

GAO

August 1993

# MEDICAID DRUG FRAUD

## Federal Leadership Needed to Reduce Program Vulnerabilities



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**Human Resources Division**

B-246968

August 2, 1993

**The Honorable Charles Rangel  
House of Representatives****The Honorable Edolphus Towns  
Chairman, Subcommittee on Human Resources  
and Intergovernmental Relations  
Committee on Government Operations  
House of Representatives**

Prescription drug diversion has been a problem in the Medicaid program for at least the past decade. A common drug diversion scheme is the so-called "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs mainly to obtain reimbursement. Patients are often knowing participants in these schemes, allowing use of their Medicaid recipient numbers for billing purposes in exchange for cash, drugs, or other inducements.

Medicaid, the largest government health program for the poor, is a logical target of drug diversion because it typically includes prescription drugs in its covered services. It accounts for 80 percent of all federal spending on prescription drugs. In 1991, prescription drugs accounted for 7 percent of Medicaid spending—more than physicians' services, more than any noninstitutional benefit provided by the program. By 1996, Medicaid is expected to spend \$10 billion on prescription drug benefits, nearly double the 1991 figure of \$5.5 billion. In Florida and Texas, the recent rate of increase has been even greater, with expenditures more than doubling between 1987 and 1991.

The incentive to abuse the Medicaid drug benefit is considerable: some prescription drugs have psychological or physical effects similar to those of illicit drugs; others have substantial monetary value, and profiteers can divert them for resale through illicit channels.

This report responds to your request, Congressman Rangel, in your former capacity as Chairman of the House Select Committee on Narcotics Abuse and Control, and your subsequent request, Congressman Towns, in your capacity as Chairman, Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations. Concerned about the costly exploitation of Medicaid's drug benefit, you asked us to assess the extent of the drug diversion problem, the reasons it persists, and what actions are being taken to bring it under

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control. An overview of our review and our findings follows. Appendix I presents additional details.

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## Background

The pursuit of drug diversion in the Medicaid program entails a complex administrative structure. At the federal level, the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) funds and oversees the program. No organizational unit within HCFA is dedicated to curbing fraud and abuse, however, and HCFA is not directly involved in drug diversion cases. Each state administers the program through its own Medicaid agency—variously situated in departments such as health, welfare, or human services—that is also responsible for maintaining program integrity.

It is not unusual for a drug diversion case to involve five or more state, local, and federal agencies during its investigation, prosecution, and resolution. In a case of provider abuse, state Medicaid agencies are authorized to take certain administrative actions. Where fraud or some other form of intentional wrongdoing is suspected, cases in most states are referred for investigation to organizationally separate Medicaid Fraud Control Units (MFCUS). Some MFCUS have statutory authority to prosecute these cases; others must refer the cases to local, county, state, or federal prosecutors. Court probation offices can become involved to collect court-ordered fines, costs, and restitution.

Individuals convicted of crimes involving Medicaid drug diversion are also subject to various civil sanctions.<sup>1</sup> At the state level, the Medicaid agency may exclude them from the program for a period of time, and professional licensing agencies may suspend or revoke their licenses to practice in that state. Alternatively, they may receive lesser penalties—or none at all. Federal action may also be taken: the HHS Office of the Inspector General may—and in some cases must—direct HCFA to exclude the provider from participation in Medicare and other federal health programs. Also, the Department of Justice may seek substantial monetary penalties under the False Claims Act, or HHS may do so under the Civil Monetary Penalties provisions of the Social Security Act.

To determine the extent of Medicaid prescription drug diversion, we conducted a telephone survey of the 42 MFCUS<sup>2</sup> and visited four states reporting significant pill mill problems: California, Florida, New York, and

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<sup>1</sup>Some civil sanctions may be applied even when the offender is not convicted of a criminal offense.

<sup>2</sup>Other states lack separate units dedicated to the pursuit of Medicaid fraud.

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Texas. We interviewed officials at the state Medicaid agencies, MFCUS, state licensing authorities, and appropriate HHS regional offices. We also met with representatives of the Department of Justice, the HHS Office of the Inspector General, HCFA, and the National Association of State Attorneys General. Through Medicaid, Medicare, Treasury Department and law enforcement agency records, and banking records obtained under subpoena, we conducted an independent investigation in New York seeking evidence of collusion between providers that state authorities believe have been individually engaged in Medicaid improprieties. Some such cases had been prosecuted independently, and others were resolved without prosecution.<sup>3</sup> Finally, we analyzed records in the four states pertinent to 1991 MFCU drug diversion convictions. Further details of our approach appear in appendix II.

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## Results in Brief

Twenty-one of the MFCU directors told us of problems involving drug diversion. These took many forms, including pharmacists who routinely added medications to customers' orders, keeping the extras for themselves or to sell to others; clinics that inappropriately provided Medicaid recipients with completed prescription forms (scrips) that were then traded for merchandise from local pharmacies or sold on the street to the highest bidder; and typical pill mill schemes in which recipients, in exchange for abusable drugs, allowed physicians, pharmacies, and labs to use their Medicaid numbers to bill for services not needed or not rendered. Participants in drug diversion schemes therefore frequently face added charges of fraud, false claims, or other related violations of state or federal law.

Several factors complicate attempts to curb these schemes. Some relate to data inadequacies: Medicaid agencies typically do not have data available that are accurate, complete, timely, and in convenient form to highlight aberrant billing or referral patterns. Staff shortages, in the face of lengthy and complex case preparation and of difficulties inherent in ending schemes involving multiple participants, hamper investigative agencies.

States are taking steps to address these problems. One approach focuses on deterrence or early detection through up-front controls. Another approach involves after-the-fact pursuit and punishment. These measures appear to be achieving some success, particularly in New York. Moreover,

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<sup>3</sup>Settlements may be negotiated in which, for example, a provider voluntarily withdraws from program participation on condition that contemplated or actual criminal charges are dropped.

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these state initiatives are effective against both prescription drug diversion and associated types of Medicaid fraud.

Despite these local success stories, however, diversion persists. Lack of resources precludes state agencies from following up cases of potential diversion. For this and other reasons, state and federal agencies also fail to use their authority to impose sanctions and recover program losses. Offenders frequently retain some connection with health care delivery, with the consequent opportunity for future violations.

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## Principal Findings

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### Drug Diversion Is Widespread

We found prescription drug diversion to be a problem in many states, often occurring in conjunction with other types of fraud. The economic incentives are substantial (see app. III). Blatant examples include a doctor writing 2,000 prescriptions a month; a pharmacist billing for more than 30 prescriptions a day for a single recipient; a patient who, in one 4-day period, had the same three lab tests five times and filled six prescriptions for Zantac;<sup>4</sup> and an organized network of colluding physicians, pharmacists, patient brokers, and other middlemen, some of whom transferred money overseas through the Bank of Credit and Commerce International (BCCI). Specific fraud schemes are summarized in figure 1.

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<sup>4</sup>Zantac is an ulcer medication. It heads the list of the most popular abused drugs in New York (see app. III)—not for its physiological or psychological effect—but because it is sold to middlemen and back to pharmacies for recycling at a substantial profit.

Figure 1: Examples of Recent Drug Diversion Practices

<p><b>Pill Mills</b></p> <p>Six New York doctors and five of their associates were indicted on charges of defrauding Medicaid by billing for unnecessary office visits, diagnostic tests, and prescription drugs. The indictment alleged that Medicaid recipients were induced to come to clinics where—in exchange for their valid Medicaid recipient numbers—they obtained scrips for expensive drugs for which they had no legitimate medical need. The clinics used the recipients' Medicaid numbers to bill for thousands of unnecessary lab tests and procedures. The recipients obtained the prescriptions and sold them to middlemen, who in turn resold them to pharmacies.</p> <p>Medicaid billings by this group during the period of investigation exceeded \$8 million.</p>	<p><b>Cash for Scrips</b></p> <p>A pharmacy and its owners were indicted for billing New York State for drugs never provided to patients. Allegedly, they paid \$10 to \$40 dollars to Medicaid recipients for each scrip. Additionally, they charged to Medicaid prescriptions never ordered by a physician, though purportedly resulting from physicians' telephone requests.</p> <p>In the 3 years before indictment, the pharmacy generated more than \$3.5 million in Medicaid billings.</p>
<p><b>Merchandising</b></p> <p>The state of Florida prosecuted a Florida pharmacy owner and two clerks for giving Medicaid recipients store credit or merchandise in exchange for scrips never filled. The pharmacy billed Medicaid for the drugs. State officials suspect the drugs were shipped to Cuba, sold over the counter one pill at a time, or never purchased from the manufacturer.</p> <p>During the 3 years prior to indictment, Medicaid payments to the pharmacy totaled \$1.1 million.</p>	<p><b>Sex for Drugs</b></p> <p>A Baltimore doctor pleaded guilty to Medicaid fraud in providing prescriptions and drug samples to at least 11 women in exchange for sexual favors. He billed Medicaid for bogus office visits. An attorney for the Maryland MFCU stated that the physician maintained a large medical practice serving a subculture of drug abusers seeking prescriptions for narcotics, tranquilizers, and sleeping pills.</p> <p>In the 4 years before his plea, the physician generated more than \$600,000 in Medicaid billings.</p>

**Why Drug Diversion Persists**

Several factors contribute to the persistence of drug diversion. First, Medicaid agencies generally do not have systematic procedures that promptly warn of providers' aberrant billing and referral patterns. Second, as with other criminal cases, such problems as staff shortages and the sluggish and erratic movement of cases through investigative agencies hamper the pursuit of fraud cases and limit the recovery of misspent Medicaid dollars. Finally, the tendency to pursue one provider at a time in

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prescription drug schemes involving a network of wrongdoers has little effect on continuing fraudulent operations.

