CBO TESTIMONY

Statement of
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on
Fraud, Waste, and Abuse in Medicare

before the
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NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EDT), Monday, July 31, 1995.

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The budget resolution assumes that the Congress will take actions to reduce the growth of Medicare spending by $270 billion over the 1996-2002 period. As the Congress considers alternative approaches to meeting that target, it is repeatedly confronted with claims that fraud, waste, and abuse are major factors contributing to current levels of outlays and rates of growth in Medicare. Both the general public and many Members of Congress feel that reducing or eliminating illegal or inappropriate behavior on the part of some health care providers would in turn reduce or eliminate the need for making more difficult decisions about how to limit the rate of growth in federal health spending.

Evaluating proposals to reduce fraud, waste, and abuse in Medicare involves addressing three questions. First, what kinds of spending are embodied in the terms fraud, waste, and abuse? Second, what steps could be taken to reduce fraudulent or wasteful spending and improve the integrity of the Medicare program? Finally, how would the Congressional Budget Office (CBO) estimate the savings that might stem from such efforts?

DEFINING FRAUD, WASTE, AND ABUSE

The terms waste, fraud, and abuse are often raised in discussions of federal health spending without being clearly defined or distinguished from the spending for health services that Medicare is intended to cover. One way to think of those issues is to

place all of the activities for which Medicare reimburses providers on a spectrum. At one end of the spectrum are activities that are unmistakably illegal. For example, a health care provider--or, more accurately, nonprovider--who deliberately bills Medicare for services that have not been rendered to a covered beneficiary is clearly engaging in a fraudulent activity. At the other end of the spectrum are the medically necessary, competently performed, and fairly priced health care services for which Medicare is intended to pay.

Although those poles are relatively easy to identify, there is ample room between them. Moreover, no clear line separates abusive activities from fraud. One definition that has been put forth distinguishes abusive activities as those that are not illegal but that violate the intent of the program. That definition, however, offers little guidance in practice. Consider, for example, whether the following examples should be described as abuse:

- A technician mistakenly takes an X-ray of a patient's left leg, then takes a second X-ray when he discovers his error. The hospital bills Medicare for both X-rays.

- A physician admits a patient to a hospital to ensure that drugs are paid for that would not otherwise be covered under Medicare.

- To offset lower fees paid by Medicare, a physician begins recommending follow-up office visits for certain conditions that previously did not warrant such visits.

- A managed care plan markets itself in a way that attracts relatively healthy beneficiaries, thus increasing its profits by reducing the costs of care below those envisioned in the risk-contract reimbursement formula.

Depending on one's perspective, those activities might or might not be characterized as abusive. A definitive characterization, however, would require an understanding of both Congressional intent--that is, knowing the objective of the legislation that permitted (or prohibited) a particular activity--as well as the intent of providers or beneficiaries and the circumstances surrounding their actions. Certainly, some Medicare spending reflects abusive activities; how much is considerably less clear.

Distinguishing between spending that is wasteful and spending that is appropriate is even harder. Among the factors making that determination problematic are the uncertainties of medical science and the lack of financial incentives to limit spending.

Medicare pays for services whose ultimate success is often unknown at the individual level. For example, even the most appropriate use and careful application of diagnostic tests will often rule out a particular illness rather than confirm its presence. In addition, treating a particular illness often allows several approaches, whose costs may vary substantially. Differences in approach may reflect lack of scientific consensus or simply differences in patterns of practice among providers. Studies show that the incidence of many medical procedures varies far more among regions of the country than can be explained by differences in the characteristics of the population of patients.

Advances in medical science may reduce, but will probably never eliminate, uncertainties in diagnosis and treatment. Although negative test results or failed treatments may seem wasteful after the fact, that vantage point is not necessarily the appropriate one from which to assess the value of the services. Similarly, one may expect medical approaches to particular illnesses to become more similar over time as the most successful methods become apparent. Efforts to reduce spending by forcing that convergence to happen more quickly may stifle innovation.

