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High-Risk Series

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# Medicare Claims

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**Comptroller General**
**of the United States**

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The President of the Senate
The Speaker of the House of Representatives

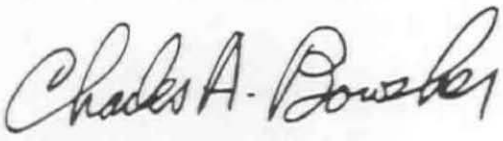
In January 1990, in the aftermath of scandals at the Departments of Defense and Housing and Urban Development, the General Accounting Office began a special effort to review and report on federal government program areas that we considered "high risk."

After consulting with congressional leaders, GAO sought, first, to identify areas that are especially vulnerable to waste, fraud, abuse, and mismanagement. We then began work to see whether we could find the fundamental causes of problems in these high-risk areas and recommend solutions to the Congress and executive branch administrators.

We identified 17 federal program areas as the focus of our project. These program areas were selected because they had weaknesses in internal controls (procedures necessary to guard against fraud and abuse) or in financial management systems (which are essential to promoting good management, preventing waste, and ensuring accountability). Correcting these problems is essential to safeguarding scarce resources and ensuring their efficient and effective use on behalf of the American taxpayer.

This report is one of the high-risk series reports, which summarize our findings and recommendations. It describes our concerns over the Medicare program's efforts to safeguard program dollars. Weaknesses in the Health Care Financing Administration's management of the program and insufficient funding of safeguard activities expose Medicare to unnecessary loss through waste, fraud, and abuse.

Copies of this report are being sent to the President-elect, the Democratic and Republican leadership of the Congress, congressional committee and subcommittee chairs and ranking minority members, the Director-designate of the Office of Management and Budget, and the Secretary-designate of Health and Human Services.



Charles A. Bowsher

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# Overview

The federally funded Medicare program is the nation's largest payer of health care benefits. In 1991 the program enrolled about 35 million beneficiaries and processed about 600 million claims, paying physicians and other providers over $110 billion in medical benefits—about 15 percent of all the money spent on health care in the United States. All health insurers, including more than 1,000 private payers, face the need to control these high costs and are seeking to curb unnecessary expenditures lost through waste, fraud, and abuse.

Medicare is administered by the Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services (HHS). By law, HCFA contracts with private insurance companies to process Medicare claims and pay providers on the government's behalf and monitors the contractors' performance.

## The Problem

In recent years, the Medicare program has lost billions of dollars to waste, fraud, and abuse. Though Medicare's losses cannot be quantified precisely, health industry experts estimate that fraud and abuse could account for as much as 10 percent of the nation's total health care costs.

## The Causes

HCFA relies on numerous contractors to process Medicare's claims and to protect program funds through review activities called payment "safeguards." However, HCFA's inability to properly manage contractors' safeguard activities and too little money earmarked for these activities have left Medicare dollars exposed to loss and waste. For example, we have found that:

- Although many Medicare beneficiaries call in to complain about waste and abuse, contractors have often failed to investigate these complaints. In one case, follow-up on complaints about eye care services led to a provider's agreement to refund over $2.5 million to the federal government.

- Hospitals owed Medicare over $170 million in overpayments, but contractors did little to reclaim the money. HCFA, moreover, was unaware of contractor inaction because it had no systems to monitor this information.

- Contractors paid an estimated $2 billion in claims that should have been paid by other health insurers.

Medicare is vulnerable to exploitation for other reasons: payment policies permit excessive reimbursement rates for certain

services, such as high-tech and laboratory services, and loose controls over who can bill Medicare have made the pursuit of fraudulent providers difficult.

## GAO's Suggestions for Improvement

HCFA needs to exercise stronger leadership in managing the Medicare program. In particular, it needs to improve oversight of contractors' activities aimed at reducing waste, fraud, and abuse. HCFA also needs to reduce payments that are excessive and to tighten controls over who is allowed to bill the Medicare program. Finally, the Congress should modify budget procedures—that is, allow increased safeguard funding without having to cut spending elsewhere—to allow adequate and stable Medicare contractor funding for safeguard activities to be appropriated.

