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

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Health, Education and Human Services Division

B-280577

July 15, 1998

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

Subject: Medicare: Fraud and Abuse Control Pose a Continuing Challenge

Dear Mr. Chairman:

A program susceptible to fraud and abuse, Medicare is one of the largest, most expensive federal programs, with fiscal year 1997 spending of about $200 billion. The Health and Human Services' (HHS) Office of the Inspector General (OIG) recently completed its financial audit of the Health Care Financing Administration (HCFA)--the HHS agency that administers Medicare. In its report, the HHS OIG highlighted this vulnerability, reporting that in 1997 an estimated $20 billion of Medicare expenditures were for claims that did not comply with Medicare rules.

As your Committee prepares for a hearing to examine how to prevent losses from fraud and abuse in federal programs, you asked us to summarize our findings on safeguards in the Medicare program. At your request, this report discusses fraud and abuse in both Medicare's fee-for-service (the traditional Medicare program in which beneficiaries may choose their own providers) and managed care programs (in which beneficiaries select a managed care plan and must use only providers participating in that plan). More specifically, the report highlights (1) the impact of inadequate program safeguard funding on efforts to combat improper Medicare payments, (2) ineffective management and oversight of fee-for-service payments and operations, and (3) ineffective oversight of Medicare managed care plans.

The information in this report is based on our recent studies, testimonies, and the three High-Risk Series[1] reports on Medicare issued since 1992. The High-

[1]Medicare (GAO/HR-97-10, Feb. 1997), Medicare Claims (GAO/HR-95-8, Feb. 1995), and Medicare Claims (GAO/HR-93-6, Dec. 1992).

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Risk reports culminated a special effort, begun in 1990, to review federal program areas identified as high risk because of vulnerabilities to waste, fraud, and abuse.

In summary, although the majority of health care providers participating in Medicare provide quality services and bill the program properly, its size, complexity, and rapid growth make it an attractive target for fraud and abuse. More specifically, HCFA's past program safeguard efforts have been hindered because budgetary constraints have reduced resources for these efforts as the number of claims has grown. Although the Health Insurance Portability and Accountability Act of 1996 (HIPAA) provided HCFA an ensured and increasing funding source for program safeguard efforts,[2] shortcomings in HCFA's management of these efforts have contributed to Medicare losses. For example, HCFA has been slow to employ the funds the Congress provided under HIPAA. HCFA has agreed to set contractor program safeguard budgets in a more timely manner in the next fiscal year. In addition, HCFA has not adequately screened providers before admitting them to the Medicare program but is beginning to take steps to tighten admission standards for home health agencies (HHA), a well-known problem area.

Medicare's managed care program is vulnerable to other forms of fraud and abuse--such as not providing beneficiaries all the services a plan is paid to provide--that could be reduced through competition among health maintenance organizations (HMO). HCFA's oversight of the Medicare HMOs has often been ineffective. Furthermore, HCFA's efforts to comply with the Balanced Budget Act of 1997 (BBA)[3] and provide information about HMO performance to beneficiaries so that they can make informed choices when selecting an HMO have been slower than necessary.

BACKGROUND

Established under the Social Security Amendments of 1965, Medicare is a two-part program: (1) "hospital insurance," or part A, which covers inpatient hospital, skilled nursing facility, hospice, and home health care services, and

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[2]P.L. 104-191, Aug. 1996, sec. 201(b), 110 Stat. 1936, 1993 (establishing the Medicare Integrity Program, which includes section 1817(k) of the Social Security Act, to be classified at 42 U.S.C. i(k)).

[3]P.L. 105-33, Sec. 4001, 111 Stat. 251, 278 (establishing the Medicare+Choice Program, which includes section 1851(d), within the Social Security Act, to be classified at 42 U.S.C. 1395w-21(d)).

(2) "supplementary medical insurance," or part B, which covers physician and outpatient hospital services, diagnostic tests, and ambulance and other medical services and supplies. In fiscal year 1997, part A covered an estimated 39 million aged and disabled beneficiaries. Medicare beneficiaries receive benefits either through the traditional fee-for-service Medicare program, or they may enroll in an HMO that has contracted with HCFA.

