

GAO

Report to the Chairman, Human  
Resources and Intergovernmental  
Relations Subcommittee, Committee on  
Government Reform and Oversight,  
House of Representatives

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September 1995

# MEDICARE SPENDING

## Modern Management Strategies Needed to Curb Billions in Unnecessary Payments







United States  
General Accounting Office  
Washington, D.C. 20548

**Health, Education, and  
Human Services Division**

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The Honorable Christopher Shays  
Chairman, Human Resources and  
Intergovernmental Relations Subcommittee  
Committee on Government Reform and Oversight  
House of Representatives

Dear Mr. Chairman:

The 104th Congress has been examining ways for Medicare to avoid spending billions of dollars in unnecessary payments. Specifically, your Subcommittee has been exploring the legal and administrative enforcement tools available to Medicare to act against those providers who defraud or abuse the program, the beneficiary, and the taxpayer. Although strengthening enforcement is critical, an earlier phase of fraud fighting—identifying the program’s vulnerabilities and the measures needed to curb losses—is an equally vital component. Therefore, you asked us to examine the weaknesses responsible for Medicare’s vulnerability to provider exploitation and ways to remedy them.

To develop this information, we drew from an extensive body of GAO work over the last few years focusing on Medicare fraud and abuse. (See the list of related GAO products at the end of this report.) We supplemented this work with interviews of officials in various offices of the Health Care Financing Administration (HCFA), including the Bureau of Policy Development, Bureau of Program Operations, Office of Legislative and Intergovernmental Affairs, and the Office of the Administrator, and with HCFA contractors.

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## Results in Brief

Medicare’s vulnerability to billions of dollars in unnecessary payments stems from a combination of factors. First, Medicare pays higher than market rates for certain services and supplies. For example, Medicare pays more than the lowest suggested retail price for more than 40 types of surgical dressings. (In one case, Medicare pays 86 cents for a 36-cent gauze pad.) Second, Medicare’s collection of anti-fraud-and-abuse controls does not systematically prevent the unquestioned payment of claims for improbably high charges or manipulated billing codes. Third, Medicare’s checks on the legitimacy of providers are too superficial to detect the potential for scams. These weaknesses are aggravated by the fact that Medicare’s efforts to address them, as well as its efforts to penalize

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wrongdoers, are too slow to be effective in curbing avoidable costs or deterring further fraud and abuse.

Various health care management strategies help private payers alleviate these problems, but these strategies are not generally used in Medicare. The program's pricing methods and controls over utilization, consistent with health care financing and delivery 30 years ago, are not well aligned with today's major financing and delivery changes. To some extent, the predicament inherent in public programs—the uncertain line between adequate managerial control and excessive government intervention—helps explain the dissimilarity in the ways Medicare and private health insurers administer their respective “plans.”

We believe a viable strategy for remedying the program's weaknesses consists of adapting the health care management approach of private payers to Medicare's public payer role. Such a strategy would focus on pre-enforcement efforts and would include (1) more competitively developed payment rates, (2) enhanced fraud and abuse detection efforts through modernized information systems, and (3) more rigorous criteria for granting authorization to bill the program.

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## Background

Medicare is the nation's largest single payer of health care costs. In 1994, it spent \$162 billion, or 14 percent of the federal budget, on behalf of about 37 million elderly and disabled people. Approximately 90 percent of Medicare beneficiaries obtained services on an unrestricted fee-for-service basis; that is, patients chose their own physicians or other health care providers, with charges sent to the program for payment. This set-up mirrored the nation's private health insurance indemnity plans, which prevailed until the 1980s.

Since then, revolutionary changes have taken place in the financing and delivery of health care. Greater competition among hospitals and other providers has enabled health care buyers to be more cost-conscious. Private payers, including large employers, use an aggressive management approach to control health care costs. HCFA, within the Department of Health and Human Services (HHS), is Medicare's health care buyer. HCFA's pricing of services and controls over utilization have been carefully prescribed by interrelated statute, regulation, and agency policy.

HCFA contracts with about 72 private companies—such as Blue Cross and Aetna—to handle claims screening and processing and to audit providers.

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Each of these commercial contractors works with its local medical community to set coverage policies and payment controls in addition to those that have been established nationally by HCFA. As a result, billing problems involving waste, fraud, and abuse are handled, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

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## Several Factors Make Medicare Appealing Target for Abuse

Most observers agree that the majority of Medicare providers seek to abide by program rules and strive to meet beneficiaries' needs. But certain characteristics of the program and the way it is administered create a climate ripe for abuse by some providers. For many supplies and services, Medicare reimbursement far exceeds market rates. Scrutiny of incoming claims is often inadequate to reveal overpricing or oversupply. And providers are allowed to participate in the program without sufficient examination of their qualifications and their business and professional practices.