We have also emphasized that the threat of insurance fraud and abuse is endemic not just to Medicare but to the entire health care system. In a recent report and at congressional hearings, we have asked the Congress to consider establishing a national health insurance fraud commission—composed of public and private insurers, among others—that would develop

recommendations for combating health care fraud and abuse.

# Contractor Network Complicates Program Management

Medicare is the fourth largest item in the federal budget after defense, social security, and interest payments on the national debt. Moreover, the program has grown considerably. Since 1975, beneficiary enrollment has grown from 25 million to about 35 million, while claims volume has increased by over 450 percent. In recent years, Medicare benefit outlays rose by 60 percent, from about $70 billion in 1985 to over $110 billion in 1991.

The Medicare program operates through a complicated administrative structure. More than 80 contractors process, pay, and review claims. This structure has been shaped by Medicare's historical dependence on private insurers to perform claims processing and payment review tasks.

To pay providers accurately and promptly, the law that established the Medicare program in 1965 provided for contracting with insurance companies—Blue Cross and Blue Shield plans and other private insurers. This arrangement was pragmatic in that insurance companies had both claims-processing experience and an understanding of the medical practices of their communities. Payment safeguard activities have also been largely contractor-managed

operations, permitting contractors broad discretion in acting to protect Medicare program dollars. As a result, there are significant variations in contractors' implementation of Medicare's payment safeguard policies.

# Management Weaknesses Contribute to Unnecessary Expenditures

Over the years, the quality of contractors' administration of Medicare has been uneven, and HCFA has not adequately managed the contractor network to identify and correct program weaknesses. HCFA's lax management of the contractors has contributed to billions of dollars lost to waste, fraud, and abuse. For example, contractors have allowed complaints of fraud to go uninvestigated; had failed, until recently, to collect over $170 million of overpayments to hospitals and other providers; and have paid nearly $2 billion in claims that should have been paid by other insurers. Furthermore, certain Medicare payment policies have been overly generous and have unintentionally discouraged providers billing the program from prescribing services judiciously. Finally, in just a single case of fraud, Medicare lost over $5 million due to loose controls over who can bill the program.

## Inadequate Management and Reduced Funding Weaken Payment Safeguards

HCFA has not carefully monitored Medicare's payment safeguard activities, which vary by contractor and are left largely to the contractor's discretion. Moreover, reduced funding by the Congress for payment safeguard operations has caused contractors to focus more on paying claims quickly than

on reviewing the accuracy of payments made.

For example, until recently, HCFA provided virtually no guidance to Medicare contractors regarding the investigation of beneficiary complaints—a primary source of fraud, waste, and abuse leads. Contractors' failure to adequately investigate beneficiary complaints of provider fraud and abuse results in missed opportunities to (1) identify billings for services not rendered, (2) recover overpayments, (3) impose penalties, and (4) send a message to the provider community that fraudulent or abusive behavior will not be tolerated.

One case demonstrates the value of dealing with beneficiary complaints effectively. In that case, beneficiary complaints prompted the contractor initially to pursue a provider for billing irregularities. Upon further investigation, 100 apparently similar complaints surfaced, encompassing about 300 fraudulent claims. The provider involved agreed to refund over $2.5 million to the federal government. HCFA has recently issued guidance instructing contractors on the proper handling of beneficiary complaints.

HCFA also did not give adequate guidance to Medicare contractors on recovering hospital overpayments. The refundable amounts, referred to by hospitals as credit balances, typically occurred when both 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 ensure that refunds were promptly recovered. Subsequently, in 1992 HCFA instructed Medicare contractors to have hospitals report amounts owed and to recover the mistaken payments. Over 9,000 hospitals and other providers reported $171.7 million in Medicare overpayments, of which $109.9 million had been repaid as of June 1992. HCFA recently implemented a reporting and tracking system to monitor such overpayments and ensure that they are promptly recovered.

