

States have the predominant responsibility to see that claims are processed correctly and that adequate fraud and abuse controls are in place. While some states are experimenting with measures to curb fraud and abuse, including managed care alternatives such as HMOs, their efforts are hampered by the same management problems that affect Medicare, as well as resource limitations. As a result, data are used ineffectively and convicted offenders receive light penalties and their postconviction involvement in federal health programs is poorly scrutinized and inadequately controlled.

Data to Detect Fraud Are Not Effectively Used

State Medicaid agencies have claims data and other records that can be used to identify patterns of potential fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, in our recent study of prescription drug diversion, we found that state Medicaid agencies--faced with unreliable and incomplete data--generally do not rely on analyses of their data to identify patterns of potential fraud or abuse. Instead, most alleged abuses are identified through tips or other fortuitous means. Other abuses are referred to prosecutors by the state agency responsible for administering the program, but even these abuses are seldom revealed by routine analysis of existing claims data.

An example from California illustrates how fraud goes undetected far too often. We found that a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of prescription drugs. For 3 years the volume of prescriptions was improbably high--in many cases more than 20 prescriptions a day for a single recipient. The state's reporting system, however, did not trigger an investigation of the pharmacist nor of any of the recipients. A tip ultimately revealed the scheme.

Complexity of Administration Makes Extensive Coordination Necessary

Curbing Medicaid fraud is complicated by the numerous jurisdictions having responsibility. For example, a typical drug diversion case may involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. However, at the time of our study, no organizational unit within

HCFA was dedicated to curbing fraud and abuse, and HCFA was not directly involved in drug diversion cases. It is too early to judge whether the recent appointment of HCFA's focal point for health care fraud issues can significantly improve coordination, but the appointment is a step in the right direction.

Financial and Other Penalties Are Light

Unscrupulous providers can reasonably anticipate very light penalties--if they are caught. First, in response to limited resources, prosecutors settle many cases short of conviction. Plea bargaining is common. Many first offenders are subject to what in Florida, for example, is called pretrial diversion, or equivalent agreements whereby their court records are sealed if they abide by the terms of judicially approved probation for 1 year.

Second, financial penalties are light even for a provider whose billings can be in the millions of dollars. In more than one-half the cases we reviewed across four states, restitution amounts were nominal--$5,000 or less. Providers usually paid these amounts. But in cases in which courts set restitution at $20,000 or more, the Medicaid agency recovered only a small percentage of the dollar amount established. In one case in which restitution was set at $220,000, only $4,000 had been repaid over 2 years later.

Although providers convicted of Medicaid fraud are generally excluded from the program, offenders frequently retain some connection with health care delivery and, therefore, have subsequent opportunities to commit violations. Federal laws are in place to exclude convicted providers from program participation, but apparently no one with authority and adequate resources is following up on individuals charged or convicted. In Florida, for example, we found that

-- of nine individuals charged with Medicaid fraud in 1990, five--including a pharmacist excluded from program participation--were employed (as of July 1992) in pharmacies that served Medicaid recipients, and

-- of five pharmacies charged with fraud in 1990, three were excluded from Medicaid participation. One pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership. One of the new owners is married to the convicted former owner.

Faced with such problems in following up on crimes within their own borders, it is not surprising that state officials cannot prevent incursion by offenders from out of state. We found that several providers in New York who were suspected or convicted of fraud, were associated with Florida health care facilities: a

clinical lab, and a nursing home that reportedly receives both Medicare and Medicaid funds.

Some State Initiatives Appear Promising

States have some systematic controls designed to prevent prescription drug diversion and other types of Medicaid fraud. Because even the best up-front controls are never 100-percent effective, states also have procedures for pursuit, punishment, and financial recovery.

Advanced identification technology and automated systems that can flag suspicious activity can prevent or detect fraud early on. Recent initiatives in some states include (1) the use of identification cards that resemble credit cards and that monitor utilization, (2) prescription-filing systems that can instantly link orders to the filing physician, and (3) data analysis techniques that can promptly identify physicians prescribing and patients receiving high volumes of drugs.

Other initiatives focus on pursuit and punishment. One approach to swifter and more certain pursuit of offenders uses multiagency task forces to coordinate case development. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies. In New York, for example, providers applying for Medicaid certification agree up front that the state can unilaterally cancel their participation without proof of fraud.