Perhaps more important than the potential waste from the technical aspects of medical care is the institutional environment in which Medicare beneficiaries and health care providers meet. In markets where consumers are well-informed and pay the full costs of purchasing goods and services themselves, economists would

generally not view waste as a relevant issue because people can be presumed to purchase only goods and services that are of value to them. That presumption, however, is much less valid for Medicare. Beneficiaries have had little incentive to concern themselves with costs because they may pay little or nothing at the margin for additional services. Moreover, consumers of health care are often ill-equipped to assess the risks and benefits of alternative therapeutic approaches. The financial incentives faced by health care providers in the fee-for-service sector also encourage the provision of more rather than fewer services.

Medicare spending can be reduced by changing the financial incentives given to beneficiaries and providers. For example, increasing the exposure of beneficiaries to the costs of health care at the margin could make them more cost-conscious and potentially reduce spending. As long as most Medicare beneficiaries have first-dollar coverage through the Medicaid program or through private medigap insurance, however, reducing health spending by this route is difficult. Certain types of managed care could also reduce the use of health care services--in this case by altering the incentives of providers. How much of the reduction would occur through cutting unnecessary services is less clear.

Since 1990, the General Accounting Office (GAO) has made a special effort to review and report on federal programs especially vulnerable to fraud, waste, abuse, and mismanagement. Both Medicare and Medicaid are included in that group of programs. A number of GAO reports have been released that describe specific problems or that suggest ways the Health Care Financing Administration (HCFA) might more effectively reduce the potential for fraud and abuse in its programs.

GAO has cited several factors that make it difficult to ensure the integrity of the Medicare program. One of those is the continued emphasis on unmanaged fee-for-service care, which generates incentives for providers to bill for unnecessary care. Currently, only about 9 percent of Medicare beneficiaries are enrolled in health maintenance organizations (HMOs). GAO notes, however, that managed care plans offer the potential for a different kind of abuse, which is to provide inadequate services. In the fee-for-service sector, problems include:

- *Weak controls for detecting questionable billing practices.* All Medicare bills are screened for consistency and completeness as part of the initial processing

of claims. Even very high volumes of services to individual patients or by individual providers do not necessarily trigger further review before payment. Currently, less than 5 percent of Medicare claims are reviewed.

- *Inadequate checks on the legitimacy of those billing the program.* Medicare lacks stringent requirements for issuing billing numbers to certain providers. In some cases, phantom companies with only a post office box number have qualified to bill the Medicare program. Also, surveys of providers are too infrequent to ensure their continued compliance with Medicare's conditions of participation.

- *Little chance of being prosecuted or penalized.* The weak controls on billing mentioned above make it unlikely that inappropriate claims will be detected, but when they are detected recovery is uncertain. Penalties are often light, large penalties are difficult to collect, and providers often continue to bill Medicare.

HCFA believes that investment in anti-fraud and abuse activities yields a high return, paying for itself many times over by reducing spending for Medicare benefits. The Congress has established other objectives as well, however, which conflict with the objective of deterring fraud and abuse. Two of those other objectives are to ensure reasonably prompt payment to providers and to keep down the costs of

processing claims. Currently, the same conflicting objectives are set for Medicare's contractors. As a result, efforts to detect fraud and abuse may be curtailed because they would increase the costs of processing claims.

It is unrealistic to think that fraud and abuse could be eliminated from Medicare, but their extent could be reduced. HCFA and other federal agencies already have a number of initiatives in place and others in the planning stages that are intended to enhance the integrity of the Medicare program. A number of initiatives are under way at HCFA:

- HCFA is establishing a Medicare Transaction System for processing all Medicare claims. By 1999, that centralized system will replace the 10 different systems now used by Medicare contractors and will integrate claims from Part A and Part B. All claims for a given beneficiary or provider will be in the system, thereby simplifying claims processing and improving the agency's ability to detect inappropriate billings.

- HCFA is running a demonstration program in four states, intended to determine whether simplified and more comprehensive mailings of EOMB (explanation of Medicare benefits) statements to beneficiaries can be used as a cost-effective check on inappropriate billings. Currently, Medicare enrollees

do not receive notices when benefits are paid on their behalf for services that do not require patient cost sharing (primarily home health and laboratory services).