These problems may be partly related to budget cutbacks that have affected program administration. Although Medicare's payment safeguard activities have been

consistently cost-effective—returning over $11 for every $1 spent since 1989—contractor budgets for these functions have not kept pace with the growth in claims volume. Specifically, from 1989 to 1992, claims volume rose by about 40 percent, while contractors' funding for payment safeguards was cut by about 4 percent.

Medicare's secondary payer program demonstrates Medicare's exposure to loss resulting from these cutbacks. In 1990 and 1991, we found a large inventory of potential mistaken Medicare payments that were not being investigated. Contractors were doing little to recover these claims, at least in part because their funding for these activities had been significantly reduced.

In mid-1991 HCFA implemented a system to track the outstanding amounts from the mistakenly paid claims. Contractors reported unrecovered payments amounting to over $1.1 billion, along with a large backlog of additional claims for which overpayments had not been determined. We estimated that an investigation of these additional claims would reveal another $1 billion in mistaken payments owed by primary insurers. In 1992 the Office of Management and Budget released additional

money to the contractors for recovery activities.

In its fiscal year 1993 budget, HHS increased funding for Medicare's payment safeguard activities to $395.7 million, or 15.4 percent over the previous year's funding. The increase will allow contractors to begin replacing staff lost to cutbacks in prior years and begin accommodating the growing claims workload. Hiring and training the necessary staff and implementing expanded safeguard programs will take time; for this reason, the assurance of stable safeguard funding is needed. Payment safeguard activities save Medicare much more than they cost, but under federal budget procedures, safeguard funding can be increased only by cutting spending elsewhere. We believe the Congress should consider modifying the budget procedures to better ensure adequate and stable funding of Medicare's contractor safeguard activities.[1]

[1]Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service compliance activities without necessitating spending cuts elsewhere. We suggest using this method of funding compliance activities as a model.

## Flawed HCFA Policies Expose Medicare to Waste and Abuse

Several Medicare payment policies have left the program vulnerable to provider abuse or excessive spending. For example, Medicare's high payment rates for advanced technology services have encouraged needless proliferation of diagnostic radiology equipment in certain localities. In addition, other policies overcompensate laboratory providers and health maintenance organizations (HMOs) for services rendered.

New medical technologies tend to spread rapidly once they are declared eligible for Medicare reimbursement. As new technology matures, reductions in equipment costs, improvements in efficiency, and increased utilization can decrease unit costs. In some cases, however, Medicare payment rates have not been lowered to reflect these decreased costs. This has encouraged the proliferation of high-cost, low-volume providers.

For example, Medicare payments for magnetic resonance imaging (MRI) services are based partly on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historically allowed charges. Despite efforts

to standardize Medicare's payment for MRI services, HCFA did not fully adjust such payments to reflect declining unit costs. Accordingly, in 1992 we recommended that HCFA periodically adjust payment rates for these services and for other evolving technologies to reflect costs incurred by high-volume, efficient providers.

Medicare payments for laboratory services are also excessive. Laboratories' profit rates from Medicare business substantially exceed their overall profit rates, indicating that Medicare's fee schedules are too high. Comparable profit rates would mean that Medicare is neither subsidizing nor being subsidized by other payers. By reducing Medicare payments for laboratory services to equalize profit rates, Medicare would save approximately $150 million annually. Accordingly, we asked the Congress in 1991 to consider legislation that would cap Medicare's payments for clinical laboratory tests and would ensure that Medicare's contribution to laboratory profits not exceed the laboratories' overall profit rate. Capping fees at 76 percent of the median of all fee schedules would accomplish this goal.

