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NURSING HOMES

Too Early to Assess New Efforts to Control Fraud and Abuse

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Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the challenges that exist in combatting fraud and abuse in the nursing facility environment. While the Medicaid program is the largest single payer for nursing facility care, Medicare, the national health insurance program for the elderly and certain disabled people, pays a substantial proportion of the health care costs of nursing facility residents. For the opportunistic provider, a nursing home represents a vulnerable elderly population in a single location and the opportunity for multiple billings. Many nursing home patients are cognitively impaired, and their care is controlled by the nursing facility. Because these patients would probably not realize what items or special services were billed on their behalf, some providers may take advantage of the situation by submitting fraudulent claims.

My comments will draw heavily from reports we have recently issued that focused on cost growth and fraudulent and abusive billings for ancillary services and supplies for nursing facility residents.[1] I will describe how providers have exploited the Medicare program, why they were able to do so, and what steps have been taken to protect the program from the recurrence of such reimbursement schemes. I will also describe the special vulnerabilities associated with individuals who are eligible for both Medicare and Medicaid. They are poor and are less likely to have family members in the community to represent their interests.

In summary, while most providers abide by the rules, some unscrupulous providers of supplies and services have used the nursing facility setting as a target of opportunity. This has occurred for several reasons:

- the complexities of the reimbursement process invite exploitation and
- insufficient control over Medicare claims has reduced the likelihood that inappropriate claims will be denied.

We are encouraged by a number of recent efforts to combat fraud and abuse—the pending implementation of provisions in the Health Insurance Portability and Accountability Act (HIPAA) and a legislative proposal made by the administration. While these efforts should make a difference in controlling fraud and abuse in nursing homes, it is too early to tell whether these efforts will be sufficient.

[1]See the list of related GAO products at the end of this testimony.

Background

Medicare falls within the administrative jurisdiction of the Health Care Financing Administration (HCFA) of the Department of Health and Human Services (HHS). HCFA establishes regulations and guidance for the program and contracts with about 72 private companies—such as Blue Cross and Aetna—to handle claims screening and processing and to audit providers. Each of these commercial contractors works with its local medical community to set coverage policies and payment controls. As a result, billing problems are handled, for the most part, by contractors, and they are the primary referral parties to law enforcement agencies for suspected fraud.

Medicare's basic nursing home benefit covers up to 100 days of certain posthospital stays in a skilled nursing facility.[2] Skilled nursing facilities submit bills for which they receive interim payment; final payments are based on costs within a cost-limit cap. This benefit is paid under part A, Hospital Insurance, which also pays for hospital stays and care provided by home health agencies and hospices.

Even if Medicare beneficiaries do not meet the conditions for Medicare coverage of a skilled nursing facility stay, they are still eligible for the full range of part B benefits. Although Medicaid or the resident may be paying for the nursing home, Medicare will pay for ancillary services and items such as physical and other types of therapy, prosthetics, and surgical dressings. Part B is voluntary part of the Medicare program that beneficiaries may elect and for which they pay monthly premiums. Part B also pays for physician care and diagnostic testing.

About 6 million people have both Medicare and Medicaid coverage, and, of these, over 4.8 million represent state "buy-ins" for Medicare coverage.[3] Dually eligible beneficiaries are among the most vulnerable Medicare beneficiaries. They are generally poor, have a greater incidence of serious and chronic conditions, and are much more likely to be institutionalized. As a matter of fact, about 1.4 million reside in institutions, while only 600,000 of the approximately 31 million Medicare beneficiaries without Medicaid coverage are in institutions. Over half of all dually eligible patients over 85 reside in nursing facilities.

[2]Under the Medicare part A nursing home benefit, skilled nursing facilities are nursing homes that maintain a full-time staff of medical professionals who provide daily care for patients with complex medical or rehabilitative needs.

[3]States frequently pay the premium for part B coverage for Medicaid recipients.

When a copayment is required, a Medicare beneficiary or a representative designated by the beneficiary, receives an "Explanation of Medicare Benefits" (EOMB), which specifies the services billed on behalf of the individual. The EOMB is an important document because beneficiaries and their families can use it to verify that the services were actually performed. The dually eligible population, however, often does not have a representative in the community to receive and review this document. In fact, many nursing home patients actually have the nursing home itself receive the EOMBs on their behalf.

Multiple Billing Methods for Services in Nursing Facilities Leave Medicare Vulnerable

In 1996, Medicare spent $11.3 billion on skilled nursing facility benefits and an undetermined amount on part B ancillary services and items. The providers of these services and items can bill Medicare in a variety of ways. With this variety comes the opportunity to blur the transactions that actually took place and inflate charges for services rendered.