- Operation Restore Trust is a HCFA demonstration in five states targeted toward nursing facilities, home health agencies, and suppliers of durable medical equipment. The demonstration (which builds on an earlier demonstration limited to south Florida) is intended to identify and correct processes in the Medicare and Medicaid programs that make them unnecessarily vulnerable to fraud and abuse. One prominent feature of the demonstration is coordination among federal, state, and private health plans--an important factor because fraudulent practices are rarely targeted toward only one insurer.

- HCFA is also examining ways to improve the provider enrollment process so that fraudulent or unqualified providers are unable to bill Medicare. Some improved procedures have already been put in place for suppliers of durable medical equipment through the National Supplier Clearinghouse, which contains nationwide information on those suppliers. Clearly, HCFA needs stronger requirements for granting Medicare participation, as well as periodic resurveys of participating providers to ensure that they remain in compliance. But HCFA is still reviewing possible corrective actions to take in those areas.

- HCFA has taken steps to focus resources better on fraud and abuse. One individual now serves as the focal point for those activities, reporting directly to the HCFA Administrator. Further, the agency recently established special units at each contractor's site to develop and pursue fraud cases in Medicare. Previously, such activities were collateral duties for contractors, and those duties were given low priority.

The Department of Health and Human Services (HHS) has drafted the Medicare and Medicaid Payment Integrity Act of 1995, which is intended to increase its capacity to combat fraud and abuse in Medicare and Medicaid. One provision would establish an HHS Fraud and Abuse Control Fund, which would finance further investigations of fraud and abuse from funds collected from previous settlements involving Medicare and Medicaid claims, after reimbursing the programs for their losses. A second provision would provide a dependable, long-term funding source from the Medicare trust funds to be used for initiatives to improve the integrity of the Medicare program. That funding would support specialized fraud and abuse units with multiyear contracts. Under current law, funding for activities to improve program integrity is subject to the annual appropriation process and to the statutory limits on discretionary appropriations. Because of the resulting instability in funding, HCFA has found it difficult to invest in developing strategies to control fraud and abuse, nor have Medicare contractors had much incentive to hire and train qualified auditors and investigators.

The Inspector General of the Department of Health and Human Services has been giving greater emphasis to investigating suspected instances of fraud in Medicare and Medicaid. The Inspector General estimates that each dollar spent on these investigations has generated about $7 in recoveries or fines on average for 1990 through 1994. In addition, the Attorney General has said that deterring health care fraud and abuse is the number two priority at the Department of Justice, right after deterring violent crime.

ISSUES RELATING TO BUDGET SCOREKEEPING

Although many proposals to reduce fraud, waste, or abuse in Medicare pose challenges for budget estimators, the difficulty of preparing estimates is not a bar to using such proposals as part of a reconciliation package. Even if data are scanty, CBO will provide the best possible estimate using the information that is available. Congressional scorekeeping rules, however, do prevent CBO from assigning savings to certain proposals for increasing activities to safeguard payments. The final portion of this statement will illustrate the kinds of proposals to which CBO would assign savings and the much smaller set of proposals to which savings could not be credited.

Changes in the Structure of Benefits and Administration

Many of the elements of Medicare that lead to excessive spending are embedded in the legislation establishing the program--particularly, the emphasis on unmanaged fee-for-service care and the cumbersome procedures required to revise certification requirements and payment rates. Legislation modifying those elements of the program could result in quantifiable savings.

For example, the General Accounting Office suggests that Medicare be allowed to price services and procedures more competitively. According to GAO, that recommendation could encompass streamlining processes required to revise excessive payment rates, allowing competitive bidding for services, and negotiating prices. CBO has prepared estimates for many specific proposals of this type, such as limiting payments to physicians in hospitals whose costs far exceed the national median, bundling payment for post-acute care services into payments to hospitals, requiring competitive bidding for certain durable medical equipment and diagnostic tests, establishing payment limits for outpatient department services not covered under current cost limits, and revising cost limits for home health services and skilled nursing facilities.

Another GAO recommendation is to require health care providers to demonstrate their suitability as a Medicare vendor before giving them unrestricted

billing rights. Under that rubric GAO mentions establishing preferred provider networks, developing more rigorous criteria for authorization to bill the program, and using private entities to provide accreditation or certification. CBO has already prepared an estimate for a proposal to establish a preferred provider option for both Parts A and B of Medicare.