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## Above-Market Rates for Many Services Encourage Oversupply

Unlike the more prudent payers, Medicare pays substantially higher than market rates for many services. For example:

- The HHS Office of Inspector General reported in 1992 that Medicare paid \$144 to \$211 each for home blood glucose monitors when drug stores across the country sold them for under \$50 (or offered them free as a marketing ploy).<sup>1</sup> HCFA took nearly 3 years to reduce the price to \$59.
- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other surgical dressings. Medicare pays more than VA for each of the nine types of dressing purchased by both VA and Medicare. For all practical purposes,

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

HCFA is prohibited from adjusting the prices for these and similar supplies.<sup>2</sup>

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

HCFA contacts told us that resources are not available to routinely check market prices for items covered by Medicare. Yet excessive payment rates unnecessarily increase Medicare costs and can encourage an oversupply of services. Further, our work has shown how costly technology proliferates when HCFA does not review payment rates during the time that a technology matures, its procedures become more widely used, and providers' costs per procedure decline. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.<sup>3</sup> High Medicare payments for MRI scans supported a proliferation of MRI machines in some states. In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various covered benefits, such as overpriced procedures, selected durable medical equipment items, clinical lab tests, intraocular lenses, CT scans, and MRIS.

## Medicare Does Not Adequately Check Claims to Prevent Inappropriate Payments

Medicare's claims processing contractors employ a number of automated controls, some highly sophisticated, to prevent or remedy inappropriate payments.<sup>4</sup> Although these measures are effective in some instances, our work shows that improbable charges or unlikely payments sometimes escape the controls and go unquestioned.

For example, contractors who process Medicare claims for medical equipment and supplies do not necessarily review high-dollar claims for

<sup>2</sup>42 U.S.C. 1395m(i) required HCFA to establish a fee schedule for surgical dressings based on average historical charges. However, when the benefit was expanded to cover new categories of dressings, HCFA did not have data on the charges for these categories. HCFA used as a proxy the median price in supply catalogs. The median is necessarily higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule, nor can it adjust the schedule if retail prices decrease. While HCFA is authorized to increase payments annually based on the consumer price index, it lacks authority to reduce such payments.

<sup>3</sup>Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

<sup>4</sup>Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Other controls automatically deny claims or recalculate payment amounts. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

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newly covered surgical dressings.<sup>5</sup> One contractor paid \$23,000 when the appropriate payment was \$1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. The contractors' automated controls, however, did not flag either of these questionable billings.

In addition, Medicare controls to detect code manipulation, a type of billing abuse that affects all insurers, are limited. In congressional testimony in May 1995, we reported the results of our study of private sector computer software controls used to detect coding abuses.<sup>6</sup> We compared what Medicare actually paid providers against what would have been allowed by four commercial firms that market computerized systems to detect miscoded claims.<sup>7</sup> We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that, had Medicare used this commercial software, the government would have realized substantial savings.<sup>8</sup>

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## Medicare Does Not Adequately Screen Providers for Credibility

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

The following examples from our work and that of the HHS Inspector General show instances in which wrongdoers obtained Medicare provider numbers and billed the program extensively over the past several years:

- Five clinical labs (to which Medicare paid over \$15 million in 1992) have been under investigation since early 1993 for the alleged submission of

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<sup>5</sup>In March 1994, Medicare's surgical dressing benefit was greatly expanded to include various types and sizes of gauze pads not previously covered and to extend the duration of coverage to whatever is considered medically necessary.

<sup>6</sup>See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135), both issued May 5, 1995.

<sup>7</sup>Providers bill their charges to Medicare according to an official book of procedure codes. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit.

<sup>8</sup>HCFA reports that new controls over claims processing, instituted since 1993, are also likely to help Medicare avoid unnecessary costs.

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false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

- A therapy company added \$170,000 to its Medicare reimbursements over a 6-month period, while providing no additional services, by creating a "paper organization" with no space or employees. The company simply reorganized its nursing home and therapy businesses to allocate a large portion of its total administrative costs to Medicare.
- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

The conditions of program participation for Medicare providers range from stringent to minimal, according to the type of service or supply provided. For most provider categories, these conditions are established by statute.<sup>9</sup>

- For some professionals, such as physicians, state licensure is required. Licensing boards typically perform background checks on the applicant's medical education, disciplinary actions, and related information.<sup>10</sup> However, states are slow to take action to penalize health care providers that engage in abusive billing practices.
- Institutional providers (hospitals, clinics, home health agencies, rehabilitation agencies, and others) are surveyed and certified by state agencies as meeting Medicare requirements (and perhaps additional state conditions). However, unscrupulous institutions have found various ways to circumvent these precautions.
- Nonmedical providers, such as suppliers of medical equipment, have historically been subject to few such provisions. Even though HCFA has recently taken steps to improve the application process in this area, where the number of providers is growing rapidly, in some respects the requirements remain superficial. In 1993, a newly established National Supplier Clearinghouse began issuing supplier numbers to providers submitting claims for durable medical equipment, prosthetics, orthotics, and supplies. To apply for a supplier number, the provider must complete

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<sup>9</sup>While the Secretary of HHS may impose additional requirements—and has done so in some instances—these must relate directly to patients' health or safety. See, for example, 42 U.S.C. 1395x(e)(9) for hospitals and 1395x(o)(6) for home health agencies.

