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# MEDICARE

## Modern Management Strategies Needed to Curb Program Exploitation

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss ways for Medicare to avoid spending billions of dollars in unnecessary payments. As we testified before this Subcommittee in March and have documented in numerous reports and other congressional testimony, Medicare sustains billions of dollars in losses to waste, fraud, and abuse. (See app. I for a list of related GAO products.)

Today this Subcommittee is exploring the legal and administrative enforcement tools available to Medicare to punish those providers who defraud or abuse the program, the beneficiary, and the taxpayer. While strengthening enforcement is critical, our work focuses on an equally vital but earlier phase of fraud fighting--identifying the program's vulnerabilities and the measures needed to curb losses. Therefore, you asked us to examine, using our findings on waste, fraud, and abuse, the weaknesses responsible for Medicare's vulnerability to provider exploitation and ways to remedy these weaknesses.

In brief, Medicare's vulnerability stems from a combination of factors: (1) higher than market rates for certain services, (2) inadequate checks for detecting fraud and abuse, (3) superficial criteria for confirming the authenticity of providers billing the program, and (4) weak enforcement efforts. Various health care management techniques help private payers alleviate these problems, but these techniques 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 entail (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.

#### 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-services 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. The Health Care Financing Administration (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 statute, regulation, or agency policy.

HCFA contracts with about 73 private companies--such as Blue Cross and Aetna--to handle claims screening and processing, and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. 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.

ABOVE-MARKET RATES FOR MANY SERVICES ENCOURAGE OVERSUPPLY

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 for 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

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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.

dressings. Medicare pays more than VA for each of the nine types of dressing purchased by both VA and Medicare. For all practical purposes, 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.

Such excessive payment rates can encourage an oversupply of services and thus foster a climate ripe for abuse.<sup>3</sup> Our work has shown that Medicare's excessive payment rates for certain services have supported the proliferation of costly technology.

Magnetic resonance imaging (MRI) equipment is a case in point. As we reported in 1992,<sup>4</sup> high Medicare payments for MRI scans supported a proliferation of MRI machines in some states. The problem is that, once a new medical procedure is approved for coverage, HCFA does not systematically review payment rates as technologies mature and become more widely used, and as providers' costs per service decline. In the absence of systematic adjustment, the Congress has had to act legislatively, reducing rates for various covered benefits, such as overpriced procedures, selected durable medical equipment items, clinical lab tests, intraocular lenses, MRIs, and CT scans.

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<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, because the benefit was expanded, HCFA did not have such data. Instead, it used a gap-filling process based on the median price in supply catalogs. This 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>The HHS Inspector General is authorized (under 42 U.S.C. 1320a-7(b)(6)) to exclude from Medicare any providers charging Medicare in excess of their usual charges without good cause. However, no regulations to implement this provision have been developed, and the authority has never been used.

<sup>4</sup>Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

EVIDENCE OF ABUSIVE BILLING  
INDICATES MEDICARE'S CHECKS  
ON PAYMENTS ARE NOT ADEQUATE

Medicare's claims processing contractors employ three basic electronic controls to detect waste, fraud, and abuse. Some are programmed into claims processing software and are designed to spot filing errors. For example, if a provider's billing number or beneficiary identification number is incomplete or otherwise manifestly incorrect, the computer automatically holds the claim until the data are corrected. Other 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. A third kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

However, our work shows that improbable charges or unlikely payments often escape the controls and go unquestioned. For example, none of the contractors who process claims for medical equipment and supplies automatically reviews high-dollar claims for newly covered surgical dressings.<sup>5</sup> In consequence, one such 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. Neither of these abuses came to light through a systematic examination of claims data.

In congressional testimony earlier this year, we reported the results of our study on private sector technology--computer software controls--used to detect certain billing abuses.<sup>6</sup> We compared what Medicare actually paid providers against what would have been paid by four commercial firms that market computerized systems to detect miscoded claims.<sup>7</sup> We invited each firm to

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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. For example, a comprehensive code covers the fee for removing a ruptured appendix, which includes making the incision to reach the

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 saved \$3 billion over 5 years by detecting these billing abuses.