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**States Are Addressing These Problems**

All states have up-front controls designed to prevent Medicaid fraud. Since these are never 100 percent effective, they also have procedures for pursuit, punishment, and financial recovery. In their attempts to curb drug diversion, states have adopted a variety of approaches, and some federal initiatives are also assisting their efforts. (App. IV lists the major initiatives of the states visited. App. V describes related federal measures.)

Recent efforts emphasizing up-front controls include the use of identification (ID) cards that resemble credit cards, prescription-filing systems that can instantly link orders to the prescribing physician, and data analysis techniques that can promptly identify physicians and patients prescribing and receiving high volumes of drugs.

Initiatives that focus on pursuit and punishment include (1) establishing multiagency task forces to coordinate case development, (2) implementing stronger laws and administrative procedures to expedite disciplinary actions, and (3) improving recovery of monetary losses by requiring high-volume providers to post performance bonds or other financial security as a condition of program participation.<sup>5</sup> These measures appear to be achieving some success, particularly in New York. Moreover, these state initiatives are not specific to prescription drug diversion. They are also effective against other associated types of Medicaid fraud.

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**Efforts Insufficient Without Added Support**

Drug diversion continues, however, in many areas of the United States. State and federal officials cite lack of adequate resources as the primary reason their efforts have failed to control this type of fraud.

State officials expressed frustration at their lack of sufficient resources to address more fraud cases, at lengthy and frequently unproductive investigations, and at the prevalence of repeat offenders and resilient schemes. Many leads go unpursued—in Florida, for example, the MFCU rejects more than 90 percent of referrals from the state Medicaid agency. This leads to a no-win situation: Medicaid agency personnel are reluctant to invest a lot of effort developing cases that are likely to be rejected, and

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<sup>5</sup>In New York, where this approach has been adopted, a high-volume provider is defined as one with anticipated Medicaid billings exceeding \$500,000 a year.



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MFCU officials are more likely to reject ill-prepared cases because of the additional burden imposed on their own limited staff.

Even when pursued, cases drag on for years—half of those we reviewed took more than 3 years to resolve.<sup>6</sup> Penalties are light: almost no one went to prison, and many offenders retained their connection with the health care system—sometimes even continuing as Medicaid providers—with consequent potential for further violations.

Moreover, many perpetrators of prescription drug fraud, even when convicted, profit financially from their crimes. In the cases we reviewed, the combination of restitution ordered by the courts, subsequent recovery efforts by state Medicaid agencies, and additional federal recoupment actions failed to offset likely program losses. For the most part, amounts recovered were nominal because Medicaid and the investigative agencies did not use their authority to recover losses and penalize fraudulent or abusive providers. The main reason given for lack of action was staffing constraints in all agencies involved—from the state Medicaid agency, to the courts, to the Office of the HHS Inspector General.

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## Conclusions

States' emphasis on developing preventive measures is well placed because efforts to recover losses are seldom successful. Promising initiatives include tighter controls on provider enrollment, utilization limits, electronic verification of claims, and earlier and more sophisticated analyses of claims data.

States have also recognized the need to supplement prevention with added support for investigation, prosecution, enforcement, and recovery efforts. As a part of this undertaking, they have encouraged increased cooperation among agencies—an approach that is especially important in addressing highly organized networks designed to divert drugs and engage in other fraudulent health care schemes. Despite these initiatives, Medicaid drug diversion remains widespread and persistent, suggesting that state agencies need additional help and encouragement in controlling prescription drug fraud and related abuse. While the current economic environment makes it unlikely that overall resources can be increased significantly, the New York state experience has demonstrated the potential savings achievable from initiatives addressing these problems.

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<sup>6</sup>This period was measured from the time cases were first reported to the MFCU through provider exclusion from Medicare.

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We believe that drug diversion should be addressed in the context of Medicaid fraud, rather than as an isolated phenomenon, for the following reasons:

- Medicaid prescription drug diversion frequently occurs along with other types of Medicaid fraud, such as billing for office visits, lab tests, and other services not medically necessary or that may not even have been provided; and
- many of the initiatives described in this report as targeting prescription drug diversion apply equally to controlling other forms of Medicaid fraud that frequently accompany this scam.

HCFA could assume an active leadership role in orchestrating and encouraging states' efforts by raising their sensitivity to the financial benefits of such initiatives and by conducting concerted assessment and guidance activities. In particular, it could foster the development and implementation of preventive measures such as those contributing to New York's success in reducing diversion.

In addition, HCFA could address other overarching concerns revealed by our study, such as determining whether—and how—state laws, federal requirements, and other factors inhibit prosecution or attempts to recover payment of claims subsequently determined not to be authorized by law.

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## Recommendation to the Secretary of HHS

We recommend that the Secretary of HHS direct the Administrator of HCFA to develop an overall strategy to address prescription drug diversion as part of the larger problem of Medicaid fraud. This would highlight the importance of lessons learned from state initiatives and their applicability to health care in general. One key element of such a strategy might be the designation of a unit within HCFA responsible for (1) conducting continuing evaluations of state initiatives targeting prescription drug diversion and other Medicaid fraud and (2) providing guidance and technical assistance tailored to individual state problems.

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We performed our field work in accordance with generally accepted government auditing standards between December 1991 and December 1992. As you requested, we did not obtain written agency comments on this report because of time constraints, but we did show a draft to HCFA officials and made modifications as appropriate. They generally agreed with our findings and conclusions. We also obtained

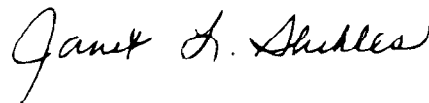
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comments on relevant sections of the draft from officials in the four states on which we focused.

We are sending copies of this report to interested congressional committees, to the Secretary of Health and Human Services, and to appropriate officials in the states where we did our work. We will also make copies available to others on request.

This report was prepared under the direction of Edwin P. Stropko, Assistant Director, Health Financing and Policy Issues. If you have any questions, please call him at (202) 512-7108. Other major contributors to the report are listed in appendix VI.

Sincerely yours,



Janet Shikles  
Assistant Comptroller General

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**Abbreviations**

BCCI	Bank of Credit and Commerce International
CMPL	Civil Monetary Penalties Law
DEA	Drug Enforcement Administration
DUR	drug utilization review
ECM	Electronic Claims Management
EOMB	Explanation of Medical Benefits
FBI	Federal Bureau of Investigation
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
ID	identification
MADAS	Medicaid Abusable Drug Audit System
MFCU	Medicaid Fraud Control Unit
MMIS	Medicaid Management Information System
OBRA	Omnibus Budget Reconciliation Act
OIG	Office of the Inspector General
POS	point-of-service
SURS	Surveillance and Utilization Review Subsystem

# Extent and Persistence of Medicaid Prescription Drug Diversion

## Diversion Is Significant Problem, Taking Many Forms

### Drug Diversion Is Widespread

Schemes to divert Medicaid drugs operate in many states. Half of the 42 Medicaid Fraud Control Units (MFCUs) we contacted reported this problem, including 7 of the 10 most populous states (see table I.1). The fraud appears in locations as diverse as New York City and Buckhannon, West Virginia.

