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Report to Congressional Requesters

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MEDICARE IMPROPER PAYMENTS

While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain

GAO/AIMD/OSI-00-281

Contents

Abbreviations

BBA	Balanced Budget Act of 1997
CERT	Comprehensive Error Rate Testing
CMN	Certificate of Medical Necessity
CPT	Current Procedural Terminology
DME	Durable Medical Equipment
DOJ	Department of Justice
EDP	Electronic Data Processing
FBI	Federal Bureau of Investigation
EOMB	Explanation of Medical Benefits
FID	Fraud Investigation Database
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IDPA	Illinois Department of Public Aid
MFRP	Model Fraud Rate Project
MSP	Medicare as Secondary Payer
OI	Office of Investigations
OIG	Office of Inspector General
PEPP	Payment Error Prevention Program
PPS	Prospective Payment System
PRO	Peer Review Organizations
PSC	Program Safeguard Contractor
SSA	Social Security Administration

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Accounting and Information
Management Division

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September 15, 2000

The Honorable John R. Kasich
Chairman
Committee on the Budget
House of Representatives

The Honorable Saxby Chambliss
Chairman
Task Force on Health
Committee on the Budget
House of Representatives

This report responds to your requests that we review the Health Care Financing Administration's (HCFA) efforts to enhance the measurement of improper payments in the Medicare fee-for-service program. On July 12, 2000, we testified[1] before the Committee's Task Force on Health in which we described HCFA's efforts and provided recommendations for improving the usefulness of future improper payment measurements. As discussed in our recent report on improper payments across the federal government,[2] causes of improper payments—that is, payments made for unauthorized purposes or excessive amounts—range from inadvertent errors to outright fraud and abuse. In its report on the review of fiscal year 1999 Medicare fee-for-service claims, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) classified improper payments they identified into one of four types of errors: (1) insufficient or no documentation, (2) lack of medical necessity, (3) incorrect coding, and (4) noncovered or other errors.

As steward for the Medicare program, the Health Care Financing Administration (HCFA), an operating division within HHS, is accountable for how it spends Medicare dollars and is responsible for safeguarding against improper payments. Identifying the extent of improper payments and their causes, including those attributable to potential fraud and abuse,

[1] *Medicare Improper Payments: Challenges for Measuring Potential Fraud and Abuse Remain Despite Planned Enhancements* (GAO/T-AIMD/OSI-00-251, July 12, 2000).

[2] *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments* (GAO/AIMD-00-10, October 29, 1999).

is the first step toward implementing the most cost-effective ways to reduce losses. Recognizing that improper payments are a drain on the program's financial resources— resources intended to provide essential health care services to millions of elderly and disabled Americans, HCFA has designated ensuring the integrity of the Medicare program a top priority. Moreover, in its priority management objective of verifying that the right person is getting the right benefit, the Office of Management and Budget recognizes that measuring the extent of improper payments and addressing their underlying causes are essential elements for ensuring that program payments are made correctly.

In conjunction with its audit of HCFA's annual financial statements since 1996, the HHS OIG has conducted a nationwide study to estimate Medicare fee-for-service improper payments.[3] The statistically projectable results cited in the OIG's study have provided valuable insights regarding the extent of Medicare vulnerabilities. Results from the most recent study indicate that, of the $169.5 billion in fiscal year 1999 Medicare fee-for-service claim payments, an estimated $13.5 billion, or about 8 percent, was paid improperly. The magnitude of these estimated improper payments has led to considerable concern regarding HCFA's efforts to protect Medicare dollars as well as the need to obtain a better understanding of the nature and extent of the problems.

To demonstrate a commitment to improving payment safeguards, in January 2000, HCFA reaffirmed its goal of reducing the Medicare fee-for-service payment errors to 5 percent or less by the year 2002, about a 3 percent or $5 billion reduction from fiscal year 1999 levels. However, without definitive information on the extent of improper payments, including those attributable to potential fraud and abuse,[4] HCFA's ability to fully measure the success of its efforts remains limited. Accomplishing this

[3]The Chief Financial Officers Act of 1990, as expanded by the Government Management Reform Act of 1994, requires 24 major departments and agencies, including HHS, to prepare and have audited agencywide financial statements. Major "components" of these 24 agencies, such as HCFA, may also be required to have audited financial statements.

[4]Because the ultimate determination of fraud and abuse involves legal proceedings that often take several years to resolve, using information about the causes of improper payments as soon as practical to develop ways to address root causes would help to improve the effectiveness of management efforts to increase accountability over federal assets. Attributing the cause of improper payments to potential fraud and abuse recognizes this limitation but still provides program managers and others meaningful, timely information to develop the most effective solutions.

goal will depend, in part, on HCFA's ability to further develop improper payment measures to enable it to more effectively focus specific corrective actions. In response to this need, HCFA has begun three projects intended to enhance its understanding of improper payments and help it develop targeted corrective actions.

Given the importance of Medicare to millions of beneficiaries and concerns about the financial health of the program, you asked us to identify structural problems that exist in the Medicare claims processing system which contribute to inherent vulnerabilities resulting in erroneous Medicare payments. Further, you asked us to focus our review on (1) what HCFA proposals have been designed or initiated to measure Medicare improper payments and (2) the status of these proposals and initiatives and how will they enhance HCFA's ability to comprehensively measure improper Medicare payments and the frequency of kickbacks, false claims (for example, billing for services not provided), and other inappropriate provider practices.

Results in Brief

Since 1990, we have designated Medicare as a high-risk program,[5] recognizing that the size of the program, its rapid growth, and its administrative structure continue to present vulnerabilities that challenge HCFA's ability to safeguard against improper payments, including those attributable to fraud and abuse. Due to the broad nature of health care fraud and abuse, a variety of detection methods and techniques—such as contacting beneficiaries and providers and performing medical records reviews, data analyses, and third party verification procedures—are being utilized to uncover suspected health care fraud and abuse. Efforts to measure the extent of improper payments, and ultimately to stem the flow of Medicare losses, depend upon the use of an effective combination of these techniques.

The OIG's study to measure the extent of Medicare fee-for-service improper payments was a major undertaking and, as we recently reported,[6] the development and implementation of the methodology (referred to as "current methodology") it used as the basis for its estimates represent significant steps toward quantifying the magnitude of this problem. It is

[5] *High-Risk Series: An Update* (GAO/HR-99-1, January 1999).

[6] *Efforts to Measure Medicare Fraud* (GAO/AIMD-00-69R, February 4, 2000).

important to note, however, that this methodology was not intended to and would not detect all potentially fraudulent schemes perpetrated against the Medicare program. For example, because the methodology generally assumes that medical records received for review are valid and thus represent actual services provided, improper payments supported by falsified documentation may go undetected. Rather, it was designed to provide users of HCFA's financial statements with an initial estimate of Medicare fee-for-service claims that may have been paid in error and has served as a performance measure for the program. However, given the size and complexity of the Medicare program, the usefulness of this estimate as a tool for targeting specific corrective actions is limited.

HCFA has initiated three projects designed to enhance its ability to measure the extent of Medicare fee-for-service improper payments. Two of these projects are designed to improve the precision of future improper payment estimates and help develop corrective actions to reduce losses; however, like the current methodology, they are not specifically designed to identify and measure the extent of improper payments attributable to potential fraud and abuse. The third project, while still in the concept phase, will test the viability of using a variety of investigative techniques to develop a potential fraud and abuse rate. Expanding the scope of these projects to include additional potential fraud and abuse identification techniques would enhance HCFA's ability to more comprehensively measure the nature and extent of Medicare fee-for-service improper payments and the usefulness of these efforts for developing solutions.

Determining the most appropriate combination of improper payment identification techniques to incorporate into measurement efforts requires careful evaluation. Some techniques may be challenging to implement, such as contacting beneficiaries due to difficulties in locating them. Further, efforts to measure improper payments may seem expensive, and maximizing the value of administrative resources used to accomplish this task will depend on HCFA's ability to apply the most effective detection techniques most efficiently. Given the size and vulnerability of the Medicare program, however, these represent prudent, needed investments toward creating more sophisticated controls to help ensure program integrity.

HCFA has been a leader among other federal agencies in its efforts to measure the extent of improper payments and we support the efforts it has taken thus far. Further, considering the challenges associated with identifying and measuring improper payments, the HCFA projects discussed in this report represent important steps toward advancing the

usefulness of its improper payment measurement efforts. However, we believe HCFA's efforts to measure Medicare fee-for-service improper payments can be further enhanced with the use of additional fraud detection techniques. Accordingly, we are making recommendations designed to assist HCFA in its efforts to further enhance its ability to measure the extent of losses emanating from Medicare fee-for-service payments. In comments on a draft of this report, HCFA generally agreed with our conclusions and recommendations. Further, HCFA also discussed a number of efforts underway to promote program integrity along with challenges HCFA faces in implementing additional fraud detection techniques.

Scope and Methodology

To fulfill our objectives, we analyzed the current methodology and HCFA's three planned projects related to improper payment measurement; related documents discussing the methodologies, designs, planned steps, and time frames for implementation of these initiatives; our reports; and relevant HHS OIG reports. We also interviewed HCFA officials and other recognized experts in health care and fraud detection in academia, federal and state government, and the private sector on the various types of improper payments and the techniques used to identify and measure them. We requested comments on a draft of this report from the HCFA Administrator or her designee. We have incorporated any changes as appropriate and have reprinted HCFA's response in appendix III. We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards. See appendix I for a more detailed discussion of our objectives, scope, and methodology.

Background

The Medicare program provides health care coverage to people 65 and over and to some disabled persons.[7] With total benefit payments of $201 billion in fiscal year 1999, Medicare enrollment has doubled since 1967 to nearly 40 million beneficiaries today. Beneficiaries can elect to receive Medicare benefits through the program's fee-for-service or managed care options. With benefit payments of $169.5 billion in fiscal year 1999 and about 85 percent of participating beneficiaries, the fee-for-service option represents

[7]The 1965 legislation establishing Medicare originally covered people 65 and over. Legislation in 1972 broadened the program to cover certain disabled people and those with permanent kidney failure.

the most significant part of the program. The managed care option accounts for the remaining $37 billion and 15 percent of participating beneficiaries. The program comprises two components: Hospital Insurance or Medicare Part A covers hospital, skilled nursing facility, home health, and hospice care; Supplementary Medical Insurance, or Part B, covers physician, outpatient hospital, home health, laboratory tests, durable medical equipment (DME), designated therapy services, and some other services not covered by Part A.

HCFA has primary responsibility for administering the Medicare program. HCFA's administration of the Medicare fee-for-service program is decentralized. Each year, about 1 million providers enrolled in the program submit about 900 million fee-for-service claims to over 50 Medicare contractors for payment. In addition to processing these claims, contractors help administer the Medicare program by managing the billions of dollars used to pay those claims, protecting Medicare from fraud and abuse, and providing education and services to beneficiaries and providers.

