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MEDICARE

Private Payer Strategies Suggest Options to Reduce Rapid Spending Growth

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Medicare: Private Payer Strategies Suggest Options to Reduce Rapid Spending Growth

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss strategies to curb escalating Medicare spending. There is no shortage of numbers to illustrate the importance of controlling federal outlays for this program. On average, Medicare spending has grown by over 10 percent a year since 1989—twice the rate of the national economy. Medicare's part A trust fund, which pays for hospital and other institutional services, is projected to run out by mid-2001—a year sooner than projected last year.[1]

Over the past few years we have reported in some detail on several of Medicare's flawed pricing and reimbursement policies and on weak controls over utilization. We have noted how these problems amount to bad business practices and that aspects of the Medicare program must be modernized in today's highly competitive health care market.[2] Today, I'd like to summarize these findings and outline several basic steps that would lead to a better managed, less costly health care program.

In brief, we believe that while the Congress considers long-term restructuring efforts, immediate efforts to improve Medicare's traditional fee-for-service program could bring about much needed savings. This program currently serves about 90 percent of beneficiaries and with better management could run more efficiently while continuing to serve well the nation's elderly. This means allowing Medicare to use tools similar to those used by private payers to manage health care costs. Negotiated discounts, competitive bidding, preferred providers, case management, utilization review—these and other tools enable private payers to use market forces to control health care costs, but most are not authorized for general use by the Department of Health and Human Services' (HHS) Health Care Financing Administration (HCFA), which administers Medicare. This results in a publicly financed program that pays higher than market rates for certain services and supplies, and sometimes pays without question for improbably high levels of services. Recent HCFA initiatives and pending legislation passed by the House of Representatives,[3] however, offer promise for making some program improvements. In addition, HCFA should test the feasibility of applying management strategies in high-cost,

[1]Based on CBO's March 1996 baseline projection for Medicare.

[2]A list of related GAO products is at the end of this statement.

[3]H.R. 3103, the Health Coverage Availability and Affordability Act of 1996, passed the House of Representatives on March 28, 1996.

high-utilization areas. Finally, the Congress needs to give HHS the flexibility to make prompt price adjustments.

Background

Medicare is the nation's largest single payer for health care. In 1995, it spent an estimated $177 billion, or 12 percent of the federal budget, on behalf of more than 37 million elderly and disabled people. The Congressional Budget Office (CBO) projects that, under current program law, program spending will almost double in the next 6 years to an estimated $332 billion by 2002. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with bills sent to the program for payment. This set-up mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, many changes have taken place in the financing and delivery of health care. Large health care purchasers have used leverage on hospitals and other providers to obtain lower prices. Private payers, including large employers, use an aggressive management approach to control health care costs. HCFA is Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by interrelated statute, regulation, and agency policy.

HCFA contracts with about 70 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 in addition to those that have been established nationally by HCFA. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

The health care delivery system has become more complex since Medicare began 30 years ago. In addition to physicians and hospitals, a greater variety of providers bill Medicare, including multilayered corporations providing clinical laboratory services, home health care, rehabilitation therapy, and medical equipment and supplies. Even some of Medicare's claims processing contractors are investing in provider networks, which

means that insurance companies responsible for reviewing the appropriateness of Medicare claims are also, through the medical networks they own, billing the program. At a time when the volume of Medicare claims has exceeded 800 million a year, Medicare is being billed increasingly by entrepreneurial entities rather than by medical professionals.

Categories With Fastest Growth Rates Coincide With Those Least Managed in Medicare

Although growth rates for inpatient hospital and physician services have moderated since the 1980s, Medicare spending remains high. Combined spending for these services amounted in 1994 to $120 billion—nearly three-fourths of total Medicare spending. The sheer size of these categories means that each percentage point of growth represents hundreds of millions of dollars.