<sup>10</sup>This is done using sources such as the American Medical Association profile, kept on all licensed physicians; the Federation of State Medical Boards' data bank; and the National Practitioners Data Bank.



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a detailed application, but privacy concerns preclude the Clearinghouse from verifying the accuracy of social security and tax identification numbers required on the application. Also, the Clearinghouse does not routinely perform background checks on the owners or verify that supplier facilities really exist.

HCFA's Program Integrity Group is currently examining ways of limiting participation of suppliers and providers to those that appear to be legitimate business entities. Medicare contractors are currently piloting the use of commercial databases that compile information on the stability and business histories of providers and suppliers as one way of screening out those with high-risk potential.

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## Medicare's Response to Problems Too Slow to Be Effective

Whether because of strict constraints imposed by statute or because of its own burdensome regulatory and administrative procedures, HCFA is slow and often ineffectual in addressing problems involving overpricing, inadequate payment controls, or abusive providers.

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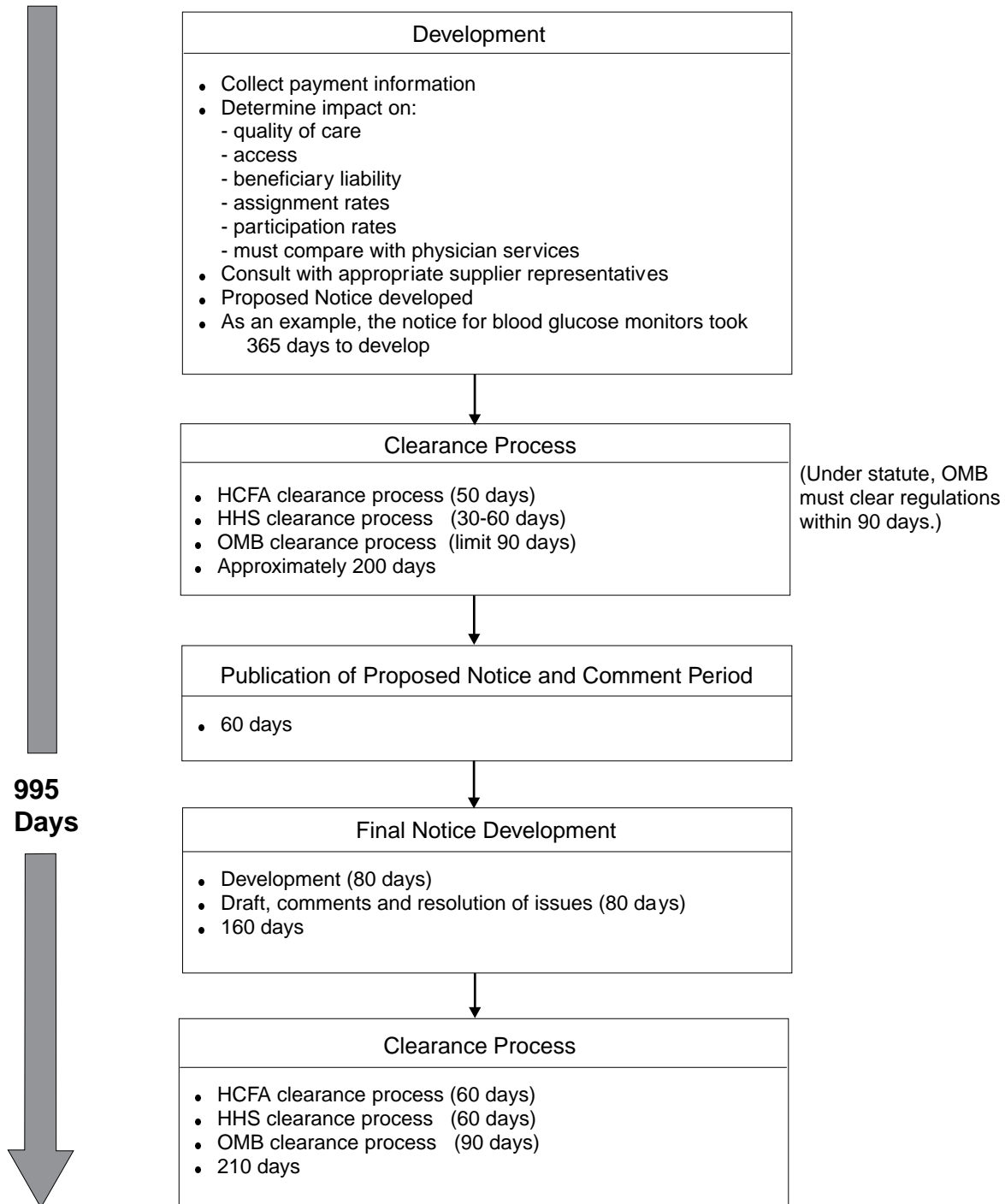
## Pricing Changes Slow or Unworkable