Fee-for-Service Program

In 1997, Medicare's fee-for-service program covered about 85 percent, or 33 million, of Medicare's beneficiaries. Physicians, hospitals, and other providers submit claims to Medicare for payment for services provided to beneficiaries. HCFA administers Medicare's fee-for-service program largely through a network of over 60 claims processing contractors, that is, insurance companies–such as Blue Cross and Blue Shield plans, Mutual of Omaha, and CIGNA–that process and pay Medicare claims. In fiscal year 1997, contractors processed about 900 million Medicare claims.

As Medicare contractors, these companies use federal funds to pay health care providers and beneficiaries and are reimbursed for administrative costs incurred in performing the work. They are also responsible for program safeguard activities intended to protect Medicare from paying inappropriate claims.[4] The contractors have broad discretion in conducting these safeguard activities, resulting in significant variations among contractors in implementing these activities.

Managed Care Program

Medicare's managed care program covers a growing number of beneficiaries–more than 5 million at the end of 1997–who have enrolled in an HMO for their medical care rather than obtain services from individual providers. The growth in Medicare managed care enrollees is expected to continue, fueled in part by the BBA, which provided for new types of Medicare managed care plans and increased plan payments in many areas that previously lacked a managed care option. The managed care program, which is funded from both parts A and B

[4]Although under section 202 of HIPAA, the HHS Secretary is authorized to enter into contracts with entities other than its current contractors to perform program safeguard activities, HCFA has not yet awarded any contracts of this type. 110 Stat. 1936, 1996 (to be classified at 42 U.S.C. 1395ddd).

funds, consists mostly of HMOs under so-called "risk contracts" with HCFA.[5] These HMOs are paid a monthly amount, fixed in advance, by Medicare for each beneficiary enrolled rather than for each service provided. In this sense, the HMO has a "risk" contract because, regardless of what it spends for each enrollee's care, it assumes the financial risk of providing all needed health care in return for the payments received. HMOs profit if their costs of providing services are lower than the predetermined payment but lose money if their costs are higher than the Medicare payment.

Medicare Fraud and Abuse

Fraud and abuse encompasses a wide range of improper billing practices that include misrepresenting or overcharging for services delivered. Both result in unnecessary costs to Medicare, but a fraud conviction requires proof of intent to defraud. Abuse typically involves actions that are inconsistent with Medicare billing rules and policies. Practically, whether and how a wrongful act is addressed depends on the size of the financial loss incurred and the evidence establishing intent. For example, small claims are generally not pursued as fraudulent because of the cost involved in investigation and prosecution.

The pursuit of fraud and abuse often begins with the claims processing contractors, who review submitted claims and respond to beneficiary complaints. They develop cases for referral to the HHS OIG for possible criminal or civil prosecution and administrative sanction. Potential fraud cases referred to the HHS OIG require careful documentation by the contractor, entailing data analyses, claims audits, interviews with patients, and medical records reviews.

HHS OIG investigations may involve, among other things, additional interviews or analyses of medical records and subpoena of financial records. If satisfied that the evidence warrants prosecution, the OIG forwards the case to a U.S. attorney in the Department of Justice. The U.S. attorney then decides whether to prosecute the case. If the U.S. attorney obtains an indictment and finally a conviction, further work is necessary to establish administrative sanctions and

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[5]Other Medicare managed care plans include cost contract HMOs and health care prepayment plans. Cost contract HMOs allow beneficiaries to choose health services from their HMO network or outside providers. Health care prepayment plans cover only part B services. Together, both types of plans enrolled less than 2 percent of the Medicare population in 1997.

recover overpayments. Thus, although the mechanics for pursuing Medicare fraud are in place, the extensive resources and interagency coordination required for case development can stall the pursuit of a case at many points and delay its resolution for years. HIPAA has provided additional funding to the HHS OIG, Department of Justice, and the Federal Bureau of Investigation to support their pursuit of health care fraud cases.