**Table I.1: Medicaid Fraud Control Units Citing Problems With Pill Mills**

Ranked by population in relation to 50 states

Rank	State	Rank	State
1	California	20	Minnesota
2	New York	21	Louisiana
3	Texas	23	Kentucky
4	Florida	28	Oklahoma
6	Illinois	29	Oregon
8	Michigan	34	West Virginia
9	New Jersey	37	New Mexico
13	Massachusetts	43	Rhode Island
14	Indiana	46	Delaware
18	Washington		District of Columbia
19	Maryland		

Economic incentives for diverting Medicaid prescription drugs are substantial (see app. III), and program losses from this type of fraud can be significant. In one recent case, for example, eight Texas physicians with combined single-year Medicaid billings of about \$11 million were convicted on drug diversion charges. Some were writing as many as 2,000 prescriptions, called scrips, a month. On a broader scale, New York's Department of Social Services estimated that, in 1990, pill mills and related schemes cost it at least \$75 million—about 10 percent of the state's total Medicaid expenditures for prescription drugs. The Federal Bureau of Investigation (FBI) has testified before the Congress on the continued existence in 1992 of such fraud in New York and other states.

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## Schemes to Divert Drugs Vary

Drug diversion schemes varied within and among the states we visited. For example, officials in Texas said that Medicaid recipients paid physicians cash for scrips that they had filled at local pharmacies. They sold the drugs—which cost the pharmacy less than 50 cents per pill—on the street for as much as \$85 a pill. In California, clinic owners paid absentee doctors for the use of their provider numbers and paid drivers to bring in Medicaid enrollees as patients. Clinics phoned in prescriptions to colluding pharmacies, which provided bulk pick-up or delivery of the drugs. Both clinics and pharmacies billed for additional tests not performed or medications not provided. In Florida, Medicaid recipients traded scrips to pharmacies for cash or merchandise.

In New York, we have found evidence that networks exist involving clinics, pharmacies, labs, “patient brokers,” and “middlemen distributors”: clinics pay a fee to patient brokers to locate Medicaid enrollees, often directing them to target groups of homeless people and drug addicts. Clinic personnel draw blood from these “patients” and provide them with scrips for various medications. The clinic bills Medicaid for an office visit and additional unnecessary services.<sup>1</sup> The blood is shipped to labs that perform numerous unneeded tests for which they bill Medicaid. Pharmacists fill the scrips and bill Medicaid. Medicaid recipients sell the prescribed drugs to middlemen in exchange for cash or illicit drugs. While this cycle is repeated, the diverted drugs are collected and resold at lower-than-wholesale prices. These drugs find their way back into pharmacies and repeatedly are dispensed and billed to Medicaid.

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## Why Drug Diversion Persists

Drug diversion schemes are resistant to enforcement efforts for several reasons. First, Medicaid agencies tend to rely on fortuitous rather than systematic detection—tips and referrals rather than built-in warning signals. Second, the process of building a fraud case is labor-intensive and the pay-off is small; program losses are not recovered, and convicted providers can often continue to operate under another guise or start new scams later. Finally, although drug diversion schemes may involve a broad network of colluding parties, authorities tend to investigate and prosecute offenders individually, allowing the scheme to continue to operate.

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## Diversion Not Detected Promptly

State Medicaid agencies generally do not rely on analyses of automated paid claims data as a primary source for identifying potential drug

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<sup>1</sup>This is a violation because medical necessity has not been established. The physician signing the prescription or the order for blood tests may never even have seen the patient.

diversion. One reason is that the data are not necessarily used to generate reports identifying even obvious problems indicating potential drug diversion.<sup>2</sup> For example, in California, a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of drugs. For 3 years the volume of prescriptions was improbably high—in many cases more than 20 prescriptions a day for a single recipient. The state's reporting system, however, did not trigger an investigation of the pharmacist nor of any of the recipients.<sup>3</sup>

A second reason is that existing reports are viewed as cumbersome to use or as unreliable unless much more work is done to compile and analyze the information. Staffing constraints make this work impractical, particularly since prescription drug diversion is only one of many fraud and abuse activities that Medicaid officials must address. Thus, to identify diversion activities, Medicaid agencies tend to rely, for example, on tips from individuals or referrals from other agencies rather than on their routine data reports.<sup>4</sup>

A third reason is that the unavailability or inaccuracy of data can reduce states' abilities to produce reports that highlight problems. Most state Medicaid agencies do not have readily accessible data on ownership of pharmacies and clinics, which could reveal connections between suspect facilities.<sup>5</sup> In addition, pharmacies often do not comply with the requirement to identify on submitted claims the physician prescribing the order. Without this information, Medicaid agencies cannot easily detect physicians' suspicious prescribing habits or pharmacies' unusually high volume of referrals from a small number of physicians.

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## **Criminal Pursuit Lengthy and Often Unproductive**

State officials expressed frustration at their lack of sufficient resources to address more fraud cases, at lengthy and frequently unproductive investigations, and at the prevalence of repeat offenders and resilient schemes. In Florida, for example, Medicaid agency staff detected far more

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<sup>2</sup>While agencies can obtain reports to satisfy this need, this frequently entails extra costs and staff to interpret them once they are produced. The systems that produce the reports are often operated by contractors, who charge a fee for every report produced. States are reluctant to invest in reports that do not have demonstrable benefits, when they already lack adequate resources to follow up on existing leads.

<sup>3</sup>A tip ultimately revealed the scheme.

<sup>4</sup>Paid claims data are useful, however, in building a case after detection.

<sup>5</sup>The Health Care Financing Administration (HCFA) maintains paper records of such information on facilities that it oversees, including clinics and labs but not pharmacies.



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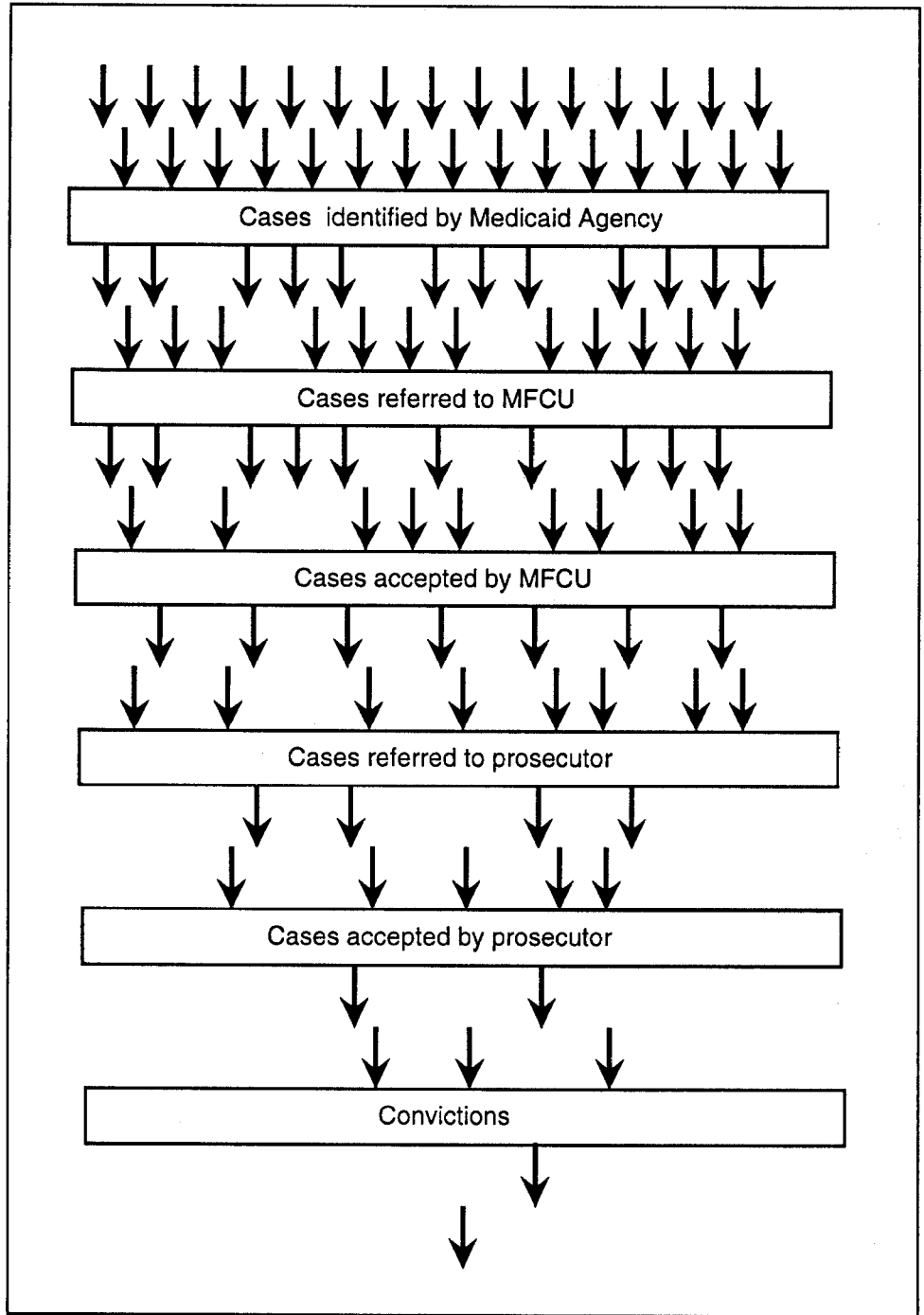
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Prescription Drug Diversion**

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instances of likely drug diversion than they had resources to investigate, leaving many leads unexamined. Other states identified similar problems.