Smaller categories of services, however, have displayed much more rapid growth through the 1990s, helping to drive total Medicare spending to double-digit inflation. Home health agency (HHA) and skilled nursing facility (SNF) services each grew at an average annual rate of 28 percent from 1990 through 1996.[4]

Table 1: Average Annual Growth Rates for Selected Categories of Medicare Spending

Numbers in percent

Years	Total	Inpatient	Physician	SNF	HHA
1980-89	10.2	9.5	13.8	27.3	14.0
1990-96	11.3	5.9	7.0[a]	28.0	28.4

[a]Percentage is based on data through 1994.

Private insurers and employer purchasers have sought to stem such health cost escalation by shifting from their role as passive payers to become more prudent managers of health care costs. Some 90 percent of health plans—from fee-for-service to managed care—actively manage costs through price competition and negotiation and utilization monitoring techniques. By contrast, Medicare's reimbursement policies and claims payment activities have not been adapted to the contemporary marketplace and today's demands for fiscal discipline in public programs.

[4]This is based on the latest CBO baseline projections for 1995 and 1996, since actual data are not yet available. From 1990 through 1994, the growth rate was even higher—over 35 percent per year.

SNF and HHA Categories Illustrate Cost Consequences of Unmanaged Health Services

The home health and SNF spending categories, in particular, illustrate the damaging effects of reimbursement policies that fail to incorporate effective pricing and utilization management techniques.

Inadequate Monitoring of HHA Payments

In the case of home health services, for example, Medicare pays HHAs on the basis of costs but uses few tools to determine whether the costs are reasonable. Also, physicians are not required to see the patients for whom they sign plans of care and are not held accountable if they approve inappropriate levels of service. Medicare does not require HHAs to provide beneficiaries or physicians with information on the home health services billed on their, or their patients', behalf. The Medicare contractors, moreover, pay 97 percent or more of home health claims without review.[5] Even when reviews are done, Medicare claims processing contractors rarely visit HHAs or beneficiaries to verify the actual and appropriate provision of services. One consequence of such neglect is the escalation of visits per Medicare beneficiary, which rose an average of about 20 percent a year from 1989 to 1994.

In July 1995 we reported that the largest privately held HHA in the United States, which was being investigated for fraud, obtained 95 percent of its total revenues from Medicare.[6] Current and former employees told us medical records were altered and forged to ensure continued or prolonged home health care visits. Services were provided to patients who were not homebound[7]—for example, one who routinely drove a vehicle to go grocery shopping and one who walked a few blocks alone daily to eat at the local senior citizens' center.

This company also visited patients more frequently than did most other HHAs. Although wide variation in utilization rates is a key indicator that an inappropriate level of services is being provided, Medicare contractors do not have the capacity to manage home health payments by scrutinizing agencies' claims in markets showing utilization outliers. Our March 1996 report on home health utilization shows huge variations in the level of

[5]Because of limited resources, contractors' medical review of claims has declined from 62 percent of all claims in fiscal year 1987 to about 3 percent in 1995.

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

[7]42 U.S.C. 1395f(a) requires that, to qualify for home health services under Medicare, a beneficiary must be confined to the home.

services provided across geographic areas and provider types.[8] For example, in 1993 patients in southeastern states received on average more than twice as many visits as patients in northwestern states. Furthermore, diabetics received an average of about twice as many visits from proprietary HHAs as from voluntary or government-run agencies.

Inadequate Monitoring of SNF and Ancillary Service Payments

Skilled nursing facilities represent another area in which Medicare's unguarded reimbursement policies have been exploited. In this setting, a population with extensive health care needs grouped together at a single location offers unscrupulous providers the opportunity for volume billing, and Medicare often does not look for warnings of egregious overutilization or rapid increases in billings. Under Medicare's provisions for reimbursement, providers can bill Medicare directly, without the SNF or attending physician affirming whether the items were necessary or provided as claimed. In other words, medical equipment suppliers, providers of rehabilitation therapy, and providers of X rays and other diagnostic tests can determine levels of services and bill Medicare with little or no oversight. In addition, Medicare's automated systems do not capture data in a way that would practically allow them to flag indications of improbably high charges or levels of services at individual facilities. This is in part because the data are not organized to report which beneficiaries are in nursing homes.