Medicare's Antifraud-and-Abuse Efforts Are Based Largely on Contractors' Program Safeguards

HCFA relies on program safeguards that consist largely of contractors' efforts to detect improprieties both before and after paying claims. In addition to indications of potential fraud that contractors receive from beneficiary complaints, detection efforts include prepayment reviews of providers' claims and postpayment analyses, such as review of claims from selected providers or of selected services and audits of provider cost reports.

HCFA funds five main types of program safeguard activities carried out by Medicare contractors: medical review, medicare secondary payer, audits of provider cost reports, fraud units, and provider education. Medical review includes automated and manual pre-payment and post-payment reviews of Medicare claims. It is directed toward identifying claims for noncovered or medically unnecessary services. Medicare secondary-payer efforts focus on identifying other primary sources of payment, such as employer-sponsored health insurance or third-party liability settlements, for claims submitted to Medicare. Audits involve auditing cost reports submitted by institutional providers such as hospitals and skilled nursing facilities. Contractor fraud units investigate potential cases of fraud or abuse identified through beneficiary complaints, other contractor safeguard units, or other sources. Fraud units develop and refer cases to the HHS OIG and Department of Justice. Provider education may include mailings to providers, briefings, and seminars about Medicare billing policies.

BUDGET CONSTRAINTS AND INCREASED NUMBER OF MEDICARE CLAIMS HAVE WEAKENED REVIEW OF CLAIMS AND PROVIDERS

In recent years, HCFA and its claims processing contractors have struggled to carry out critical claims review and provider audit activities with a budget that on a per claim basis has been declining substantially. For example, between 1989 and 1996, the number of Medicare claims climbed 70 percent to over 800

million; during that same period, claims review resources grew less than 11 percent. Adjusting for inflation and claims growth, the amount contractors could spend on review declined from $.74 to $.48 per claim.

The deterioration of Medicare's controls over home health payments exemplifies the effect of the inadequate funding of program safeguards. Between 1988 and 1996, Medicare spending for home health care grew from $2.1 billion to $18 billion; it is expected to reach nearly $22 billion in fiscal year 1998. Along with increasing expenditures, the number of HHAs also increased–from about 5,800 to over 9,000 in the same time period. Despite this dramatic rise in home health care expenditures, contractors' reviews of home health claims dropped–from 62 percent in 1987 to no more than 3 percent in 1996.[6]

The infrequency of the intermediaries' medical review of claims and limited physician involvement in overseeing HHAs' plans of care have made it nearly impossible to determine whether the beneficiary receiving home health services qualified for the benefit, needed the care received, or even received the services billed to Medicare. In addition, because of the small percentage of claims chosen for review, HHAs that billed for noncovered services are much less likely to be identified than was the case a decade earlier. In March 1998, we reported on improper activities at a Mississippi HHA that illustrate the kinds of problems that can go undetected with an inadequate level of reviews:

- Although the agency reported that one elderly patient had poor endurance, walked with a cane, and appeared homebound, when we visited, he was moving a 5-foot-long piece of telephone pole across his yard.

- When we visited another patient reported homebound by the agency, we found that she was providing day care to four children approximately 5 years old or younger. The responsible Medicare contractor told us that such activity was inconsistent with someone who should have been unable to leave home without "a considerable, taxing effort"–a condition for the homebound status that is required for eligibility for home health benefits.

In addition to steep declines in the percentage of home health claims reviewed, the percentage of HHA cost reports being audited by HCFA's contractors has

[6]In 1996, HCFA established a target of reviewing 3 percent of claims. However, because the 3-percent target applied to all part A claims, the actual proportion of home health claims reviewed, which are a subset of part A claims, could actually be as low as 1 percent.

declined. Between 1991 and 1996, the chances that any institutional provider's cost report would receive a detailed review fell from about 17 to about 8 percent.

The BBA included several provisions designed to slow the growth in home health expenditures, including tightening payment limits immediately and instituting a prospective payment system (PPS) for home health care.[7] Although a PPS alone will not eliminate fraud and abuse, it should enable Medicare to give agencies increased incentives to control costs. HCFA has considerable discretion in designing and implementing the home health PPS. HCFA's actions in designing a PPS will determine to a large extent the success of the legislation in curbing abusive billing practices and slowing the rapid growth in spending for this benefit.

