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FRAUD AND ABUSE IN MEDICARE AND MEDICAID: STRONGER ENFORCEMENT AND BETTER MANAGEMENT COULD SAVE BILLIONS

EIGHTH REPORT

BY THE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

together with

ADDITIONAL VIEWS

JUNE 27, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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(II)

LETTER OF TRANSMITTAL

HOUSE OF REPRESENTATIVES,
Washington, DC, June 27, 1996.

Hon. NEWT GINGRICH,
Speaker of the House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: By direction of the Committee on Government Reform and Oversight, I submit herewith the committee's eighth report to the 104th Congress.

WILLIAM F. CLINGER, Jr.,
Chairman.

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Union Calendar No. 320

104TH CONGRESS, 2nd Session | HOUSE OF REPRESENTATIVES | REPORT 104–641

FRAUD AND ABUSE IN MEDICARE AND MEDICAID: STRONGER ENFORCEMENT AND BETTER MANAGEMENT COULD SAVE BILLIONS

JUNE 27, 1996.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. CLINGER, from the Committee on Government Reform and Oversight, submitted the following

EIGHTH REPORT

On June 20, 1996, the Committee on Government Reform and Oversight approved and adopted a report entitled "Fraud and Abuse in Medicare and Medicaid: Stronger Enforcement and Better Management Could Save Billions." The chairman was directed to transmit a copy to the Speaker of the House.

I. SUMMARY

Fraud and abuse are serious drains on Medicare and Medicaid programs. The General Accounting Office (GAO) estimates that as much as 10% of annual Government outlays in Federal health care programs are lost to fraudulent and wasteful provider claims.[1] If that estimate is correct, it would mean almost $32 billion was lost in FY 95. Given that Medicare and Medicaid together account for $269.16 billion in Federal health care spending in FY 1995, Federal losses to these programs associated with fraudulent and abusive practices approached $27 billion. Finding new ways to curb these losses has been a major bi-partisan concern in recent years.

Both the Medicare and Medicaid programs are vulnerable to fraud and abuse. There are strong incentives to overprovide services; weak fraud and abuse controls to detect questionable billing practices; few limits on those who can bill; and ineffective enforcement tools. The Medicare program is particularly vulnerable be-

[1] GAO Report: "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse," GAO/HRD–92–69, 5/7/92, p. 1.

cause the Department of Health and Human Service's (HHS) Health Care Finance Administration (HCFA) continues to pay higher than market rates for certain services and supplies. This makes the program an attractive target for increasingly sophisticated, multi-state or national fraud schemes.

Medicare is also vulnerable because perpetrators know there is little chance of being caught. Federal enforcement activities have been uncoordinated and ineffectively carried out, and HCFA's anti-fraud-and-abuse controls fail to systematically prevent the unquestioned payment of claims.[2] Screening of claims for medical necessity and other criteria is inconsistently applied. Vendors sanctioned for fraud or abuse are not effectively barred from continued participation in Federal health programs because the exclusion sanction is under utilized. This points to insufficient coordination between those charged with enforcing existing anti-fraud statutes.

HCFA, the HHS–OIG, and DOJ have outlined initiatives for curtailing fraudulent and abusive practices in Medicare and Medicaid programs. However, the extent to which these initiatives will result in improvements to the Federal Government's health care anti-fraud capabilities is uncertain. HCFA has under development the Medicare Transaction System (MTS) to centralize claims review and processing functions now handled by 72 contractors.

The GAO characterized MTS a system "at risk"[3] in terms of cost and scheduling. Meanwhile, near-term opportunities for more effective anti-fraud programs may be missed while HCFA places most of its hopes on the far-off prospect of the MTS.

Waste, fraud and abuse in Medicare and Medicaid will never be completely eliminated. However, billions could be saved by stronger enforcement and better management—actions which would not place excessive demands on available budgets.

Findings in brief:

1. There is insufficient coordination among Government agencies combatting waste, fraud and abuse in the Medicare and Medicaid programs.

2. HCFA does not require Medicare Part B contractors to use software capable of screening out claims for inappropriate medical services.

3. HCFA is reluctanct to exercise its statutory "inherent reasonableness" authority to adjust reimbursement rates for durable medical equipment and supplies because the process is costly and cumbersome. This makes Medicare an attractive target for fraud and abuse. As a result, the Government too often pays more than the market price for certain equipment and supplies costing taxpayers billions of dollars.

4. HCFA's Medicare Transaction System (MTS) project is vulnerable to cost overruns and schedule delays due to the agency's lack of a disciplined management process.

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[2] GAO Report: "Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments," GAO/HEHS–95–210, 2/95, p. 1–2.

[3] *Status of the Medicare Transaction System: The Health Care Financing Administration's Planned Data System to Control Fraud and Abuse, Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 11/16/95. (Prepared written statement of Frank Reilly, GAO's Director of Information Resources Management, p. 2.)

Recommendations in brief:

1. Congress should require HCFA, HHS IG, DOJ, State Medicaid Fraud Control Units and other appropriate law enforcement entities establish a joint program to coordinate fraud detection and prevention activities, and to apply the exclusion sanction against vendors more effectively.
2. HCFA should require its contractors to use autoadjudication prepayment screens to ensure that Medicare does not continue to pay claims for medically unnecessary services.
3. Congress should revise HCFA's "inherent reasonableness authority" to require a price adjustment for a Medicare item or service within 1 year of initiating a review of that item or service through the issuance of an interim final regulation.
4. HCFA should develop a comprehensive management plan to address the cost and scheduling challenges associated with the Medicare Transaction System (MTS). Until that plan is developed, HCFA should focus greater resources on effective, near-term antifraud efforts.

II. BACKGROUND

Total health care spending in the United States reached $949.4 billion[4] in FY 94, and waste, fraud and abuse in health care programs have become issues affecting every American. According to GAO, 10% of every health care dollar spent in this Nation is lost to fraudulent and wasteful provider claims.[5] Applying this estimate to all health care spending, which includes Medicare and Medicaid, means that more than $100 billion, or more than $274 million a day, was lost to fraud and abuse in FY 95.

Medicare and Medicaid programs together represent more than one-quarter of all U.S. health care spending. Federal outlays to Medicare in FY 95 were $159.8 billion[6] while Federal and State outlays to Medicaid were $156.2 billion.[7] Other Federal health care programs such as Civilian Health and Medical Program of the United States (CHAMPUS) and Federal Employee Health Benefit Plan (FEHBP) cost the Federal Government $3.3 billion and $16.2 billion[8] respectively in FY 95. Applying GAO's 10% estimate to Medicare and Federal Medicaid outlays means that about $26.9 billion was lost to fraud and abuse in FY 95.

Medicare, the Nation's largest single payer of health care costs, provided health coverage for approximately 37 million elderly and disabled in FY 95.[9] Medicare spending in Part A, which includes hospital inpatient, home health and skilled nursing services, represents nearly two-thirds of total program spending; Part B, which includes hospital outpatient, physician and laboratory services, represents about one-third of total spending.[10]

Medicaid, which is jointly financed by States and the Federal Government, provided health and long-term care coverage for 33.5

[4] "National Health Care Expenditures," Health Affairs, Project Hope, p. 1.
[5] See *Supra* note 1.
[6] Historical Tables, Budget of the United States Government, Fiscal Year 1997, p. 59. $89.07 billion was the Federal share of Medicaid in FY 95.
[7] Congressional Budget Office (CBO), 3/96 "Baseline Report: Medicaid."
[8] Appendix, Budget of the United States, Fiscal Year 1997, p. 923.
[9] See *Supra* note 2 p. 2.
[10] The Henry J. Kaiser Family Foundation: "The Medicare Program," 12/95, p. 1.

million low income women, children, elderly, blind, and disabled Americans in FY 95.[11] Although women and children represent almost 73 percent of Medicaid's beneficiaries, they represent 28 percent of the program's costs. Most of Medicaid spending is provided to the disabled and the elderly who represent 28 percent of its population but 59 percent of the program's costs.[12]

Both programs fall within the administrative jurisdiction of the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (HHS). Under Medicaid, States have the predominate responsibility to exercise fraud and abuse controls. Curbing Medicare fraud and abuse is a Federal responsibility.