In a recent letter to a congressional subcommittee, the HHS Inspector General characterized as "absurd" the situation limiting HCFA's ability to make timely adjustments to payment levels.<sup>11</sup> The Inspector General's Office identified home glucose monitors (the item cited earlier as being sold for \$50 while Medicare paid up to 4 times as much) as an overpriced item in 1992. The final notice establishing special payment limits (about \$59) for this item was published in the Federal Register on January 1995. HCFA documented that the process required to lower the reimbursement for these monitors, under the agency's "inherent reasonableness" authority, took almost 3 years (see fig. 1). The Inspector General estimates that this delay cost Medicare \$10 million. Industry sources characterized this response as "speedy," noting that few suppliers commented on the proposed rule, thus allowing it to become final with little change.

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<sup>11</sup>Letter dated July 25, 1995, to the Chairman, Subcommittee on Oversight and Investigations, Committee on Commerce, House of Representatives.

**Figure 1: HCFA's Process for Using Inherent Reasonableness Authority**



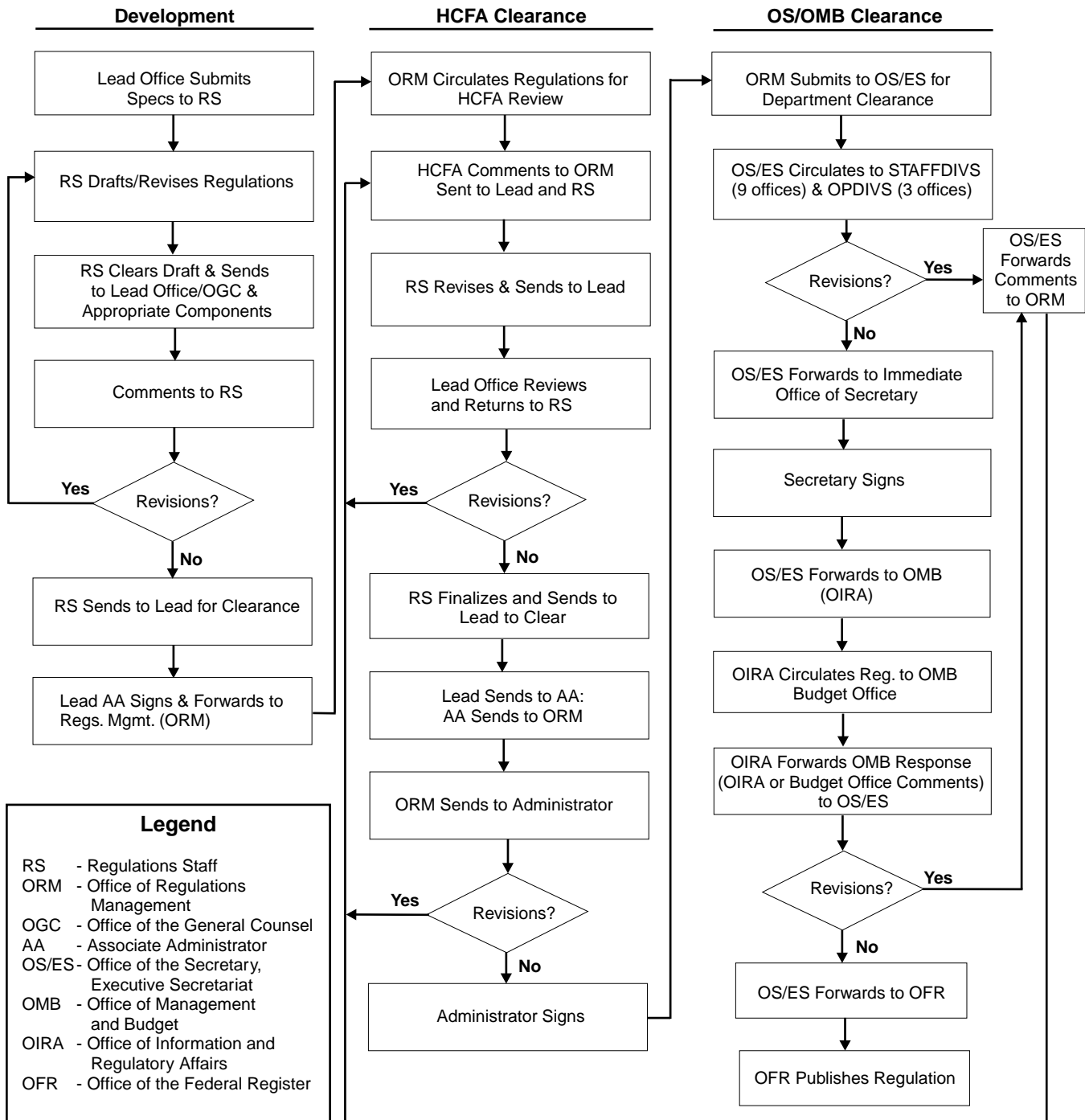
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Source: HCFA's Bureau of Policy Development.