Ancillary services and items for Medicare beneficiaries in nursing facilities can be provided by the nursing facility itself, a company wholly or partially owned by the nursing facility, or an independent supplier or practitioner. Our work has shown that

- independent providers and suppliers can bill Medicare directly for services or supplies without the knowledge of the beneficiary or the facility and
- companies that provide therapy are able to inflate their billings.

Outside Providers and Suppliers Bill Medicare Directly

Nursing facilities often do not have the in-house capability to provide all the services and supplies that patients need. Accordingly, outside providers market their services and supplies to nursing facilities to meet the needs of the facilities' patients. HCFA's reimbursement system allows these providers to bill Medicare directly without confirmation from the nursing facility or a physician that the care or items were necessary or delivered as claimed. As a result, the program is vulnerable to exploitation.

According to the HHS Inspector General, provider representatives typically enter nursing facilities and offer to handle the entire transaction—from reviewing medical records to identify those patients their products or services can help, to billing Medicare—with no involvement by nursing facility staff. Some of these facilities allow providers or their representatives to review patient medical records despite federal regulatory standards prohibiting such unauthorized review. These

representatives gain access to records not because they have any responsibility for the direct care of these patients, but solely to market their services or supplies. From these records, unscrupulous providers can obtain all the information necessary to order, bill, and be reimbursed by Medicare for services and supplies that are in many instances not necessary or even provided. In 1996, we reported the following examples:[4]

- A group optometric practice performed routine eye examinations on nursing facility patients, a service not covered by Medicare. The optometrist was always preceded by a sales person who targeted the nursing facility's director of nursing or its social worker and claimed the group was offering eye examinations at no cost to the facility or the patient. The nursing facility gave the sales person access to patients' records, and this person then obtained the information necessary to file claims. Nursing staff would obtain physicians' orders for the "free" examinations, and an optometrist would later arrive to conduct the examinations. The billings to Medicare, however, were for services other than eye examinations—services that were never furnished or were unnecessary.
- The owner of a medical supply company approached nursing facility administrators in several states and offered to provide supplies for Medicare patients at no cost to the facility. After reviewing nursing facility records, this company identified Medicare beneficiaries, obtained their Medicare numbers, developed lists of supplies on the basis of diagnoses, identified attending physicians, and made copies of signed physician orders in the files. The supplier then billed Medicare for items it actually delivered but also submitted 4,000 fraudulent claims for items never delivered. As part of the 1994 judgment, the owner forfeited $328,000 and was imprisoned and ordered to make restitution of $971,000 to Medicare and $60,000 to Medicaid.
- A supplier obtained a list of Medicare patients and their Medicare numbers from another supplier who had access to this information. The first supplier billed Medicare for large quantities of supplies that were never provided to these patients, and both suppliers shared in the approximately $814,000 in reimbursements.

We found that nursing home staff's giving providers or their representatives inappropriate access to patient medical records was a major contributing cause to the fraud and abuse cases we reviewed.

[4]Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Reimbursement for Therapy Services Is Complicated and Vulnerable to Waste and Abuse

Many nursing facilities rely on specialized rehabilitation agencies—also termed outpatient therapy agencies—to provide therapy services. These agencies can be multilayered, interconnected organizations—each layer adding costs to the basic therapy charge—that use outside billing services, which can also add to the cost. In those situations in which the nursing facility contracts and pays for occupational and speech therapy services for a Medicare-eligible stay, Medicare might pay the nursing facility what it was charged because of the limited amount of review conducted by claims processing contractors. In practice, however, because of the difficulty in determining what are reasonable costs and the limited resources available for auditing provider cost reports, there is little assurance that inflated charges are not actually being billed and paid.[5]

Until recently, HCFA had not established salary guidelines, which are needed to define reasonable costs for occupational or speech therapy. Without such benchmarks, it is difficult for Medicare contractors to judge whether therapy providers overstate their costs. Even for physical therapy, for which salary guidelines do exist, the Medicare-established limits do not apply if the therapy company bills Medicare directly.

This is why Medicare has been charged $150 for 15 minutes of therapy when surveys show that average statewide salaries for therapists employed by hospitals and nursing facilities range from $12 to $25 per hour. Our analysis of a sample drawn from a survey of five contractors found that over half of the claims they received for occupational and speech therapy from 1988 to 1993 exceeded $172 in charges per service. Assuming this was the charge for 15 minutes of treatment—which industry representatives described as the standard billing unit—the hourly rate charged for these claims would have been more than $688. It should be noted that neither HCFA nor its contractors could accurately tell us what Medicare actually paid the providers in response to these claims. The amount Medicare actually pays is not known until long after the service is rendered and the claim processed. Although aggregate payments are eventually determinable, existing databases do not provide actual payment data for any individual claim.