In January of this year we reported that a wide array of provider types—including physicians, optometrists, psychiatrists, laboratories, and medical equipment suppliers—have fraudulently or otherwise inappropriately billed Medicare for services and supplies furnished to nursing facility residents.[9] The wrongdoing has generally focused on billing Medicare for unnecessary or undelivered services, or misrepresenting a service to obtain reimbursement. The investigations we reviewed probed activities in over 40 states, with many providers operating in multiple states.

Not only are payments for the ancillary services provided to SNF patients poorly policed, payments to SNFs themselves are difficult to monitor. Medicare pays SNFs on the basis of costs. But as with home health care, Medicare has only limited tools to determine whether the costs are

[8]Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

[9]Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

reasonable. This is particularly pertinent to rehabilitation therapy, services that account for 30 percent of SNF costs. Specifically, Medicare places no absolute dollar limits on reimbursements for occupational or speech therapy, and charges for therapy services are not linked through billing codes to the amount of time spent with patients or the treatment provided. In other words, Medicare has no easy way to limit the amount it will pay for occupational or speech therapy or to determine whether a charge is for 15, 30, or 60 minutes of treatment. Absent any benchmarks, and with limited resources available for auditing, it is largely infeasible for Medicare contractors to judge whether therapy providers have overstated their costs.

Last year we reported that Medicare had been charged as much as $600 for an hour of therapy services.[10] HCFA has acknowledged the problem and recently estimated that implementing salary equivalency guidelines for speech and occupational therapy, in conjunction with adjusting other salary guidelines, could save $1.4 billion over the next 6 years. To date, however, the salary guidelines have not been established. Although occupational therapists in SNFs earn on average $23 per hour, we recently found in one contractor's files that more than 25 percent of submitted charges for one unit (undefined) of occupational therapy exceeded $195, and some approached $1,500 per unit.

Under Medicare rules for reimbursing SNFs, the problem of overpaying for rehabilitation therapy services becomes compounded. That is, Medicare pays SNFs a portion of their overhead expenses, based on the percentage of their total Medicare-related business. The higher the Medicare-related payments to rehabilitation agencies (or other outside contractors), the more Medicare business an SNF can claim, and the higher the percentage of its overhead that can be charged to the program. Further, as noted by the Prospective Payment Assessment Commission (PROPAC), SNFs may cite high use of ancillary services, such as therapy, to justify an exemption from routine service cost limits, thereby increasing their payments for routine (bed, board, nursing) services.[11]

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

[11]Report and Recommendations to the Congress (Washington, D.C.: PROPAC, Mar. 1, 1996).

Medicare's Response to Long-Standing Problems Too Slow to Be Effective

Allowing payment problems to continue unchecked results in billions of dollars of unnecessary spending. HCFA has been aware of the rehabilitation therapy overcharging problem since 1990. In 1993 HCFA began studies to develop averages for therapists' salaries. Its most recent analysis is expected to be completed some time this summer. Given the usual time involved in the federal notification and publication requirements for changing Medicare prices, salary equivalency guidelines—which are key to Medicare's determination of reasonable costs—are unlikely to be implemented before the middle of 1997 at the earliest.

This situation is consistent with HCFA's past experience of taking years to adjust excessively high payment rates. It took almost 3 years to lower the price of an item it paid up to four times more for than consumers paid at the local drug store. HCFA can adjust prices that are inherently unreasonable, but its authority to do so is very limited and involves a complex set of procedures that take a long time to complete.[12] Because of the time and resources involved, HCFA only occasionally uses this process. In an August 1995 report, we showed that Medicare paid higher than the retail prices for 44 types of surgical dressings.[13] Under the Omnibus Budget Reconciliation Act (OBRA) of 1987, however, even the unwieldy inherent reasonableness authority to change these prices was effectively eliminated. Before 1987, individual Medicare contractors had the authority to adjust prices to reflect local market conditions using a publication and notification process that could be completed in less than 90 days. In a letter to a congressional subcommittee, the HHS Inspector General last year characterized as "absurd" the situation limiting HCFA's ability to make timely adjustments to payment levels.[14]

Medicare Program Overdue for Change

Because of strict statutory constraints and its own burdensome regulatory and administrative procedures, HCFA is slow to address overpricing and overutilization problems. As we reported to the Congress last September, many of the tools Medicare's contractors use to manage their commercial insurance plans are not authorized for use in the Medicare program.[15]

[12]The relevant statutory provision is 42 U.S.C. 1395m(a)(10)(B).