HCFA began investigating a second overpriced item, oxygen equipment, in November 1994. The Inspector General estimates that, if Medicare were able to pay the same price for oxygen concentrators as that paid by the Department of Veterans Affairs, it could realize as much as \$4.2 billion over 5 years. As an immediate remedy, the Inspector General recommended a congressionally mandated reduction of 25 to 50 percent in Medicare's payment rates for oxygen services and equipment.

A HCFA official explained that HCFA lacked resources to deal with questions of reasonable pricing for more than one item at a time, though the agency would like to compare prices for about 80 of the supplies and services that are most costly overall. In December 1994, the Secretary of HHS announced an initiative to "dramatically shorten" the time it takes to issue final regulations to 24 months. The current regulatory process within HHS is shown in figure 2. HCFA has not yet developed its implementation plan under this initiative.

Figure 2: HCFA's Regulatory Process



(Figure notes on next page)

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Source: HCFA's Bureau of Policy Development.

We have stated repeatedly in congressional testimony that, in pricing services more competitively, Medicare should streamline the processes required to revise excessive payment rates. Consistent with this conclusion, the Inspector General states that HCFA “[...] should not have to spend valuable resources conducting studies and issuing formal rules just to adjust its payments to the going rate.” Possible remedies suggested by the Inspector General include allowing the HHS Secretary to set maximum prices on the basis of simple market surveys, or, if the formal rulemaking process is preserved, allowing the Secretary to make an interim adjustment in fees while the studies and rulemaking take place.

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## Resource and Automation Limitations Hinder Fraud and Abuse Detection Efforts

Despite HCFA's awareness of weaknesses in its controls over payment of claims—the program's chief administrative function—its enhancement of these controls is problematic. In the current fiscal environment, resources are particularly scarce. In addition, Medicare's existing computer systems and related software for processing and paying claims do not adequately detect Medicare billing abuses.

Effective monitoring and analysis of claims both before and after payment often demand the investment of time by qualified professionals.<sup>12</sup> For example, claims control activities carried out by Medicare's claims processing contractors include singling out individual claims for review in the course of automated checks and determining whether denial is appropriate. Payments may be delayed while claims undergo further review or attempts are made to recover previous overpayments. Contractor staff also conduct postpayment analyses to detect aberrant patterns of billing.

In recent years, contractor funding on a per claim basis has declined, as shown in table 1. As a consequence, contractors have had to shut off automated controls, or screens, that screen claims for coding errors and billing abuses. When running, the screens flag questionable claims that are suspended for further review. Several contractors short on qualified staff to review suspended claims therefore shut off some screens to avoid

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<sup>12</sup>Some controls, such as those included in the commercial software discussed earlier, deny or adjust claims payments “automatically,” that is, without human intervention. These controls, however, are not applicable to all claims.

accumulating a backlog of unpaid claims that would compromise their ability to meet prompt payment standards.

**Table 1: Per Claim Funding of Medicare Contractors for Selected Activities**

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

In the past, we have recommended augmenting anti-fraud-and-abuse activity funding by exempting Medicare's safeguard activities from the discretionary spending cap imposed by the Budget Enforcement Act of 1990. Although this proposal has its advocates, scorekeeping rules preclude the Congressional Budget Office from scoring the anticipated savings from enhanced safeguard activities as an offset to their cost. HHS has proposed a funding alternative that would entail the creation of a revolving trust fund for Medicare safeguard activities. At this time information on the HHS proposal is incomplete, making it too soon to determine the extent to which the revolving fund approach would produce scorable savings.<sup>13</sup>

In addition to funding declines, automation limitations impair Medicare's efforts to curb abuses. Improvements lie ahead in the form of the Medicare Transaction System (MTS), but this system is not scheduled to be fully implemented until September 1999. MTS is intended to replace the 10 existing automated systems used by contractors at 56 sites for processing and paying claims. With a single, integrated system, HCFA hopes to improve administrative efficiency, enhance its ability to manage contractors, and place greater emphasis on safeguarding program dollars. According to the HCFA Administrator, MTS will track all claims for each beneficiary and be able to identify suspicious activities.

We have recommended that, in the interim, HCFA take advantage of available off-the-shelf software. The agency is currently evaluating certain software packages to determine their potential utility for the Medicare program. HCFA officials said that they have to resolve three key issues: whether commercial system rules match or can be modified to match Medicare payment policies; to what extent commercial firms would be

<sup>13</sup>For a detailed discussion of alternatives for funding anti-fraud-and-abuse activities, see GAO/HEHS-95-263R (forthcoming).