While investigations proceed slowly, losses mount. Cases move sequentially through state, local, and federal agencies that function much like filters (see fig. I.1): at each stage, more are eliminated. A drug diversion investigation, as with other fraud, can stall at any of the various agencies—the Medicaid agency; MFCU; federal, state, or local prosecutor—if the backlog of cases is too large to accept new ones. In Florida, the MFCU typically rejects more than 90 percent of the Medicaid agency's fraud referrals because of its own staffing constraints.

Figure I.1: Typical Progression of Drug Diversion Cases



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In addition, state laws sometimes lack the fine tuning needed to achieve desired results—a situation also encountered with other criminal investigations. In New York state, for example, MFCU officials believe the state needs a felony statute for Medicaid fraud because cases involving diversion of noncontrolled drugs must usually be prosecuted as misdemeanors. In contrast, Medicaid fraud is a felony in Florida, and convictions lead to mandatory loss of professional licenses for physicians and pharmacists. The severity of the penalty, however, may work against prosecutors seeking convictions. In all four of the Florida cases we examined in which medical professionals were charged, the court withheld adjudication, and consequently all retained their licenses.<sup>6</sup> Florida officials told us that few of their cases go to trial, most are plea bargained, and 75 percent of first-time offenders receive probation.

**Review of MFCU Convictions**

For those cases pursued as fraud, the outcome is often neither timely nor satisfactory. Of the 39 drug diversion cases settled in 1990 or 1991 in the four states reviewed,

- almost half took more than 2 years from the time they were reported to the MFCU until they were adjudicated;<sup>7</sup>
- most involving license revocation, suspension, or probation took much longer to resolve—up to nearly 7 years from the time these cases were reported to the MFCU until the licensure agency took action; and
- penalties were mild: few went to prison, and more than half the convicted professionals experienced no licensure action, not even probation.<sup>8</sup>

In addition, the government has little assurance that individuals or organizations convicted of fraudulent activities will no longer be in a position to defraud the program. The most telling statistics come from the Florida Medicaid drug diversion cases:<sup>9</sup>

<sup>6</sup>Florida has a law that allows the court to enter into deferred prosecution agreements with defendants. By signing such an agreement, providers agree to certain restrictions or conditions—such as payment of restitution over a set period of time. In exchange, no finding of guilt or innocence is entered into court records.

<sup>7</sup>Exclusion from Medicaid—which took an average of 6 months following adjudication—occurred in 21 of the 39 cases. In 15 of the cases, the person convicted was not an enrolled provider. Two people or facilities were not excluded. Exclusion from Medicare and other federal health programs occurred in 24 of the cases. Six resulted in no exclusion. Nine decisions were still pending as of December 31, 1992. (Three remained unresolved as this report was going to press.)

<sup>8</sup>This was the status as of December 31, 1992.

<sup>9</sup>When GAO brought these situations to the attention of Florida Medicaid officials, they said that either they were not aware of their status or they had not yet determined whether terms of exclusion had been violated. Under some conditions, an excluded individual may be connected with a participating facility in a limited capacity.

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- Of nine individuals charged with fraud in 1990, five—including a pharmacist excluded from program participation—are currently employed in pharmacies that are Medicaid providers.
- Of five pharmacies charged with fraud in 1990, three were excluded from Medicaid. Yet the owner of one sold it and is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership (one of the new owners is the spouse of the convicted former owner).

Although laws are in place to deal appropriately with such situations, no one with the authority and adequate resources is following up on these cases.

### Investigation of Networks

States face additional difficulties investigating and prosecuting drug diversion networks. These schemes can involve not only Medicaid providers but also nonprovider entrepreneurs, recipients, middlemen, and even physicians not enrolled in Medicaid.<sup>10</sup> Many schemes involve third-party insurers other than Medicaid, necessitating coordination between the MFCU and agencies with jurisdiction over the other scheme participants. A schematic representation of the agencies involved in pursuing Medicaid drug diversion in the State of New York—including all phases from initial investigation through final sanctions—illustrates the complexity of agency relationships. (See fig. I.2.)

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<sup>10</sup>For example, a non-Medicaid physician may be paid in cash for providing the scrip, but the prescription drugs are billed to Medicaid.

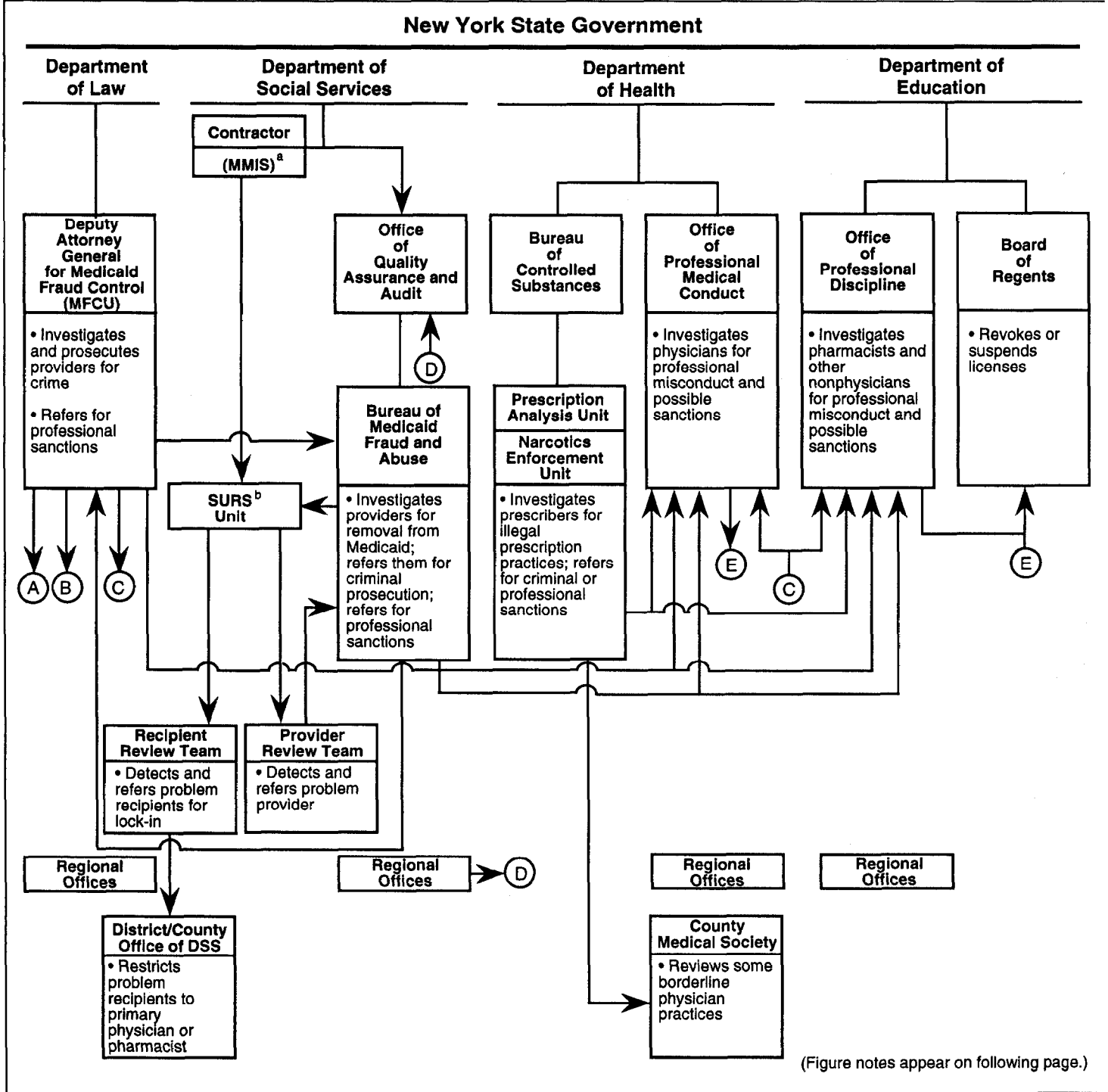
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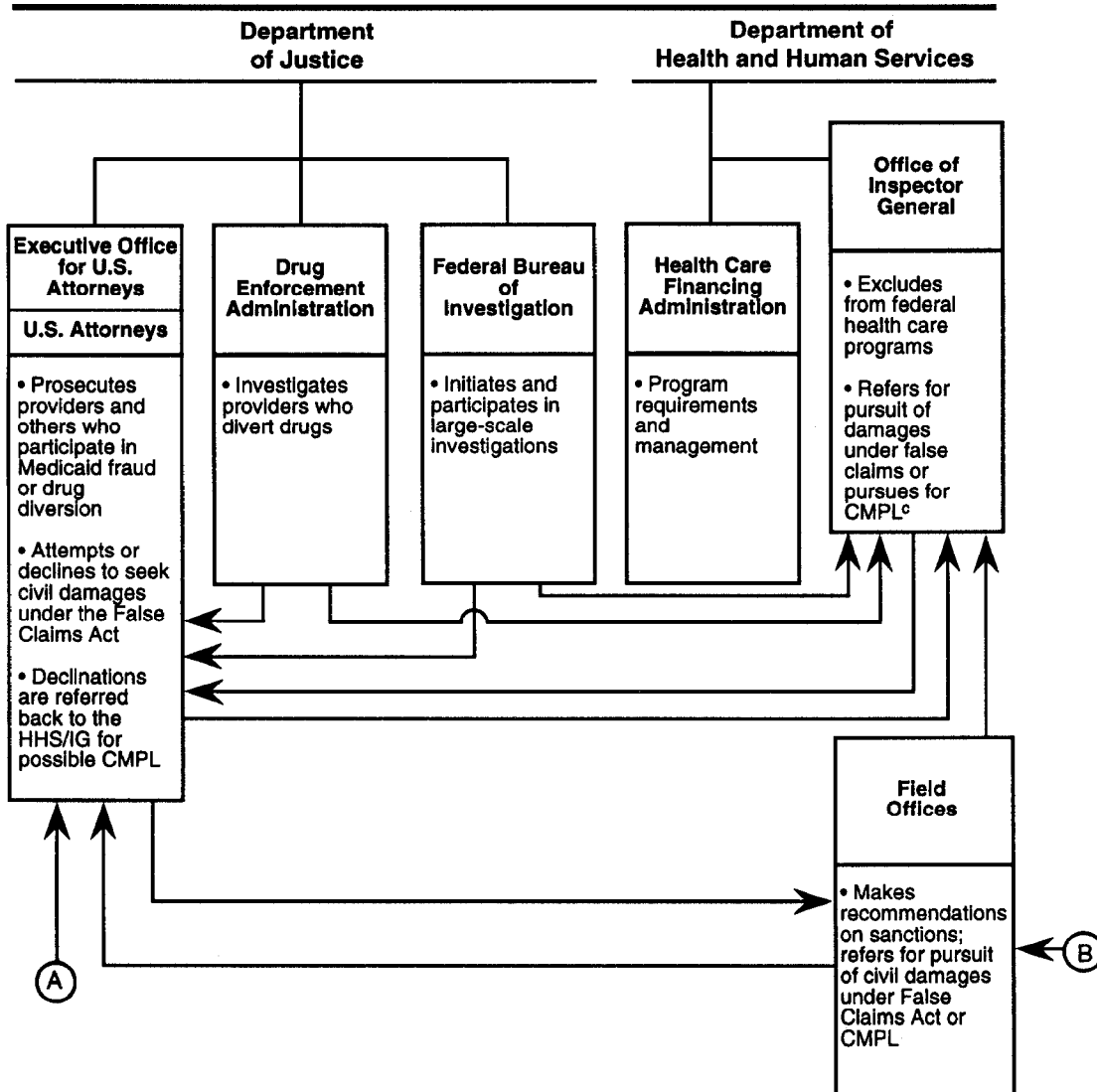
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**Figure I.2: Organizations Involved in Pursuing Medicaid Prescription Drug Diversion in New York State**