Medicaid is ". . . highly vulnerable to fraud because of its size, structure, target coverage."[13] GAO reports show that medical professionals or businesses that engage in fraudulent and abusive practices have targeted both Medicaid and Medicare resulting in unnecessary expenditures by both programs as well as by private health care insurers. The opportunities for fraud and abuse exist because each program provides incentives to submit claims for services that are not needed, not provided, or overpriced.[14]

Medicare contracts with 72 private companies to handle claims screening and processing and to audit providers. Certain characteristics of the program and the way it is administered create a climate ripe for abuse by some providers. For many supplies and services, Medicare reimbursement far exceeds market rates.[15] Scrutiny of incoming claims is often inadequate to reveal overpricing or oversupply. And providers are allowed to participate in the program without sufficient oversight of their qualifications or their business and professional practices.[16]

In testimony before the Human Resources and Intergovernmental Relations (HRIR) Subcommittee, GAO stated, "HCFA should be a leader in developing effective ways to manage health care expenditures. With Medicare, this would entail such things as: exploring opportunities to improve case management in settings such as nursing homes where fraud and abuse have been a recurring problem; seeking ways to strengthen requirements for providers that request authorization to bill the program; and developing and requiring contractors to implement better computerized checks to flag questionable claims or providers.

"With respect to Medicaid, we find similar problems that need to be addressed. Being a state-administered program, however, HCFA's role shifts from that of direct program management to one of leadership. This would entail documenting, guiding, coordinating, and encouraging the states' efforts. HCFA could also address other—overarching concerns revealed by our study, such as whether—and how—state laws, federal requirements, and other factors

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[11] The Henry J. Kaiser Family Foundation: "Medicaid Facts," 12/95, p. 1.

[12] Ibid.

[13] GAO Report: "Medicaid: A Program Highly Vulnerable to Fraud," GAO/T–HEHS–94–106, 2/25/94, p. 1.

[14] *Agency Oversight Hearing on HHS: The Mission of HHS: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 3/22/95. (Prepared written statement of Sarah Jagger, Director of Health Financing and Policy, General Accounting Office, p. 87.)

[15] See *Supra* note 2 p. 3.

[16] Ibid.

inhibit prosecution or attempts to recover payment of claims subsequently determined not to be authorized by law. Moreover, while all jurisdictions have resource constraints that limit oversight, investigation, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have."[17]

GAO stated in its March 1995 testimony, "Administrative reform proposals from this and the last Congress present features that would help correct [HCFA's] systemic weaknesses and oversight problems . . ." and that HCFA's adoption of ". . . broad-based administrative reforms would significantly enhance the detection and pursuit of fraudulent and abusive providers."

Distinctions should be made among waste, fraud and abuse since these terms are often used interchangeably. These are the generally accepted definitions:

• Waste: the incurring of unnecessary costs as a result of inefficient practices, systems or controls by management. Example: HCFA's failure to require its Medicare contractors to use automated prepayment computer screening for medical necessity of provider claims could save millions, even hundreds of millions, of dollars annually.[18]

• Fraud: gaining something of value through intentional misrepresentation or concealment of material facts. Example: Prescription drug diversion schemes cost the Medicaid program billions of dollars; New York State alone estimates that it loses $150 million a year to fraudulent prescription drug operations.[19]

• Abuse: any practice not consistent with rules, regulations or ethical standards which provides unfair gain for those with access to programs or responsibilities in the public trust. Example: Medicare was billed $8,415 for therapy to one nursing home resident of which over half, or $4,580, was for charges added by the billing service for submitting the claim—a bill-padding practice which is permissible under Medicare rules.[20]

Waste, fraud and abuse in Medicare and Medicaid will never be completely eliminated. Any major reductions in these unacceptable losses, however, would contribute to the long-term financial solvency and stability of these at-risk Government programs, both which are growing at an average annual rate of approximately 10%.[21]

The need to confront waste, fraud and abuse in the Nation's health care plans more aggressively is recognized by both Democrats and Republicans. In the 103d Congress, the Subcommittee on Human Resources and Intergovernmental Relations (HRIR), chaired by Rep. Edolphus Towns (D–NY), held three hearings on waste, fraud and abuse in Medicare and Medicaid. Two hearings fo-

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[17] *Agency Oversight Hearing on HHS: The Mission of HHS: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 3/22/95. (Prepared written statement of Sarah Jagger, Director of Health Financing and Policy, General Accounting Office, p. 92.)

[18] GAO Report: "Medicare: Millions Can Be Saved by Screening Claims for Overused Services," GAO/HEHS–96–49, 2/96, p. 3.

[19] *Waste in Human Service Programs: Other Perspectives: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 5/23/95. (Testimony of Doug Kennedy, New York Post Investigative Reporter.) (Original transcipt p. 82, in subcommittee files.)

[20] See *Supra* note 2 p. 4.

[21] See *Supra* note 7.

cused on Medicaid fraud and prescription drug diversion, recommending that HCFA develop a strategy to address drug diversion which includes designating a unit within HCFA to provide assistance to State Medicaid agencies. A hearing of HRIR Subcommittee on July 27, 1994 marked up Section 5401 of H.R. 3600, the Health Security Act, directing the Secretary of HHS and the Attorney General to establish a program to "prevent, detect and control health care fraud and abuse." [22]

This bi-partisan effort in the subcommittee continued in the 104th Congress. The HRIR Subcommittee, chaired by Rep. Christopher Shays, held eight hearings that considered waste, fraud and abuse in health care programs:

1. HRIR Subcommittee hearing on Department of Health and Human Services, March 1, 1995.
2. HRIR Subcommittee follow-up hearing on Department of Health and Human Services, March 22, 1995.
3. HRIR Subcommittee hearing on Waste in Human Service Programs, May 23, 1995.
4. HRIR Subcommittee hearing on Keeping Fraudulent Providers Out of Medicare and Medicaid, June 15, 1995.
5. HRIR Subcommittee hearing on H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995 and H.R. 1850, the Health Care Fraud and Abuse Act of 1995, September 28, 1995.
6. HRIR and Government Management, Information, and Technology (GMIT) joint Subcommittee hearing on the Oversight and Review of Medicare's Transaction and Information Systems, November 16, 1995.
7. HRIR Subcommittee hearing on Screening Medicare Claims for Medical Necessity on February 8, 1996.
8. HRIR and GMIT joint Subcommittee hearing on H.R. 3224, the Health Care Fraud and Abuse Prevention Act of 1996, H.R. 1850, the Health Care Fraud and Abuse Act of 1995 and H.R. 2480, Inspector General for Medicare and Medicaid, May 2, 1996.

As noted above, the subcommittee reviewed four pieces of legislation introduced in the 104th Congress to address the challenges of combatting fraud and abuse in health care programs, including Medicare and Medicaid: H.R. 2326, H.R. 3224, H.R. 1850 and H.R. 2480.