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willing to disclose information about their systems in order to allow physicians and other interested parties to comment on Medicare policies; and what would be the cost and technical feasibility of installing the commercial software on existing contractor claims processing systems, especially in light of their pending replacement by MTS. On the basis of our discussions with commercial firms, we believe that these reservations can be resolved.

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## Penalties for Wrongdoing Unduly Delayed

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or having to repay fraudulently obtained money. Few cases are pursued as fraud. Even when they are, many are settled without conviction, penalties are often light, and providers frequently continue in business. These are characteristics of health care fraud (and of white-collar crime in general) and are not confined to Medicare. They are variously attributed to the complexity of cases, lack of resources, necessity for interagency coordination, and uncertainty of outcome. In recent testimony before this Subcommittee, the Special Counsel for Health Care Fraud at the Department of Justice noted that health care fraud cases are extremely resource-intensive and are among the most document-intensive of all white-collar crime.<sup>14</sup>

Ironically, incentives for certain providers to challenge HCFA's pursuit of wrongdoing are embedded in Medicare law. Under 42 U.S.C. 1395x(v), certain provider types, such as home health agencies and skilled nursing facilities, are able to sue HCFA and its contractors and have their legal expenses reimbursed by Medicare—even if the provider's suit is unsuccessful. In one case, Medicare allowed a home health agency under investigation for defrauding Medicare to receive reimbursement for legal expenses of nearly \$3 million. Contractor officials believe that there is a direct relationship between the home health agency's history of litigious behavior and Medicare's practice of reimbursing legal expenses in this manner.

## Case Development

Various entities are involved in the identification and pursuit of potentially fraudulent activities, including not only Medicare contractors and HHS but also law enforcement agencies at all levels. The lack of resources hampers investigations and leads to extended delays in case resolution. Our recent investigation of inappropriate therapy billings for Medicare beneficiaries

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<sup>14</sup>Statement of Gerald M. Stern, Special Counsel, Health Care Fraud, Department of Justice, concerning Medicare and Medicaid fraud and abuse, June 15, 1995.

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in nursing homes<sup>15</sup> traced one case from the initial beneficiary complaint through its close-out by the HHS Inspector General. This case took almost 3 years, and the resolution was inconclusive.

Pursuit of Medicare fraud typically involves Medicare's claims processing contractors and the HHS Inspector General's headquarters and regional offices. As the first line of defense, the contractors are the recipients of beneficiary complaints, a significant source of fraud case leads, and of referrals made by HCFA. Fraud units at each contractor site investigate leads and refer persuasive cases to the HHS Inspector General, whose regional and headquarters offices decide whether to become further involved and whether to seek civil or administrative sanctions.<sup>16</sup> The California region's Inspector General said that his region's practice is to seek civil monetary penalties only in those cases with significant potential for financial recovery in terms of both amount of fraud and collectibility. In 10 to 20 percent of cases a year, the provider declares bankruptcy or has no identifiable assets. The Inspector General does not—and cannot afford to—pursue those cases. We were told “this is a cash-based industry, and it is very hard to recover assets.”

Many fraud cases are negotiated among the various parties involved before going to trial to explore possible plea bargains. While the cases are developed at regional Inspector General offices, which are also empowered to negotiate lower-dollar cases (those with settlement values under \$100,000), they must still be reviewed and approved by headquarters, which has only three qualified and available negotiators for the entire country. Cases settled through such negotiation offer providers an opportunity to avoid being excluded from (prohibited from billing) Medicare. Ninety percent of cases judged by the Inspector General to have merit are settled through negotiation.

## Exclusion

The Secretary of HHS has the authority to exclude health care providers from Medicare for a number of reasons, and has delegated these authorities to the HHS Inspector General. Program exclusion is mandatory following convictions for Medicare or Medicaid program-related crimes or

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<sup>15</sup>Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

<sup>16</sup>The HHS Inspector General has no authority to pursue criminal action; this is the province of the Department of Justice, which can also initiate civil actions in federal court. In Medicare cases, Inspector General investigators provide the information on which the Department of Justice bases its decision. The Inspector General may also refer cases to local or state law enforcement agencies if the cases are declined by the Department of Justice.



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for patient abuse and neglect. Under other conditions, the Inspector General can exercise judgment as to whether exclusion is appropriate.

Despite egregious cases of Medicare fraud, however, corporate providers have been allowed to continue their program participation. In one of the more significant federal health care fraud prosecutions to date, a clinical laboratory company acknowledged over \$100 million in fraud committed as part of a nationwide scheme against Medicare, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)<sup>17</sup> over a 4-year period. The lab was allowed to negotiate a civil settlement including language that specifically permitted its continued participation in all three programs.