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**Federal Government**



<sup>a</sup> Medicaid Management Information Systems

<sup>b</sup> Surveillance and Utilization Review System

<sup>c</sup> Civil Monetary Penalties Law

A second difficulty states face is that the complexity of these cases requires more staff, money, and time than are generally available. Such schemes are rarely prosecuted in their entirety. Instead, suspected providers tend to be investigated individually. Pursuing providers individually, however, allows the overall operation to continue largely unabated.

One major cooperative effort, the FBI's Operation Goldpill, reflects a new strategy focusing on multidefendant conspiracy indictments rather than single-defendant prosecutions. The 2-year investigation revealed the illegal diversion of individual prescriptions, the repackaging and distribution of medications obtained through bulk purchase, and overbilling by pharmacies of Medicaid and other insurers. Working with other federal agencies and with state MFCUS and regulators, approximately 1,000 FBI agents participated in Operation Goldpill—the FBI's largest health care undercover operation—involving 50 cities nationwide. As of December 1992, 254 defendants had been charged, 120 arrested, 116 locations searched, 11 pharmacies seized, \$10.8 million in assets seized, and \$6.6 million levied in fines.

Following leads from New York's Department of Social Services—the state's Medicaid agency—we are conducting our own investigation to assess if cases pursued individually were likely to have involved multiprovider collusion. We are focusing on cases involving abusive clinical labs, which are typically involved in more complex pill mill operations and for which ownership and employee data were readily available.<sup>11</sup> We have found linkages that were not reflected in the original investigations. Evidence points to the existence of one or more broad networks involving multiple providers—including pharmacies—as well as middlemen, foreign nationals, and off-shore money transfers. Figure I.3 depicts the overall structure of such a network as revealed by our analysis to date.

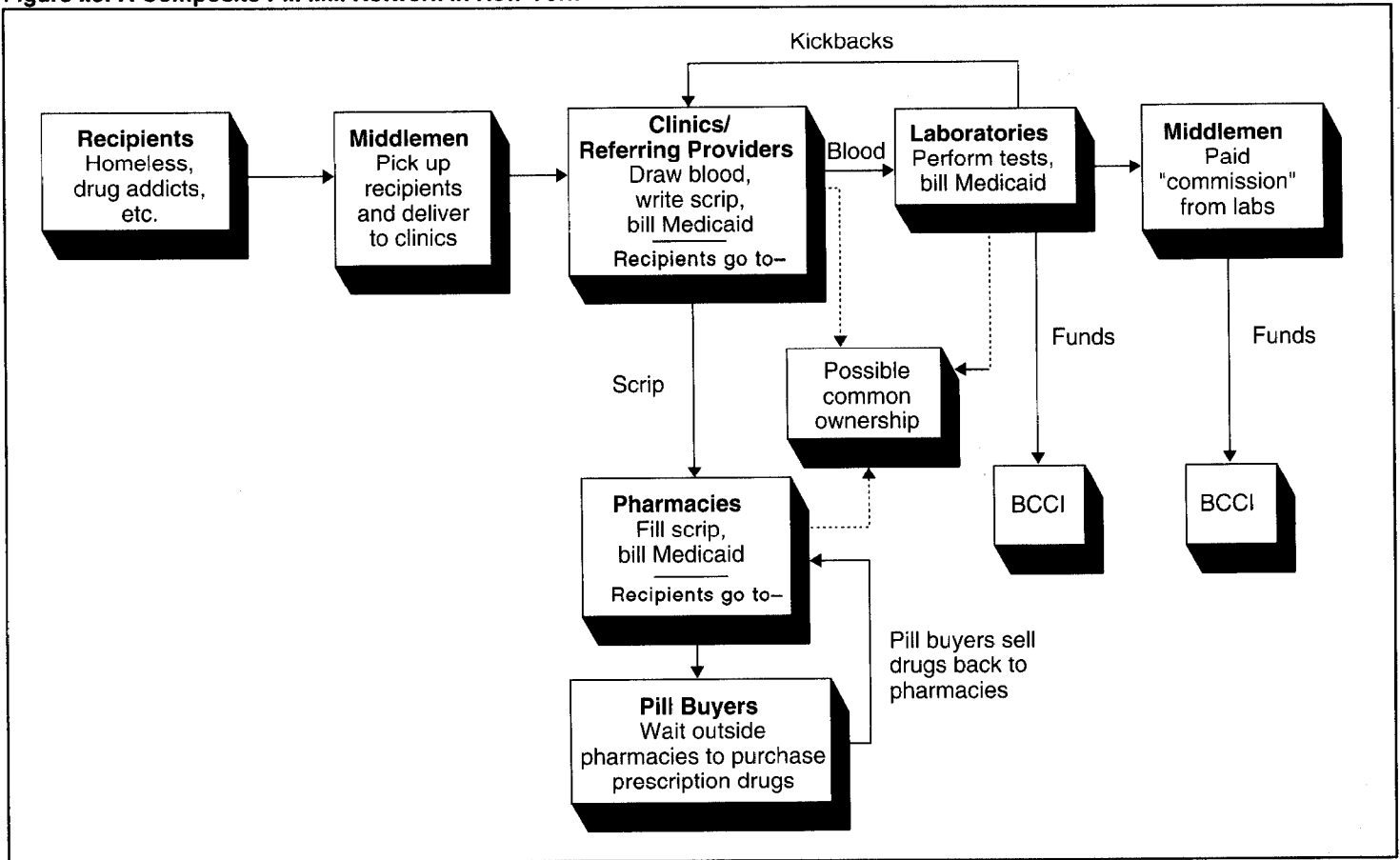
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<sup>11</sup>We compiled a list of 68 suspect labs based on HCFA and New York State Medicaid agency records of labs that HCFA identified as "problems," were suspended from Medicare or Medicaid participation, or voluntarily withdrew from these programs while under investigation.



