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MEDICARE

Reducing Fraud and Abuse Can Save Billions

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Mr. Chairman and Members:

I am pleased to be here to discuss the challenges that Medicare faces in battling fraud and abuse in the health care system. Medicare is highly vulnerable to such exploitation, as we have pointed out many times. We have issued two reports on this topic in our High-Risk Series, and--most recently--a report to your Committee focusing on abusive billings for therapy services to nursing home residents. My comments draw heavily from these and other recent reports and testimonies on this subject.[1]

Today I would like to describe the ways that certain providers exploit the program, why they are able to do so, what steps Medicare has taken already and what remains to be done to protect the program and the taxpayers against fraudulent reimbursement schemes and abusive billing practices.

In brief, Medicare is overwhelmed in its efforts to keep pace with, much less stay ahead of, those bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. These include

-- Weak fraud and abuse controls to detect questionable billing practices: Even extraordinarily high volumes of services to individual patients or by individual providers may not trigger questions or claims review efforts--a psychiatrist was paid over a prolonged period for a volume of services approaching 24 hours a day.

-- Few limits on those who can bill: Even companies with no address other than a post office box number can qualify to bill the program for virtually unlimited amounts--shell companies with no employees have billed the program large sums for rehabilitation therapy services.

-- Overpaying for services: Medicare sometimes pays more than the market price for medical services and supplies--86 cents for a gauze pad that costs another federal agency 4 cents or $186 for a home blood testing device widely available in drug stores for less than $50.

These problems are exacerbated by a combination of factors involving the program's budget, management, and leadership. Despite some recent HCFA initiatives, solving these problems will require both greater investment in the people and technology needed to manage efforts to ensure that federal dollars are spent appropriately and more demanding standards for providers seeking authority to bill Medicare.

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[1]See Related GAO Products at the end of this testimony for a list of reports and testimonies addressing this exploitation.

BACKGROUND

Medicare--the federal program that finances health care for the elderly and disabled, and the nation's largest health payer--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 insurance companies--such as Blue Cross and Blue Shield, Travelers, and Aetna--to process Medicare claims. These contractors also perform payment safeguard or payment control activities to ensure that Medicare dollars are used to pay only claims that are appropriate. Such controls are programmed into computer claims processing software, and 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 those claims until the data are reviewed. The development and implementation of these controls are generally the responsibility of Medicare's contractors. In fiscal year 1994, Medicare contractors paid almost 700 million claims, totaling $162 billion, for about 36 million elderly and disabled Americans.

The best way to understand what Medicare payment controls accomplish is to examine what occurs when there are breakdowns in controls. In some instances, Medicare has paid 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 1 beneficiary 240 times.

-- In 1994, five individuals pleaded guilty to defrauding insurers, including Medicare, of approximately $4 million by using illegally obtained beneficiary identification numbers and billing the programs for large quantities of diagnostic services never provided.

Medicare contractors acknowledge that they have difficulty controlling widespread billing abuses for claims submitted for medical supplies, and home health, psychiatric, diagnostic, and rehabilitation therapy services, among others. Our past work on Medicare fraud has implicated psychiatrists, pharmacists, family practitioners, and clinical laboratories, among others.

MEDICARE CLAIMS SYSTEM IS VULNERABLE

Medicare could manage care more effectively by using its substantial claims data to identify problem areas and implement corrective actions. We are finding this to be the case in a study we are now doing for this Committee on fraud and abuse in nursing

homes. 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, our work is showing.

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 them operating in multiple states. Table 1 provides typical examples of Medicare fraud in nursing homes, drawn from completed or active fraud investigations.

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 about 26 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 (EKG)
Clinical lab	Received reimbursement for excessive transportation costs for specimens--corresponding to over 4 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 usually not covered by Medicare
Dentist	Billed for oral cancer examinations while providing routine dental care not covered by Medicare

We are finding that problems such as these persist because Medicare contractors do not have sufficient computerized checks to flag unusually high volumes of a service or supply item provided to a beneficiary or to the beneficiaries at a particular care site, such as a nursing home. Moreover, it is easy for providers to obtain authorization to bill Medicare. These two factors allow

unscrupulous providers to obtain a Medicare provider number, bill the program extensively, receive large payments over a brief period, and then 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 bill Medicare large sums over 6 to 9 months and then, when they received inquiries from Medicare, to go out of business.

Excessive Reimbursement Levels for Rehabilitation Therapy Illustrate Medicare's Vulnerabilities

The overpayments and abusive billing for rehabilitation therapy services that we reported to your Committee in March illustrate two additional underlying causes for abuse: paying too much for services or supplies and enforcing only weak requirements governing legitimacy of providers.

An entire industry 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.

Some of this cost growth is attributable to the excessive rates Medicare pays for therapy services. For example, 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 less than the amount claimed, it nevertheless pays rates that are many times the average salary range.

For example, in one documented Tennessee case, a speech therapist's salary and benefits for 1 hour's therapy (rounded) amounted to $19. But 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).

Few Requirements Governing Legitimacy of Providers

Another exploitation of Medicare therapy reimbursement stems from the loose requirements for certification to bill the program. For example, a Georgia contractor reported that Medicare 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.

Therapy companies can also use a skilled nursing facility's provider number to bill Medicare. Under such an arrangement, some therapy companies bill Medicare as if the patients had received services in that nursing facility although the patients may be anywhere in the country.