Medicare's flat-rate payments to HMOs can also be abused by providers. Medicare pays

HMOs a flat monthly fee per enrollee based on the average cost of serving a Medicare beneficiary in the fee-for-service sector. Studies suggest that HMOs attract healthier-than-average beneficiaries, however, and that HCFA does not adjust the payment rate to reflect the lower cost and utilization level of an HMO's healthier beneficiaries. As a result, HMOs have received payments estimated to be more than Medicare's costs would have been if the enrollees had remained in the fee-for-service sector.[2]

Other problems related to HMOs include the potential underprovision of services (such as failing to order appropriate diagnostic tests or failing to follow up on abnormal test results) and the violation of requirements that protect Medicare beneficiaries from unfair marketing practices and from inappropriate denial of claims for services. Over the past 5 years HCFA has experienced recurring problems with its enforcement of Medicare requirements regarding provision of services, marketing practices, and other practices aimed at protecting Medicare beneficiaries. Accordingly, in 1991 we recommended that HCFA establish policies that make the terms for sanctioning HMOs

[2]Mathematica Policy Research, Inc., The Impact of the Medicare Demonstrations on the Use and Cost of Services, Final Report, January 31, 1989.

explicit in order to prevent the abuse of program dollars and to protect Medicare beneficiaries. We also asked the Congress to consider giving HCFA greater discretion to suspend Medicare enrollment or impose civil monetary penalties when HMOs fail to correct compliance deficiencies promptly.

## Weak Billing Controls Invite Exploitation of Medicare

Control over the issuance of billing identification numbers, known as provider numbers, is a long-standing program weakness that makes Medicare seriously vulnerable to fraud. Under some contractors' procedures, certain types of providers applying for billing identification numbers receive little scrutiny of their qualifications or of their business and investment relationship to other medical facilities. For these providers, contractors have difficulty identifying whether an applicant has been disciplined by the program, has outstanding Medicare debts, or has the financial wherewithal to maintain solvent business operations. In addition, HHS's Office of the Inspector General reports that Medicare contractors often cannot identify or deactivate numbers for providers that have lost the legal authority to practice.[3]

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

Limited controls over provider numbers were an integral part of a multimillion-dollar fraud scheme involving mobile physiology labs, referred to as the "rolling labs" scheme. Fraudulent billings were masked behind at least 30 different corporate names and Medicare provider numbers. The multiple provider numbers greatly complicated contractors' 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 has been unable to recover overpayments to providers affiliated with the scheme.

To respond to ownership and provider number problems, HCFA has recently issued regulations and guidance to improve contractor control over the acquisition of provider numbers. Included are provisions requiring noninstitutional providers to submit information on owners or individuals with management interests and requiring applicants seeking to qualify as equipment suppliers to meet certain standards.

# Challenges Are Common to All Health Payers

Several aspects of the rolling labs scheme discussed above illustrate the vulnerability of Medicare and the other health insurers to fraud. Efforts to address fraud and abuse present all health payers with common difficulties. These include the considerable costs involved in investigating and prosecuting fraud and abuse, the difficulty of recovering lost monies, and the need to balance monetary controls with concerns over excessive regulations.

## Rolling Labs Case Illustrates Systemic Health Insurance Problems

Perpetrators of the rolling labs scheme initially focused their operations on Medicare. However, once their fraudulent activities were uncovered, they shifted from Medicare to private payers. Both public and private payers found their attempts to recover overpayments stymied, despite having won convictions. In studying how the scheme managed to stay viable for several years, we found that:

- Considerable losses to the health care system can occur as a result of even a single scheme. The rolling labs operation is believed to have affected over 90 percent of the health plans in California and to have involved $1 billion in fraudulent billings. Although Medicare uncovered the operation

and successfully prosecuted certain individuals associated with it, the program was unable to recover over $5 million, almost the entire amount of the identified Medicare overpayments to the providers involved.

- Providers can bill insurers with relative ease, because they are often not required to meet specific requirements. The services provided by the rolling lab do not require licensure in many states, and many insurers do not have specific requirements for those who can bill for medical services. Because many of the rolling lab billing addresses were post-office boxes, payers could not identify the location of the labs.

- The obstacles to prosecuting and recovering losses are daunting. The rolling lab operators were successfully prosecuted in 1987 by Medicare and in 1990 by private insurers. Private insurers spent $1 million in their investigative and prosecutorial efforts. Although they won an $18 million judgment, they have recovered virtually nothing.