**Appendix I  
Extent and Persistence of Medicaid  
Prescription Drug Diversion**

**Figure I.3: A Composite Pill Mill Network in New York**



The following are indications that led us to infer a high level of conspiratorial activity:

- **Commonality of personnel:** We found overlap among lists of employees, owners, and directors of the 68 suspect labs.<sup>12</sup> For example, 23 percent of the lab directors had worked in more than one such facility, while other individuals owned more than one. One individual was listed as director or

<sup>12</sup>HCFA maintains these records in paper form for facilities that it monitors, including clinics and labs but not pharmacies.

assistant director of two labs that were administratively excluded from Medicaid for fraudulent billing. No criminal charges were filed.<sup>13</sup>

- **Commonality of foreign connections:** We found overlap between lists of convicted or indicted participants in schemes to defraud Medicaid and individuals transferring funds overseas. Financial records showed that some of the lab owners and employees frequently moved money out of the country. Enforcement agencies could therefore not recover these assets. Some of the money was transferred through the Bank of Credit and Commerce International (BCCI), whose recent collapse was associated with charges of money laundering, drug trafficking, and political corruption. Some of the offenders convicted in these cases avoided incarceration by fleeing the country; others—excluded from Medicaid for excessive billing practices—retain their connection with health care facilities.<sup>14</sup>
- **Commonality of recipients:** We identified a pool of Medicaid patients (or their recipient identification numbers) common to several suspect labs, pharmacies, and referring providers. For example, claims data revealed that one recipient had the same three lab tests five times in 4 days at three different labs and six prescriptions for Zantac in the same 4 days at six different pharmacies. In all, Medicaid paid more than \$3,000 during an 18-day period for this recipient: \$1,718 for 142 lab tests—mostly duplicative—and \$1,314 for 85 prescriptions. One lab involved in this example billed Medicaid for more than \$80 million in 2 years.<sup>15</sup>

Law enforcement agencies, in these and other instances, have concentrated their investigations on lab cases, drug diverting pharmacies, or abusive providers but have not built broad-based conspiracy cases linking such operations in the way that our research shows them to be linked.<sup>16</sup> We found that law enforcement agencies have not followed financial trails demonstrating that individuals billing Medicaid have used off-shore fund transfers to make money defrauded from program operations unrecoverable by U.S. authorities.

<sup>13</sup>She is now the owner-director of a third lab that is currently billing Medicare but has not applied for Medicaid enrollment. A Department of Health and Human Services (HHS) Medicare Enrollment Specialist said this lab was allowed to enroll in Medicare because the owner had never been convicted of a criminal offense related to a federal health care program.

<sup>14</sup>Such connections may consist, for example, of undeclared ownership interests or ownership by a spouse or close relative.

<sup>15</sup>In a single month—during which Medicaid billings exceeded \$4.5 million, Medicare billings were over \$70,000, and private insurers were charged more than \$221,900—a full-time salesman for the lab transferred more than \$245,000 overseas through BCCI.

<sup>16</sup>The Department of Justice plans to focus more extensively on health care fraud conspiracies.

**Appendix I  
Extent and Persistence of Medicaid  
Prescription Drug Diversion**

**Failure to Recover Losses  
Fosters “Crime Pays”  
Outcome**

Many perpetrators of prescription drug fraud, even when convicted, profit financially from their crimes. In the cases we reviewed, the combination of restitution ordered by the courts, subsequent recovery efforts by state Medicaid agencies, and additional federal recoupment actions failed to offset likely program losses. For the most part, amounts recovered were nominal because Medicaid and the investigative agencies did not use the authorities they have to recover losses and penalize fraudulent or abusive providers. The main reason given for lack of action was staffing constraints (see table I.2).

**Table I.2: Medicaid Recoveries  
Collected in Cases Reviewed**

<b>Recovery effort</b>	<b>Dollar amount collected</b>
Court-ordered restitution	\$173,588
Medicaid agency recovery of overpayments <sup>a</sup>	108,075
Civil monetary penalties imposed <sup>b</sup>	0
<b>Total recoveries during period</b>	<b>\$281,663</b>

Note: Billings exceeded \$12 million during the 3-year period covering all these investigations.

<sup>a</sup> Applied in only two cases.

<sup>b</sup> Not applied at either state or federal level.

**Restitution**

Amounts of restitution—money that convicted providers are ordered to pay back—are usually nominal, even though provider billings can be in the millions of dollars, including extensive fraudulent activity. This situation results from several contingent factors—including the fact that sentencing after criminal convictions may focus on punishment rather than restitution. Law enforcement officials often pursue allegations of drug diversion through undercover operations in which providers are caught in illegal transactions, such as making drug buys or writing phony scrips. The transactions may be few—only enough to warrant conviction—and may therefore involve as little as a few hundred dollars.<sup>17</sup> Amounts established for restitution cannot exceed those claimed in charges proven in court. Moreover, because most cases are settled through negotiation and pleading to lesser charges, restitution amounts may be even further reduced in some instances. Consequently, these amounts do not compensate for the full extent of Medicaid losses through such fraudulent activity.

<sup>17</sup>Medicaid prescriptions cost an average of \$17 during the last 5 years for the four states we visited.

In addition, amounts obtained through restitution are often a fraction of those ordered by the court (a problem not unique to Medicaid fraud cases). In more than half the cases we examined, restitution amounts were nominal—amounting to \$5,000 or less. Providers usually paid these amounts. In those cases where restitution was assessed at \$20,000 or more, however, the Medicaid agency recovered only a small percentage of the amounts established. For example, in a case where restitution called for \$220,000, only \$4,000 was recovered. Neither the Medicaid agency in its monitoring role nor the court probation department charged with collections was aware that the provider had stopped making restitution payments. The probation department had only three officers to cover a caseload of 5,000. In a New York case in which only \$50,000 of a \$300,000 assessment was collected, eventual repayment of the remainder is contingent upon the owner's success in selling his pharmacy and the building that houses it. Opportunities exist for convicted owners to avoid repayment by various actions, including hiding assets under other names, transferring funds overseas, or declaring bankruptcy.<sup>18</sup>

## Recovery

Despite available options, agencies rarely pursue recovery of losses beyond those sought through restitution. As a supplement to criminal investigation and prosecution, state Medicaid agencies can audit providers' records to determine overpayment amounts to be recovered. Agencies need to consider the universe of a provider's claims to establish an overpayment amount that will make the audit worthwhile. They can do so without exhaustively reviewing claims, by projecting losses from a sample, an approach often used in Medicare to establish overpayment amounts. In addition, for certain referred cases, HHS or the Department of Justice can impose monetary penalties, and some of the proceeds may be returned to the Medicaid program. In Medicaid fraud cases, however, state agencies seldom do audits when criminal charges are involved, and federal agencies seldom invoke the Civil Monetary Penalty Law (CMPL) or the False Claims Act, both of which allow severe financial penalties for filing unwarranted or unsubstantiated claims.

A major reason cited for the lack of state and federal agencies' action was scarce resources and the poor prospect of recovering substantial funds. Some state officials also cited legal concerns. Medicaid agencies avoid auditing providers against whom a law enforcement agency is developing a criminal case. Officials told us they interpreted state laws as either

<sup>18</sup>Medicare and Medicaid overpayments once had priority in bankruptcy cases, but it was eliminated by the Bankruptcy Reform Act of 1978 (P.L.95-598). The Office of the Inspector General, in a May 1992 report, recommended that HCFA propose a legislative change to restore this priority. HCFA has the matter under consideration.

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precluding or hindering parallel development of cases. In their opinion, for example, disclosure provisions of these laws could require the testimony of law enforcement officials at administrative hearings before the criminal case is fully prepared, thereby compromising subsequent use of the evidence.