To begin addressing the historically inadequate funding for program safeguards, the Congress, through HIPAA, established the Medicare Integrity Program, which subsumes HCFA's previous program safeguard activities. The Congress stipulated annual funding levels to be appropriated from the Medicare trust fund for these activities. In 1994, HHS proposed such a program safeguard funding arrangement, saying that it would improve program safeguards by creating "a stable level of funding from year to year so that HCFA and its contractors could plan and manage the function on a multi-year basis." HHS went on to say that "Past fluctuations in funding have made it difficult [for contractors] to retain experienced staff who understand the complexities of the program." Starting with the $440 million available for program safeguard activities in 1997 and the $500 million expected to be used for fiscal year 1998, HIPAA will increase funding annually up to a maximum of $720 million in 2003 and the following fiscal years. Table 1 shows funding levels provided by HIPAA in the Medicare Integrity Program for fiscal years 1997 through 2003 and beyond.

[7]A system in which payment is based on a fixed, predetermined amount per unit. P.L. 105-33, Sec. 4603, 111 Stat. 251, 433 (amending section 1848(f) of the Social Security Act, to be classified at 42 U.S.C. 1394w-4(f)).

Table 1: Medicare Integrity Program Funding Under HIPAA, Fiscal Year 1997 and Beyond

Dollars in millions

1997	1998	1999	2000	2001	2002	2003 and beyond
$440	$500[a]	$560	$630	$680	$700	$720

[a]This does not include the additional $50 million of supplemental program safeguard funding made available by HHS' fiscal year 1998 appropriation.

HIPAA has ensured increasing funds for program safeguards in 1998 and beyond. In the first year after HIPAA's passage (fiscal year 1997), however, the $437.9 million of Medicare Integrity Program funds spent was actually about 1 percent less than the $441.1 million spent in fiscal year 1996–the last year before HIPAA's passage. This occurred because in 1996 HCFA transferred funds from claims processing operations to fund program safeguard efforts.[8]

MANAGEMENT PROBLEMS ALSO AFFECT FEE-FOR-SERVICE SAFEGUARD ACTIVITIES

Independent of the question of adequate funding is the issue of whether HCFA is using available resources as effectively as possible. Because HCFA has been slow in notifying contractors of their safeguard budgets, even though HIPAA funding was ensured, Medicare contractors have delayed expanding their safeguard staffs. In addition, HCFA has not taken full advantage of the controls contractors could use to screen for inappropriate claims by identifying effective screens and distributing them to other contractors. Moreover, despite deficiencies that might have been corrected in Medicare's current claims processing system, HCFA worked on developing a new system, which ultimately failed. Finally, HCFA has allowed providers to easily enter the

[8]Under HIPAA, HCFA can no longer transfer funding between program operations, which are paid for from HCFA's operating budget, and program safeguards, which are paid for from the Medicare Trust Fund, without specific legislative authority.

Medicare program without adequately ensuring their trustworthiness and their likelihood of providing quality care and complying with HCFA's billing rules.

Even With Ensured Funding, Contractors' Budget Notifications for 1998 Safeguard Activities Were Not Timely

HCFA did not take advantage of its advance knowledge that its fiscal year 1998 program safeguard funding would be at least $60 million more than it was in fiscal year 1997, ensured by HIPAA, by notifying contractors of their program safeguard budgets at the beginning of the fiscal year. HCFA did not notify contractors of their fiscal year 1998 program safeguard funding until January 1998--nearly one-third of the way into the fiscal year. Contractor officials told us that as a result they delayed hiring program safeguard staff for expanding their safeguard activities. In response to a recommendation in our June 1, 1998, report on HCFA's use of antifraud-and-abuse authorities, HCFA has said that it will notify its contractors of their base program safeguard budgets for 1999 before the start of the fiscal year.