Ensuring the integrity of the Medicare fee-for-service program is a significant challenge for HCFA and its Medicare claims administration and program safeguard contractors[8] and peer review organizations (PROs).[9] They are HCFA's front line defense against inappropriate payments, including fraud and abuse, and should ensure that the right amount is paid to a legitimate provider for covered and necessary services provided to eligible beneficiaries. Except for inpatient hospital claims, which are reviewed by the PROs, Medicare contractors perform both automated and manual prepayment and postpayment medical reviews of Medicare claims. Various types of pre- and postpayment reviews are available to contractors to assess whether claims are for covered services that are medically necessary and reasonable. These include automated reviews of submitted claims based on computerized edits within contractors' claims processing systems, routine manual reviews of claims submitted, and more complex

[8]The Health Insurance Portability and Accountability Act (HIPAA) of 1996 authorized HCFA to contract with entities for reviews of providers of Medicare services. Contracts with these entities, referred to as program safeguard contractors, are for the performance of medical review, utilization review, fraud review, cost report audit, and other program integrity support efforts.

[9]PROs are independent physician organizations that review medical services provided to Medicare beneficiaries in settings such as acute care and specialty hospitals and ambulatory surgical centers for unreasonable, unnecessary, and inappropriate care.

manual reviews of submitted claims based on medical records obtained from providers.

In addition to performing medical reviews of provider claims, Medicare contractors employ fraud units specifically responsible for preventing, detecting, and deterring Medicare fraud and abuse. They accomplish these tasks by identifying program vulnerabilities; proactively identifying incidents of fraud that exist within their service areas; and taking appropriate actions on cases identified, including making referrals to law enforcement officials. Also, fraud units develop and determine the factual basis of allegations of fraud made by beneficiaries, providers, and other sources.

Recent enactment of two legislative reforms—The Health Insurance Portability and Accountability Act in 1996 (HIPAA), P.L. 104-191, and The Balanced Budget Act of 1997 (BBA), P.L. 105-33—have helped HCFA's efforts to protect against improper payments by providing opportunities to enhance Medicare's antifraud and abuse activities. Specifically, in addition to authorizing program safeguard activities to be performed by program safeguard contractors, HIPAA established the Medicare Integrity Program, which provides HCFA with assured levels of funding for Medicare program safeguard activities. The five main types of program safeguard activities include (1) medical reviews of claims, (2) determinations of whether Medicare or other insurance sources have primary responsibility for payment—referred to as Medicare as Secondary Payer (MSP), (3) audits of cost reports, (4) identification and investigation of potential fraud cases, and (5) provider education and training. Indeed, as we reported in August 1999,[10] total program safeguard expenditures have increased for most of these activities since 1995, with medical review experiencing the largest overall increase. In that report, we noted that HCFA is emphasizing prepayment claims reviews to promote correct claims payment, thereby helping to avoid the difficulties of the "pay and chase" activities associated with postpayment medical reviews. Similarly, BBA provides HCFA with additional opportunities to enhance program integrity by providing HCFA more authority to keep dishonest health care providers out of the Medicare program, exclude providers who are found to be abusing the program, and impose monetary penalties on providers as necessary.

[10] *Medicare: Program Safeguard Activities Expand, but Results Difficult to Measure* (GAO/HEHS-99-165, August 4, 1999).

HCFA's commitment to identifying fraud and abuse is articulated in its Strategic Plan, which calls for aggressive action to minimize waste, fraud, and abuse in the administration of its programs, including Medicare. HCFA issued its Comprehensive Plan for Program Integrity in March 1999, which is composed of 10 initiatives to focus efforts in two broad areas it considers to have significant opportunities for improvement—improving HCFA program integrity management and addressing service-specific vulnerabilities. These and other initiatives are designed to help HCFA meet one of its program integrity goals included in its Annual Performance Plan—to reduce the error rate for all Medicare fee-for-service payments to 7 percent in fiscal year 2000 and 5 percent in fiscal year 2002.

Medicare Is Vulnerable to Fraud and Abuse

Since 1990, we have designated the Medicare program as a high-risk area, and it continues to be one today. Many of Medicare's vulnerabilities stem from the overall size of the program, the broad range of services it provides, and its rapid growth as well as other factors—such as previously reported weaknesses associated with HCFA's decentralized administrative structure, highly automated claims processing operations, and the voluminous, changing billing codes used by providers to claim reimbursement—that result in an increased risk of making inappropriate payments. These vulnerabilities make the largest health care program in the nation a perpetually attractive target for exploitation. Wrongdoers continue to find ways to dodge program safeguards. The dynamic nature of fraud and abuse requires constant vigilance and the development of increasingly sophisticated measures to detect fraudulent schemes and protect the program.

Program Size, Broad Range of Services, and Rapid Growth Create Inherent Vulnerabilities for Improper Payments

Annually, about 1 million providers submit about 900 million fee-for-service claims to Medicare contractors for payment. These claims cover a vast array of services or supplies provided to millions of eligible beneficiaries, including inpatient and outpatient hospital, skilled nursing facility, home health, hospice, physician, laboratory, and other services and supplies; durable medical equipment; and designated therapy. Obviously, performing extensive reviews of all claims prior to payment to determine their appropriateness would be cost prohibitive and inefficient. Therefore, HCFA and its Medicare contractors rely on a combination of computerized edits and pre- and postpayment reviews of selected claims to target their efforts for detecting those that should not be paid.

However, contractors' efforts to prevent and detect improper payments are challenged due to the sheer volume of claims they are required to process and the need to pay providers promptly. Recognizing the difficulties associated with the "pay and chase" aspects of recovering inappropriate payments identified through postpayment reviews, HCFA is moving toward more extensive use of prepayment reviews. Yet, despite the increase in prepayment reviews performed, claims that should not be paid continue to be paid incorrectly. Postpayment utilization and medical record reviews may catch some errors but not all—creating opportunities for unscrupulous providers and suppliers to defraud the program. For example, while performing the current methodology for fiscal year 1998 claims, OIG auditors identified numerous errors resulting in the improper payment of a complex claim submitted by a provider who, according to OIG auditors, had a long history of questionable billing practices. Although the provider's claims had been subjected to extensive pre- and postpayment reviews, the claim paid in error was submitted during a period when focused prepayment reviews of all claims were not in effect. Further, according to OIG auditors, the improper payment occurred as a result of the provider altering a previously denied claim in such a manner that allowed it to pass through the contractor's automated prepayment edits without being rejected or flagged for manual review.

Since the Medicare program is the fastest growing sector of federal budget outlays, these challenges are expected to continue. Currently, Medicare accounts for about 10 percent of total federal revenues, and with the retirement of the baby boom generation beginning around 2010, Medicare is projected to grow rapidly, reaching 24 percent of total federal revenues in 2050. Therefore, absent improvements over internal controls, the potential for additional or larger volumes of improper payments will be present.

Decentralized Administrative Structure and Inadequate Controls Over Operations Foster Additional Risks for Improper Payments

HCFA's administration of the Medicare fee-for-service program is decentralized and highly automated—relying on the combined efforts of numerous external and internal entities and electronic data processing (EDP) systems to meet its responsibilities for managing the program properly. Managing these combined efforts presents significant challenges and places significant reliance on the effectiveness of internal controls. Our previous reports as well as those by the HHS OIG have consistently expressed concerns regarding the effectiveness of internal controls related to HCFA's oversight of the Medicare program and its EDP systems that create an increased risk for improper payments occurring without prompt prevention or detection.

Effective oversight of the over 50 Medicare claims processing contractors and their program safeguard efforts is vital to minimize improper payments and ensure program integrity. HCFA carries out its oversight responsibilities primarily through the efforts of its 10 regional offices. Yet, our recent reports as well as recent OIG and financial statement audit reports express concerns over the effectiveness of these oversight efforts. In July 1999, based on our review of HCFA's oversight of its claims processing contractors, we reported[11] that, despite its efforts, HCFA's oversight had significant weaknesses that left the agency without assurance that contractors are paying providers appropriately. Further, we identified two aspects of HCFA's organizational structure that created problems for overseeing contractors effectively: dispersed central office responsibility for contractor activities among seven components and indirect reporting relationships between its 10 regional offices and the central office units responsible for contractor performance. HCFA has developed a contractor strategic plan and reorganized its contractor management activities so that all contractors are assigned to one of four Consortium Contract Management Offices which, according to HCFA officials, have staff with the expertise needed to address contractor management and systems issues. These and other measures have been designed to improve contractor oversight, but it is too early to determine whether these changes have been sufficient to fully address the identified weaknesses.

In connection with their audits of HCFA's annual financial statements, the OIG and auditors from independent public accounting firms have consistently found numerous weaknesses in the significant data processing operations at both HCFA's central office and various contractor offices. These operations process and maintain eligibility systems. To facilitate consistency in the processing of fee-for-service claims, contractors use one of several "shared" systems which perform various types of edits before authorizing the payment of claims. In addition, claims are checked against the Common Working File, consisting of seven distributed databases maintained throughout the United States, where edits are performed for items such as beneficiary eligibility, deductibles and limits, and duplicate payments. As a result of their review of critical EDP controls to ensure the integrity, confidentiality, and availability of Medicare data, auditors concluded that weaknesses exist, such as unauthorized access to "shared"

[11] *Medicare Contractors: Despite Its Efforts, HCFA Cannot Ensure Their Effectiveness or Integrity* (GAO/HEHS-99-115, July 14, 1999).

system source codes and ability to implement local changes to programs used to process claims, that do not effectively prevent activities possibly leading to improper payments.

Voluminous and Changing Billing Codes Can Contribute to Inappropriate Payments

The use of incorrect billing codes is a problem faced both by public and private health insurers. Medicare pays Part B providers a fee for each covered medical service identified by the American Medical Association's uniformly accepted coding system, called the physician's Current Procedural Terminology (CPT). To be able to describe so many different services, the coding system is voluminous and undergoes annual changes. As a result, physicians and other providers may have difficulty identifying the codes that most accurately reflect the services and products provided. Not only can this lead providers to inadvertently submit improperly coded claims, it can make it easier for unscrupulous individuals to deliberately abuse the billing system. Due to the huge number of claims processed, the integrity of the program, in part, relies on providers (1) being knowledgeable of proper billing procedures and (2) only claiming medically necessary and covered services or supplies that were actually provided to eligible beneficiaries.