Better coordination between MFCUS and Medicaid agencies could allay these problems. In practice, however, agencies make little effort to time audits and criminal investigations so that civil recoveries can be made without compromising criminal prosecution. Agencies did not try to audit providers before criminal cases were closed in any of the cases we reviewed. Even following criminal convictions, few Medicaid agencies do companion audits—in only two of the cases reviewed were convicted providers audited and overpayments sought. Medicaid agency officials attribute their reluctance to resource limitations, exacerbated by the age of the cases at closure.

Moreover, federal requirements tend to discourage states from pursuing comprehensive recoveries. Under these requirements, states must pay HCFA, within 60 days of notifying the provider, the federal share of an overpayment amount established through recovery procedures.<sup>19</sup> Thus, if the state does not promptly recover its money from the offender, it has to repay HCFA from state funds.<sup>20</sup> Moreover, the amount initially established is due even if the state subsequently negotiates a lower settlement with the provider.

As for imposing financial penalties, CMPL gives HHS the authority to recoup double the amount inappropriately billed as well as \$2,000 per line item on each claim. Under the False Claims Act, the Department of Justice has the authority to recoup triple the amount inappropriately billed as well as \$10,000 per claim. Both penalties require a lesser standard of proof than is needed to obtain a criminal conviction. Some states have comparable laws.

As a practical matter, however, agencies' timing for implementing the civil penalty approach makes success unlikely. That is, agencies generally wait until criminal prosecution is completed before they explore the penalty

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<sup>19</sup>These requirements were designed to encourage speedy action by states in following up on routine audits; however, they may be less appropriately applied in criminal cases.

<sup>20</sup>In one state we visited, only 10 percent of 1988's estimated overpayments had been recovered by the end of January 1989. This suggests that the average recovery period significantly exceeded 60 days. More recent data are not available.

option. By this time, claims are old—sometimes beyond the statute of limitations—and providers have had ample time to disperse their remaining assets. Officials cited lack of resources, other priorities, and uncertainty of successful outcome as reasons for not invoking the penalty laws.

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## **State Initiatives Show Promise in Moderating Drug Diversion**

States have introduced approaches aimed at reducing losses due to Medicaid fraud. (App. IV lists the major initiatives of the states visited.) Highlights include

- prevention and enhanced detection through advanced identification technology and automated systems that flag suspicious activity immediately;
- bypassing the criminal pursuit process through innovative administrative remedies such as Florida’s guidelines and sanctions matrix, now embodied in state law, or streamlining it through interagency task forces that strive to expedite investigations involving several agencies; and
- stronger tools for collecting losses, such as requiring certain high-volume providers to post performance bonds or other forms of financial security.

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## **Focus on Prevention, Early Detection Could Account for Reduced Medicaid Drug Payments**

New York has introduced a combination of prevention and early detection controls. The state’s Department of Social Services correlates the implementation of these controls with an 8-percent decrease in the number of Medicaid prescription claims during the past 5 years and a sharp reduction in spending for the most abused drugs. These innovations include the following:

- **Electronic Medicaid Eligibility Verification System:** Under this credit-card-type system, Medicaid recipients have an electronically coded card that lets the Medicaid agency track receipt of each covered service or prescription at the time of service. Within 24 hours, system-generated reports indicate how many recipients a particular provider has seen, what services were provided, and what was ordered for the recipients. Although HHS has encouraged all states to implement electronic point-of-service

(POS) claims management systems for prescription drug claims,<sup>21</sup> New York is one of the few states where such a system is operational.<sup>22</sup>

- Utilization thresholds: New York has caps, or thresholds, on the use of prescription drugs and Medicaid services that work in combination with the electronic verification system. If the system shows that a Medicaid recipient has already reached a yearly service utilization threshold, the provider can assure payment only by first obtaining a waiver from the Medicaid state agency to provide the service.
- Post and clear: As an adjunct to the electronic verification system, New York also uses “post and clear” for certain providers. When physicians order medication for a patient on a prescription form, they must also electronically “post” an order in the system that is subsequently “cleared” by the pharmacy rendering the service. The system thus prevents the prescribing physician from disclaiming responsibility and detects any attempt by the pharmacist to bill Medicaid for more prescriptions than the physician ordered.

## Facilitating Criminal and Disciplinary Actions

To expedite final case resolution, states have sought ways to reduce procedural delays. New York has recently mandated tight time frames for initiating and completing disciplinary actions by the states’ professional licensing authorities, which have the power to suspend or revoke a provider’s license to practice. In a similar vein, the HHS Inspector General recently agreed to exclude New York state providers convicted of Medicaid fraud from Medicare upon receipt of a sworn affidavit of adjudication from the MFCU, instead of—as previously—waiting for official court documents.

In addition, states are finding ways to avoid lengthy and costly trials.<sup>23</sup> Several states are making greater use of negotiation involving all interested parties, to reach what are termed “global” settlements. As an alternative approach, New York has established Medicaid provider agreements (which the state regards as contracts) for pharmacists that can be terminated by either party without cause. Such contractual

<sup>21</sup>The establishment of drug utilization review (DUR) systems is required under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990—P.L.101-508). Its primary purpose was to improve the monitoring of pharmacological treatments, rather than fraud control.

<sup>22</sup>Officials in Florida told us they were in the process of implementing an on-line POS system. According to a May 1992 HHS report, New York and Massachusetts were the only states with such a system in 1991, and only 10 states had definite plans to introduce one. However, the report noted in an epilogue that all major suppliers of Medicaid management information systems were now developing POS technology, meaning that POS systems will likely find increasing use in the Medicaid program.

<sup>23</sup>This approach entails making trade-offs between harsher sanctions and faster resolution of cases.

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arrangements preclude the need for prosecution to discipline malfeasant providers.<sup>24</sup>

Some states have also participated in efforts that focus on interagency coordination to help disable organized networks. In Operation Goldpill, the FBI worked with the federal Food and Drug Administration, Drug Enforcement Administration (DEA), HHS Inspector General, and Postal Inspection Service; with state MFCUS, police units, attorney generals' offices, and licensing boards; and with private insurers and the pharmaceutical industry. In just one of Operation Goldpill's many fraud cases, agents seized \$1.9 million in cash, representing the proceeds of a pharmacist's fraudulent Medicaid billings.

Continuing this emphasis on health care fraud, the Department of Justice is encouraging states to set up cooperative working groups. Florida and other states have established multiagency task forces to coordinate the investigative procedures of the various agencies involved. Some task forces work to streamline the investigative process by arranging for agencies to make decisions and actions concurrently that would otherwise take place sequentially. Others jointly develop fraud cases.

As another approach to targeting networks, state and federal authorities are increasingly using criminal conspiracy and asset forfeiture statutes. These laws provide a broader arsenal of legal remedies to recover losses and bar participants from continuing to operate in the medical field. According to an FBI official, "forfeiture strips accused offenders of their ill-gotten gains and...without capital or collateral, defrauders find it difficult to relocate and continue their illegal practices."<sup>25</sup>

New York and Florida have made regulatory and administrative changes, including

- holding persons ordering or prescribing excessive or medically unnecessary medical care or services responsible for their orders—New York State's Department of Social Services investigates and, if appropriate, takes administrative action to recover overpayments under this provision

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<sup>24</sup>New York has used this authority against various providers, including pharmacies, and been upheld in court. Texas has a similar termination provision, but has never used it. HCFA prepared a model statute along these lines, but the states' reception was mixed.

<sup>25</sup>Joseph L. Ford, "Investigating a National Problem Through a Global Strategy," Federal Bar News and Journal, Vol. 40, No.1, (January 1993), pp. 66-69.



when all or most of a physician's patients receive the same tests or prescriptions;<sup>26</sup>

- requiring enrollment and closer monitoring of physicians' assistants, who, in some instances, are providing patients with previously signed prescription forms; and
- requiring expanded ownership information as a condition of provider enrollment and comparing it to state business filings; information from these records can reveal connections between Medicaid facilities and physicians not otherwise evident.

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## Improving Collections

To help collect overpayments, fines, and other financial penalties, states have developed several recovery initiatives. New York requires high-volume Medicaid pharmacies to post performance bonds or other financial security to improve the state's chances of recovering losses if fraud is detected. New Jersey permits freezing of a provider's bank account or other assets under certain circumstances. Texas also has the power to freeze and seize assets, and the MFCU is currently exploring its application in cases of Medicaid fraud. According to investigators and state officials, drugs are often diverted by individuals able to move assets out of the country, and therefore states need the ability to identify and freeze assets before they are hidden or otherwise protected from seizure.

Appendix V discusses federal initiatives that support or enhance state efforts to control Medicaid drug diversion.

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<sup>26</sup>The regulation specifically assigns joint and separate liability to the person furnishing such services, the person under whose supervision they were furnished, and the person causing them to be furnished.

