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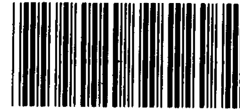

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# MEDICARE

# Contractor Oversight and Funding Need Improvement

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## SUMMARY

Like other insurers, Medicare is vulnerable to serious financial losses through exploitation by unscrupulous providers, through erroneous program payments, and through excessive reimbursement rates. Given the magnitude and growth of Medicare spending, it is increasingly important that those who administer the program--the Health Care Financing Administration (HCFA) and its contractors--assure that current expenditures are accurate and appropriate.

Medicare's administrative network, consisting of over 80 contractors, facilitates the handling of local needs and differences. This has led to significant variations in administrative practices among contractors, which presents HCFA with a management challenge. When providing direction to its contractors, HCFA must maintain a balance between, on the one hand, developing national program policies and operations that protect program funds, and on the other, preserving the autonomy of contractors to run their own operations and that of providers to make decisions about rendering medical services.

GAO's work in recent years suggests that HCFA may need to exercise more active oversight over its contractors. For example, investigations into allegations of fraud and abuse and recovery of mistaken payments have not been adequate. In addition, certain contractors' lax controls over provider billing numbers have made it more difficult to detect fraudulent entrepreneurs that bill Medicare for millions of dollars in phony or unnecessary diagnostic tests. HCFA's limited oversight of payment methods for emerging technologies has resulted in high payment rates that contributed to the excessive proliferation of expensive equipment in some localities.

These problems have occurred at the same time that funding for Medicare's program safeguards has not kept pace with the growth in claims volume. Stable and adequate funding is required to assure contractors of the government's commitment to improve safeguard activities. Otherwise contractors have little incentive to perform these resource-intensive activities--from investigating beneficiary complaints to reducing backlogs of identified overpayments--on their own initiative. Consequently, GAO continues to support modifying the budget process to better enable appropriate funding for Medicare program administration.

In addition, GAO believes that HCFA must take a more active stance to hold contractors accountable for their performance in program administration. To monitor and direct contractor actions, HCFA may need to develop better information systems, more focused performance measures, and stronger contractor guidance.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here to discuss the challenges that the Medicare program faces in assuring that payments to medical providers are timely and accurate while minimizing the loss of funds through fraud, waste, and abuse. These challenges are hardly unique to Medicare: similar challenges face all health insurers.

Actions taken to combat Medicare fraud and abuse are known collectively as payment safeguard activities. Medicare generally devotes more resources to safeguard activities than do private sector companies. But several GAO studies over the past few years have shown that Medicare actions are still inadequate.

We released a report 2 weeks ago in which we discussed the enormous cost the nation incurs as a result of health insurance fraud and abuse.[1] Nobody knows for sure how much is lost, but many believe fraud and abuse account for some 10 percent of all health care spending. In that report we called for a national commission to develop remedies, in part because of the inability of thousands of individual insurers to successfully address fraud and abuse independently.

A major impediment to detecting fraud and abuse in health care payments is the complexity of the health insurance system. Over 1,000 payers process 4 billion claims annually to pay hundreds of thousands of providers. Medicare itself expects to process 600 million claims for about 34 million beneficiaries. In the current health insurance environment, profiteers are able to stay ahead of those who pay claims for several reasons. These include the (1) independent operations of the various health insurers that limit collaborative efforts to confront fraudulent providers, (2) growing financial ties between health care facilities and the practitioners who control referrals to those facilities, and (3) costs associated with legal and administrative remedies to fraud and abuse. Finally, an insurer's efforts against unscrupulous providers can result in scams being shifted to other insurers.

Medicare not only is subject to many of the problems common to all payers, but also faces a challenge attributable to its complex administrative structure. The Health Care Financing Administration (HCFA), which oversees the program, operates through numerous contractors responsible for the daily tasks of claims processing and administration. This administrative network facilitates the handling of local needs and differences, but it can and has led to significant variations in administrative practices and payment policies among geographic areas. Finding the appropriate level of national uniformity while leaving enough discretion to handle local differences and foster innovative approaches to address fraud, waste, and abuse is a significant difficulty facing HCFA.