The Health Care Fraud and Abuse Prevention Act of 1996, H.R. 3224, was introduced by Congressman Steven Schiff (R–NM), vice chairman of the Government Reform and Oversight Committee, and Congressman Christopher Shays (R–CT), HRIR chairman. In Title I: Federal enforcement authorities are required to coordinate their efforts more effectively and establish a control account, funded by fines and damages, to help defray Federal and State costs of prevention and detection of fraud and abuse. In Title II: all health care fraud, whether in public or private programs, would become a Federal crime for the first time. In Title III: new tools are provided for the HHS Inspector General (IG) to better combat Medicare and Medicaid fraud and abuse.

[22] Activities of the House Committee on Government Operations, Report 103–884, 1/2/95, p. 218 & p. 294.

In the 103d and 104th Congress, language similar to H.R. 3224 was drafted to combat the pervasive waste, fraud and abuse in the health care industry. Senator William Cohen (R–ME) issued an investigative staff report [23] in July 1994 which recommended:

- Making all health care fraud and abuse a violation of Federal law.
- Establishing a data base available to all program administrators, private insurers and law enforcement groups which will identify persons or providers who have been found guilty of fraud.
- Establishing standard penalties for fraud which, for a first time offender, require mandatory exclusion from the programs for a specified period of time as well as assessment of civil monetary penalties.
- Strengthening certification standards and procedures for providers.
- Enhancing provider responsibility and accountability for electronic media claims; requiring contractors to utilize automated computer screening of provider claims.
- Making HCFA's pricing of medical equipment and services more current, competitive and market sensitive in its reimbursement of provider claims.
- Improving anti-kickback laws.

Congressmen Shays and Schiff have also introduced H.R. 3225 which would require HHS to adopt timely, market-sensitive pricing of equipment and services to avoid overpayment of claims made by health care providers.

The Health Care Fraud and Abuse Act of 1995, H.R. 1850, was sponsored by Congressman Edolphus Towns (D–NY), ranking member of the HRIR Subcommittee. Title I of H.R. 3224 is similar to H.R. 1850 which calls for increased coordination among Medicare and Medicaid law enforcement agencies.

The Inspector General for Medicare and Medicaid Act of 1995, H.R. 2480, was sponsored by Congressman Jack Quinn (R–NY). This bill creates a separate IG office for Medicare and Medicaid.

Other legislation with new health care anti-fraud provisions includes The Medicare Preservation Act of 1995, H.R. 2491, and The Health Care Availability and Affordability Act, H.R. 3103. Some provisions of H.R. 3224 were included in these two bills. Both measures passed the House.

III. FINDINGS

1. There is insufficient coordination among Government agencies combatting waste, fraud and abuse in Medicare and Medicaid programs.

Overlapping jurisdictions of Federal, State and law enforcement agencies responsible for investigations and prosecutions of Medicare and Medicaid fraud present significant coordination problems. The agencies that share jurisdictions include: DOJ, including the FBI and U.S. attorneys; HHS IG; HCFA Office of Program Integrity; Department of Defense IG; Drug Enforcement Agency; Internal Revenue Service; State and local authorities; and State Medic-

[23] "Gaming the Health Care System: Investigative Staff Report," Senator William Cohen, ranking member, Senate Special Committee on Aging, p. 4.

aid Fraud Control Units (MFCUs). Additional groups involved in combatting health care fraud are: Medicaid contractor fraud units; Medicaid administrators; U.S. Postal Inspectors; Veterans Affairs IG; Department of Labor IG; Office of Personnel Management IG; and others.

During a June 1995 hearing, Dr. Bruce Vladeck, HCFA's Administrator, was asked how these multi-jursidictional agencies approach Medicare and Medicare fraud cases and ensure preventing abusive providers from continuing to bill the programs. He reported, "Again, as you know, the process of excluding providers from the [Medicare] system is one that under law is the responsibility of the Inspector General. I would defer to her in talking about that process." [24] He further explained, "To be blunt, I think there was some history within the Health Care Financing Administration growing out of past history of an attitude that fraud and abuse problems are the Inspector General's, the FBI responsibility, and we [HCFA] have other things to do." [25]

Vladeck added, "As a part of our emphasis—as a central part of our emphasis on the importance of program integrity, we have invested enormous resources and energy in substantially strengthening our working relationships with the Inspector General, with the Department of Justice, with the components of the Department of Justice such as the FBI and the U.S. attorneys, not only in Washington where it is critically important, but more importantly in the field, at the level of relationships between individual contractors, individual U.S. attorneys offices, local FBI offices and so forth. We have somewhat more about that in my statement, but frankly, I am happy to defer to my colleagues from the Inspector General and from the Department of Justice to tell you more about how some of those relationships work."

Chairman Shays rejected Dr. Vladeck's statements responding that "candidly I am concerned by the attitude that I think is coming across to me, and that is revoking of billings is the responsibility of the Inspector General." [26]

Chairman Shays wanted to know why HCFA did not more aggressively urge inclusion of the exclusion sanction more often in fraud cases settled by the Department of Justice.

The chairman asked Dr. Vladeck, "Is it your attitude that when you see someone who has defrauded the system, do you not weigh in and say . . . there is no way we should allow this person to continue to be in the [Medicare] system?" [27] Dr. Vladeck responded, "We generally weigh in when we are asked." [28] He added that, "Historically, there has been no participation by us in the settlement."

The need for greater coordination between the Government agencies overseeing the Medicare and Medicaid programs was expressed

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[24] *Keeping Fraudulent Providers out of Medicare and Medicaid: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 6/15/95. (Testimony of Dr. Bruce Vladeck, Administrator of the HCFA.) (Original transcript, p. 22, in subcommittee files.)

[25] Ibid p. 21.

[26] HRIR hearing of 6/15/96. (Testimony of Rep. Christopher Shays, chairman of the HRIR Subcommittee.) (Original transcript, p. 39, in subcommittee files.)

[27] Ibid p. 40.

[28] HRIR hearing of 6/15/95. (Testimony of Dr. Bruce Vladeck, Administrator, HCFA.) (Original transcript, p. 40, in subcommittee files.)

by several witnesses. Rufus Noble, Inspector General for Florida's Health Care Administration, said, "There remains tremendous need to improve coordination among the various organizations that have responsibilities for identifying, investigating and prosecuting health care fraud and abuse. While some intergovernmental coordination and information sharing between public and private organizations occur, more could be done." [29]

Sarah Jaggar, Director of GAO's Health Financing Division, in a March 1995 hearing said that ". . . numerous jurisdictions have responsibility over Medicaid fraud and abuse matters. It is not unusual for a prescription drug fraud case [for example] to involve five or more state, local and federal agencies in its investigation, prosecution and resolution." [30]

William Mahon, executive director, National Health Care Anti-Fraud Association, told the subcommittee that "fraud is most effectively addressed through cooperative public-private efforts. Dishonest providers do not defraud either public or private health care programs exclusively nor do they defraud only one payer at a time. Any discussion of health care fraud must also acknowledge the reality that the public's loss to health care fraud is twofold . . . once through fraud against tax-funded government program, and again when private health insurance plans are the target." [31]

In testimony, HCFA claimed the benefit of "unprecedented" [32] coordination between HCFA, Medicare contractors, State Medicaid agencies, State Attorneys General and the HHS IG in their joint anti-fraud initiative called the South Florida Workgroup. Another special project led by the HHS IG, Operation Restore Trust, emphasizes "improved communications between federal and state agencies." [33]

Operation Restore Trust was launched by the administration in May 1995. It is a major demonstration project that involves HCFA, HHS–OIG, DOJ, U.S. attorneys, and the State Medicaid Fraud Control Units. Operation Restore Trust has targeted four areas of excessive and unnecessary spending growth in the five States which comprise more than a third of all Medicare and Medicaid beneficiaries—New York, Florida, Illinois, Texas, and California. A comprehensive evaluation of the effectiveness of this program has not yet been conducted.