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

[14]Letter dated July 25, 1995, to the Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives.

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

In stark contrast to private payers, HCFA and its contractors generally cannot

- use such utilization controls as prior approval or case management to coordinate and monitor expensive services and specialist care;
- encourage the use of "preferred providers"—those who meet utilization, price, and quality standards; or
- negotiate with select providers for discounts, promptly change prices to match those available in the market, or competitively bid prices.

Not surprisingly, Medicare's ability to emphasize cost efficiency in its dealings with suppliers, physicians, and institutions that habitually provide excessive services is limited, and for certain services Medicare pays higher prices than its private sector counterparts. (See app. I for details on commonly used private sector strategies and their applicability to Medicare. See also chapter 11 of the Physician Payment Review Commission's (PPRC) 1996 Annual Report to Congress.)[16]

The recognition that Medicare needs to change its role from largely a claims processor to prudent manager is beginning to take shape in HCFA itself as well as in pending legislation passed by the House of Representatives last month. For example, HCFA has planned, among several new initiatives,

- a demonstration testing the concept of competitive bidding for certain supplies, such as oxygen, hospital beds, and urological and incontinence products;
- an improvement on earlier case management experiments by which primary care physicians would, for example, provide comprehensive management for beneficiaries with specific diagnoses, such as diabetes, hypertension, or congestive heart failure, for which Medicare would reimburse them with a bundled, capitated payment as is currently done on a monthly basis for end-stage renal disease patients; and
- a demonstration in selected locations that allows beneficiaries to join preferred provider organization health plans, which are not currently available under Medicare.

HCFA has interpreted current law as precluding it from contracting with entities other than insurance companies. Certain provisions in the Health Coverage Availability and Affordability Act of 1996 would give HCFA the funding and flexibility to make its contractor network better managers of

[16]Washington, D.C.: PPRC.

program dollars. In particular, HCFA[17] would have the authority to contract directly with companies specializing in utilization review and fraud detection to monitor and adjudicate claims. In essence, HCFA could contract with the companies best suited to perform medical, utilization, and fraud reviews; audit cost reports; revisit payment decisions and recover overpayments; provide education on payment integrity and benefit quality assurance issues; and provide more specific guidance on coverage of medical equipment and supplies. Increased flexibility and an accompanying assured funding stream, such as that proposed in this legislation, would significantly enhance HCFA's ability to curb overutilization and inappropriate billings.

Despite these initiatives, however, important tools would still be unavailable to the Medicare program. For example, HCFA uses profiling—that is, statistical analyses—to identify "outlier" providers whose practice patterns differ markedly from those of their peers. While the private sector is free to use profiling results to provide financial rewards or penalties (in the form of exclusion from preferred provider networks), HCFA lacks the authority to do so. In addition, HCFA and its contractors have no viable statutory authority to require prior approval of select procedures. Most important, HCFA does not have the authority needed to promptly correct overpricing problems.

Conclusions

The problems facing Medicare confront private insurers as well, but they are equipped with a larger and more versatile inventory of health care management strategies than HCFA currently has. These strategies may not be deployable in every aspect, but in general they suggest ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care approaches in their capacity as private insurers. If they applied similar approaches to Medicare, the government might be able to avoid spending substantial sums unnecessarily.

Medicare needs to redefine itself from being a passive payer of claims to becoming a prudent manager of health care costs. Major reimbursement reforms may be an ultimate solution, but HCFA needs to begin immediately to manage Medicare's high-growth-rate areas, such as home health and SNF care. Reducing services and prices to appropriate levels is paramount before locking in existing cost structures through payment system reforms. This will entail several steps:

[17]Technically, the authority is granted to HHS, of which HCFA is a part.