INSTANCES OF BILLING SCAMS SUGGEST  
MEDICARE'S CHECKS OF PROVIDER  
BUSINESSES ARE SUPERFICIAL

Our studies and those of the HHS Inspector General have found that unscrupulous individuals or companies can be authorized to bill Medicare even if they do not qualify as legitimate providers. This puts them in a position---from within Medicare--to deploy fraudulent or abusive billing schemes. 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 show instances in which such providers obtained Medicare provider numbers and billed the program extensively over the past several years:

- Five clinical labs (that Medicare paid over \$15 million in 1992) have been under investigation since early 1993 for the alleged submission of 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 wheelchair van service obtained a Medicare provider number as an ambulance service. The provider was not licensed by the state as an ambulance service, nor did the provider have the equipment required by Medicare to qualify as an ambulance service. Over 16 months, on behalf of just one beneficiary, the van service billed Medicare \$62,000 for 240 ambulance trips--about 1 trip every 2 days at nearly \$260 per trip.
- 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 so that a large portion of its total administrative costs could be allocated to Medicare.

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appendix and closing the wound. A physician could miscode the claim by including three separate codes--one for making the incision, one for closing the wound, and the correct one--the comprehensive code covering removal of the appendix.

-- 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>8</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>9</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, etc.) are surveyed and certified by state agencies as meeting Medicare requirements (and perhaps additional state conditions). However, as our cited cases illustrate, there are many ways in which these precautions prove inadequate.
- 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, in some respects the requirements remain superficial. The National Supplier Clearinghouse was created to issue supplier numbers to providers desiring to submit claims for durable medical equipment, prosthetics, orthotics, and supplies. To apply for a supplier number, the provider must complete a detailed application. Because of privacy concerns, however, the clearinghouse cannot verify the accuracy of two important

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<sup>8</sup>While the Secretary 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>9</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.



items on these applications--social security and tax identification numbers. Also, the clearinghouse does not routinely perform background checks on the owners or verify that supplier facilities really exist.

EFFORTS TO PENALIZE WRONGDOERS  
LARGELY INEFFECTUAL AS DETERRENTS

Currently, providers who defraud or otherwise abuse health care payers have little chance of being prosecuted or having to repay fraudulently obtained money. Although legal and administrative enforcement tools are available to Medicare,<sup>10</sup> few cases are pursued. 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.

Our review of Medicaid prescription drug fraud cases illustrates problems that are typical of health care fraud prosecution--the consequences for the convicted wrongdoer are often nominal. We found that few providers went to prison, and few had their licenses suspended or revoked. In many cases, convicted individuals or organizations resurfaced as health care providers serving Medicaid patients. In more than half the cases reviewed, assessed restitution amounts were \$5,000 or less. In one instance where a provider was assessed \$220,000 for restitution, Medicaid recovered only \$4,000. In a New York case in which only \$50,000 of a \$300,000 assessment was collected, eventual repayment of the remainder was contingent upon the owner's success in selling his pharmacy and the building that houses it. Opportunities exist for convicted owners to avoid repayment by various actions, including hiding assets under other names, transferring funds overseas, or declaring bankruptcy.<sup>11</sup>

Moreover, our reviews in Medicare have shown that often suspicious providers either are not or cannot be adequately pursued. We have found the following:

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<sup>10</sup>For example, 42 U.S.C. 1320a-7, 1320a-7a, and 1320a-7b authorize exclusion from Medicare, civil monetary, and criminal penalties, respectively.

<sup>11</sup>Medicare and Medicaid overpayments once had priority in bankruptcy cases, but this was eliminated by the Bankruptcy Reform Act of 1978 (P.L. 95-598). The HHS Office of Inspector General, in a May 1992 report, recommended that HCFA propose a legislative change to restore this priority.

- In some cases providers are asked to repay only nominal amounts of the estimated overpayments made by Medicare. To illustrate, a psychiatrist who in 1993 received about \$440,000 in Medicare payments was submitting questionable bills. The Medicare contractor selected 15 of the psychiatrist's patients as a sample, reviewed their claims, and found that 75 percent were overstated (a total of about \$5,700) due to miscoding or misrepresentation. Rather than project the overpayment amount to estimate and recoup Medicare's total loss, the contractor requested recoupment of only the \$5,700, sent the psychiatrist an educational letter,<sup>12</sup> and closed the case.
- In many cases providers submitting improbable claims are not reviewed. For example, in an ongoing assignment, we asked the Medicare contractor to obtain and review the medical records supporting 85 high-dollar medical supply claims. These included supply claims for a month in excess of \$17,000 for some patients. In 45 percent of the cases (totaling almost \$500,000), the providers did not submit the supporting medical records and had the claims denied. The contractor does not routinely follow up in cases where a provider does not submit requested documentation to ascertain why and whether documentation is available for the provider's other claims.
- In some instances, technicalities preclude holding any individual or entity responsible for large, documented losses. Medicare contractors, for example, lack authority to assess overpayments using claims for care that physicians order from suppliers or laboratories. In one case, a contractor could not collect a \$123,000 overpayment assessed from a laboratory affiliated with a scheme that defrauded Medicare. An administrative law judge ruled that, since the laboratory acted on physicians' orders, the laboratory could not be held liable for the costs billed.