Dr. Helen Smits, HCFA's deputy administrator, testified that "this joint effort [Operation Restore Trust] should yield substantial savings to the government. We must recognize that fraud and abuse is pervasive throughout the health care industry in this country; Medicare and Medicaid are not the only targets. The private sector faces at least as great a problem as the government. As

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[29] HRIR hearing of 6/15/95. (Prepared written statement of Rufus Noble, Inspector General, Florida Agency for Health Care Administration, p. 3, in subcommittee files.)

[30] HRIR hearing of 3/22/95. (Testimony of Sarah Jaggar, Director of Health Financing and Policy, General Accounting Office.) (Original transcript, p. 20, in subcommittee files.)

[31] HRIR hearing of 6/15/95. (Prepared written statement of William Mahon, executive director, National Health Care Anti-Fraud Association, p. 3, in subcommittee files.)

[32] *H.R. 2326, the Health Care Fraud and Abuse Prevention Act of 1995 and H.R. 1850, the Health Care Fraud and Abuse Act: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR 9/28/95 hearing. (Prepared written statement of Dr. Helen Smits, deputy administrator, HCFA, p. 3, in subcommittee files.)

[33] Ibid.

a result, public/private partnerships that bring together the best thinking and best practices are the key to reducing fraud and abuse."[34]

In his subcommittee testimony, Gerald Stern, DOJ Special Counsel for Health Care Fraud reported that "the Attorney General in 1993 determined that health care fraud enforcement would be her number two new initiative, behind violent crime." The Special Counsel also advised the subcommittee that the Department of Justice's program would involve "increased resources, investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions, criminal, civil, and administrative." However, Sterm opposed any legislative restriction on procecutorial discretion on the use of the exclusion sanction.

In a September 1995 report, GAO found that "despite the egregious cases of Medicare fraud, corporate providers have been allowed to continue their program participation. In one of the more significant Federal health care fraud prosecutions to date, a clinical laboratory company acknowledged over $100 million in fraud committed as part of a nationwide scheme against Medicare, Medicaid and CHAMPUS over a four year period. The lab was allowed to negotiate a civil settlement including language that specifically permitted its continued participation in all three programs."[35]

2. HCFA does not require Medicare Part B contractors to use software capable of screening out claims for inappropriate medical services.

The Social Security Act (SSA)[36] requires Medicare to pay only for items and services that are reasonable and necessary for the diagnosis and treatment of a medical condition. The SSA also requires Medicare contractors to apply appropriate safeguards against unnecessary utilization of items and services furnished by health care providers and suppliers.[37]

HCFA regulations mandate that contractors conduct prepayment and postpayment reviews of claims to identify inappropriate services and take corrective action when indicated. Prepayment medical review can identify certain claims before they are paid if they are subjected to autoadjudicated computer screening. The screens compare the diagnosis on the claim with the acceptable diagnostic treatments specified in the medical policy. For example, the autoadjudicated screen would deny the claim for a chest x ray if the patient diagnosis was a sprained ankle.

In a survey of 17 of 29 Medicare Part B contractors, GAO found more than half were not using medical necessity prepayment screens.[38] GAO reviewed six groups of procedures that rank among the most costly Medicare services and reported, "Most of the contractors we surveyed routinely pay claims for procedures suspected to be widely overused without first screening those claims against medical necessity criteria."[39]

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[34] Ibid, p. 1.
[35] See *Supra* note 2 p. 15.
[36] 42 U.S.C. Section 1842(b)(3).
[37] Section 1842 (a)(2)(B) of the Social Security Act.
[38] See *Supra* note 18 p. 3.
[39] Ibid p. 7.

GAO attributes the infrequent use of medical necessity prepayment screens to a lack of leadership on HCFA's part. GAO stated, "HCFA does not have a national strategy for using prepayment screens to deny payments for unnecessary service among Medicare's most highly overused procedures. Moreover, the agency does not ensure that contractors implement prepayment screens or other corrective actions for these procedures."[40]

According to GAO, HCFA required contractors to review 15% of all claims before payment in 1991 but reduced the mandatory number of claims reviewed to 4.6% in 1995.[41] This is despite a 32.5% increase in claims and a $54 billion increase in outlays. Medical review as a percentage of contractor budget has decreased from 10.7% to 7.1% in 1995.[42]

GAO's review of just 7 of the 17 contractors revealed that between $29 million and $150 million was paid for claims that may have been medically unnecessary.[43] GAO concluded in their report that because the remaining contractors were not using medical necessity screens for some of these procedures, they may also have paid millions of dollars in Medicare claims for services that should have been denied.[44]

In the first quarter of FY 95, fewer than one-half of the 17 contractors surveyed were using prepayment screens according to GAO.[45] Ten of the contractors lacked a screen for echocardiography, although it is the most costly diagnostic test in terms of total Medicare payments.[46]

GAO found "for widely overused procedures, such as the six we tested, autoadjudication screens can be a low-cost, efficient way to screen millions of claims against basic medical necessity criteria. Contractor officials said that these screens are much less expensive to implement than screens that suspend for manual review. Consequently, as funding for program safeguards declines, autoadjudication screens can be used to maintain or even increase the number of claims reviewed."[47]

HCFA's strategy to protect beneficiaries and the integrity of the Medicare program relies on contractors ". . . who have the experience and expertise to identify potential abuse in their area and to act quickly to report it. HCFA expects contractors to identify items and services that are vulnerable to abuse, develop appropriate local medical review policies, educate providers and implement prepayment screens."[48]

GAO reported, "HCFA has chosen to avoid the appearance of interfering in local medical practice . . . (although) Medicare leg-

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[40] Ibid p. 13.
[41] Ibid p. 4.
[42] According to Medicare Contractor Activities charts supplied by HCFA dated 10/17/95.
[43] See *Supra* note 18.
[44] Ibid.
[45] Ibid p. 7.
[46] Ibid p. 8.
[47] Ibid p. 12.
[48] *Screening Medicare Claims for Medical Necessity: Oversight Hearing Before the Subcommittee on Human Resources of the House Committee on Government Reform and Oversight,* HRIR hearing of 2/8/96. (Testimony of Gary Kavanagh, deputy director of the Bureau of Program Operations, HCFA.) (Original transcript, p. 78, in subcommittee files.)

islation does not preclude HCFA from requiring its contractors to screen claims for nationally overused services."[49]

However, HCFA testified on its management initiative and technologies to improve the claims review process. The "focused medical review" process, adopted by HCFA in 1993, concentrates the analysis of claims data on local utilization patterns. It requires each of the 29 contractors to target services that are vulnerable to abuse in their local area and prevent payment of unnecessary or fraudulent claims through prepayment screening and development of local and model medical review policies. In another example, on January 1, 1996, Medicare contractors implemented coding screens based on recommendations made by AdminaStar, a firm contracted by HCFA in 1994 for that purpose.

3. HCFA is reluctanct to exercise its statutory "inherent reasonableness" authority to adjust reimbursement rates for durable medical equipment and supplies because the process is costly and cumbersome. This makes Medicare an attractive target for fraud and abuse. As a result, the Government too often pays more than the market price for certain equipment and supplies costing taxpayers billions of dollars.