Fraud Schemes Are Diverse and Vary in Complexity

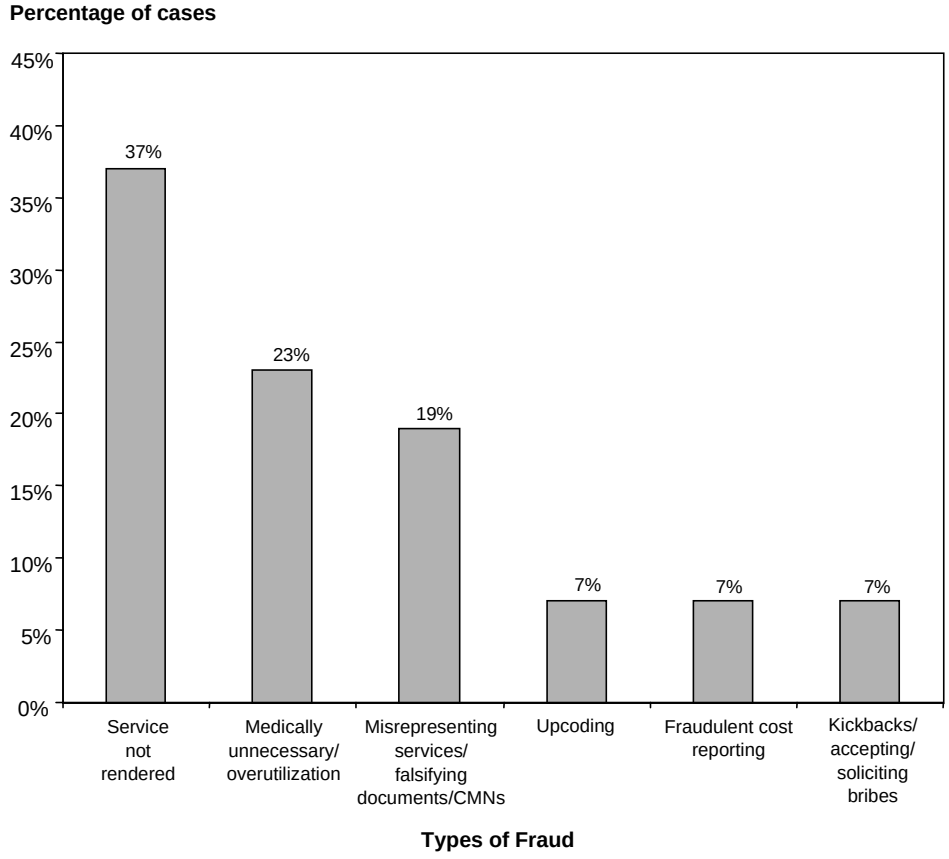
The program's vulnerabilities have been compounded by the emergence of organized groups of criminals who defraud and abuse Medicare. This has led to an array of fraudulent schemes that are diverse and vary in complexity. For example, based on our recent review of seven investigations of fraud or alleged fraud, we reported that the criminal groups involved had created as many as 160 sham medical entities—such as medical clinics, physician groups, diagnostic laboratories, and durable medical equipment companies—or used the names of legitimate providers to bill for services not provided.[12]

Medicare contractors and PROs are identifying thousands of improper payments each year due to mistakes, errors, and outright fraud and abuse. They refer cases of potential fraud and abuse to the OIG and Department of Justice (DOJ) so they can investigate further, and if appropriate, pursue criminal and civil sanctions. HCFA tracks the cases referred by Medicare contractors and PROs to the OIG and DOJ in its Fraud Investigation

[12] *Criminal Groups in Health Care Fraud* (GAO/OSI-00-1R, October 5, 1999).

Database (FID).[13] Figure 1 shows the six most common types of potential fraud and abuse cases in the FID and the relative frequency of these cases. Definitions of these common types of fraud and abuse and examples are provided in appendix II.

Figure 1: Fraud Investigation Database Statistics for Cases Referred, 1993 Through April 2000



Source: Prepared by GAO from data in HCFA's FID. We did not independently verify this information.

[13]The Fraud Investigation Database is a comprehensive nationwide system devoted to Medicare fraud and abuse data accumulation. The system was created in 1995, but contains data on potential fraud and abuse referrals going back to 1993.

We were unable to assess the level of actual or potential program losses for the different types of potential fraud or abuse due to the limited financial data in the FID. However, HCFA officials told us that while more complex types of fraud or abuse, such as fraudulent cost reporting and kickback arrangements, may be less frequent than other types, such cases often involve significantly greater losses.

Efforts to Measure Potential Fraud and Abuse Rely on Effective Use of Diverse Techniques

Given the broad nature of health care fraud and abuse, efforts to measure its potential extent should incorporate carefully selected detection techniques into the overall measurement methodology. With billions of dollars at stake, health care fraud and abuse detection has become an emerging field of study among academics, private insurers, and HCFA officials charged with managing health care programs. A variety of methods and techniques are being utilized or suggested to improve efforts to uncover suspected health care fraud and abuse. Such variety is needed because one technique alone may not uncover all types of improper payments.

Although the vast majority of health care providers and suppliers are honest, unscrupulous persons and companies can be found in every health care profession and industry. Further, fraudulent schemes targeting health care patients and providers have occurred in every part of the country and involve a wide variety of medical services and products. Individual physicians, laboratories, hospitals, nursing homes, home health care agencies, and medical equipment suppliers have been found to perpetrate fraud and abuse.

Given the increasingly sophisticated and dynamic nature of health care fraud and abuse, fraud and abuse detection is not an exact science. No matter how sophisticated the techniques or the fraud and abuse audit protocols, not all fraud and abuse can be expected to be identified. However, using a variety of techniques holds more promise for estimating the extent of potentially fraudulent and abusive activity and also provides a deterrent to such illegal activity. Health care fraud experts and investigators have identified techniques that can be used to detect fraudulent and abusive activity—techniques currently performed by Medicare contractor medical review and fraud units to detect potential fraud and abuse in the Medicare fee-for-service program. Table 1 summarizes the most promising techniques they identified along with some of their limitations.

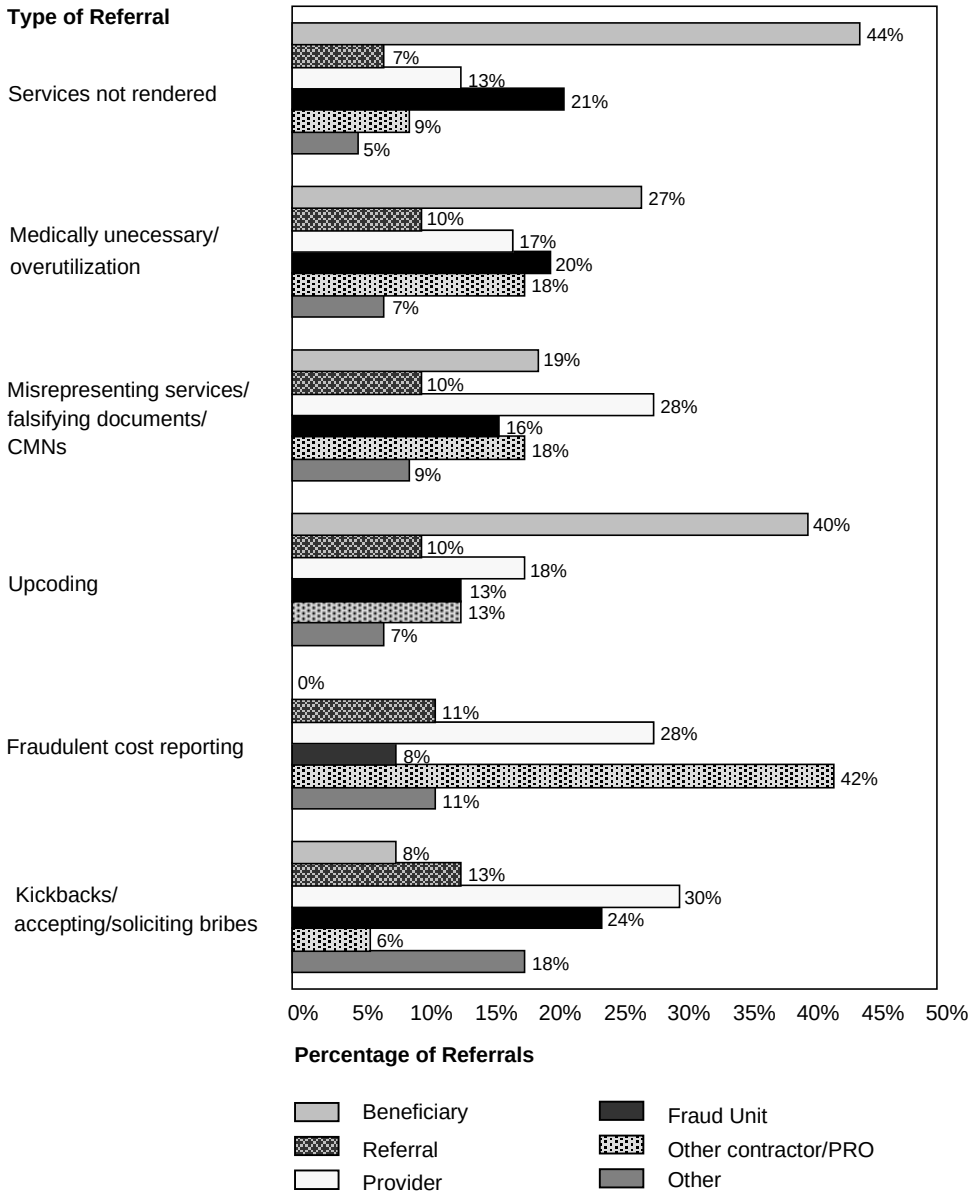
Table 1: Techniques for Detecting Potential Fraud and Abuse

Medical record review: Doctors and nurses review medical records to assess whether the services billed were allowable, reasonable, medically necessary, adequately documented, and coded correctly in accordance with Medicare reimbursement rules and regulations. **Limitations:** Medical reviews may not uncover services that have not been rendered or billing for more expensive procedures when the medical records have been falsified to support the claim.
Beneficiary contact: Verify that the services billed were actually received through contacting the beneficiary either in person or over the phone, or by mailing a questionnaire. **Limitations:** Beneficiary may be difficult to locate and not be fully aware of, or understand the nature of, all services provided. Contact may not reveal collusion between the beneficiary and provider to fraudulently bill for unneeded services or services not received. In some instances, medical necessity and quality of care may be difficult to judge.
Provider contact: Visit provider to confirm that a business actually exists, that the activity observed supports the number of claims being submitted by the provider, and that medical records and other documentation support the services billed. **Limitations:** Provider contact may not reveal collusion between the provider and beneficiary to fraudulently bill for unneeded services or services not rendered. In some instances, medical necessity and quality of care may be difficult to judge.
Data analysis: Examine provider and beneficiary billing histories to identify unusual or suspicious claims. Provider focused data analysis attempts to identify unusual billing, utilization, and referral patterns relative to a provider's peer group. Beneficiary focused data analysis looks for unusual treatment patterns such as visiting several different providers for the same ailment or claims for duplicate or similar services. **Limitations:** Data analysis may only identify the most flagrant cases of potential fraud and abuse because it relies on detecting unusual patterns relative to the norm. Application of additional techniques may be necessary to assess the appropriateness of unusual patterns identified.
Third party contact/confirmation: Validate information relied on to pay claims with third parties to assist in identifying potential fraud and abuse. For example, verify that a provider is qualified to render medical services to Medicare beneficiaries through contacting state licensing boards or other professional organizations. Also, other entities, such as employers, private insurers, other governmental agencies (e.g., Internal Revenue Service, Social Security Administration, state Medicaid agencies) and law enforcement authorities represent valuable sources in determining the validity of claim payments when the reliability of data from primary sources (e.g., claims data, beneficiaries, and providers) is questionable. **Limitations:** Does not address utilization patterns, whether services were rendered, the need for services, or quality of services.