1. The Congress should enact funding and contractor reform provisions similar to those contained in H.R. 3103. Such reforms would give HCFA the flexibility to hire the private sector expertise necessary to apply the best health cost management practices.

2. HCFA needs to target Medicare's high-cost, high-utilization areas for running demonstrations to apply such strategies as the use of case management and companies specializing in utilization review. For example, HCFA could identify, as the focus of the demonstrations, geographic areas with particularly high home health or SNF costs per Medicare beneficiary.

3. The Congress should give HHS the flexibility to make prompt adjustments to fee schedules when overpriced services and supplies are identified. For example, Medicare should be able to reduce fee schedule prices for surgical supplies within 90 days, similar to what was customary before OBRA 1987.

We have included as appendix II a list of GAO recommendations recently made to correct specific Medicare payment problems.

Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

Contributors

For more information on this testimony, please call Edwin P. Stropko, Associate Director, at (202) 512-7119. Other major contributors included Audrey Clayton, Patricia Davis, Hannah Fein, and Barry Tice.

Common Private Sector Strategies and Applicability to Medicare

Private sector strategy	Description	HCFA's current practice	HCFA explanation
Prompt reaction to market prices	Change prices quickly when paying more than competitively necessary	Prices generally not adjusted for declines in the price of product or service[a]	Pertinent statute generally permits appropriate adjustments only after a complex administrative process[b]
Negotiate with select providers	Selectively contract with providers to deliver certain services, such as hip replacements, at a specific price	Same payments generally made to any provider selected by beneficiary to provide services	Statute does not permit providers to be excluded unless they engage in certain prohibited practices[c]
Competitive bidding and negotiations	Set prices for services or service packages based on competitive process	Prices are set under complex formulas, but demonstration involving competitive procedures is proposed	Statute generally provides only for all area providers to be paid the same amount for service;[d] legislation prohibits proposed demonstration[e]
Preferred provider network	Promote use of a network of selected providers meeting price, practice style, and quality criteria	Payments generally made to any provider selected by beneficiary to provide medical services	Statute guarantees beneficiary freedom to choose providers;[f] statutory authority to contract with health maintenance organizations (HMOs) only[g]
Prior authorization	Require prior approval of select procedures	No prior approval of hospitalizations or other procedures	No viable statutory authority for requiring prior approval; statute prohibits interference with practice of medicine[h]
Case management	Assist high-cost patients in selecting appropriate services efficiently	Assistance not provided to patients in selecting services efficiently	Statute prohibits interference with practice of medicine[i]
Contract with utilization review companies	Use companies specializing in utilization review to monitor and adjudicate claims	HCFA contracts with private entities—generally insurance companies—to process claims[j]	Statute provides no specific authority for contracting with utilization control organizations[k]
Greater use of commercial technology to detect billing abuses	Use off-the-shelf software that flags billing problems and automatically adjusts payments	HCFA directs contractors to develop system capabilities, without guidance on use of specific technologies	HCFA concerned about adaptability and relevance to Medicare

(Table notes on next page)

[a]For example, although 42 U.S.C. 1395u(b)(8) and (9) provide HCFA with authority to adjust payments when the established rates under a fee schedule are found to be inherently unreasonable, detailed procedures are mandated that include a lengthy notice and comment period.

[b]For example, 42 U.S.C. 1395m(a)(10)(B) provides HCFA with authority to adjust prices for durable medical equipment, excluding surgical dressings, but only after completion of a cumbersome administrative process. The one time this process was used, it took 3 years to complete.

[c]42 U.S.C. 1320a-7 provides for mandatory and permissive exclusion of providers who are, for example, convicted of certain program-related crimes.

[d]42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

[e]In 1985, HCFA started the process to perform a demonstration of competitive bidding related to laboratory services, and it was set to begin in 1987. That year and in several subsequent years, however, provisions were included in the respective budget reconciliation laws specifically prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration but has since requested authority to introduce competitive bidding, without success.