A September 1995 GAO report stated: "For many supplies and services, Medicare reimbursement far exceeds market rates."[50]

Under the law, HCFA reimburses providers and suppliers of durable medical equipment (DME) according to a fee schedule that is annually adjusted for inflation.[51] To change the price for an individual item or service, HCFA must observe a regulatory process establishing that the fee is not inherently reasonable.[52] Under this inherent reasonable (IR) process, HCFA must, through an elaborate and detailed economic analysis, prove the Medicare fee is "grossly excessive" or "grossly deficient."[53]

The economic analysis is mandated by the Omnibus Budget Reconciliation Act of 1987 (OBRA '87)[54] and requires HCFA to document the following conditions:

- The prevailing charges for a service in a particular locality are significantly in excess or below prevailing charges in other comparable localities.
- Medicare and Medicaid are the sole or primary sources of payment for this item or service.
- The marketplace is not competitive.
- There has been an increase in charges that cannot be explained by inflation or technology.
- The higher price does not reflect a new technology.
- The prevailing prices are substantially higher than prices paid by other purchasers in the same area.

During a May 2, 1996 hearing, Michael Mangano, Principal Deputy Inspector General for HHS testified, "The most important message I would like to leave today with this committee is that the

[49] See *Supra* note 18 p. 13.
[50] See *Supra* note 2 p. 3.
[51] Section 1834(a)(10)(B) of the Social Security Act, 42 U.S.C. 1395m(a)(10)(B).
[52] Ibid.
[53] Section 1842(b)(8) and (b)(9) of the Social Security Act, 42 U.S.C. 1395u(b)(8) and (b)(9).
[54] Section 1842(b)(8)(B)(ii)(I)–(IV) of the Social Security Act, 42 U.S.C. 1395u(b)(8)(B)(ii)(I)–(IV).

Medicare program is far too limited in how they can act and how quickly they can act. When we identify a particular piece of equipment that is just overpriced or what we would call 'inherently unreasonable,' Medicare can't really react fast enough to the marketplace to adjust that price downward. Instead, they have to use, at the current time, the rule-making process, which usually takes about two to four years. It is time-consuming and resource-intensive." [55]

According to a September 1995 GAO report, the IR process to change the price of home glucose monitors took HCFA 995 days to complete.[56] HCFA has begun the IR process with another DME item, home oxygen concentrators, which began in November 1994 [57] and has not yet issued a final rule setting the new price. The GAO study reported if Medicare were able to pay the same price for oxygen concentrators as that paid by the Department of Veterans Affairs, it could realize as much as $4.2 billion in savings over 5 years.[58]

The complexity of the process and the length of time it takes HCFA to complete the process once begun do not effectively protect the Medicare program from waste. The resources and time required to change a price make it an inefficient procedure. GAO recently concluded, "HCFA is slow and often ineffectual in addressing problems involving overpricing . . ." [59] Since 1992, HCFA has only invoked its IR authority twice to adjust the prices of Medicare items—home glucose monitors and oxygen concentrators.

The HHS IG characterized the current price adjustment system as "absurd." [60] The IG concluded, "While some of these requirements [of the Social Security Act or the Administrative Procedures Act] may serve useful purposes . . . some may prevent program managers from taking appropriate action to improve program operations." [61]

HCFA's inability to adjust prices in a timely manner creates a climate for abuse by some providers and results in billions of taxpayer dollars lost every year.[62] As the HHS IG so eloquently stated, "when Willie Sutton was asked why he robbed banks, he responded 'Because that's where the money is.' Today's criminals may be more sophisticated, but in a way they remain true to their forebears. They go where the money is." [63] The HHS IG estimates that timely adjustment of the prices of home glucose monitors and

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[55] *Joint hearing on H.R. 3224, the Health Care Fraud and Abuse Prevention Act of 1996, H.R. 1850, the Health Care Fraud and Abuse Act of 1995 and H.R. 2480, Inspector General for Medicare and Medicaid: Oversight Hearing Before the Subcommittee on Human Resources and the Subcommittee on Government Management, Information, and Technology of the House Committee on Government Reform and Oversight,* HRIR and GMIT joint hearing of May 2, 1996. (Testimony of Michael Mangano, Principal Deputy Inspector General, HHS.) (Original transcript, p. 42, in subcommittee files.)

[56] See *Supra* note 2 p. 8.

[57] Ibid p. 9.

[58] Ibid.

[59] Ibid p. 7.

[60] Ibid p. 7.

[61] HHS IG letter to Representative Bill Archer, chairman of the House Ways and Means Committee dated May 9, 1996, in subcommittee files.

[62] See *Supra* note 2 p. 1.

[63] HRIR hearing of 3/22/95. (Prepared written statement of June Gibbs Brown, Inspector General, HHS, p. 10, in subcommittee files.)

oxygen concentrators could have saved $10 million over 3 years and $4.2 billion over 5 years respectively.[64]

In a February 1996 report, the IG found that Medicare payments for enteral nutrients are excessive, because reimbursement rates are set too high. Other examples of excessive reimbursement rates include Medicare reimbursement for Category I nutrients [the simplest and most widely used formulas]. Medicare pays $0.61 per unit, while average cost to a nursing home is approximately $0.43 per unit. The IG estimates that if enteral nutrients were recognized as a food, Medicare would save approximately $170 million annually.[65]

The IG found in a March 1994 report that ambulatory surgical centers were paying $126 for an intraocular lens (IOL) insertion while the Medicare reimbursement was $200.[66] In addition, the IG reported in May 1993 HCFA's current reimbursement for hospital beds does not reflect the useful life of the bed. Medicare pays for the use of the bed on a monthly basis and a typical bed can be rented 7.5 to 10 times over its useful life, resulting in total Medicare payments of around $7,000 while the bed could be acquired for an average of $1,000.[67] All of these examples resulted in excessive payments to suppliers.

In FY 95, the Medicare program paid $5.99 billion in DME claims.[68] This multi-billion dollar industry derives substantial benefit from HCFA's inability to adjust prices of Medicare items and services on a more timely basis.

4. HCFA's Medicare Transaction System (MTS) project is vulnerable to cost overruns and schedule delays due to the agency's lack of a disciplined management process.

The Medicare Transaction System (MTS) is HCFA's computer modernization project for Medicare claims processing. The single automated system will replace the nine current claims processing systems used by Medicare contractors. It is projected to be fully implemented in 1999.

The goals for MTS as reported by HCFA are: improved service to beneficiaries and health care providers; enhanced program safeguards; inclusion of managed care and other alternative payment methods; and improved control of Medicare program expenditures.[69]

Currently, HCFA contracts with 44 fiscal intermediaries and 28 carriers which operate nine different computer programs to process Medicare claims. According to Dr. Bruce Vladeck, the current decentralized contractor arrangement is expensive because every change in Medicare policy or procedures requires modification of all nine systems.[70]

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[64] Ibid p. 7.

[65] HRIR and GMIT joint hearing of 5/2/96 (Prepared written statement of Michael Mangano, Principle Deputy Inspector General, HHS, p. 9, in subcommittee files.)

[66] Ibid p. 12.

[67] Ibid.

[68] According to information provided by Michael Mangano, Principal Deputy Inspector General for HHS, in response to verbal request from HRIR Subcommittee on May 3, 1996.

[69] HRIR hearing of 11/16/95. (Prepared written statement of Dr. Bruce Vladeck, administrator, HCFA, p. 1, in subcommittee files.)

[70] Ibid, p. 3.

In 1995 testimony before a joint hearing of the HRIR Subcommittee and the Subcommittee on Government Management, Information, and Technology, Dr. Vladeck reported that HCFA began to develop MTS in the early 1990's to meet the need for a "single national claims processing and information system for the Medicare program." [71]

Criticism of MTS has focused on HCFA's management of the risks associated with such a large procurement project. According to testimony during the joint hearing, GAO supports HCFA's decision to pursue MTS but has serious concerns about possible cost overruns and unrealistic scheduling of the project.