- The replication of similar schemes in southern California suggests that the profitability of health insurance fraud may outweigh the risk of getting caught. At least

six schemes having characteristics similar to the rolling lab are believed to exist in California. Investigators believe such schemes are also operating in other states.

## Need for National Commission

Fraud and abuse problems beset all health payers. Our recent work demonstrates that Medicare's problems with prosecution and financial recovery are similar to those facing private health insurers. In addition, privacy concerns have inhibited payers from sharing data collection techniques or other strategies that could help identify questionable billing patterns.[4] Finally, payers share concerns over how to protect benefit dollars without putting an undue paperwork burden on providers or requiring them to follow complicated regulations.

Recently we suggested that the Congress establish a national health insurance fraud commission to develop ways to enhance the efforts of independent payers, public payers, and state insurance and licensing agencies as well as state and federal law enforcement agencies. The commission would be responsible for analyzing trade-offs and

[4]With respect to standardizing claims data, HHS has already begun to develop a national strategy to coordinate independent private insurers with public payers to streamline the costs of administering health insurance.

developing recommendations to the Congress. It would address such issues as (1) how insurers can coordinate and fund case development and prosecution efforts, (2) whether and how to regulate unlicensed medical facilities, and (3) how insurers can standardize claims information and billing rules.

# Conclusions and Action Needed

Our work suggests that, to reduce Medicare's risk of financial loss, (1) HCFA needs to assume a more active management posture over contractors' program operations and (2) legislation is needed to assure that HCFA can adequately and consistently fund contractors' safeguard activities. HCFA's inadequate oversight of contractor operations, flaws in payment policies, loose controls over billing procedures, and weak enforcement actions against noncompliant HMOs have led to wasteful spending and program fraud and abuse. In addition, funding of Medicare's payment safeguard activities over the past decade has fluctuated, has not matched the rising volume of claims, and has hampered contractor performance of activities that protect program dollars. For each of these areas, we have made recommendations to HCFA or the Congress.

We also believe that, with efforts to detect and prosecute health insurance fraud and abuse fragmented between the independent operations of the various health insurers, a nationally coordinated effort is needed to combat fraud and abuse effectively. We have therefore suggested that the Congress establish a national commission, which could consider such issues as

- standardization of claims administration,
- sharing information on individuals suspected of fraudulent or abusive practices,
- regulation of providers,
- the creation of state model statutes, and
- joint funding of investigations and prosecutions.

# Related GAO Products

Medicare: One Scheme Illustrates Vulnerabilities to Fraud and Abuse (GAO/HRD-92-76, Aug. 26, 1992).

Medicare: Reimbursement Policies Can Influence the Setting and Cost of Chemotherapy (GAO/PEMD-92-28, July 17, 1992).

Durable Medical Equipment: Specific HCFA Criteria and Standard Forms Could Reduce Medicare Payments (GAO/HRD-92-64, June 12, 1992).

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

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992).

Medicare: Shared Systems Policy Inadequately Planned and Implemented (GAO/IMTEC-92-41, Mar. 18, 1992).

Medicare: Payments for Medically Directed Anesthesia Services Should Be Reduced (GAO/HRD-92-25, Mar. 3, 1992).

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

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: Effects of Durable Medical Equipment Fee Schedules on Six Suppliers' Profits (GAO/HRD-92-22, Nov. 6, 1991).

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

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

Medicare: Information Needed to Assess Payments to Providers (GAO/HRD-91-113, Aug. 8, 1991).

Medicare: Payments for Clinical Lab Tests Are Too High (GAO/HRD-91-59, June 10, 1991).

Medicare: Flawed Data Add Millions to Teaching Hospital Payments (GAO/IMTEC-91-31, June 4, 1991).

Medicare: Further Changes Needed to Reduce Program Costs (GAO/HRD-91-67, May 15, 1991).

Medicare: Variations in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991).

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991).

Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries (GAO/HRD-90-79, May 10, 1990).

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