PRIVATE SECTOR MANAGEMENT TECHNIQUES  
SUGGEST WAYS TO REMEDY PROGRAM WEAKNESSES

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

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<sup>12</sup>Educational letters are sent by claims processing contractors to notify providers of billing errors. HCFA--seeking to maintain a good relationship with the physician community and to limit provider hassle--emphasizes education as an appropriate tool to get providers to bill correctly the first time.

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 1.

**Table 1: Commonly Used Private Sector Techniques and Applicability to Medicare**

<b>Private sector technique</b>	<b>Description</b>	<b>HCFA's current practice</b>	<b>HCFA explanation</b>
<b>Prompt reaction to market prices</b>	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 completing a complex administrative process <sup>b</sup>
<b>Negotiate with select providers</b>	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>
<b>Competitive bidding and negotiations</b>	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 specifically prohibits proposed demonstration <sup>e</sup>
<b>Preferred provider network</b>	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>
<b>Preadmission review</b>	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>
<b>Case management</b>	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>
<b>Contract with utilization review companies</b>	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>

<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.

For the most part, the pricing and utilization and quality control mechanisms used in the private sector are not available to Medicare, constraining HCFA and its contractors from adopting similar measures.<sup>13</sup> For example, HCFA is generally unable to

- 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. (We elaborated on competitive bidding and negotiation strategies in congressional testimony last month.<sup>14</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 Medicare's 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.

#### FACTORS LIMITING HCFA'S FLEXIBILITY

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 techniques are dissimilar:

- First, the government must not interfere in medical practice.<sup>15</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

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<sup>13</sup>42 U.S.C. 1395b-1 provides detailed authorization for experiments and demonstration projects related to incentives for economy while maintaining or improving quality in the provision of health care, but HCFA has found it of limited value.

<sup>14</sup>Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

<sup>15</sup>42 U.S.C. 1395.

differently than the privately insured.<sup>16</sup> The functions delegated include establishing policies on when claims for services are medically necessary--and today most such "medical policies" are still established by Medicare's private contractors.

- Second, Medicare beneficiaries should be free to choose their own health care providers.<sup>17</sup> However, many of the private sector innovations credited with cost savings rely on managed care techniques that structure and constrain that choice. Staff- and group-model health maintenance organizations (HMO) explicitly restrict a patient's choice of health care providers (e.g., 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>18</sup>
- Third, as a public program, Medicare changes require public input and are difficult to make without consensus. 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>19</sup>

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<sup>16</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.

<sup>17</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>18</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>19</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

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 foster HCFA's reluctance to act without specific statutory authority.<sup>20</sup>

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.

### CONCLUSIONS

In conclusion, Medicare's vulnerability to exploitation can be summarized as follows:

- Despite the current competitive health care market, Medicare often pays more than the market price for medical services and supplies.
- Although payment of claims for services provided constitutes the program's chief administrative function, Medicare does not use available state-of-the art technology to screen claims for overcharging or overutilization.
- Despite the increase in nonmedical providers billing for services and supplies, Medicare does little to scrutinize the legitimacy of providers billing the program.

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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>20</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.



-- Despite the availability of legal and administrative enforcement tools, few wrongdoers are convicted or otherwise penalized.

The problems facing Medicare confront private insurers as well, but they are armed with a larger and more versatile arsenal of health care management techniques than HCFA currently has. These techniques may not be wholly applicable to Medicare, 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 techniques and use state-of-the-art technology in their capacity as private insurers. If they were able to apply these techniques to Medicare, the program's weaknesses could be significantly remedied.

Given Medicare's vulnerabilities, a more modern approach tailored to the program would adopt the following three strategies:

1. Allow Medicare 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. Enhance Medicare's antifraud and abuse efforts. 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. Require providers to demonstrate their suitability as a Medicare vendor 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.

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

For more information on this testimony, please call Edwin P. Stropko, Assistant Director, at (202) 512-7108. Other major contributors included Audrey Clayton, Hannah Fein, Valerie Miller, and Craig Winslow.

RELATED GAO PRODUCTS

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/HEHS/T-95-157, May 16, 1995).

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.

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).

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

High-Risk Series: Medicare Claims (GAO/HR-93-6, Dec. 1992).

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