## SPECIAL CHALLENGES FACING MEDICARE MANAGERS

In 1965, when the Medicare program was enacted, the law called for insurance companies--private insurers and Blue Cross and Blue Shield plans--to process and pay claims. This arrangement was pragmatic in that insurance companies had both claims-processing experience and an understanding of the medical practices of their communities. As a result, contractors were given considerable discretion in setting and implementing payment and safeguard policies. Much of this latitude is retained to this day.

The efficient management of the Medicare program therefore depends on how well the contractors perform their jobs and in turn on how well HCFA oversees contractor performance. This administrative arrangement has its advantages and its disadvantages. One advantage is that contractors have the flexibility to develop effective claims-processing systems and medical review policies supported by aggressive payment safeguard activities. A disadvantage is that HCFA's ability to manage a consistent, national program is limited by the variation in contractors' interpretation of Medicare rules and regulations. In providing direction to its contractors, HCFA must maintain a balance between, on the one hand, developing national program policies and operations that protect program funds, and on the other, preserving the autonomy of contractors to run their own operations and that of providers to make decisions about rendering medical services.

HCFA has sought to maintain this balance by gradually moving toward fewer contractors over the years and by adopting more uniform data-processing systems that should permit greater uniformity in contractor payment-processing and safeguard activities. This will also facilitate more rapid and consistent implementation of HCFA contractor directives and other program changes.

Despite these initiatives, we and others have identified recent problems in program operations. These suggest that HCFA may need to increase oversight of its contractors and that, working together with the Congress, HCFA needs to seek to attain adequate and stable funding for program safeguard activities.

## PROGRAM WEAKNESSES SUGGEST NEED FOR STRONGER HCFA OVERSIGHT ROLE

Let me cite some of the problems we have identified in our audit work that illustrate oversight weaknesses. These include investigation of fraud and abuse allegations, recovery of hospital overpayments, control over who can bill the program, and payment methods for emerging technologies.

## Contractors' Complaint Investigations and Overpayment Recovery Efforts

We recently reported on two areas where limited HCFA oversight of Medicare contractors contributed to a breakdown in program protections. The areas involved the investigation and referral of beneficiary complaints and the recovery of overpayments to hospitals. We found that contractors did not adequately investigate beneficiary complaints or recover credit balances owed to Medicare and that HCFA's contractor monitoring systems did not identify these performance problems.

HCFA provided virtually no program guidance to Medicare contractors regarding the investigation of beneficiary complaints--a primary source of fraud, waste, and abuse leads. In fiscal year 1990, Medicare contractors reported receiving about 18 million calls from program beneficiaries. A small but significant portion of the complaints we monitored at five contractors were allegations of fraud and abuse. Half the beneficiary complaints alleging fraud and abuse were not referred to carrier investigative staff. Moreover, many complaints that were properly referred were not adequately investigated.[2]

Carriers' failure to adequately investigate beneficiary complaints of provider fraud and abuse can result in missed opportunities to recover overpayments, impose penalties, and send a message to the provider community that fraudulent or abusive behavior will not be tolerated. The potential of effective investigation and referral is illustrated by one case in which a provider was initially pursued for billing irregularities for eye care services because of beneficiary complaints. Upon further investigation of over 100 apparently similar complaints, about 300 fraudulent claims were detected. The provider involved agreed to refund over $2.5 million to the federal government.