Frank Reilly, GAO's Director of Information Resources Management, testified that HCFA has allowed the MTS to proceed ". . . despite (1) difficulties in defining requirements, (2) a compressed schedule containing significant overlap of system-development phases, and (3) a lack of reliable information about costs and benefits." [72] Based on GAO's review of these issues, Mr. Reilly concluded that the MTS goal to improve processing of Medicare claims is at risk.[73]

HCFA's schedule for MTS set April 1996 as the completion date for current requirements of the system, and August 1996 as completion date for future requirements. Concurrently, HCFA's contractor will begin building the system prototype to be tested beginning in September 1997. After 24 months of testing, HCFA expects the prototype to be perfected and fully implemented.[74]

GAO determined that MTS deadlines will not allow adequate time for proper development of current and future requirements as well as testing of the prototype system. In testimony, Mr. Reilly said that "the system's future capabilities may be seriously constrained" [75] because the design may not reflect key requirements.

Delays in the MTS schedule affect cost projections. According to GAO testimony, the current cost projections are based on 1992 estimates and have not been updated "in over three years." [76] Mr. Reilly testified that "in our experience, problems related to requirements definition, schedule and cost often contribute to extensive delays . . . [and] . . . large cost increases." [77]

Private sector witnesses echoed concerns about risks in the MTS project. Gary Rudin, corporate vice president of EDS' Health Care Group, stated, "MTS is heading towards development of a new monolithic system that by the time it is implemented may well be obsolete . . . We recommend that the MTS initiative be revisited,

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[71] HRIR hearing of 11/16/95. (Testimony of Dr. Bruce Vladeck, administrator, HCFA, p. 27, in subcommittee files.)

[72] HRIR hearing of 11/16/95. (Prepared written statement of Frank Reilly, Director of Information Resources for Health, Education and Human Services, General Accounting Office, p. 2, in subcommittee files.)

[73] Ibid.

[74] According to MTS timeline provided by HCFA staff in response to a 8/2/95 information request from the HRIR Subcommittee.

[75] HRIR 11/16/95 hearing. (Prepared written statement of Frank Reilly, Director of Information Resources for Health, Education and Human Services, General Accounting Office, p. 10, in subcommittee files.)

[76] Ibid, p. 64.

[77] Ibid, p. 62.

considering the dramatic changes in health care and technology over the last five years."[78]

The chairmen and ranking members of each subcommittee have requested that GAO continue its review of the MTS project specifically focusing on minimizing risks and delivering the project on a realistic schedule.[79] That study is underway.

IV. RECOMMENDATIONS

1. Congress should require HCFA, HHS IG, DOJ, State Medicaid Fraud Control Units and other appropriate law enforcement entities establish a joint program to coordinate fraud detection and prevention activities, and to apply the exclusion sanction against vendors more effectively.

Informal agreements or joint operations between Government agencies cannot effectively combat Medicare and Medicaid fraud on a continuing basis nor can they restore the trust of the American taxpayers.

In testimony, Gerald Stern, DOJ's Special Counsel on Health Care Fraud, asked for the subcommittee's assistance in the Department's efforts to fight fraud in the Medicare and Medicaid programs. He said "better communication among all of us has allowed us to choose the most the most appropriate sanction or sanctions to address particular health care fraud problems."[80] Congress should expand permissive and mandatory exclusion authority and HHS OIG and DOJ should use the sanction in enforcement actions and settlements.

Congress should ensure effective coordination of public and private anti-fraud enforcement by enacting legislation to require annual enforcement planning and to permit greater information sharing.

Legislation should require the IG and Attorney General to establish a joint program to prevent, detect and control health care fraud including State agencies and local law enforcement, require IG and AG to consult with regularly State and local agencies, and should establish health care fraud and abuse control account in Dept. of Treasury.

2. HCFA should require its contractors to use autoadjudication prepayment screens to ensure Medicare does not continue to pay claims for medically unnecessary services.

Screening guidelines should be established to ensure Medicare does not continue to pay claims for medically unnecessary services. Sarah Jaggar, GAO's Director of Health Financing, urged HCFA ". . . to hold its contractors accountable for implementing local policies and prepayment screens . . . [in order] to control payments for widely overused procedures."[81]

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[78] HRIR hearing on 11/16/95. (Testimony of Gary Rudin, corporate vice president of Health Group, EDS, p. 109, in subcommittee files.)

[79] Joint letter from the Subcommittee on Human Resources and Intergovernmental Relations and the Subcommittee on Government Management, Information, and Technology to Charles A. Bowsher, Comptroller General, General Accounting Office, dated 4/22/96.

[80] HRIR hearing of 6/15/95. (Testimony of Gerald Stern, Special Counsel for Health Care Fraud, DOJ, p. 82, in subcommittee files; *see also,* Prepared Written Statement of Gerald Stern, p. 16–17, in subcommittee files.)

[81] Ibid.

Ms. Jagger said, "Problems with controlling payments for widely overused procedures persist because HCFA lacks an effective national strategy. Although the need for national leadership is compelling, HCFA has not exercised its statutory authority to take an active role in promoting more local medical policies and prepayment screens for widely overused procedures."[82] According to Ms. Jaggar, "If the use of autoadjudication screens were expanded to all of Medicare's contractors, the savings we identified would likely be hundreds of millions of dollars . . ."[83]

3. Congress should revise HCFA's "inherent reasonableness" authority to require a price adjustment for a Medicare item or service within 1 year of initiating a review of that item or service through the issuance of an interim final regulation.

Michael Mangano, Principal Deputy Inspector General for HHS, testified in a May 2, 1996 hearing that "We have issued numerous reports on problems with . . . (durable medical equipment) . . . and undertaken a large number of investigations. In general, even when the IG or HCFA identifies a particular piece of equipment as significantly overpriced (i.e., as "inherently unreasonable"), the Department or carriers cannot adjust reimbursement levels without going through the regulatory process that . . . is resource-intensive and time-consuming . . ."[84]

Mr. Mangano reported, "There are some things Congress can do to improve the Medicare program . . . statutory improvements can be made to allow greater program flexibility and to close loopholes in the law. HCFA can promulgate rule-makings to adjust prices to reflect market conditions . . ."[85]

Mr. Mangano concluded: "We recommend that the Congress enact legislation which would allow HCFA to apply "inherent reasonableness" in setting reimbursement amounts (this would allow downward adjustments)."

This legislative language was introduced on March 29, 1996 by Representatives Shays (R–CT), Schiff (R–NM) and Barrett (D–WI). H.R. 3225 would require the Secretary to issue an interim final regulation adjusting the price for a Medicare item or service within 1 year of initiating the review of that item under HCFA's inherent reasonableness authority.

4. HCFA should develop a comprehensive management plan to address the cost and scheduling challenges associated with the Medicare Transaction System (MTS). Until that plan is developed, HCFA should focus greater resources on effective, near-term anti-fraud efforts.

On April 24, 1996 HCFA issued Request for Proposals (RFPs) to design and build two claims processing MTS sites and one analysis center.[86] Issuance of these RFPs is on schedule with HCFA's origi-

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[82] See *Supra* note 18.

[83] HRIR and GMIT joint hearing of May 2, 1996. (Testimony of Sarah Jaggar, Director of Health Financing Policy, GAO.) (Original transcript, p. 12, in subcommittee files.)

[84] Ibid p. 3.

[85] Ibid p. 5.

[86] "HCFA Unveils Medicare RFP", Federal Computer Week, 5/6/96, p. 22.

nal timetable for MTS which suggests that HCFA has not revised its schedule to reflect the concerns raised by GAO in testimony.