Those examples are but a few of the ways in which this Committee might achieve real savings by improving the management of the Medicare program. The Congressional Budget Office will continue to work closely with your staff to provide estimates of those or similar provisions that the Committee may wish to consider.

Payment Safeguard Activities

In a few situations, however, Congressional scorekeeping rules preclude CBO from assigning savings to proposals to improve the management of federal programs, including Medicare. Even before the passage of the Congressional Budget Act and the creation of CBO, Congressional scorekeeping employed the principle that changes in discretionary appropriations for administrative activities do not produce scorable savings or costs in direct spending programs or tax receipts. That principle was given the force of law by the scorekeeping rules included in the conference report accompanying the Omnibus Budget Reconciliation Act of 1990.

Although somewhat arbitrary, the principle is consistent with the current structure of the budget process, which assumes a clear distinction between the budgetary effects of discretionary spending on the one hand and of mandatory spending and revenues on the other. The Balanced Budget Act controls mandatory spending and revenues by the pay-as-you-go process. Separate caps on budget authority and outlays limit discretionary spending. Congressional controls on revenues and mandatory spending involve a five- or ten-year horizon, but the controls on discretionary spending apply only to the budget year. The costs of bills affecting revenues or mandatory spending are measured as deviations from current law, whereas appropriation bills are assigned their full cost. In addition, the current process lacks a mechanism for charging or crediting the Appropriations Committees with changes in revenues resulting from changes in funding levels. Moreover, if savings were scored for increases in administrative funding, costs would have to be shown if administrative funding was reduced. Such savings or costs might arise from even small increases or decreases in many budget accounts, thus significantly complicating the scoring of appropriation bills.

In two instances, special provisions have been made for enforcement initiative --in both cases for the Internal Revenue Service (IRS)--but the basic scorekeeping rule has been maintained. The Budget Committees and the Office of Management and Budget agreed to include revenues resulting from increased spending on IRS enforcement as part of the projected savings from the bipartisan budget agreements

of 1989 and 1990. However, the additional revenues were not attributed to a particular bill and were not reflected in the Congressional scorekeeping system.

Section 25 of the budget resolution for 1995 provided that, for purposes of points of order under the Congressional Budget Act, the discretionary spending limits and the allocations of spending authority to the Appropriations Committees would be increased to reflect the amounts of additional budget authority and outlays provided for the IRS compliance initiative. That provision did not create problems under the Balanced Budget Act only because the budget resolution held discretionary spending below the limits established in the act. Also, no increase in revenues was assumed to result from the additional administrative spending. Section 209 of the budget resolution for 1996, however, repealed the special allowance for the IRS. Although the resolution assumes that the IRS compliance initiative will be fully funded, the conferees expressed concern about efforts to circumvent the discretionary caps and felt that the IRS should not be funded outside the caps.

CONCLUSION

Fraud and abuse clearly exist in Medicare, just as in all other public and private health plans, but estimates of potential losses from fraud and abuse are inherently speculative. If HCFA and private insurers had good information about the extent of

the problem, they would know how to eliminate it. Moreover, fraud and abuse are not easily trimmed from the edges of the program but are marbled throughout the system. In Medicare, as elsewhere in the federal budget, there is no line item labeled "fraud, waste, and abuse."

The General Accounting Office and others have made many suggestions for reducing what they see as wasteful spending by pricing Medicare services and procedures more competitively and choosing health care providers more selectively. Some of those proposals could significantly slow the growth of spending in Medicare. In contrast, several considerations limit the savings to be expected from new payment safeguard initiatives. No savings should be expected without an assurance that the funding intended for specific initiatives to promote program integrity will be used for those purposes and that funding will be maintained in future years. Even with such assurances, and with some evidence of the savings achieved by similar initiatives in the past, the amount of savings to be expected is uncertain because diminishing returns are sure to set in as additional resources are devoted to those activities. Finally, CBO must evaluate any legislative proposal using the scorekeeping rules established by law and longstanding practice. If the Congress finds that spending more on efforts to further program integrity would represent good Medicare policy, however, it can and should ensure the necessary funding.