Consequently, health care experts and investigators also told us that effective detection of potential fraud and abuse necessarily involves the application of several of these techniques and considerable analysis, especially for the more sophisticated types of billing schemes and kickback arrangements. In addition, data on fraud referrals contained in the FID indicate that information necessary for identifying potential Medicare fraud and abuse comes from a variety of sources, as shown in figure 2. In particular, these data and the fraud experts we spoke with suggest that Medicare beneficiaries represent a valuable source for detecting certain types of potential fraud and abuse, especially services not rendered. HCFA officials told us that beneficiary complaints stem largely from the beneficiaries' review of their explanation of Medicare benefit (EOMB)

statements received after a provider bills Medicare for health services and supplies that are reportedly provided. These findings suggest that potential fraud and abuse can only be comprehensively measured by effectively applying a variety of investigation techniques using a variety of sources.

Figure 2: Sources of Common Fraud and Abuse Referrals, 1993 Through April 2000



See the following page for descriptions of referral sources.

Referral Sources

Beneficiary: A person eligible to receive Medicare payment or services. This category includes beneficiary telephone, walk-in, and written complaints.

Referral: A formal submission of a case by various federal investigators (for example, Federal Bureau of Investigation, Office of Inspector General, and Health Care Financing Administration).

Provider: Persons or entities, including their employees and former employees, who provide health care services or supplies to Medicare beneficiaries.

Fraud Unit: Individuals responsible for preventing, detecting, and deterring Medicare fraud and abuse. Such a unit is located at each HCFA contractor.

Other contractor/PRO: In addition to fraud units, Medicare contractor medical review, claims processing, and audit units perform a broad range of activities in the identification of fraud, including reviews of submitted claims and medical records by medical professionals to assess whether services billed were allowed, medically necessary, adequately documented, and coded correctly in accordance with Medicare requirements. In addition, audits of provider cost reports are performed to determine the appropriateness of costs reimbursed in connection with the cost report settlement process.

Other: In addition to the sources listed above, referrals of fraud and abuse cases are sometimes generated based on leads obtained via calls made to the OIG Hotline, from media sources, or other anonymous sources. The OIG Hotline allows employees and the public to directly report allegations or provide information regarding problems of possible waste, mismanagement, and abuse in the Medicare program.

Source: Prepared by GAO from data in HCFA's FID and interviews with HCFA and contractor officials. We did not independently verify information contained in HCFA's FID.

Planned HCFA Projects Designed to Provide Some Improvements

The inherent vulnerabilities of the Medicare fee-for-service program have fueled debate over how extensively the measurement of potential fraud and abuse should be pursued to provide information that policymakers and HCFA managers need to effectively target program integrity efforts. Implementing the current methodology to estimate improper payments is a major undertaking and represents an attempt to give HCFA a national estimate of payment accuracy in the Medicare program. The current methodology focuses on estimating Medicare payments that do not comply with payment policies as spelled out in Medicare laws and regulations but does not specifically attempt to identify potential fraud and abuse. In addition to the current methodology, HCFA has three projects in various stages of development that are designed to enhance the capability to uncover potential fraud and abuse and help HCFA better target program safeguard efforts over the next few years.

Current Methodology Not Designed to Measure the Full Extent of Potential Fraud and Abuse

The primary purpose of the current methodology is to provide an estimate of improper payments that HCFA can use for financial statement reporting purposes, and to the degree that it can measure improper payments, it has served as a performance measure. The OIG is responsible for overseeing the annual audit of HCFA's financial statements, as required by the Chief Financial Officers Act of 1990 as expanded by the Government Management Reform Act of 1994. The current methodology has identified improper payments ranging from inadvertent mistakes to outright fraud and abuse. However, specifically identifying potentially fraudulent and abusive activity and quantifying the portion of the error rate attributable to such activity has been beyond the scope of the current methodology.

The focus of the current methodology is on procedures that verify that the claim payments made by Medicare contractors were in accordance with Medicare laws and regulations. The primary procedures used are medical record reviews and third party verifications. Medical professionals working for Medicare contractors and PROs review medical records submitted by providers and assess whether the medical services paid for were allowable, medically necessary, accurately coded, and sufficiently documented. OIG staff perform various procedures including third party verifications to ensure that health care providers are in "good standing" with state licensing and regulatory authorities and are properly enrolled in the Medicare program. They also verify with the Social Security Administration (SSA) that the beneficiaries receiving the services were eligible for them.

The OIG reported that the medical reviews conducted in the current methodology have been the most productive technique for identifying improper payments—detecting the overwhelming majority of the improper payments identified.[14] According to OIG officials, medical reviews have led to some major prosecutions. In addition, some of the health care fraud experts we talked with stated that such medical reviews are most effective in detecting unintentional errors. They also told us that medical reviews are less effective in identifying potentially fraudulent and abusive activity because clever providers can easily falsify supporting information in the medical records to avoid detection.

With respect to identifying potentially fraudulent or abusive activities, OIG officials indicated that medical reviews performed during the current methodology have resulted in referrals to its Investigations Office. However, they acknowledge that the current methodology generally assumes that all medical records received for review are valid and thus represent actual services provided. In addition, they agree that additional improper payments may have been detected had additional verification procedures been performed, such as (1) confirming with the beneficiary whether the services or supplies billed were received and needed and (2) confirming the nature of services or supplies provided through on-site visits and direct contact with current or former provider employees. Recognizing the potential for abuse based on past investigations—such as falsified certificates of medical necessity or where beneficiaries are not "homebound," a requirement for receiving home health benefits—the OIG has included face-to-face contact with beneficiaries and providers when reviewing sampled claims associated with home health agency services. Further, during the course of our review, OIG officials stated that they will conduct beneficiary interviews when reviewing DME claims selected in its fiscal year 2000 study. However, according to OIG officials, they have not extended this or certain other techniques to the other numerous types of claims included in its annual review because they consider them costly and time-consuming.

Accordingly, the OIG recognizes that the current methodology does not estimate the full extent of Medicare fee-for-service improper payments, especially those resulting from potentially fraudulent and abusive activity for which documentation, at least on the surface, appears to be valid and

[14] *Improper Fiscal Year 1999 Medicare Fee-For-Service Payments*, Department of Health and Human Services, Office of Inspector General, February 2000, A-17-99-01999.

complete. In fact, the OIG testified[15] that its estimate of improper payments did not take into consideration numerous kinds of outright fraud, such as phony records or kickback schemes. To identify potential fraud, the OIG also relies on tips received from informants and other investigative techniques.

A secondary benefit that has been derived from the current methodology is that it has prompted HCFA into developing additional strategies, as we discuss later, for reducing the types of improper payments identified. However, HCFA is limited in developing specific corrective actions to prevent such payments because the current methodology only produces an overall national estimate of improper payments. Having the ability to pinpoint problem areas by geographic areas below a national level (referred to as subnational), Medicare contractors, provider types, and services would make improper payment measures a more useful management tool.

HCFA Projects Enhance Error Rate Precision and Some Potential Fraud and Abuse Detection Capabilities

HCFA has two projects that center on providing it with the capability of producing improper payment rates on a subnational and provider type basis—the Comprehensive Error Rate Testing (CERT) project and the surveillance portion of the Payment Error Prevention Program (PEPP). By examining more claims, these projects are designed to improve the precision of future improper payment estimates and provide additional information to help develop corrective actions. However, since the methodologies associated with the CERT and PEPP projects incorporate techniques for identifying improper payments that are similar to those used in the current methodology, the extent to which these two projects will enhance HCFA's potential fraud and abuse measurement efforts is limited.

HCFA has a third project in the concept phase that will test the viability of using a variety of investigative techniques to develop a potential fraud rate for a specific geographic area or for a specific benefit type. This project, called the Model Fraud Rate Project (MFRP), provides HCFA the opportunity to pilot test more extensive detection techniques that, if effective, could be incorporated into the other measurement methodologies to improve the measurement and, ultimately, prevention of

[15]July 17, 1997, testimony of the HHS Inspector General in a hearing before the House Committee on Ways and Means, Subcommittee on Health, entitled *Audit of HCFA Financial Statements*.

potential fraudulent and abusive activity. Table 2 compares the scope and potential fraud and abuse detection capabilities of the current methodology to the HCFA projects.

Table 2: Comparison of HCFA Efforts to Measure Medicare Improper Payments

	Current methodology	Comprehensive Error Rate Testing (CERT)	Payment Error Prevention Program/Surveillance (PEPP)	Model Fraud Rate Project (MFRP)

Key design attributes	• First national statistically valid estimate for all types of fee-for-service claims, beneficiaries, and providers
	• Includes tests for:
	  • medical necessity and reasonableness,
	  • proper documentation,
	  • proper coding,
	  • provider eligibility,
	  • determination of whether providers are subject to current sanctions or investigations,
	  • beneficiary eligibility,
	  • duplicate payments,
	  • Medicare as secondary payer (MSP) compliance,
	  • compliance with pricing, deductible, coinsurance, and other selected rules
		• Test procedures expected to be similar to current methodology
		• Independent medical review
		• Larger sample and on-going reporting improves analyses/utility
		  • statistically valid national error rates by contractor, provider type, benefit category, and claims processing,
		  • trend analysis to assist in targeting of integrity efforts
		• Potential platform for testing claims software
			• Designed to estimate payment error rates for inpatient Prospective Payment System (PPS) claims by state
			• Larger sample and frequent reporting designed to improve analyses and targeting of integrity efforts
			• Tests focus on:
			  • medical necessity and reasonableness,
			  • unnecessary admissions,
			  • incorrect diagnostic coding,
			  • some quality of care measures
				• Pilot study to develop a model fraud rate
				• Scope focused on specific benefit or geographic area
				• Fraud investigative techniques will be used:
				  • beneficiary contact,
				  • medical records review,
				  • provider and beneficiary profiling,
				  • investigation of complaints
				• Results to be categorized under fraud types and causes

Limitations for detecting potential fraud and abuse	• Significant reliance on the integrity of medical records • Lacks provider-focused data analysis during testing • Limited provider or beneficiary validation • Not designed to identify certain types of fraud or abuse	• Similar to current methodology	• Similar to current methodology • Scope limited to inpatient PPS	• Plan for comprehensive nationwide study evolving • Limited provider or third party validation
Status	• Fourth annual review completed	• Contract awarded 5/2000 • Phased implementation designed to be completed by 10/2001	• Contracts completed 3/2000 • Baseline error rates and first quarterly report due by 9/2000	• Concept currently under development • Pilot testing projects designed to be implemented by 10/2000
Costs	• 1999 review $4.7 million	• Base year $2 million plus $4 million annually thereafter	• $7.5 million annually	• Not yet determined

The CERT project focuses on reviewing a random sample of all Part A and B claims processed by Medicare contractors each year except inpatient Prospective Payment System (PPS) hospital claims. It involves the review of a significantly larger random sample of claims and thus, according to HCFA officials, allows HCFA to project subnational improper payment rates for each Medicare contractor and provider type. It is the largest of the projects and is undergoing a phased implementation with a scheduled completion date of October 2001. In addition to developing subnational error rates, HCFA officials stated that the CERT project will also be used to develop performance measures that will assist HCFA in monitoring contractor operations and provider compliance. For example, CERT is designed to produce a claim processing error rate for each contractor that will reflect the percentage of claims paid incorrectly and denied incorrectly, and a provider compliance rate that indicates the percentage of claims submitted correctly.