HCFA's lack of response to GAO testimony is troubling to both the HRIR and the GMIT Subcommittees. As noted earlier, GAO is continuing to study the design and implementation of the MTS system "to determine the extent to which HCFA is managing the MTS projecto as an investment that will maximize benefits, minimize risks, and be delivered on schedule."[87]

In the absense of a comprehensive MTS management plan, HCFA should focus its resources on specific existing anti-fraud techniques which would result in substantial savings for the Medicare program. For example, HCFA should require its contractors to implement prepayment screens to ensure Medicare pays only for items and services that are reasonable and necessary for the diagnosis and treatment of a medical condition.

Another opportunity for immediate anti-fraud prevention is the implementation of a unique identifier system for Medicare providers and suppliers. This would limit providers to one universal identification number and require use of the universal number by every provider in the submission of a Medicare claim. Implementation of this system would inhibit the ability of fraudulent providers and suppliers to hide behind multiple identifier numbers when submitting claims.

[87] Letter of May 23, 1996 to Reps. Shays, Towns, Horn and Maloney from Patricia Taylor, Director, Health, Education and Human Services Information Systems Issues, General Accounting Office. In subcommittee files.

ADDITIONAL VIEWS OF HON. CARDISS COLLINS, HON. EDOLPHUS TOWNS, HON. HENRY A. WAXMAN, HON. TOM LANTOS, HON. ROBERT E. WISE, JR., HON. MAJOR R. OWENS, HON. LOUISE SLAUGHTER, HON. BERNARD SANDERS, HON. KAREN L. THURMAN, HON. THOMAS M. BARRETT, HON. BARBARA-ROSE COLLINS, HON. JAMES P. MORAN, HON. GENE GREEN, HON. CHAKA FATTAH, AND HON. ELIJAH E. CUMMINGS

This investigative report (the Report) results from a Human Resources and Intergovernmental Relations Subcommittee examination of the high incidence of waste, fraud and abuse in Medicare and Medicaid programs. The subcommittee sought to determine the efficacy of Federal efforts to minimize excessive or unnecessary health care expenditures. Toward this end, the subcommittee considered issues related to the extent of fraud and abuse in Medicare and Medicaid; current detection, prevention and enforcement initiatives; and opportunities that exist, as well as those which must be created by legislation, to improve Federal efforts.

We generally support the Report. However, we are concerned that in some instances, its characterization of deficiencies in Federal anti-fraud efforts is based on information and testimony that is more than a year old. The accuracy of that information and testimony is not disputed. Nevertheless, we find that it has limited utility as a current measure of the effectiveness of the Administration's detection, prevention and enforcement initiatives. A full understanding of the efficacy of Federal efforts requires the consideration of the evolution in those efforts as well as additional facts or factors that the Report omits. Our additional views seek to strengthen the Report by providing updated and clarifying information regarding the Administration's anti-fraud and abuse objectives and accomplishments.

Medicare and Medicaid together accounted for $269 billion in Federal health care spending in fiscal year 1995. Of that amount, the General Accounting Office (GAO) estimates that as much as 10 percent, nearly $27 billion, was lost to fraud and abuse. The subcommittee found that opportunities for fraud have persisted for several reasons, including the tremendous purchasing power of the Medicare and Medicaid programs; traditional deficiencies in HCFA's administrative practices and management controls; overlapping and unclear jurisdictions of Federal and State agencies responsible for health care fraud enforcement; inadequate or underutilized civil and criminal statutes; a cumbersome and resource-intensive price adjustment system; limitations in HCFA's authority to exclude fraudulent or abusive vendors from participation in the programs; and the propensity of opportunistic and sophisticated crimes against the programs to outpace anti-fraud management practices and technologies.

Although Medicare and Medicaid program losses due to fraud and abuse cannot be totally eliminated, subcommittee consensus was that an effective anti-fraud strategy can recapture potentially billions of taxpayer dollars. Given the pending shortfalls in the Medicare Trust Fund, reductions in budget growth in both programs, and the general trend toward government downsizing—the need to preserve scarce resources and maximize the use of available budgets has never been more acute. Additionally, we believe that the systemic corruption of these programs, perpetrated by criminal providers, undermines the quantity and quality of care available to Medicare and Medicaid beneficiaries—the aged, the poor, and the disabled—the most vulnerable American citizens.

Despite fraud and abuse problems, it is important to note that at least 90 percent of Medicare and Medicaid claims are legitimate, and that the majority of providers are honest and support standards for participation and entry in the programs. During a May 2, 1996 legislative hearing convened jointly by the Human Resources and Intergovernmental Relations and Government Management, Information, and Technology Subcommittees, Mr. Rick Doherty, testifying on behalf of the National Association for Medical Equipment Services, reminded Members that "[t]hese people are really fringe operators and are not representative of the industry. The difficulty is getting rid of those players without using a broad brush and punishing the entire system and the legitimate providers, in particular."

The U.S. Department of Health and Human Services (HHS) Health Care Financing Administration (HCFA) has administrative oversight of the Medicare and Medicaid programs. As stated by Sarah Jaggar, GAO Director for Health Financing and Policy Issues in subcommittee testimony on February 8, 1996, "HCFA's primary responsibility is to pay for medically necessary treatment in accordance with policies and good medical practice." HCFA's responsibility as it pertains to controlling fraud and abuse is confined to prevention. Responsibility for investigating and prosecuting health care fraud and abuse is dispersed among many agencies at both the Federal and State levels. Among those Federal agencies with some jurisdiction in anti-fraud and abuse enforcement efforts are the HHS Office of the Inspector General (HHS–OIG); the Department of Justice (DOJ); the Federal Bureau of Investigation (FBI); the Drug Enforcement Administration; the Food and Drug Administration; the Postal Inspection Service; and the Department of Labor Office of the Inspector General. The Federal agencies principal to the subcommittee's investigation were the Health Care Financing Administration, the HHS Office of the Inspector General, and the Department of Justice.

The longstanding difficulties in integrating the anti-fraud functions of HCFA, the HHS–OIG, and DOJ have contributed to the prevalence of unnecessary and excessive Medicare and Medicaid spending. We concur with the Report's first finding that "there is insufficient coordination among government agencies combating waste, fraud and abuse in Medicare and Medicaid programs." However, we also find that the Administration is making significant progress in improving coordination. The Report insufficiently acknowledges this progress, in part, because the subcommittee took

a snapshot of the Administration's performance prior to its execution of initiatives to improve coordination efforts.

For example, the hearing record establishing the existence of deficiencies in the coordination of Federal anti-fraud activities was built primarily on GAO and agency testimony received by the subcommittee in March and June 1995, which in turn reflected information gathered over past months. Operation Restore Trust, the Administration's major health care anti-fraud project, was put in place in May 1995. It is jointly carried out by HCFA, HHS–OIG, and the Administration on Aging, and involves an intergovernmental team that includes DOJ, the U.S. Attorneys' offices, and the State Medicaid Fraud Control Units, was put in place in May 1995. In its first year, Operation Restore Trust appears to have improved coordination between government agencies at Federal and State levels, including improved information-sharing between Medicare and the 54 Medicaid programs in order to detect fraud schemes across program lines. Although its effectiveness has not been objectively evaluated, we find that consideration of accomplishments of Operation Restore Trust is integral to any assessment of Federal coordination efforts.