Despite fiscal year 1998 budget increases, contractors we visited have not increased their staff involved in program safeguard activities, such as provider audit and claims review. These contractors had not increased their staffs because of uncertainty about their funding for the year. In fact, contractors' staffing for some important program safeguard activities is now less than it was before HIPAA. For example, two contractors we visited in March 1998 reported fewer staff for auditing provider cost reports than they had in September 1996 before implementation of HIPAA. One contractor employed 77 audit staff, 11 fewer than it had in September 1996. The other contractor employed 151 audit and reimbursement staff, 7 fewer than in 1996. This contractor's medical review staff had also declined from 86 in 1996 to 83 at the time of our visit.

HCFA Has Not Routinely Made Information on Effective Payment Controls Available to Contractors

HCFA has not coordinated contractors' program safeguard activities, such as claims screening, leading to unnecessary or inappropriate payments. Part B contractors establish their own medical policies and screens, which are the criteria used to identify claims that may not be eligible for payment. Certain policies and the screens used to enforce these policies have helped some Medicare contractors avoid making unnecessary or inappropriate payments. Because HCFA has not adequately coordinated contractors' use of these

policies and screens, however, possible savings have been lost. For example, as we reported in 1996, for just 6 of Medicare's top 200 most costly services in 1994, use of certain contractors' medical policy screens by all of Medicare's part B contractors could have saved millions to hundreds of millions of dollars annually.[9]

Lack of Needed Information Systems Hampers Efforts to Detect Fraud and Abuse

HCFA recognizes that an on-line claims processing system enabling contractors to compare new claims with those already submitted on behalf of a beneficiary, other claims submitted by the provider, and still other claims for the same procedure or item would greatly enhance its fraud and abuse detection capabilities. HCFA's efforts to develop such a system--known as the Medicare Transaction System (MTS)--have been unsuccessful, however. Without such a system, contractors cannot screen for suspiciously large reimbursement increases over a short period or improbable quantities of services claimed for a single day of care. The following examples from in our previous work highlight the problem:

- A Medicare contractor paid a supplier $211,900 for surgical dressing claims in 1992. For the same quarter a year later, the contractor paid the same supplier more than $6 million. Medicare had no system for identifying the 2,800-percent increase in the amount claimed beforehand, an amount that at least superficially appeared suspicious.

- A contractor paid claims for a supplier's body jackets[10]--totaling $32,000, $95,000, $235,000, and $889,000 over four quarters--that had averaged about $2,300 per quarter for five previous consecutive quarters. The contractor had no information with which to identify the seeming incongruity.

- A contractor reimbursed a clinical psychology group practice for individual psychotherapy visits of 45 to 50 minutes. Three psychologists in the group were billing for 17 to 42 nursing facility patients per day. On many days, the leading biller of this group would have had to work

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[9]Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

[10]A body jacket is a custom-fitted spinal brace made of a rigid plastic that conforms to the body and largely immobilizes it.

more than 24 uninterrupted hours to provide the services he claimed. The contractor had no information system, however, to enable it to compare this group's claims to its previous claims before paying the group.

- A contractor paid a podiatrist $143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve at least 34 patients a day, 5 days a week. The contractor had no information system to enable it to compare this provider's claims to its previous claims before paying the provider.

In these last two cases, the contractors became suspicious only when family members and beneficiaries complained.

HCFA stated that MTS, among other things, would provide on-line access to beneficiary patient histories. Currently, Medicare's parts A and B claims processing systems are incompatible, making it difficult to spot schemes that involve billing both parts for the same service. Specifically, Medicare's discrete parts A and B processing systems are not designed to easily identify, on-line, all the medical services and devices billed on behalf of an individual beneficiary. As a result, providers can improperly bill both parts with little danger of detection. In a recent review of medical supply payments, for example, we noted that providers can bill both an intermediary and a carrier for the same supply item on behalf of an individual beneficiary[11] We found instances of duplicate payments and noted that contractors lacked effective tests to determine whether both carriers and intermediaries paid for the same items. The HHS OIG has reported similar problems with payments for other services such as ambulance transportation and diagnostic laboratory tests.[12]

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

[12]Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Medical Necessity, OEI-03-90-02130, HHS OIG (Washington, D.C.: Aug. 1994); Ambulance Services for Medicare End-Stage Renal Disease Beneficiaries: Payment Practices, OEI-03-90-02131, HHS OIG (Washington, D.C.: Mar. 1994); and Review of Separately Billable End-Stage Renal Disease Laboratory Tests, #A-01-96-00513, HHS OIG (Washington, D.C.: Oct. 1996).