The PEPP project is similar to the CERT project and is designed to develop payment error rates for the Part A inpatient PPS hospital claims not covered by CERT. PEPP is designed to produce subnational error rates for each state and for each PRO area of responsibility. Claim reviews under PEPP are designed to be continual in nature, with results reported quarterly. HCFA officials stated that the project is the furthest along in implementation, with the first quarterly reports expected in September 2000. The contractors and PROs implementing the project are expected to identify the nature and extent of payment errors for these inpatient claims and implement appropriate interventions aimed at reducing them.

After their full implementation, HCFA intends to develop a national improper payment rate by combining the results of the CERT and PEPP projects. This rate will be compared to the rate produced by the current methodology to identify, and research reasons for, any significant variances among results. While the national estimate will continue to provide valuable information concerning the extent of improper payments, HCFA officials state that the availability of reliable estimates at the subnational levels contemplated by these efforts will greatly enhance the usefulness of these estimates as management tools. For example, based on reports of extensive fraud and abuse in Florida by the OIG, HCFA established a special satellite office in Miami as part of its Operation Restore Trust in 1995. This effort has led to numerous investigations and the identification of potentially fraudulent and abusive activity emerging and existing in that area. Similarly, if implemented correctly, the increased precision contemplated with the planned measurement enhancements may indicate

various “hot spots” of potential fraud and abuse throughout the country, thereby increasing HCFA’s ability to more effectively focus its program integrity efforts.

While enhancing the precision of improper payment estimates will offer a richer basis for analyzing causes and designing corrective actions, conceptually, the MFRP holds the most promise for improving the measurement of potential fraud and abuse. However, the Medicare contractor assisting HCFA in developing this project is dropping out of the Medicare program in September 2000 and has ceased work on the project. Efforts to date have focused on developing a potential fraud rate for a specific locality and specific type of Medicare service; however, HCFA intends to eventually expand the scope of the project to provide a national potential fraud rate. As currently conceived, the project involves studying the pros and cons of using various investigative techniques, such as beneficiary contact, to estimate the occurrence of potential fraud. HCFA officials informed us that before the contractor ceased work on this project, it conducted a small pilot test using beneficiary contact as a potential fraud detection technique that identified some of the challenges HCFA will face in implementing this technique. The results of the test are discussed later.

HCFA is seeking another contractor to take over implementation of the project. The contractor eventually selected will be expected to produce a report that identifies the specific potential fraud and abuse identification techniques used, the effectiveness of the techniques in identifying potential fraud and abuse, and recommendations for implementing the techniques nationally. The contractor will also be expected to develop a “how to manual” that Medicare contractors and other HCFA program safeguard contractors (PSC) can use to implement promising techniques. HCFA officials stated that promising techniques identified through MFRP could also be exported to the CERT and PEPP projects and the current methodology to enhance national and subnational estimates of potential fraud and abuse over time.

Expanding the Scope of the HCFA Projects Could Enhance Measurement of Potential Fraud and Abuse

Collectively, HCFA’s projects do not comprehensively attempt to measure potential fraud and abuse or evaluate the specific vulnerabilities in the claims processing process that may be allowing fraud and abuse to be perpetrated. Table 3 shows the limited use of selected identification elements among the current methodology and the HCFA projects. The MFRP project’s scope, for example, does not include studying the viability

of making provider and supplier contact or using third party confirmations to detect potential fraud and abuse.

Contacting beneficiaries and checking providers are valuable investigative techniques used to develop potential fraud and abuse cases. For example, California officials recently visited all Medicaid[16] DME suppliers as part of a statewide Medicaid provider enrollment effort and found that 40 percent of the dollars paid to the suppliers was potentially fraudulent. The on-site visits not only helped to identify the fraudulent activity, but also to obtain sufficient evidence to support criminal prosecutions for fraud. Since Medicare also covers DME supplies for eligible beneficiaries, the problems found during this effort indicate that similar risks could exist for potential fraud and abuse in the Medicare program.[17]

[16]The Medicaid program represents the primary source of health care for medically vulnerable Americans, including poor families, the disabled, and persons with developmental disabilities requiring long-term care. Medicaid is administered in partnership with the states pursuant to Title XIX of the Social Security Act with combined state and federal medical assistance outlays in fiscal year 1999 totaling $180.8 billion.

[17]According to its Comprehensive Plan for Program Integrity, HCFA has begun conducting routine on-site visits to DME suppliers seeking to enter the Medicare program as part of its provider enrollment process.

Table 3: Methodologies for Estimating Medicare Improper Payments

	Key characteristics	Current methodology	CERT	PEPP	MFRP
Measurement elements	**Scope**				
	• Geographical	Nationwide	Nationwide[a]	Nationwide[a]	Evolving[b]
	• Claim type	All	All but inpatient	Inpatient only	
	Measurement				
	• Technique used	Sampling	Sampling	Sampling	Sampling
	• Annual claims sample size	5,000 – 8,000	100,000+	55,000+	Not yet determined
	Classification of errors[c]				
	• Cause	○	○	○	●
	• Type	●	●	●	●
Identification elements	**Claims validation**				
	• Medical record and claims processing review	●	●	●	●
	• Beneficiary contact	○[d]	○[d]	○	●
	• Provider/supplier contact[e]	○[d]	○	○	○
	• Third party contact/confirm-ation[f]	●	○	○	○
	• Data analysis[g]				
	• Provider focused[h]	○	○	○	●
	• Beneficiary focused	●	○	○	●

[a]The CERT and PEPP projects also provide for estimates of improper payments at the subnational and provider type levels.

[b]The scope of the MFRP is still conceptual. Efforts to date have focused on developing a potential fraud rate for specific benefit types and specific localities and to eventually expand efforts to provide a national rate.

[c]Errors can be classified in many ways; table 3 shows two types of categories. For example, cause classifications may include inadvertent billing errors or possible fraud and abuse errors. Type categories may include documentation errors or lack of medical necessity errors.

[d]Methodology includes face-to-face contact with beneficiaries and providers for home health agency claims only.

[e]Other than requests for medical records.

[f]Third party contact/confirmation, for example, may include contact with state licensing boards or other professional organizations to verify provider standing. This example represents only one of the numerous methods of utilizing third party confirmation to identify improper payments.

[g]See table 1 for a discussion of data analysis techniques for detecting potential fraud and abuse.

[h]OIG officials recently told us that each year at the end of the their review, after all data has been entered in their national database, they profile each provider type in the claims sample.

Including an assessment of the likely causes of specific payment errors could help HCFA better develop effective strategies to mitigate them. The current methodology classifies errors by type, such as lack of documentation or medically unnecessary services, which is used to show the relative magnitude of the problems. Knowing the relative magnitude of a problem offers perspective on what issues need to be addressed. For example, based on its review of errors identified in the current methodology, HCFA recently issued a letter to physicians emphasizing the need to pay close attention when assigning CPT codes and billing Medicare for two closely related, yet differing, types of evaluation and management services.

Further analysis of identified improper payments that provide additional insights into possible root causes for their occurrence is essential for developing effective corrective actions. For example, if errors are resulting from intentionally abusive activity, specific circumstances or reasons that permit the abuse to be perpetrated can be analyzed to develop and implement additional prepayment edits to detect and prevent their occurrence. In this regard, we have long advocated enhancing automated claims auditing systems to more effectively detect inappropriate payments due to inadvertent mistakes or deliberate abuse of Medicare billing systems.[18] Also, developing or strengthening specific enforcement

[18]*Medicare Billing: Commercial System Could Save Hundreds of Millions Annually* (GAO/AIMD-98-91, April 15, 1998) and *Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse* (GAO/AIMD-95-135, May 5, 1995).

sanctions offer an additional tool to deter providers or suppliers from submitting inappropriate claims.

Likewise, numerous individuals and entities are involved throughout the entire Medicare claims payment process, including providers, suppliers, employees (caregivers, clerks, and managers), Medicare claims processing contractors, HCFA, beneficiaries (and their relatives), and others. Interestingly, in its review of Illinois Medicaid payments,[19] the Illinois Department of Public Aid (IDPA) determined that over 45 percent of the errors it identified were inadvertent or caused by the IDPA itself during the process of approving services or adjudicating claims, and that 55 percent appeared to be caused by questionable billing practices. IDPA officials told us that having a clear understanding of the root causes for these errors has been instrumental in developing effective corrective actions. Similarly, attributing the causes of Medicare fee-for-service improper payments to those responsible for them could provide HCFA with useful information for developing specific corrective actions.

Certain third party validation techniques are included and have been successfully implemented in the current methodology. For example, OIG staff confirm a provider's eligibility to bill the Medicare program by contacting state licensing boards to ensure that the doctors billing Medicare have active licenses. They also verify with SSA that beneficiaries are eligible to receive medical services under the Medicare program. However, as currently conceived, none of the HCFA projects include third party contact as a potential fraud detection technique.

Implementing More Aggressive Fraud Detection Techniques Will Require Careful Study and Additional Resources

The experiences of recent efforts to apply more aggressive fraud detection techniques coupled with our discussions with patient and provider advocacy groups indicate that finding successful protocols for implementing some detection techniques may require careful study. Our review of three studies that have attempted to use beneficiary contact as a measurement device—the MFRP and two Medicaid studies in Texas and Illinois—indicate that, while useful, it is a challenging technique to implement.

[19]Payment Accuracy Review of the Illinois Medical Assistance Program, Illinois Department of Public Aid, August 1998.

- The initial contractor for the MFRP conducted a small pilot test using beneficiary contact to verify Medicare billed services and found that making contact was more difficult than anticipated. Telephone contact was the most cost-effective approach for contacting beneficiaries, but the contractor could reach only 46 percent of them due to difficulty in obtaining valid phone numbers and difficulty in actually talking to the beneficiary or his or her representative once a valid number was located. Using more costly and time-consuming approaches, such as mailing written surveys and conducting face-to-face interviews only increased the success rate to 64 percent. To maximize the effectiveness of these alternative approaches, the contractor noted that it was important to obtain valid addresses and ensure that the written survey instrument was concise, easy to understand, and easy to complete so that the beneficiaries would take the time to respond.
- The state of Texas experienced similar difficulties contacting Medicaid recipients in a recent statewide fraud study.[20] Telephone numbers for more than half of the 700 recipients that the state attempted to contact were not available or were incorrect. The state attempted to make face-to-face contact if telephone contact was not possible, and by the study's end, over 85 percent of the recipients were contacted. The state concluded that contacting a recipient by telephone is the only cost-effective way to verify that services had been delivered. It also found that delays in making contact could affect the results since recipients' ability to accurately recall events appeared to diminish over time.
- For the Illinois Medicaid study, the IDPA found other problems in using beneficiary contact as a detection technique in the payment accuracy study of its program.[21] Department investigators met with almost 600 recipients or their representatives to verify that selected medical services had been received. The investigators found that while recipient interviews were an overall useful step in the study's methodology, they did not always produce the desired results. For example, investigators found cases where caretaker relatives could not verify the receipt of services. They also found other cases where recipients were unaware of the services received, such as lab tests, or could not reliably verify the receipt of services because they were mentally challenged.