Second, the Report includes the June 15, 1995 testimony of former DOJ Special Counsel for Health Care Fraud, Gerald Stern, that in 1993 the Attorney General determined that health care fraud enforcement would be a new DOJ initiative, second only to violent crime enforcement. The Report also records the Special Counsel's testimony that the health care fraud initiative involves "increased resources, investigations and prosecutions, greater cooperation among investigative and regulatory agencies, and coordinated use of all available sanctions, criminal, civil, and administrative." However, the Report does not describe any specific DOJ initiative to integrate its activities with other enforcement entities, nor its efforts to coordinate with HCFA's prevention priorities. We note that the Special Counsel informed the subcommittee in his June 1995 testimony that DOJ chairs an "executive-level health care fraud policy group" which has convened monthly since its formation in November 1993. This group includes senior level personnel at HCFA, HHS–OIG and the FBI.

In addition, the Report recounts an exchange between the subcommittee chairman and Dr. Bruce Vladek, HCFA's Administrator, in an attempt to demonstrate that deficiencies in coordination result in HCFA's failure to make effective use of its authority to exclude fraudulent providers from participation in the Medicare or Medicaid programs. We are concerned that the Report's presentation of the disparate responsibilities of the administrative (HCFA) and enforcement (HHS–OIG and DOJ) agencies is incomplete, providing insufficient detail regarding difficulties HCFA has encountered in exercising its exclusion authority.

The HHS–OIG audits and investigates health care providers accused of fraud against Medicare and Medicaid. The OIG is authorized to conduct civil, administrative and criminal investigations of fraud associated with these programs, and is responsible for imposing the majority of health care administrative sanctions authorized under the Social Security Act. The Omnibus Budget Reconciliation Act of 1981 specifically authorizes the OIG, acting on behalf of the

agency, to impose civil monetary penalties and assessments against health care providers who have filed false or improper claims for reimbursement under Medicare and Medicaid programs. The Medicare and Medicaid Patient and Program Protection Act of 1987 provides the agency authority to exclude both individuals and entities from participation in Medicare and State health care programs for fraudulent activities. It amended the existing mandatory authorities to cover program-related and patient abuse convictions and require program exclusions of no less than 5 years. In addition, it enacted discretionary exclusion authorities to cover a variety of offenses.

The HHS–OIG refers investigative findings directly to the Department of Justice or individual U.S. Attorneys for possible criminal or civil prosecution. There is no specific Federal health care fraud statute. However, DOJ prosecutors can use traditional criminal and civil authorities, including mail and wire fraud statutes, the False Claims Act, and false statements statutes to prosecute health care fraud and abuse. Even if health care fraud does not constitute criminal activity, DOJ may try to recover damages by seeking payment of civil penalties and restitution. Once DOJ has completed or declined criminal or civil prosecution, HHS can consider imposing administrative sanctions. Successful prosecutions may take years, involve an investment of considerable staff time and resources, and may never result in actual recovery of Federal health care dollars lost to fraud.

Dr. Vladek's testimony that "[h]istorically, there has been no participation by [HCFA] in the settlement," refers to these factors. The Report notes Dr. Vladek's statement that HCFA has "invested enormous resources and energy in substantially strengthening [its] relationship with the Inspector General, with the Department of Justice, [and] with the components of the Department of Justice such as the FBI and the U.S. Attorneys . . ." Also, the hearing record establishes that the DOJ Special Counsel for Health Care Fraud advised the subcommittee in his June 15, 1995 opening statement that "better communication among all of us has allowed us to choose the most appropriate sanction or sanctions to address particular health care fraud problems. Increasingly, we pursue parallel proceedings so that responsible companies and officials are convicted criminally and at the same time civil damages—damages and penalties are recovered."

Although oversight of the efficacy of Federal health care antifraud and abuse activities is implicit in the Committee's jurisdiction, we recommend that the Congress monitor whether improved coordination between HCFA, HHS–OIG and DOJ can be demonstrated; and whether that coordination appreciably impacts detection, prevention and enforcement efforts.

We concur with the Report's second finding that "HCFA does not require Medicare Part B contractors to use software capable of screening out claims for inappropriate medical services." It is important to note, however, that this is an explicit policy decision and not a requirement with which HCFA is failing to comply. We advocate greater use of auto-adjudicated screens as a low-cost, efficient method of determining the medical necessity of overused services. At the same time, we note HCFA's concern that auto-adjudication

is not appropriate in all cases. This concern was supported in the testimony of William Reis, a GAO official who accompanied Sarah Jaggar GAO Director of Health Financing Policy before the subcommittee on February 8, 1996: "There are some procedures that simply looking at the diagnosis is not an indicator of whether or not that claim was medically necessary . . . The only way to know if that claim was appropriate is for someone to review that documentation."

We support the Report's recommendation that HCFA require its Medicare Part B contractors to autoadjudicate screens for overused procedures. We also recommend that HCFA establish guidelines that include a national strategy for greater utilization of autoadjudicated screens where appropriate, as well as policy for determining an effective mix between manual and electronic methods.

We question the Report's characterization of HCFA's difficulty in employing its statutory "inherent reasonableness" authority as reluctance, as it does in its third finding. We concur that durable medical equipment (DME) is susceptible to pricing-generated fraud, and that the statutory price-setting system is cumbersome and often results in HCFA's paying excessive prices. The Report does not sufficiently indicate that changing the fee schedule requires a complex regulatory process to show existing prices are not "inherently reasonable," and involves an extensive data collection effort, consultation with industry representatives, publication of a notice in the Federal Register, a 60-day comment period, and publication of a final notice. We find that the Administration has demonstrated an interest in correcting this problem through its proposed balanced budget legislation. We support the Report's recommendation that price adjustments should be expedited through the issuance of an interim final regulation. In addition, we recommend that Congress work with the Administration to develop legislation that simplifies the requirements associated with HCFA's inherent reasonableness authority to enable HCFA to meet that expedited goal.

We concur with the Report's fourth finding that "HCFA's Medical Transaction System (MTS) is vulnerable to cost overruns and schedule delays due to the agency's lack of a disciplined management process. This finding correlates with the testimony of Frank Reilly, GAO Director, Information Resources Management/Health, Education and Human Services, during the November 16, 1995 joint hearing with the Government Management, Information, and Technology Subcommittee. Mr. Reilly informed the subcommittees that "while HCFA's approach to developing MTS contains several strengths, it also contains important weaknesses that are adding unnecessary risk. On the plus side, HCFA is attempting to build as much flexibility as possible into the system so it can be easily modified . . . HCFA also plans to build, test and implement MTS in stages so that problems that arise can be addressed more manageably. In addition, the system will allow direct access to claims by beneficiaries and . . . providers. The problems we see, however, seem to come from the lack of a disciplined management process. HCFA is not managing MTS as an investment."

We note that GAO, while expressing criticism of the project's significant risks, found that "if management exercises investment control and other 'Best Practices' these risks can be greatly reduced."

We again express the concern that the Report has made a static assessment of HCFA's performance. For example, current efforts deployed by HCFA to mitigate risk, including an integrated project schedule, an incremental transition schedule, and independent verification and validation of HCFA's development of the MTS project, are not noted in the Report. Whether these reforms have effectively reduced risk has not been established. GAO will continue its review of the MTS project pursuant to an April 22, 1996 letter from the chairmen and ranking members of the Human Resources and Intergovernmental Relations and Government Management, Information, and Technology Subcommittees, requesting an evaluation of the extent to which HCFA is now managing the MTS project as an investment that maximizes benefits and minimizes risks.

We concur with the Report's recommendation that in the advent of a comprehensive MTS management plan that is consistent with GAO recommendations, HCFA should ensure that effective, existing anti-fraud techniques receive the appropriate level of available resources. We recommend continued oversight of the efficacy of these interim strategies.

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HON. TOM LANTOS.
HON. ROBERT E. WISE, JR.
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