According to the Inspector General, very few companies or other entities are excluded from the program: over the past 10 years, 90 percent of the exclusions have targeted individuals. In fiscal year 1994, there were 1,265 exclusions, of which 471 were mandatory and 794 permissive. However, almost one-half (566) were for failure to repay student loans; only 289 were for Medicare-related convictions.

The dissemination of excluded provider information is not always prompt, despite recent improvements in the process of notifying contractors and other affected parties. California's Regional Inspector General for Investigations also told us that providers who continue to bill after exclusion are not always caught right away. Nor is exclusion necessarily effective—providers who move from state to state or who use more than one provider number may continue to obtain Medicare reimbursement.

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

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<sup>17</sup>CHAMPUS is a federal medical program for military dependents and retirees that pays for care received from civilian hospitals, physicians, and other providers.

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**Private Payer  
Management  
Strategies Are Not  
Generally Used by  
Medicare**

Medicare does not use (or in some cases use widely enough) private sector strategies to manage three of the factors that attract unscrupulous providers—excessive payment rates, inadequate safeguards over billing, and ineffective controls over providers. For example, private insurers and managed care organizations commonly use pricing strategies that take advantage of their buying power and of the competitive marketplace. These private payers also employ a range of techniques focusing on utilization: they examine tests and procedures for their appropriateness and their volume, and they screen providers for their practice styles and quality of care. Some price and utilization strategies that could have applicability to Medicare are detailed in table 2.

**Table 2: Commonly Used Private Sector Strategies and Applicability to Medicare**

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

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

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

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

<sup>d</sup>42 U.S.C. 1395f establishes conditions of and limitations on payment for services.

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

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

<sup>g</sup>42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances.

<sup>h</sup>42 U.S.C. 1395.

<sup>i</sup>42 U.S.C. 1395.

<sup>j</sup>These companies may arrange for utilization review to be done under subcontract.

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

## Several Factors Limit HCFA's Flexibility to Adopt Private Sector Strategies

Three principles on which Medicare was founded—as interpreted by HCFA, providers, the courts, and the Congress—help explain why Medicare practices and private payer management strategies are dissimilar:

- First, the government must not interfere in medical practice.<sup>18</sup> Medicare legislation essentially delegated many day-to-day administrative decisions to private insurers to further lessen the risk of undue federal interference and to better ensure that Medicare would treat its beneficiaries no differently than the privately insured.<sup>19</sup> The functions delegated include establishing policies to determine when services provided are medically necessary—and today most such “medical policies” are still established by Medicare’s private contractors.

<sup>18</sup>42 U.S.C. 1395.

<sup>19</sup>42 U.S.C. 1395h provides authority and detailed instructions for HCFA to contract with such entities to handle part A claims, while 42 U.S.C. 1395u provides similar guidance related to part B.

- Second, Medicare beneficiaries should be free to choose their own health care providers.<sup>20</sup> However, many of the private sector innovations credited with cost savings rely on managed care approaches that structure and constrain that choice. Staff- and group-model health maintenance organizations (HMO) explicitly restrict a patient's choice of health care providers (for example, to a set of plan-approved physicians and hospitals), while looser forms of managed care, such as preferred provider networks, give financial disincentives to the patient who chooses providers outside the plan-approved list. Although Medicare offers an HMO option to beneficiaries, HCFA has only limited statutory authority to pursue other managed care options.<sup>21</sup>
- Third, as a public program, Medicare changes require public input and hence can be cumbersome and time-consuming. Past experience suggests that changes made by HCFA will typically be contested. Given the high stakes for providers, legal challenges are apt to be pursued vigorously by those who fear that program changes would result in their receiving lower payments. Although the ultimate outcome is always uncertain, litigation—whatever the outcome—can take years to resolve.<sup>22</sup> Consequently, in considering cost-saving initiatives, HCFA must weigh the resulting expense and disruption as well as the risk of ultimate failure against anticipated savings. These circumstances may foster HCFA's reluctance to act without specific statutory authority.<sup>23</sup>

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<sup>20</sup>42 U.S.C. 1395a, the so-called freedom-of-choice provision, expressly provides that beneficiaries may obtain health services from any willing provider.

<sup>21</sup>42 U.S.C. 1395mm authorizes HCFA to contract with certain managed care entities to provide care to Medicare beneficiaries under prescribed circumstances. Our analysis suggests, however, that under the current statutory prescriptions this has not harnessed the cost-saving potential of managed care. See our recent testimony, Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-94-174, May 24, 1995).