Recovery of program losses is also receiving more attention. Stronger tools are available, such as requirements that certain high-volume providers post performance bonds or other forms of collateral as a condition of program participation.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, encouraging signs exist. For example, a combination of initiatives in New York is associated with an 8-percent decrease over five years in the number of Medicaid prescription claims and a sharp reduction in spending for the most abused prescription drugs.

EXPLORING ADMINISTRATIVE REFORM OPTIONS

In searching for solutions, we should not overlook some suggestions made in this and the last Congress for reducing vulnerability to fraud and abuse. Various administrative reform proposals include options worthy of exploration, such as streamlining and enhancing health care information systems and strengthening laws and enforcement mechanisms.

Regardless of reimbursement method--fee-for-service or managed care--the consensus is that streamlined and enhanced health care

information is needed by Medicare and Medicaid. Such information can enhance the detection and pursuit of fraudulent and abusive providers. In addition, the ability to exchange such information across programs and between monitoring and enforcement agencies can further facilitate fraud prevention, pursuit, and punishment. Such information exchange would be one element of a broader program of coordination and cooperation.

Another reform that we and others have proposed involves legislation to enable Medicare program safeguard funding, which produces at least $11 for every dollar spent, to keep pace with the growth in program expenditures. On a per-claim basis, federal funding for safeguard activities has declined by over 32 percent since 1989. Indeed, adjusted for inflation, funding per claim has decreased by 43 percent. In large part, the decline in program spending for these activities corresponds with passage of the Budget Enforcement Act of 1990. That act established limits--or caps--on domestic discretionary spending, including spending for Medicare program safeguard activities. Exceeding these caps in one domestic discretionary account requires budget reductions in other accounts, such as those for education or welfare. This means that even though appropriating additional funds for safeguard activities would result in a net budgetary gain, under current law, it would necessitate offsetting cuts in other areas. Recognizing a similar situation with respect to Internal Revenue Service compliance activities, the 1990 act included a limited exception to the spending caps to facilitate adequate funding for such compliance activities. Therefore, the Congress is able to increase funds for such activities without cutting funding for other domestic discretionary programs. If a similar exception were provided for Medicare program safeguards activities, it could ultimately lead to significant savings to the federal government.

CONCLUSIONS

As the nation's largest health payer, HCFA should be a leader in developing effective ways to manage health care expenditures. With respect to Medicare, this would entail such things as

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

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

-- developing and requiring contractors to implement better computerized checks to flag questionable claims or providers.

Because these efforts are funded out of the government's discretionary appropriations, however, funding increases would necessitate spending cuts in other government programs. We have been recommending since May 1991 that the Congress consider

extending the budget option available to the Internal Revenue Service under the 1990 Budget Enforcement Act. If a similar option was available to Medicare, HCFA would be able to provide its contractors with the necessary incentive to prevent or recover losses resulting from exploitative billings.

With respect to Medicaid, we find similar problems that need to be addressed. Being a state-administered program, however, HCFA's role shifts from that of direct program management to one of leadership. This would entail documenting, guiding, coordinating, and encouraging states' efforts. HCFA could also address other overarching concerns revealed by our study, such as whether--and how--state laws, federal requirements, and other factors inhibit prosecution or attempts to recover payment of claims subsequently determined not to be authorized by law. Moreover, while all jurisdictions have resource constraints that limit oversight, investigative, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have.

Finally, the problems facing Medicare and Medicaid are faced by all payers, underscoring the need for comprehensive solutions. Administrative reform proposals from this and the last Congress present features that would help correct systemic weaknesses and oversight problems without unduly restricting the freedom that patients and providers have come to expect when selecting their treatments. Adopting broad-based administrative reforms would significantly enhance the detection and pursuit of fraudulent and abusive providers.

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Mr. Chairman and Members of the Subcommittee, 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 Edwin P. Stropko, Assistant Director, at (202) 512-7108. Other major contributors included Audrey Clayton, Don Hunter, Roland Poirier, and Don Walthall.

RELATED GAO PRODUCTS

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).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

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

Health Insurance: More Resources Needed to Combat Fraud and Abuse (GAO/T-HRD-92-49, July 28, 1992).

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992), and related testimony (GAO/T-HRD-92-29, May 7, 1992).

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

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

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

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