We also found that HCFA was not giving adequate program guidance to contractors regarding the recovery of hospital overpayments.[3] The refundable amounts, referred to by hospitals as credit balances, typically occurred both when Medicare and other insurers mistakenly paid for the same service or when Medicare paid twice for the same service. Many of the hospitals' credit balances had been outstanding for several years, despite attempts by some to repay the money. The contractors we visited were doing little to identify amounts owed Medicare or to assure that refunds were promptly recovered. In response to a special HCFA survey of providers, over 9,000 Medicare hospitals and other providers reported $171.7 million in overpayments, of which $84.2 million had been repaid as of March 1992. HCFA plans to implement a reporting and tracking system to monitor such overpayments and assure they are promptly recovered.

Controls Over Who Can Bill Medicare

The absence of a strong HCFA role has also contributed to contractors' weak controls over who can bill the program, how to issue and when to retract provider numbers, and when to update information on providers. Under the procedures of many contractors, providers applying for billing numbers receive little scrutiny of their qualifications or their ownership or investment relationships. For certain provider types, contractors have difficulty identifying whether an applicant has been previously disciplined by the program, has existing Medicare debts, or has the financial wherewithal to maintain solvent business operations. In addition, a single provider can obtain multiple numbers. The Department of Health and Human Services (HHS) Office of the Inspector General reports that many Medicare contractors cannot identify or deactivate numbers for providers who have lost the legal authority to practice.[4] HCFA has proposed regulations and guidance to obtain ownership information, establish minimum standards for some suppliers, and improve contractor control over provider numbers.

We will soon report on how limited controls over provider numbers were an integral part of a multimillion-dollar fraud scheme involving mobile physiology labs.[5] The fraudulent billings were masked behind at least 30 different corporate names and Medicare provider numbers. The multiple numbers greatly complicated carriers' efforts to detect suspiciously high volumes of tests. In 1987 Medicare successfully prosecuted laboratory operators involved in the scheme, and one owner was imprisoned. However, Medicare's efforts to recover overpayments to providers affiliated with the scheme have not been successful, and at least $5 million has not been recovered.

Payment Methods for Emerging Technologies

Establishing payment methods for emerging technologies is another area where HFCA oversight needs improvement. Medicare's reimbursement for magnetic resonance imaging (MRI) is a case in point. HCFA established only broad guidelines for setting payments for MRI services when these were first covered in 1985. As a result, the carriers established a wide range of MRI reimbursement rates. In some localities, Medicare's payments for MRI did not reflect the lower costs per scan that efficiency and economies of scale have achieved. In these locations, Medicare's payment rates encouraged a proliferation of machines because they even permitted providers with high-cost, low-volume machines to profit from scans charged to the program. Despite recent changes in standardizing Medicare's payment for MRI services, HCFA did not fully adjust such payments to reflect declining costs.

Essentially, Medicare payment rates for new technologies are not systematically adjusted as the technology matures and unit

costs decline. Failing to make such adjustments results in unnecessarily high Medicare payments and encourages an oversupply of the equipment because profits can be earned at inefficient levels of operation.[6]

BUDGET CUTS UNDERMINE ACTIVITIES TO PREVENT FRAUD, WASTE, AND ABUSE

Many of the problems we have discussed above may be attributable to budget cutbacks that have affected program administration. Though Medicare's payment safeguard activities are cost-effective--returning nearly $11 for every dollar spent in 1989--contractor budgets to perform these functions were cut from 1989 through 1992. During this period claims volume rose by about 40 percent; however, Medicare cut its contractors' funding for payment safeguards by $15 million.

Cuts in payment safeguard areas translate into increased program losses from fraud, waste, and abuse. The largest portion of contractor safeguard funding pays for staff who perform claims reviews, investigate providers suspected of fraud or abuse, and conduct financial audits of institutions to assure the accuracy of Medicare cost-based payments. Thus, if claims volume increases while the numbers of safeguard staff remain constant or decline, contractors review a lower percentage of claims.

Funding reductions have resulted in contractors cutting back on medical and utilization reviews of claims that are essential in detecting and preventing erroneous payments. Contractors also attribute inadequate funding as the reason for not pursuing hundreds of millions of dollars owed to Medicare by private insurers whose payment responsibility was primary to Medicare's and for fewer and less timely audits of the billions of dollars claimed by hospitals and other institutional providers.