Limited Screening Allows Providers Whose Trustworthiness Is Not Ensured to Participate

Although ensuring the trustworthiness of providers before allowing them to participate in the Medicare program can be an effective program safeguard mechanism, HCFA has often not done this. In December 1997, we reported that HCFA grants certifications to HHAs without adequately ensuring that they provide quality care or meet Medicare's conditions of participation. Few HHAs had been denied entry to Medicare. The relative ease with which HHAs become certified has probably resulted in certification of some HHAs that fail to provide high-quality care and that abuse or defraud Medicare. In the case of this type of provider, the administration placed a moratorium on admitting new HHAs into the Medicare program from September 15, 1997, until January 13, 1998. The moratorium was intended to stop the certification of untrustworthy providers while HCFA strengthened its requirements for HHAs entering the program. HCFA is starting to implement some of the new requirements; others are not yet finalized.

INEFFECTIVE OVERSIGHT LEAVES BENEFICIARIES VULNERABLE TO HMO QUALITY PROBLEMS

Some have argued that moving beneficiaries into managed care–that is, into a "claimless" environment–would largely eliminate fraud and abuse problems. Unlike fee-for-service providers, physicians, hospitals, and other providers of managed care do not submit a claim to Medicare for each service. Instead, they are paid by the HMO, which in turn is paid a monthly amount by Medicare for each beneficiary enrolled. Medicare's managed care program, which enrolls more than 10 percent of Medicare's 39 million beneficiaries and is growing by about 85,000 beneficiaries per month, however, faces another type of exploitation, according to our work.

Managed care involves fixed monthly payments for each beneficiary rather than for each service. Therefore, providers that want to exploit Medicare have an incentive to underserve rather than overserve beneficiaries. Medicare HMOs can provide beneficiaries an attractive alternative to the traditional fee-for-service program because HMOs typically offer beneficiaries additional benefits, lower out-of-pocket costs, and freedom from complicated billing statements. In recent years, however, some Medicare HMOs have not complied with federal standards, and HCFA's monitoring of these HMOs has been weak, according to our work. For example, despite efforts to improve its HMO monitoring, HCFA conducted only paper reviews of HMOs' quality assurance plans, examining

only the description rather than the implementation of HMOs' quality assurance processes.[13] Moreover, HCFA has hesitated to act against noncompliant HMOs, even when a history or evidence existed of abusive sales practices, delays in processing beneficiaries' appeals of HMO decisions to deny coverage, or poor-quality care.

In the case of one Miami HMO, for example, HCFA found--in 1991, 1992, 1994, and 1996--a combination of deficiencies in marketing, enrollment, quality assurance systems, grievance and appeals procedures, and access to health services. Despite the repeated findings of this HMO's standards violations, HCFA's strongest regulatory action was to require a corrective action plan after each inspection. HCFA provided Miami area beneficiaries no information about the plan's deficiencies, while beneficiaries continued to enroll and disenroll in this plan.

Despite many beneficiary complaints, HCFA has not yet used market forces to encourage competitors to offer higher quality services. HCFA collects, but has not systematically or routinely analyzed, data on HMO activities that could be used to measure performance. Furthermore, HCFA has shared no such information with beneficiaries so that they could better choose their HMO on the basis of quality.