[20]Final Staff Draft Report on Health Care Claims Study and Comments from Affected State Agencies, Texas Comptroller of Public Accounts, December 1998.

[21]See footnote 19.

Illinois officials involved with implementing the Medicaid study told us that direct provider contact is also challenging. For example, an important consideration is whether or not to make unannounced visits. According to the Illinois officials, unannounced visits can be disruptive to medical practices and inappropriately harm the reputations of honest providers by giving patients and staff the impression that suspicious activities are taking place. Announced visits, on the other hand, can give the provider time to falsify medical records, especially if they know which medical records are going to be reviewed. The Illinois officials resolved this dilemma by announcing visits 2 days in advance and requesting records for 50 recipients so it would be difficult for the provider to falsify all the records on such short notice.

Data on fraud referrals included in HCFA's FID indicates that health care providers and beneficiaries represent important sources for identifying improper payments, particularly for certain types of potential fraud and abuse. Moreover, the application of more extensive fraud detection techniques into efforts to measure improper payments will require their cooperation. Our discussions with patient and health care provider advocacy groups indicated they may oppose the application of more extensive detection techniques due to concerns with violating doctor-patient confidentiality, protecting the privacy of sensitive medical information, and added administrative burdens. For example, officials from the Administration on Aging, an HHS operating division, told us that they discourage elders from responding to telephone requests for medical and other sensitive information. Similarly, the American Medical Association and American Hospital Association emphasize the adverse impact that meeting what they consider to be complex regulations and responding to regulatory inquiries has on health care providers' ability to focus on meeting patient needs. They also voiced concerns with the added cost that would have to be absorbed by providers to comply with even more requests for medical information in an era of declining Medicare reimbursements. Further, some of the health care experts we talked with cautioned that there are practical limits to the amount of potentially fraudulent and abusive activity that can be measured. These experts emphasize that no set of techniques, no matter how extensive, can be expected to identify and measure all potential fraud and abuse. However, despite these concerns, compliance with reasonable efforts to ensure that benefits are, in fact, paid properly is encouraged by beneficiary advocacy groups. Further, various federal laws and regulations put providers and Medicare beneficiaries on

notice that HHS and HCFA may require and use information from medical records for certain purposes.[22]

In addition to beneficiary and provider contact, the health and fraud experts we spoke with told us that validating the information that Medicare contractors are relying on to pay claims, including provider and supplier assertions concerning the appropriateness of those claims, with third parties could also help to identify potential fraudulent or abusive activity. The current methodology incorporates such procedures to confirm providers' current standing with state licensing authorities and beneficiaries' eligibility status with SSA. Other sources—such as beneficiary employers, beneficiary relatives or personal caregivers, State Medicaid agencies, and employees of providers and suppliers—could also offer useful information for assessing the appropriateness of claims. However, determining the appropriate nature and extent of third party verification procedures to incorporate into efforts to measure improper payments should be considered carefully. Excluding third party verification efforts, and therefore placing greater reliance on the accuracy of data developed internally or provided independently, should be based on risks determined through analysis of reliable indicators.

The Comptroller General's *Standards for Internal Control in the Federal Government*[23] stresses the importance of performing comprehensive risk assessments and implementing control activities, including efforts to monitor the effectiveness of corrective actions to help managers consistently achieve their goals. While the annual cost of the current methodology and the HCFA projects involve several million dollars, these efforts represent a needed investment toward avoiding significant future losses through better understanding the nature and extent of improper payments—including potential fraud and abuse. As shown in table 2, the current methodology costs $4.7 million, not counting the cost of medical review staff time at contractors. PEPP is estimated to cost $7.5 million annually, and CERT costs are expected to be over $4 million annually once fully implemented. While these may seem to be expensive efforts, when considered in relation to the size and vulnerability of the Medicare program

[22]For example, section 1815(a) of the Social Security Act, 42 U.S.C. § 1395g(a), provides that payments shall not be made to any provider unless it furnishes information the Secretary of HHS requests to determine the amounts due the provider.

[23]*Standards for Internal Control in the Federal Government* (GAO/AIMD-00-21.3.1, November 1999).

and the known improper payments that are occurring, they represent prudent, needed outlays to help ensure program integrity.

In our recent report on improper payments across the federal government,[24] we discussed the importance of ascertaining the full extent of improper payments and understanding their causes to establish more effective preventive measures and to help curb improper use of federal resources. However, as we recently testified,[25] HCFA's ability to protect against fraud and abuse depends on adequate administrative funding. Therefore, in developing effective strategies for measuring improper payments, consideration of the most effective techniques to apply in the most efficient manner is essential to maximize the value of administrative resources. While HCFA faces significant challenges for ensuring the integrity of the Medicare fee-for-service program, importantly, HCFA can use the results of these efforts to more effectively assess corrective actions, target high-risk areas, and better meet its role as steward of Medicare dollars.

MFRP Holds Some Promise for Advancing Potential Fraud and Abuse Measurement

HCFA plans to expand its efforts to measure Medicare improper payments by assessing the usefulness of performing additional fraud detection techniques with the MFRP. Meanwhile, since the current methodology and the CERT and PEPP projects do not incorporate the use of some techniques considered effective in identifying potential fraud and abuse, HCFA's ability to fully measure the success of its efforts to reduce fraud and abuse remains limited.

Health care fraud experts told us that the ability of these projects to measure potential fraud and abuse are somewhat dependent on the nature, extent, and level of fraud sophistication that may be involved. For example, the introduction of beneficiary contact, in conjunction with other techniques, should improve the ability to determine whether services were actually rendered. However, if the beneficiary is a willing participant in the potential fraud and abuse scheme, these additional techniques may not lead to an accurate determination.

[24] *Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments* (GAO/AIMD-00-10, October 29, 1999).

[25] *Medicare: HCFA Faces Challenges to Control Improper Payments (*GAO/T-HEHS-00-74, March 9, 2000).

Conclusions

The size and administrative complexity of the Medicare fee-for-service program make it vulnerable to inadvertent error and exploitation by unscrupulous providers and suppliers. Given the billions of dollars that are at risk, it is imperative that HCFA continue its efforts to develop timely and comprehensive payment error rate estimates that can be used to develop effective program integrity strategies for reducing errors and combating fraud and abuse. The current methodology represented a significant first step in obtaining such information, but the lack of key fraud and abuse detection techniques limit its effective use as a management tool to estimate potential fraud and abuse and ultimately achieve important program integrity goals. HCFA's projects could collectively address some of the limitations of the current methodology if properly executed, but do not appear to go far enough. Expanding the scope of the Model Fraud Rate Project to include studying provider visits and a more extensive assessment of the cause of improper payments and other promising techniques could help HCFA pinpoint additional high-risk areas and develop more effective corrective actions. The implementation of more extensive detection techniques is bound to be challenging and expensive, so using rigorous study methods and consulting with the people affected, such as beneficiary and provider advocacy groups, are essential steps to ensure success, as well as considering the tangible and intangible benefits of using particular techniques. Given the delays and potential challenges associated with implementing the Model Fraud Rate Project, substantial improvements in the measurement of improper payments, especially those stemming from potential fraudulent and abusive activity, will probably not be realized for a few years.

Recommendations

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse, we recommend that the HCFA Administrator take the following actions:

- Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify and measure improper payments and then evaluate their effectiveness. For example, visiting providers to verify their existence, collecting medical records and other documents supporting Medicare payments, observing the level of patient activity, and inquiring about the nature of the provider's operations with employees could provide valuable information to more accurately assess the appropriateness of claim payments and causes of improper payments. Likewise, inquiries with

Medicare beneficiaries to verify receipt of and need for services or supplies could provide similar insights. In determining the nature and extent of additional specific procedures to perform, the overall measurement approach should (1) recognize the types of fraud and abuse perpetrated against the Medicare program, (2) consider the relative risks of potential fraud or abuse that stem from the various types of claims, (3) identify the advantages and limitations of common fraud detection techniques and use an effective combination of these techniques to detect improper payments, and (4) consider, in consultation with advocacy groups, concerns of those potentially affected by their use, including beneficiaries and health care providers.

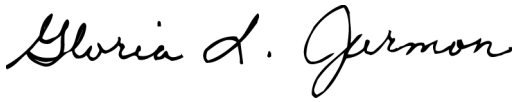
- Include in the methodologies' design, sufficient scope and evaluation to more effectively identify underlying causes of improper payments, including potential fraud and abuse, in order to develop appropriate corrective actions.

Agency Comments and Our Evaluation

HCFA's written comments are reprinted in appendix III. HCFA agreed with our recommendations and discussed additional techniques it is developing to detect potential fraud and abuse. The Administrator described some techniques outlined in this report that HCFA currently performs, such as conducting site visits as part of its provider enrollment process as well as the challenges associated with their use. Performing these activities in conjunction with on-going program integrity efforts is important. However, the Administrator's comments and our report highlight the challenges involved in incorporating additional potential fraud and abuse identification efforts into initiatives to measure Medicare improper payments. Nevertheless, despite the challenges they pose, adding these techniques is essential to gain a more comprehensive assessment of the nature, extent, and causes of their occurrence. The Administrator also provided technical comments, which we incorporated in this report as appropriate.

We are sending copies of this report to Representative John M. Spratt, Ranking Minority Member of the House Committee on the Budget and interested congressional committees. We are also sending copies of this report to the Honorable Donna E. Shalala, Secretary, and the Honorable June Gibbs Brown, Inspector General, Department of Health and Human Services; and the Honorable Nancy-Ann Min DeParle, Administrator, Health Care Financing Administration. Copies will be made available to others upon request.

Please contact me at (202) 512-4476 or by e-mail at *jarmong.aimd@gao.gov* if you have any questions about this report. Other GAO contacts and staff acknowledgements are listed in appendix IV.



Gloria L. Jarmon
Director, Health, Education, and Human Services
Accounting and Financial Management Issues

Objectives, Scope, and Methodology

Our objectives were to identify structural problems that exist in the Medicare claims processing system which contribute to inherent vulnerabilities resulting in erroneous Medicare payments and to determine (1) what HCFA proposals have been designed or initiated to measure Medicare improper payments and (2) the status of these proposals and initiatives and how will they enhance HCFA's ability to comprehensively measure improper Medicare payments and the frequency of kickbacks, false claims, (e.g., services not provided) and other inappropriate provider practices.

Through interviews with health care fraud and investigation experts, we gained an understanding of the vulnerabilities in the Medicare fee-for-service program that create opportunities for improper payments, especially those stemming from fraudulent and abusive activity, and the most promising detection techniques to identify these payments. Specifically, we talked with officials from the Department of Health and Human Service's Office of the Inspector General (OIG) and Office of Investigations (OI), Department of Justice (DOJ), Federal Bureau of Investigation (FBI), HCFA's program integrity group, HCFA's Atlanta Regional Office unit specializing in fraud detection efforts, a Medicare claims processing contractor, Association of Certified Fraud Examiners, three private health insurance organizations, National Health Care Anti-Fraud Association, Health Insurance Association of America, three states in connection with their Medicaid programs, and two academicians with notable fraud investigation experience. We also reviewed various documents including HCFA and OIG Fraud Alerts, prior GAO, OIG, and other studies on health care fraud and abuse, particularly those related to the Medicare fee-for-service program.