This practice benefits therapy companies by enabling them to evade Medicare controls that might flag overbilling. One such company, for example, divided a Texas patient's $10,950 claim for physical therapy between nursing homes that were linked to two different Medicare contractors in North Carolina and Florida.

Although aware of these problems since 1990, HCFA did not act until 1993 to advise claims processing contractors of certain irregular billing practices and of actions they could take to minimize billing problems. HCFA is also in the process of closing certain payment loopholes; however, similar efforts involving drafting and implementing guidelines have taken 3 years or more.

INEFFECTIVE MONITORING COSTS MEDICARE BILLIONS IN UNWARRANTED PAYMENTS

Other opportunities to overbill Medicare by billions of dollars exist because, unlike private payers and managed care organizations, HCFA does not effectively monitor the price or volume of services. Over 98 percent of Medicare spending is for payments to providers. Claims processing and activities to prevent inappropriate payments constitute slightly more than 1 percent of total Medicare spending. Less than one-quarter of a percent goes toward checking for erroneous or unnecessary payments.

Medicare Behind in Use of Technology to Monitor Claims Payments

Two weeks ago we testified--before the Senate Committee on Appropriations' Subcommittee on Labor, Health and Human Services, Education, and Related Agencies--regarding technology used extensively in the private sector to detect certain billing abuses.[2] Our findings contain good news and bad news. The bad news is that billing abuses cost Medicare billions. The good news is that many of these losses can be prevented.

We conducted a study comparing what four commercial firms that market computerized systems to detect miscoded claims would have paid providers against what Medicare actually paid.[3] We invited these firms to reprocess--without compensation--statistically selected claims that Medicare paid in 1993. Each firm processed over 200,000 claims. On the basis of this test we estimate that, if Medicare had used this commercial technology, the government would have saved about $640 million in fiscal year 1994--by detecting just two specific types of billing abuses.

As in our previous testimony, we want to emphasize that the vast majority of Medicare providers--92 percent in our sample--bill appropriately. Only 8 percent had one or more claims adjusted by the commercial systems. But left unchecked, these providers could cost Medicare in excess of $3 billion in unwarranted payments over the next 5 years.

The benefits to be gained from the use of commercial systems have been confirmed by both private and public insurers who already use such technology. Almost 200 private insurers, including 13 of the 20 largest, now use commercial systems to detect code manipulation.

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[2]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).

[3]Providers bill their charges to Medicare according to an official book of procedure codes. By manipulating these codes, a provider can charge Medicare more than the correct code would allow. For example, a comprehensive code covers the fee for removing a ruptured appendix, which includes making the incision to reach the appendix and closing the wound. A physician could miscode the claim by including three separate codes: one for making the incision, one for closing the wound, and the correct one--the comprehensive code covering removal of the appendix.

Funding Declines for Fraud and Abuse Controls

In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier. Yet Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Funding declines, relative to the growing number of Medicare claims, have forced HCFA to lower the proportion of claims that contractors must review. In 1989, HCFA set targets for contractors to suspend processing and review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994.

Similarly, HCFA's efforts to statistically profile claims in order to detect providers' questionable billing practices have also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year.

In some instances, for lack of adequate funding, contractors have curtailed or discontinued reviews of certain medical services, even when there was evidence of widespread billing abuse and potential for significant savings. For example, a contractor we visited last year temporarily reduced or suspended the use of five electronic controls that triggered further claims reviews. The contractor suspended the use of the controls because the volume of claims generated overwhelmed the claims review staff. These reviews had previously resulted in the denial of claims, thus saving $4 million over a 3-month period.

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 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.

HCFA studies indicate that spending for antifraud and abuse activities can reduce Medicare program costs on average by as much as 11 times the amount invested. In effect, by not adequately

funding these activities, the federal government is missing a significant opportunity to control Medicare program costs.

HCFA INITIATIVES ONLY PART OF THE SOLUTION

HCFA has begun several major initiatives to address long-standing problems with inappropriate payments. They have the potential to reduce abusive and fraudulent practices but represent only a first step toward lessening Medicare's vulnerabilities.

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. 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, but the specifics of her role have yet to be established. Furthermore, HCFA recently established special units at each contractor site to develop and pursue fraud cases within the Medicare program. Prior to 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. HCFA has also taken several steps that make it more difficult for fly-by-night providers to obtain authorization to bill the program, but these focus primarily on suppliers of medical equipment and supplies.

In addition, HHS this month 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. The nature and success of this initiative remain to be determined.

CONCLUDING OBSERVATIONS

Despite HCFA'S initiatives, program vulnerabilities persist. As the nation's largest health payer, HCFA has yet to fully develop effective ways to manage health care expenditures. This would entail such things as

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

-- 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.

Because these efforts would have to be funded out of the government's discretionary appropriations, funding increases would necessitate spending cuts in other government programs. Yet the return on such Medicare investments is substantial, more than $11 for every additional dollar. For this reason, we have been recommending since May 1991 that the Congress consider extending the budget option available to the Internal Revenue Service under the Budget Enforcement Act of 1990. 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.

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Mr. Chairman and Members, 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 and Hannah Fein.

RELATED GAO PRODUCTS

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

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6 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 (GA0/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).

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

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: 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).

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