The magnitude of the potential losses incurred by Medicare as a result of these cutbacks is illustrated in our reports on Medicare's secondary payer program. In 1990 and 1991, we found a large inventory of potential mistaken Medicare payments that were not being investigated. When HCFA implemented a system in mid-1991 to track this inventory, contractors reported over $1.1 billion in unrecovered claims that were mistakenly paid. At the same time, the contractors reported not having investigated an additional large backlog of claims to determine what amounts Medicare paid that primary insurers should have paid. We estimate that once these additional claims are investigated, over $1 billion in mistaken payments could be owed by primary insurers.[7]

Contractors were doing little to recover these claims, at least in part because their funding for these activities was significantly reduced in fiscal year 1990 and remained at that level in fiscal year 1991. As of December 1991, about 80 percent

of these claims remained unrecovered. In response to this problem, contractors were provided an additional $20 million during fiscal year 1992 to recover monies due Medicare.

In its fiscal year 1993 budget, HHS proposed increases in Medicare's payment safeguards budget. The planned increases in contractor safeguard funding, if appropriated, will allow contractors to replace staff lost to cutbacks in prior years and to accommodate the growing claims workload. It will take some time, however, to hire and train the necessary staff and to implement expanded safeguard programs.

In today's difficult budget environment, the stability of Medicare contractor funding levels will remain in question. Consequently, we continue to believe that the Congress should consider modifying the budget process to better assure adequate and stable Medicare contractor funding.[1]

## CONCLUSIONS

In conclusion, fraud, waste, and abuse contribute unnecessarily to the health care cost spiral that confronts this nation. Like most insurers, Medicare faces program losses because of inefficiency and exploitation. These expenditures are particularly troublesome in light of the current budgetary environment and increasing beneficiary out-of-pocket costs. HCFA generally places more emphasis on program safeguards than private insurers. Yet, while HCFA has generally reacted to remedy identified weaknesses, the program remains vulnerable to unwarranted losses.

In particular, Medicare administrators face unique barriers to running a consistent, equitable national program. Policymakers need to act to ensure that contractors have clear incentives to manage program dollars efficiently and effectively. One aspect of this issue is consistent funding for such activities. Contractors need some assurance that funding for safeguard activities will be stable and adequate so that they can hire and train necessary staff. Such funding would provide the incentive necessary for contractors to make a long-term commitment to improving safeguard activities.

Funding levels for these activities, however, have not been stable, especially when viewed in light of increased claims volume.

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[1]Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for IRS compliance activities without necessitating spending cuts elsewhere. We recommended using IRS' method of funding compliance activities as a potential model. See Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

Moreover, recent program changes have required additional resources from contractors. Not surprisingly, contractors report that safeguard activities have been adversely affected. Consequently, we continue to support modifying the Budget Enforcement Act to enable adequate and stable funding for Medicare program administration.

In our view, HCFA must also take a more active stance to hold contractors accountable for their performance in program administration. To monitor and direct contractor actions, HCFA may need to develop better information systems, more focused performance measures, and stronger contractor guidance.

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I want to thank you for the opportunity to speak before you today. This Committee's interest and involvement in HCFA's administration of Medicare is likely to be an important component in addressing the major challenges faced by the agency. Mr. Chairman, I would be pleased to answer any questions.

## NOTES

1. Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992). Testimony on same topic (GAO/T-HRD-92-29, May 7, 1992).

2. Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991). Testimony on same topic (GAO/T-HRD-92-2, Oct. 2, 1991).

3. Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

4. Carrier Maintenance of Medicare Provider Numbers, Department of Health and Human Services, Office of Inspector General (OEI-06-89-00870, May 1991).

5. Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, forthcoming).

6. Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, forthcoming).

7. Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

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