<sup>22</sup>For example, HCFA has in recent years made a more diligent effort to recover payments made mistakenly when other private insurers would have paid for a medical service. In 1989, the Congress permitted HCFA to begin performing a data match with the Internal Revenue Service to help identify such mistaken payments, with the result that millions have been recovered and millions more were expected to be recovered. This effort was dealt a serious blow, however, when a federal court ruled in 1994 that HCFA is bound by the claims filing deadlines set by private insurers and may not recover from third-party administrators who handle claims processing for private insurers (Health Ins. Ass'n of America, Inc. v. Shalala, 23 F.3d 412 (D.C. Cir. 1994), cert. denied, 115 S.Ct. 1095 (1995)). As a result, HCFA may be unable to recover millions in mistaken payments and may have to repay some funds previously recovered. See our testimony on this subject, Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

<sup>23</sup>The courts are not the only forum where those questioning HCFA's exercise of its Medicare responsibilities might seek redress. In 1985, HCFA started the process to perform a demonstration of competitive bidding for laboratory services, and it was set to begin in 1987. That year and for several subsequent years, however, provisions were included in the respective budget reconciliation acts prohibiting its implementation. Eventually, HCFA abandoned plans for the demonstration, but has since requested authority to introduce competitive bidding without success.

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These principles were consistent with the predominantly fee-for-service and unmanaged method by which health care was delivered and paid for three decades ago. Today, however, HCFA's capabilities to manage Medicare are misaligned with the state of the art in health care delivery and financing. For example, HCFA and its contractors generally do not

- negotiate with providers for discounts; promptly change prices to match those available in the market; or competitively bid prices for widely used items or services, such as pacemakers, intraocular lenses, cataract surgery, and wheelchairs. This has resulted in Medicare paying higher prices than other large payers. The HHS Inspector General estimates that the use of competitive bidding to price laboratory services, for example, could save \$1.4 billion over 5 years.<sup>24</sup>
- differentiate between providers who meet utilization, price, and quality standards and those who do not, and provide incentives to encourage beneficiaries to use the "preferred providers." This has hampered Medicare's ability to encourage beneficiaries to use providers meeting certain standards.
- use preadmission review or other utilization control practices to curb the excessive or unnecessary provision of expensive procedures, or use case management to coordinate and monitor high-cost patients' multiple services and specialists. This has limited Medicare's ability to emphasize cost efficiency in its dealings with those suppliers, physicians, and institutions that habitually provide excessive services.

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## Conclusions

Billions of Medicare dollars are spent on unnecessary payments. Despite the current competitive health care market, Medicare often pays more than the market price for medical services and supplies. In addition, Medicare does not use available state-of-the art technology to screen claims for overcharging or overutilization, even though payment of claims for services provided constitutes the program's chief administrative function. Finally, while the number of nonmedical providers billing for services and supplies is on the rise, Medicare does little to scrutinize the legitimacy of these providers.

Constrained by statute, burdened by regulatory and administrative procedures, or reluctant to engage in expensive litigation with an uncertain outcome, Medicare's response to problems is generally too slow

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<sup>24</sup>For further discussion of competitive bidding and negotiation strategies, see *Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems* (GAO/T-HEHS-95-174, May 24, 1995).

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to be effective. Pricing changes are slow or infeasible and penalties for wrongdoers are weakened through delay. In addition, grim fiscal realities dampen the prospect of HCFA's ability to enhance payment controls. Because Medicare's anti-fraud-and-abuse efforts are funded out of the government's discretionary appropriations, funding must compete with funding for other programs under the discretionary caps.

The problems facing Medicare confront private insurers as well, but they are armed with a larger and more versatile arsenal of health care management strategies than HCFA currently has. These strategies may not be deployable in every aspect, but in general they offer a menu of options for devising ways to make Medicare more cost effective. Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care approaches and use state-of-the-art technology in their capacity as private insurers. If they applied similar approaches to Medicare, the government might be able to avoid spending substantial sums unnecessarily. A more businesslike approach for Medicare would include the following features:

1. The ability to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates, and competitively bidding and negotiating prices.
2. The enhancement of fraud and abuse detection efforts through better data analysis. This could include completing the modernization of Medicare's claims processing and information systems and expanding the use of state-of-the-art computerized controls.
3. Requirements for providers to demonstrate their suitability as Medicare vendors before being given unrestricted billing rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to provide accreditation or certification.

In general, HCFA has been reluctant to adopt private sector business practices because its authority to do so is, in some cases, questionable. We believe that, to redefine its role as prudent manager of health care costs, HCFA would need to develop a plan specifying pricing and cost management strategies and would need to seek explicit authority from the Congress to carry out such strategies.

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## Recommendations

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

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

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## Matters for Congressional Consideration

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

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

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## Agency Comments

We provided HHS an opportunity to comment on our draft report, but it did not provide comments in time to be included in the final report.



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Please call Jonathan Ratner, Associate Director, at (202) 512-7107, if you or your staff have any questions about this report. Other major contributors include Audrey Clayton, Hannah Fein, Edwin Stropko, and Craig Winslow.

Sincerely yours,

A handwritten signature in cursive script that reads "Janet L. Shikles".

Janet L. Shikles  
Assistant Comptroller General

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# Related GAO Products

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

Medicare: Rapid Spending Growth Calls for More Prudent Purchasing (GAO/T-HEHS-95-193, June 28, 1995)

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995). Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995). Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995). Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

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

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

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

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

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

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

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