[5]Medicare reimbursement in these instances is supposed to be based on the providers' "reasonable costs."

Lax Oversight Provides Little Chance of Timely Detection of Excessive Medicare Reimbursements

HCFA pays contractors to process claims and to identify and investigate potentially fraudulent or abusive claims. We have long been critical of the unstable funding support HCFA's contractors have to carry out these program integrity activities. We recently reported that funding for Medicare contractor program safeguard activities declined from 74 cents to 48 cents per claim between 1989 and 1996. During that same period, the number of Medicare claims climbed 70 percent to 822 million.[6] Such budgetary constraints have placed HCFA and its contractors in the untenable position of needing to review more claims with fewer resources.

While Medicare contractors do employ a number of effective automated controls to prevent some inappropriate payments, such as suspending claims that do not meet certain conditions for payment for further review, our 1996 report on 70 fraud and abuse cases showed that atypical charges or very large reimbursements routinely escaped those controls and typically went unquestioned.[7] The contractors we reviewed had not put any "triggers" in place that would halt payments when cumulative claims exceeded reasonable thresholds. Consequently, Medicare reimbursed providers, who were subsequently found guilty of fraud or billing abuses, large sums of money over a short period without the contractor's becoming suspicious. The following examples highlight the problem:

- A supplier submitted claims to a Medicare contractor for surgical dressings furnished to nursing facility patients. In the fourth quarter of 1992, the contractor paid the supplier $211,900 for surgical dressing claims. For the same quarter a year later, the contractor paid this same supplier more than $6 million without becoming suspicious, despite the 2,800-percent increase in the amount paid.
- A contractor paid claims for a supplier's body jackets[8] that averaged about $2,300 per quarter for five consecutive quarters and then jumped to $32,000, $95,000, $235,000, and $889,000 over the next four quarters, with no questions asked.

In other instances, we found that providers that were subsequently investigated for wrongdoing billed and were paid for quantities of services or supplies that were unnecessary or could not possibly have been furnished:

[6] High Risk Series: Medicare (GAO/HR-97-10, Feb. 1997).

[7] GAO/HEHS-96-18, Jan. 24, 1996.

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

- A contractor reimbursed a clinical psychology group practice for individual psychotherapy visits lasting 45 to 50 minutes when the top three billing psychologists in the group were allegedly seeing from 17 to 42 nursing facility patients per day. On many days, the leading biller of this group would have had to work more than 24 uninterrupted hours to provide the services he claimed.
- A contractor paid a podiatrist $143,580 for performing surgical procedures on at least 4,400 nursing facility patients during a 6-month period. For these services to be legitimate, the podiatrist would have had to serve at least 34 patients a day, 5 days a week.

The Medicare contractors in these two cases did not become suspicious until they received complaints from family members, beneficiaries, or competing providers. The EOMB was critical in identifying the specific items and services being billed to Medicare. Although EOMBs have in the past only been required when the beneficiary had a deductible or copayment, HIPAA now requires HCFA to provide an explanation of Medicare benefits for each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed. This provision is still of limited value, however, for nursing home residents who designate the nursing home to receive the EOMBs—which is more common for the dually eligible population.

In other cases, contractors initiated their investigations because of their analyses of paid claims (a practice referred to as “postpayment medical review”), which focused on those providers that appeared to be billing more than their peers for specific procedures. One contractor, for instance, reimbursed a laboratory $2.7 million in 1991 and $8.2 million in 1992 for heart monitoring services allegedly provided to nursing facility patients . The contractor was first alerted in January 1993 through its postpayment review efforts when it noted that this laboratory’s claims for monitoring services exceeded the norm for its peers.

In all these cases, we believe the large increases in reimbursements over a short period or the improbable cumulative services claimed for a single day should have alerted the contractors to the possibility that something unusual was happening and prompted an earlier review. People do not usually work 20-hour days, and billings by a provider for a single procedure do not typically jump 13-fold from one quarter to the next or progressively double every quarter.

Initiatives Now Under Way to Address Long-Standing Problems

Initiatives on various fronts are now under way to address fraud and abuse issues we have discussed here today. Several of these initiatives, however, are in their early stages, and it is too soon to assess whether they will, in fact, prevent fraud and abuse in the nursing facilities environment.