[f]42 U.S.C. 1395a, the so-called freedom of choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

[g]42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

[h]42 U.S.C. 1395.

[i]42 U.S.C. 1395.

[j]These companies may arrange for utilization review to be done under subcontract.

[k]42 U.S.C. 1395h provides detailed authorization for HCFA to contract with private entities without competitive procedures to handle part A claims, and 42 U.S.C. 1395u provides similar authority for part B claims.

Specific Recommendations Made in Recent GAO Reports

Cited below are our recommendations and matters for congressional consideration addressing specific reimbursement system and payment control problems.

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996)

Matters for Congressional Consideration

The emphasis of Medicare's home health benefit program has recently shifted from primarily posthospital acute care to more long-term care. At the same time, HCFA's ability to manage the program has been severely weakened by coverage changes mandated by court decisions and a decrease in the funds available to review HHAs and the care they provide. The Congress may wish to consider whether the Medicare home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a posthospital acute care benefit. The Congress should also consider providing additional resources so that controls against abuse of the home health benefit can be better enforced.

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996)

Recommendation to the Congress

To curtail the practice of giving providers unauthorized access to beneficiary medical records, the Congress should authorize HHS OIG to establish monetary penalties that could be assessed against nursing

facilities that disclose information from patients' medical records not in accord with existing federal regulation.

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to

- establish, for procedure billing codes by provider or beneficiary, thresholds for unreasonable cumulative levels or rates of increase in services and charges, and to require Medicare carriers to implement automated screens that would suspend for further review claims exceeding those thresholds and
- undertake demonstration projects designed to assess the relative costs and benefits of alternative ways to reimburse nursing facilities for part B services and supplies; these alternatives should include such options as unified billing by the nursing facility and some form of capped payment.

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

Recommendations to the Secretary of HHS

We recommend that the Secretary of HHS direct the HCFA Administrator to

- develop policies and revise practices so that Medicare can (1) price services and procedures more competitively, (2) manage payments through state-of-the-art data analysis methods and use of technology, and (3) better scrutinize the credentials of vendors seeking to bill the program;
- examine the feasibility of allowing Medicare's commercial contractors to adopt for their Medicare business such managed care features as preferred provider networks, case management, and enhanced utilization review; and

- seek the authority necessary from the Congress to carry out these activities.

Matters for Congressional Consideration

Given the urgency for expediting Medicare program changes that could lead to substantial savings, the Congress may wish to consider directing the Secretary of HHS to develop a proposal seeking the necessary legislative relief that would allow Medicare to participate more fully in the competitive health care marketplace. Such relief could include allowing the Secretary of HHS to set maximum prices on the basis of market surveys, or, if the formal rulemaking process is preserved, allowing the Secretary to make an interim adjustment in fees while the studies and rulemaking take place.

The Congress may also wish to consider options for granting relief from the funding declines in Medicare's anti-fraud-and-abuse activities.

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

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to

- require that bills submitted to fiscal intermediaries itemize supplies;
- develop and implement prepayment review policies as part of the process of implementing any new or expanded Medicare coverage; and
- establish procedures to prevent duplicate payments by fiscal intermediaries and carriers.

Matter for Congressional Consideration

The fee-schedule approach to setting prices provides a good starting point for setting appropriate Medicare prices. HCFA, however, needs greater authority and flexibility to quickly adjust fee-schedule prices when market

conditions warrant such changes. To allow Medicare to take advantage of competitive prices, the Congress should consider authorizing HCFA or its carriers to promptly modify prices for durable medical equipment and other medical supplies. For this to work effectively, however, HCFA or the carriers must devote adequate resources to routine price monitoring.

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

Recommendations to the Secretary of HHS

The Secretary should direct the Administrator of HCFA to (1) set explicit limits to ensure that Medicare pays no more for therapy services than would any prudent purchaser; (2) strengthen certification requirements to better ensure that those entities billing Medicare are accountable for the services provided to beneficiaries; and (3) define billable therapy service units so they relate to the time spent with the patient.

Related GAO Products

Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Fraud and Abuse: Medicare Continues to be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

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

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

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

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