The BBA includes several consumer information provisions to help beneficiaries judge HMO quality and performance. Among the types of information that HCFA must distribute to Medicare beneficiaries in the future are plans' disenrollment rates, enrollee satisfaction measures, health outcome measures, and records of compliance with certain requirements. HCFA expects to distribute disenrollment rates in 1999. Our work shows, however, that HCFA could publish disenrollment rates this year, and, because HCFA already collects the necessary data, plans would not have to provide additional data. In fact, some HCFA regional offices have periodically distributed these data to HMOs. These statistics could help identify HMOs whose sales agents mislead or fail to adequately educate new enrollees.

As we reported in April 1998, disenrollment rates often vary widely among plans competing in the same market.[14] For example, in Tampa, PCA Health

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[13]Medicare: Increased HMO Oversight Could Improve Quality and Access to Care (GAO/HEHS-95-155, Aug. 3, 1995).

[14]Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98-142, Apr. 30, 1998).

Plans of Florida had an annual disenrollment rate of 59 percent in 1996–much higher than the 10-percent disenrollment rate of the Prudential Health Care Plan. Nearly 12 percent of all new PCA members left the plan within the first 3 months of enrolling, while only 3 percent of Prudential's new enrollees left that quickly. Both PCA and Prudential had been operating Medicare risk contracts for about 2 years and had approximately the same number of enrollees (7,600 and 9,200, respectively) in the Tampa market. Moreover, HMOs' disenrollment rates vary widely in many markets. In 55 percent of the markets served by four or more HMOs, the highest disenrollment rate was greater than four times the lowest rate in that market, according to our study. Disenrollment rates ranged from 8 to 56 percent in Houston; from 3 to 34 percent in Los Angeles; and from 8 to 38 percent in Washington, D.C. This information could alert beneficiaries to seek information about different HMOs' performance and encourage HMOs to compete on the basis of quality.

CONCLUSIONS

Medicare's size and mission make it a perpetually attractive target for exploitation. That wrongdoers continue to find ways to dodge safeguards illustrates the dynamic nature of fraud and abuse and the need for constant vigilance to protect the program. The experience of Medicare illustrates that unless adequate resources and tools are available along with strong and effective program leadership and management, fraud, abuse, and improper overpayments cannot be controlled.

As agreed with your office, we will make this correspondence available to others on request.

If you have any questions about this correspondence, please call Paul Alcocer, Assistant Director, at (312) 220-7709. Lynn Filla-Clark contributed to this correspondence, which is based largely on our previous work.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health Financing
and Systems Issues

RELATED GAO PRODUCTS

Medicare: HCFA's Use of Anti-Fraud-and-Abuse Funding and Authorities (GAO/HEHS-98-160, June 1, 1998).

Medicare: Health Care Fraud and Abuse Control Program Financial Report for Fiscal Year 1997 (GAO/AIMD-98-157, June 1, 1998).

Medicare: Many HMOs Experience High Rates of Beneficiary Disenrollment (GAO/HEHS-98–142, Apr. 30, 1998).

Medicare: Improper Activities by Mid-Delta Home Health (GAO/OSI-98-5, Mar. 12, 1998).

Medicare: HCFA Faces Multiple Challenges to Prepare for the 21st Century (GAO/T-HEHS-98-85, Jan. 29, 1998).

Medicare Home Health: Success of Balanced Budget Act Cost Controls Depends on Effective and Timely Implementation (GAO/T-HEHS-98-41, Oct. 29, 1997).

Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

Medicare Transaction System: Success Depends Upon Correcting Critical Managerial and Technical Weaknesses (GAO/AIMD-97-78, May 16, 1997) and related testimony titled Medicare Transaction System: Serious Managerial and Technical Weaknesses Threaten Modernization (GAO/T-AIMD-97-91, May 16, 1997).

Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse (GAO/HEHS-97-114, Apr. 16, 1997).

Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs (GAO/HEHS-97-63, Mar. 31, 1997).

Medicare (GAO/HR-97-10, Feb. 1997) and related testimony titled Medicare: Inherent Program Risks and Management Challenges Require Continued Federal Attention (GAO/T-HEHS-97-89, Mar. 4, 1997).

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

Medicare: Millions Can Be Saved by Screening Claims for Overused Services (GAO/HEHS-96-49, Jan. 30, 1996).

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