HHS Initiatives

Last year, we recommended that HCFA establish computerized prepayment controls that would suspend the most aberrant claims. HCFA has since strengthened its instructions to its contractors, directing them to implement prepayment screens to prevent payment of billings for egregious amounts or patterns of medically unnecessary services or items. HCFA also authorized its contractors to deny automatically the entire line item for any services that exceed the egregious service limits.

In regard to therapy services, after a lengthy administrative process, HCFA proposed salary guidelines last month for physical, occupational, speech, and respiratory therapists who furnish care to beneficiaries under a contractual arrangement with a skilled nursing facility. The administration estimates these changes will result in savings to Medicare of $1.7 billion between now and the year 2001, and $3.9 billion between now and the year 2006. The proposed rule would revise the current guideline amounts for physical and respiratory therapies and introduce, for the first time, guideline amounts for occupational therapy and speech/language pathology services.

In March 1995, the Secretary of HHS launched Operation Restore Trust (ORT), a 2-year interagency, intergovernmental initiative to combat Medicare and Medicaid fraud and abuse. ORT targeted its resources on three health care areas susceptible to exploitation, including nursing facility care in five states (California, Florida, Illinois, New York, and Texas) with high Medicare and Medicaid enrollment and rapid growth in billed services.

To address the root cause of the problems cited here today, the administration has also announced an initiative to change the way Medicare reimburses for services and supplies in skilled nursing facilities: consolidated billing. More specifically, the administration has announced that it will propose requiring skilled nursing facilities to bill Medicare for all services provided to their beneficiary residents except for physician and some other practitioner services. We support this proposal. We and the HHS Inspector General have reported on problems, such as

overutilization of supplies, that can arise when suppliers bill separately for services for nursing home residents.

A consolidated billing requirement would make it easier to control payments for these services and give nursing facilities the incentive to monitor them. The requirement would also help prevent duplicate billings and billings for services and items not actually provided. In effect, outside suppliers would have to make arrangements with skilled nursing facilities so that they would bill for suppliers' services and would be financially liable and medically responsible for the care.

Legislative Initiatives

HIPAA established the Medicare Integrity Program, which ensures that the program safeguard activities function is funded separately from other claims processing activities. HIPAA also included provisions on "administrative simplification." A lack of uniformity in data among the Medicare program, Medicaid state plans, and private health entities often makes it difficult to compare programs, measure the true effect of changes in health care financing, and coordinate payments for dually eligible patients. For example, HIPAA requires, for the first time, that each provider be given a unique provider number to be used in billing all insurers, including Medicare and Medicaid.

The new provisions also require the Secretary of HHS to promulgate standards for all electronic health care transactions; the data sets used in those transactions; and unique identifiers for patients, employers, providers, insurers, and plans. These standards will be binding on all health care providers, insurers, plans, and clearinghouses.

Conclusion

The multiple ways that providers and suppliers can bill for services to nursing home patients and the lax oversight of this process contribute to the vulnerability of payments for the health care of this population. As a result, excessive or fraudulent billings may go undetected. We are encouraged, however, by the administration's recent proposal for consolidated billing, which we believe will put more responsibility on nursing home staff to oversee the services and items being billed on behalf of residents. As more details concerning these or other proposals become available, we will be glad to work with the Subcommittee and others to help sort out their potential implications.

This concludes my prepared remarks. I will be happy to answer any questions.

Contributors

For more information on this testimony, please call Leslie G. Aronovitz on (312) 220-7600 or Donald B. Hunter on (617) 565-7464. Lisanne Bradley also contributed to this statement.

Related GAO Products

Medicare Post-Acute Care: Facility Health and Skilled Nursing Facility Cost Growth and Proposals for Prospective Payment (GAO/T-HEHS-97-90, Mar. 4, 1997).

Skilled Nursing Facilities: Approval Process for Certain Services May Result in Higher Medical Costs (GAO/HEHS-97-18, Dec. 20, 1996).

Medicare: Early Resolution of Overcharges for Therapy in Nursing Facilities Is Unlikely (GAO/HEHS-96-145, Aug. 16, 1996).

Fraud and Abuse: Providers Target Medicare Patients in Nursing Facilities (GAO/HEHS-96-18, Jan. 24, 1996).

Fraud and Abuse: Medicare Continues to Be Vulnerable to Exploitation by Unscrupulous Providers (GAO/T-HEHS-96-7, Nov. 2, 1995).

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

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Facilities (GAO/HEHS-95-23, Mar. 30, 1995).

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