We analyzed HCFA's Fraud Investigation Database (FID) to identify the most common types of potential fraud referred to the OI and DOJ for further investigation and possible criminal and civil sanctions. We also analyzed the FID to determine the most frequent sources for identifying potential fraud. The FID was created in 1995, but has data on fraud referral going back to 1993. We did not attempt to validate the database.

Through interviews with HCFA Program Integrity Group officials and reviews of HCFA documentation, including program integrity plans, project descriptions, statements of work, and requests for proposals, we identified and determined the status of HCFA projects that could improve the measurement of Medicare fee-for-service improper payments.

To assess the potential effectiveness of the techniques planned for the HCFA projects for identifying improper payments attributable to potential fraud and abuse, we (1) performed a comparative analysis of common types and sources of referrals of fraud and abuse occurring in the Medicare program, the types of techniques identified by investigative experts as most effective for identifying them, and the extent to which identified techniques are incorporated in the respective methodologies and (2) discussed the results of our analysis with officials in HCFA's Program Integrity Group and OIG.

To gain an understanding of how the implementation of additional procedures to identify and measure improper payments attributable to potential fraud and abuse could affect providers, suppliers, and recipients of health care services and supplies, we interviewed officials from patient and health care provider advocacy groups, including the American Medical Association, American Hospital Association, HHS Administration on Aging, American Association of Retired Persons, and the Health Care Compliance Association.

We requested comments on a draft of this report from the HCFA Administrator or her designee. We have incorporated any changes as appropriate and have reprinted HCFA's response in appendix III. We performed our work from November 1999 through June 2000 in accordance with generally accepted government auditing standards.

Definitions and Examples of Common Types of Potential Fraud and Abuse Referrals

Services Not Rendered

As the category indicates, cases involving billing for services not rendered occur when health care providers bill Medicare for services they never provided. Potential fraud and abuse is usually detected by statements received from the provider's patients or their custodians and the lack of supporting documents in the medical records.

For example, a provider routinely submitted claims to Medicare and CHAMPUS[1] for cancer care operations for services not rendered or not ordered; upcoded procedures, as defined below, to gain improper high reimbursement; and double billed Medicare for certain procedures. As a result of the fraudulent submissions, the provider allegedly obtained millions of dollars to which it was not entitled.

Medically Unnecessary Services and Supplies and Overutilization

Cases involving medically unnecessary services, supplies, or overutilization occur when providers or suppliers bill Medicare for items and services that are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a body part. They include incidents or practices of provider, physicians, or suppliers of services that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to Medicare, improper payments, or payments for services that do not meet professionally recognized standards of care or are not medically necessary.

For example, a provider ordered magnetic resonance imaging tests and neurological tests and investigators questioned whether the tests were medically necessary and whether the neurological tests were actually performed. Most of the tests were performed on patients who responded to the provider's advertisements in the yellow pages. After a 5 to 10 minute consultation, the provider would diagnose almost every patient with the same disorder – radiculopathy, a disease involving compression of, or injury to the roots of spinal nerves.

[1]CHAMPUS, or the Civilian Health and Medical Program of the Uniformed Services, is a fee-for-service health insurance program that pays for a substantial part of the health care that civilian hospitals, physicians, and others provide to nonactive duty Department of Defense beneficiaries.

Misrepresentation of Services and Products/Falsifying Certificates of Medical Necessity (CMNs)/Other Documents

Medicare publishes coverage rules on what goods and services the program will pay for and under what circumstances it will pay or not pay for certain goods and services. Providers sometimes bill Medicare, showing a billing code for a covered item or service when, in fact, a noncovered item or service was provided. Further, providers sometimes intentionally falsify statements or other required documentation when asked to support payments for claimed services or supplies. In particular, investigators have determined that falsification of CMNs—documents evidencing appropriately authorized health care professionals' assertions regarding the beneficiaries' needs for certain types of care or supplies, such as home health and hospice services or certain durable medical equipment—occur, providing unscrupulous providers and suppliers additional opportunities to abuse Medicare.

For example, a provider billed for an orthotic knee brace, when in fact the provider was providing Medicare beneficiaries with nonelastic compression garments and leggings. Although knee orthotics are reimbursed by Medicare and Medi-Cal[2] for a total of over $650 per brace, the nonelastic compression garment is not reimbursed by Medicare. The total billings totaled approximately $332,055.

Upcoding

One type of incorrect coding is called "upcoding." Upcoding cases result from health care providers changing codes on claim forms submitted to Medicare, causing reimbursements to be paid at higher rates than are warranted by the service actually provided. Upcoding can also result from providers billing for services actually provided by nonphysicians, which would be paid at a lower reimbursement rate.

For example, a provider allegedly submitted false claims for services provided by physicians in training and inflated (upcoded) claims in connection with patient admissions services. The provider paid the U.S. government $825,000 primarily to settle allegations resulting from an audit performed by the HHS OIG. The audit was triggered by a lawsuit filed by private citizens as authorized by the False Claims Act (31 U.S.C. sections 3729–3733).

[2]The Medicaid program for the State of California is known as the Medi-Cal program.

Fraudulent Cost Reporting

Falsifying any portion of the annual report submitted by all institutional providers participating in the Medicare program. The report is submitted on prescribed forms, depending on the type of provider (e.g., hospital, skilled nursing facility, etc.). The cost information and statistical data reported must be current, accurate and in sufficient detail to support an accurate determination of payments made for the services rendered.

For example, a provider billed Medicare for hundreds of thousands of dollars for personal expenses disguised as legitimate healthcare expenses. The personal expenses billed included an addition to a private home, vacations, and beauty pageant gowns. The provider was fined over $500,000 for the fraudulent billings.

Kickbacks and Accepting/Soliciting Bribes, Gratuities, or Rebates

Section 1128B of the Social Security Act, 42 U.S.C. § 1320a-7b(b), makes it a felony to solicit, receive, offer, or pay a kickback, bribe, or rebate in connection with the provision of goods, facilities, or services under a federal health care program, including Medicare.

For example, a provider agreed to plead guilty to conspiracy, mail fraud, and violating the anti-kickback provision and to pay $10.8 million in criminal fines in connection with its scheme to defraud Medicare. The pleas relate to kickbacks and false Medicare billings made in connection with the provider's receipt of fees from another company for the provider's management of certain home health agencies.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administ

The Administrator
Washington, D.C. 20201

DATE: AUG 28 2000

TO: Gloria L. Jarmon, Director
Health, Education, and Human Services
General Accounting Office

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: "General Accounting Office (GAO): Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain" (GAO/AIMD/OSI-00-281)

Thank you for your report on measuring potential fraud and abuse in the Medicare program. We appreciate GAO's acknowledgment of the significant work that has gone into improving HCFA's fraud and abuse efforts. Rapid change and growth in Medicare have presented immense challenges and demanded even more creative solutions from HCFA staff and contractors as we strive to "pay it right." The number and types of providers have grown exponentially, as have the types of benefits available, number of claims paid, and perhaps most importantly, the dollar amount involved.

Since the Clinton Administration took office, we have made paying right and fighting fraud, waste, and abuse one of our top priorities, and today, our efforts to identify fraud, waste, and abuse in all our programs are more effective than ever before. The results from our efforts has been record success in assuring proper payments to honest providers and penalties for problem providers. To build on this success, we have implemented an agency-wide Comprehensive Plan for program Integrity with clear objectives, such as increasing the effectiveness of medical review, targeting known problem areas, and increasing efforts to help providers comply with program rules. From April through September, 1998, we stopped about $5.3 billion from being paid to providers for inappropriate claims. Our anti-fraud efforts returned nearly $500 million to the federal government, a 65 percent increase over the previous year. And total Medicare integrity program savings in fiscal year 1999 totaled $9.9 billion.

One of the most important initiatives in our program integrity efforts has been the annual audit of Medicare payments performed by the Department of Health and Human Services Office of the Inspector General (OIG). We agree with the GAO that this audit was never designed to measure fraud in the Medicare program. Instead, the OIG audit was intended to provide support for Medicare's annual financial statement. However, the OIG's statistically valid estimate of improper payments has provided a meaningful benchmark from which HCFA's success on paying claims correctly can be measured. And, HCFA has correspondingly achieved a large decrease in

improper payments, reducing the Medicare error rate by almost half since 1996, and maintaining that progress in 1999.

HCFA has now expanded upon the efforts begun by the OIG and has developed two new projects -- the Payment Error Prevention Program (PEPP) and the Comprehensive Error Rate Testing program (CERT). HCFA designed PEPP and CERT to develop more targeted error rate estimates in States (for inpatient hospital discharges) and at Medicare contractors (for all other services). Both programs are largely consistent with the way errors are calculated in the overall national error rate, but contain some important differences. For example, rather than measuring only net errors (overpayments minus underpayments), CERT and PEPP measure absolute errors (overpayments plus underpayments). Additionally, one national contractor is used in each program, thereby enhancing consistency in medical record review. Finally, both CERT and PEPP offer more specific information about error rates -- indeed, CERT will offer not just error rates on a contractor-specific basis, but will also be able to hone in on providers and produce provider-specific error rates. The specificity of these programs will allow contractors to more precisely target specific patterns of incorrect billing.

We look forward to working with GAO and Congress to strengthen our ability to identify potential fraud and abuse in the Medicare program.

General and Technical Comments
"Medicare Improper Payments: While Enhancements Hold Promise for Measuring Potential Fraud and Abuse, Challenges Remain"

As part of our program integrity efforts, HCFA has also placed great emphasis on educating providers, suppliers and physicians about the requirements in Medicare. For example, we now require our contractors to collaborate with HCFA provider education programs to educate providers about billing correctly. This fall, contractors will be re-installing toll-free telephone lines dedicated to answering provider inquiries. We continue to use the Internet, computer-based training and provider outreach to ensure that information is available for providers to comply with our rules.

In 1999, over 68,000 users accessed our computer-assisted training, with a 39 percent point increase in subject matter knowledge. We sponsor the Medicare Resident Training Program, a satellite training session, which is promoted to medical schools, hospitals, and universities nationwide. Materials for this program include a comprehensive resource book, which contains detailed information on Medicare coverage and billing rules, including documentation guidelines for Evaluation and Management services. In 1999, 6,176 people participated in the Program, and post-assessments have shown an average increase in knowledge of 30.39 percent. We require contractors to use printed media (contractor-issued bulletins) and conduct face-to-face workshops/seminars on billing and other Medicare requirements.

This June, HCFA held a town hall meeting on pilot-testing new documentation guidelines for evaluation and management (E&M) services, which constitute the majority of Medicare claims. The guidelines will help ensure Medicare pays claims correctly while minimizing the paperwork burden for doctors. Finally, this year HCFA focused on common errors detected during the annual OIG audit of improper payments. We sent more than 800,000 letters to key providers -- all physicians, home health providers, and durable medical equipment suppliers in the Medicare program -- to address documentation problems and explain how to avoid common errors identified during the annual audit.

Because the vast majority of Medicare providers are honest, we believe the first step in safeguarding the Medicare program is ensuring that claims are paid correctly. The efforts highlighted above are essential to assure the financial integrity of the trust fund, and to protect both American taxpayers and the beneficiaries served by the Medicare program. In addition to these program integrity efforts, HCFA has also launched several initiatives specifically targeted to reducing and measuring Medicare fraud. These initiatives are discussed in the responses to the GAO recommendations below. We thank the GAO for its report, and look forward to working with you and Congress to strengthen our ability to pursue a zero tolerance policy for fraud, waste, and abuse. Our responses to specific GAO recommendations are detailed below.

GAO Recommendation

To improve the usefulness of measuring Medicare fee-for-service improper payments, including those attributable to potential fraud and abuse, we recommend that the HCFA Administrator take the following actions:

- Experiment with incorporating additional techniques for detecting potential fraud and abuse into methodologies used to identify and measure improper payments and then evaluate their effectiveness.

HCFA Response

We agree with GAO's recommendation. We are developing additional techniques for detecting potential fraud and abuse. Some examples of these techniques follow:

- **Evaluation of fraud detection software products:** Last year, HCFA contracted with an information technology company to evaluate and catalogue the functions of 10 widely used electronic fraud, waste, and abuse products. The contractor also surveyed current claims processing contractors to determine which software products such contractors were employing. The findings were that the 10 systems reviewed had considerable strengths, though their approaches to data analysis varied considerably. In many cases, contractors weaved together multiple systems to take advantage of particular strengths in each to produce an effect dubbed the "suite of systems approach." The survey also found that the effectiveness of a FWA tool is dependent on the personnel implementing the tools. Regardless of the strengths of the electronic products, tools must be underpinned by solid personnel who understand how to weave together suites of systems, and who understand data analysis and how to let the data lead them to solutions.

- **Market survey of products that identify fraud, waste and abuse.** HCFA has contracted with the same information technology firm that performed the above study to conduct a market survey to identify and catalog the functionality of commercially available FWA detection products. Working closely with both Medicare and Medicaid Program Integrity staff, this contractor has developed a market survey instrument to evaluate FWA tools, review past performance, and customer satisfaction with these products. This survey will shortly be posted to HCFA's Internet website.

- **Statistical Analysis Contractor:** Under contracting authority derived from the Medicare Integrity Program, HCFA recently awarded a contract to conduct trend studies of Medicare claims. The statistical analysis contractor (SAC) will review Medicare claims data from three states, perform analyses of utilization and payment to determine areas where HCFA should focus additional resources. If, during the course of its work, the SAC identifies aberrant pattern(s) representing significant risk to the Medicare Trust Fund, HCFA may allow the SAC to analyze data from additional states. The SAC will also evaluate electronic fraud detection software products and measure their effectiveness and efficiency in detecting Medicare fraud, waste, and abuse. The SAC will apply a

rigorous and complete testing protocol to verify vendor claims regarding functionality and performance in detecting fraud, waste, and abuse. Test results will be protected from disclosure to protect both vendor trade secrets and HCFA's sensitive fraud detection methodologies.

Technology Conference on Combating Fraud and Abuse: In June 2000, HCFA cosponsored with the Department Justice a conference on using electronic tools to combat fraud and abuse. The conference brought together both law enforcement and federal and state health care officials to (a) identify new and emerging technologies that may be applied to detecting health care fraud, waste, or abuse; (b) discuss the benefits and drawbacks of technologies currently on the market, (c) provide a networking forum for the various consumers of fraud, waste and abuse technology. Nearly 300 persons attended the conference, including representatives from HCFA's central and regional offices, the OIG, Medicaid state agencies, Medicaid fraud control units, U.S. Attorney's offices, the General Accounting Office, and the Senate Select Committee on Aging. Nearly 30 vendors displayed some of the latest fraud detection tools available in the marketplace. HCFA plans to follow up on this conference by producing a report of proceedings with recommendations for future steps, including the possibility of regional or national technology user groups.

Provider Enrollment Activities: The primary purpose of provider enrollment is to ensure that only qualified and legitimate providers, suppliers and physicians obtain billing privacy. For this reason, HCFA has placed a new emphasis on provider enrollment activities. Since 1996, HCFA has used a new provider enrollment form that collects more detailed information on applicants for Medicare billing privileges. Before providing a billing number, we conduct a data validation process, involving a variety of different data sources. Increasingly, the Internet has become a useful source of information to help validate information such as addresses. We also check licensing boards, sanction and debarment lists, and the new Healthcare Integrity and Protection Data Bank (HIPDB), a national health care fraud and abuse data collection program for reporting and disclosing certain final adverse actions taken against health care providers, suppliers, or practitioners.

Site Visits: As part of our provider enrollment process, we conduct site visits in numerous instances. Site visits are performed if a State survey (to ensure compliance with conditions of participation) has not been conducted, or if the entity or organization has not been subject to an accreditation by an approved accreditation authority (such as the Joint Commission on Accreditation of Healthcare Organizations). These are now conducted on all newly enrolling durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) entrants, independent diagnostic testing facilities, and community mental health centers. Contractors also have the flexibility to conduct site visits in other areas if they suspect problems might exist, based on beneficiary complaints, tips from State agencies or authorities, or ongoing and completed investigations.

- **Setting Standards Higher**: In certain instances we have raised standards for applicants for billing privileges. For example, because investigations by the OIG found significant problems with DME suppliers (including instances where suppliers had no business address, were located in private homes, or had no actual supply of equipment to provide) we have raised the entrance barrier for such suppliers. Before awarding billing privileges to DME suppliers, we make sure that basic business requirements—such as honoring warranties, maintaining and repairing equipment, accepting returns, maintaining a physical facility on an appropriate site, and maintaining liability insurance—are met. We also established the National Supplier Clearinghouse, a national enrollment contractor for suppliers, which conducts site visits for all newly enrolling and reenrolling suppliers. Similarly, for new CMHC applicants, we not only conduct unannounced site visits, but we also require intensified medical reviews of CMHC partial hospitalization services, with particular emphasis on five states targeted by the OIG (Florida, Texas, Colorado, Pennsylvania, and Alabama) in an October 1998 report (which found that 90 percent of CMHC partial hospitalization program claims in those states did not meet Medicare coverage requirements).

  For independent diagnostic testing facilities (IDTFs), we found that some entities that billed for and/or provided diagnostic tests often were not legitimate businesses or did not meet reasonable quality standards. To eliminate this problem, we published a regulation establishing new, higher standards for entry into the program, and told all existing entities that they had to re-enroll into the program, showing that they met the new requirements. We conducted site visits as part of this effort. After publication of the new standards, only about half of the entities previously enrolled in the program successfully re-enrolled.

- **Encouraging beneficiaries to report possible fraud.** Beneficiaries are sent an Explanation of Medicare Benefits (EOMB) to alert them to claims paid by Medicare. As a result of HCFA outreach and that conducted by our contractors, the Administration on Aging, their grantees, and other volunteers, HCFA receives literally hundreds of thousands of inquiries and complaints from beneficiaries concerned that Medicare has been billed improperly. These can lead to payment adjustments or referrals for further investigation.

The efforts highlighted above demonstrate that HCFA is serious not just about measuring fraud, but keeping fraudulent providers out of the Medicare program. However, the methods that would allow HCFA to establish fraud might be considerably different than those used to detect normal payment errors—for example, given the importance of establishing patterns, it might be more reliable to sample providers rather than individual claims. As the GAO has stated, "Data on an individual claim, taken in isolation, rarely suggest a fraudulent practice." (U.S. General Accounting Office, "Vulnerable Payers Lose Billions to Fraud and Abuse," May 1992, p. 15.)

To minimize the concern about manufactured records, it might be necessary to conduct unannounced visits to providers, or provide very little notice. Provider sampling has certain advantages methodologically, but creates great administrative burden and tension in the provider community, especially when combined with unannounced visits or other investigative techniques used to establish fraud (such as interviews with employees). The benefits of such an approach, as

weighed against the actual and the unintended costs, have not yet been thoroughly researched, and HCFA is wary of how such efforts would be viewed by providers. Already sensitive to random review of claims (in which we ask for additional documentation to support the claim), providers are very likely to object strenuously, and with some merit, to greater invasions.

Beneficiary contact might be a measurement method, but also is unproven as a reliable, valid measure in establishing the probability of fraud. Despite direct contact with beneficiaries on claims as part of its payment accuracy project, for example, the State of Illinois cautioned that "it is important to note that this study was designed to measure payment accuracy. It was never intended to measure a fraud rate. Indeed, we are not sure that is even possible." The State of Illinois concluded that establishing a fraud rate "would have required, at a minimum, conducting a criminal investigation on each service in the sample. Even then, we would not have been certain that every potentially fraudulent claim would be detected...." (Illinois Department of Public Aid, "Payment Accuracy Review of the Illinois Medical Assistance Program," August 1998, p. 3.)

HCFA's own experiences with beneficiary surveys are mixed at best. In 1999, HCFA sponsored a pilot study to estimate the rate of fraud in the claims processing system. The contractor that conducted the study found that only 49.5% of the 200 sampled beneficiaries responded to telephone, written and even face to face contacts. Thus, a sample of larger than 200 would be needed to perform a valid estimate. Furthermore, no single survey methodology was sufficient, but rather a combination of methodologies (telephone, written, and face to face) was required to maximize the response rate. This combination of methods, however, has a significant impact on both time and cost.

In addition, HCFA's Office of Strategic Planning (OSP) has been conducting the Medicare Current Beneficiary Survey (MCBS) nationwide since 1991. The MCBS queries beneficiaries about whether services billed on their behalves are actually delivered. OSP found that while most beneficiaries are concerned about fraud, they do not understand it. In fact, most beneficiaries know their primary physician's name, but they are significantly less familiar with the names of adjunct medical specialists (radiologists, therapists, surgeons) who provided other services. OSP also determined that in 30% of the cases, beneficiaries were provided with services but could not confirm the provision of these items or services. In particular, beneficiaries often forgot being provided routine medical services. Nursing home residents present additional methodological issues. For example, approximately 50% of beneficiaries in nursing homes require proxies to respond to the survey due to mental/physical disabilities. Mental or physical disabilities also require the use of proxies in approximately 15% of the general Medicare beneficiary population.

In conclusion, HCFA OSP determined that beneficiary surveys are generally an unreliable means of identifying Medicare fraud. This is due primarily to the disabling mental/physical condition of many beneficiaries who are not consistently capable of accurately recollecting the services provided. Importantly, the most severely disabled beneficiaries are also the most likely to be victimized by fraud; by contrast, beneficiaries with greater capacities to identify fraud are the least likely to be victimized. As a result, HCFA OSP concluded that self-reporting would not provide an accurate estimate of the rate of fraud in the health care system.

GAO Contacts and Staff Acknowledgments

GAO Contacts

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