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# Objectives, Scope, and Methodology

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We performed this study at the request of Congressman Rangel in his former capacity as the Chairman of the House Select Committee on Narcotics Abuse and Control; and of Congressman Towns, Chairman, Subcommittee on Human Resources and Intergovernmental Relations, House Committee on Government Operations. Our objectives were to explore (1) the nature and extent of Medicaid drug diversion, particularly pill mills; (2) the reasons such activities persist; and (3) actions being taken to curb such abuse.

To determine how many states experienced such diversion, we conducted a telephone survey of the 42 MFCUS, located in 41 states and the District of Columbia. We then focused our efforts on the four most populous states whose MFCU Directors reported a significant pill mill problem: California, Florida, New York, and Texas. We interviewed officials from the state Medicaid agencies, MFCUS, state licensing authorities, and the appropriate HHS regional offices. We also met with representatives of the Department of Justice, the HHS Office of the Inspector General, HCFA, and the National Association of State Attorneys General.

Each year, U.S. pharmacies dispense more than 1.5 billion prescriptions. The majority of these are legitimately obtained and consumed. Others, however, are diverted—channeled away from legitimate supply routes for an inappropriate or illegal purpose. According to the DEA, the greatest diversion occurs at the level of the pharmacy or prescribing physician. Our study focused on this level.

Diversion occurs in several ways, including (1) illegal sales by physicians or pharmacies; (2) procurement of prescriptions by individuals from multiple physicians under the pretext of legitimate medical need; (3) indiscriminate, inappropriate, or careless prescribing by a physician or dispensing pharmacist; (4) prescription forgeries; and (5) theft of drugs from a physician's office or pharmacy. We focused our review on cases of systematic abuse involving collusion between at least two of the parties: physicians, patients, and pharmacists.<sup>1</sup>

We obtained MFCUS' records of Medicaid drug diversion cases adjudicated during 1991 to review their outcomes and the time taken to achieve resolution. In states where this resulted in very few cases, we expanded our time frame to include 1990. We deliberately did not focus on more recent cases to allow time for completion of other actions, such as exclusion from Medicaid and Medicare, license suspension or revocation,

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<sup>1</sup>Other individuals may also be involved, for example, as financial backers or as "middlemen."

and the imposition of civil administrative penalties. Although we did not verify case records independently, we discussed individual cases with each of the agencies involved and resolved any inconsistencies.

State MFCU officials selected these cases because they involved drug diversion. The actual charges sometimes differed. It is difficult to isolate such cases, and state laws differ on what constitutes drug diversion. We rejected some cases suggested by MFCU officials for inclusion (for example, when drugs were obtained by an addicted health professional solely for his or her own use) but did not review their complete case files in search of others. Thus, it is likely that we achieved neither a complete set of related cases nor strict comparability among the states. Nevertheless, we believed—and state officials concurred—that analysis of these cases could provide broadly representative information about the process and outcome of drug diversion investigations.

We conducted our own investigation to assess whether cases pursued individually were likely to have involved multiprovider collusion. Because ownership and employee data were more readily available for labs than for pharmacies and because abusive clinical labs are typically involved in more complex pill mill operations, we focused on information about these labs.

From New York's Medicaid agency and HCFA, we obtained information that allowed us to compile a list of "suspect labs": medical labs that were excluded or voluntarily withdrew from the Medicaid or Medicare programs because they engaged in prohibited practices. To identify personnel—owners or employees—common to several of these labs, we reviewed HCFA records. We matched the list of common personnel with Department of Treasury and BCCI records of financial off-shore transfers.

The Medicaid agency provided profiles—based on filed claims—of high-volume recipients of services through several of the suspect labs. We compared these profiles to see if the suspect labs shared a common pool of such recipients and to identify possible duplication of lab tests and prescriptions.

We performed our field work in accordance with generally accepted government auditing standards between December 1991 and December 1992. The requesters asked us not to obtain written agency comments on this report because of time constraints, but we did show a

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**Appendix II  
Objectives, Scope, and Methodology**

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draft to HCFA officials. We also obtained comments on relevant sections of the draft from officials in the four states on which we focused.

# Economic Incentives to Divert Drugs

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The economic incentives for diverting drugs are substantial and apply to a wide range of medications. Pharmaceuticals prescribed for medical use—commonly termed prescription drugs—fall into two broad groupings: controlled and noncontrolled. The Controlled Substances Act divides those drugs known to have the potential for physical or psychological harm into five categories or schedules based on their potential for abuse, accepted medical use, and accepted safety under medical supervision. Schedule I controlled substances—such as heroin—have no accepted medical use in the United States and are not available to the public through legal channels. Schedules II through V contain drugs with accepted medical uses but some abuse potential. Schedule II are the most dangerous, Schedule V the least.

Legal, controlled drugs make an appealing target for diversion: they are relatively cheap and chemically pure compared to illicit drugs. The economic incentives for diversion of controlled substances are evident from table III.1: profits from street sales can amount to several thousand percent of initial investment. According to DEA, the street value of controlled substances intentionally diverted for resale to facilitate illegal drug activity is \$25 billion a year.

**Appendix III**  
**Economic Incentives to Divert Drugs**

**Table III.1: Comparative Prices of Popular Controlled Drugs**

In order of street user preference			
Name	Pharmacy price per pill	Street price per pill	Profit
Valium	\$1.04	\$6.00	477%
Ativan	1.03	5.00	385
Darvocet	0.73	2.00	174
Xanax	0.79	2.00	153
Sinequan	0.51	0.75	47
Empirin w/codeine	0.70	4.00	471
Darvon-N	0.70	2.00	186
Librium	0.97	2.00	106
Tuinal	0.43	8.00	1,760
Seconal	0.33	6.00	1,718
Fiorinal w/codeine	0.90	4.00	344
Biphedamine	2.67	7.00	162
Dexedrine	0.13	5.00	3,746
Nembutal	0.67	7.00	945
Dalmane	0.61	2.00	228
Percocet	0.85	5.00	488
Tylenol w/codeine	0.38	3.00	689
Percodan	1.09	7.00	542

The Controlled Substances Act does not cover some prescription drugs because they are deemed to lack a potential for harm. Nevertheless, these noncontrolled substances have recently become popular targets for diversion because they are comparatively easier to obtain and are particularly attractive if obtained under an insurance program—such as Medicaid—requiring no copayment.<sup>1</sup> In this case, the recipient's outlay is zero, so the price paid on the street, while typically much lower than the pharmacy price—and thus attractive to buyers—is pure profit to the sellers. DEA estimates that 36.5 million Medicaid prescriptions were abused in 1989, for a street value of \$8.7 billion. Table III.2 shows typical cost patterns for noncontrolled substances in New York.

<sup>1</sup>In some states, the Medicaid program may require a nominal copayment.

**Appendix III  
Economic Incentives to Divert Drugs**

**Table III.2: Comparative Prices of Popular Noncontrolled Drugs**

In order of street user preference		
<b>Name</b>	<b>Pharmacy price per pill</b>	<b>Street price per pill</b>
Zantac	\$1.66	\$0.37
Keflex	2.24	0.17
Dolobid	1.35	0.20
Penicillin VK	0.39	0.20
Mevacor	1.67	0.50
Feldene	2.36	0.33
Prozac	1.92	0.57
Cipro	2.15	0.33
Naprosyn	1.03	0.10
BuSpar	0.62	1.00
Dilantin	0.19	0.05
Augmentin	2.39	0.27
Aldomet	0.53	0.17
Tagamet	0.69	0.37
Procardia	0.61	0.13

# Selected Initiatives in Four States Visited

Initiative	Status			
	California	Florida	New York	Texas
<b>Up-Front Controls: Recipient-oriented</b>				
Limited number of prescriptions <sup>a</sup>	10 per month, starting next budget cycle	6 per month	14 per month	3 per month
Photo ID card	No	No	Outside of New York City	No
Managed care program	500,000 currently in such a program; 50% of all recipients within 3 years	Planned	In process; 50% of all recipients within 5 years	No
On-line eligibility verification	To be phased in between Jan. 1 and June 30, 1994	Pilot	Yes	Starting Jan. 1, 1993
<b>Up-Front Controls: Provider-oriented</b>				
Competitive bidding used as basis for enrolling pharmacies	No	No	Experiment with labs proved unworkable	No
Enrollment based on local needs	No	No	Enrollment of new pharmacies and labs restricted in some areas of New York City	No
Financial disclosure requirements imposed by Medicaid agency as condition of program enrollment	Yes	Yes	Yes	Yes
"Post and clear" <sup>b</sup>	No	No	Required for some high-volume providers	No
"Trip scrip" <sup>c</sup>	Schedule II only	Schedule II only	Schedule II and others	Schedule II only
<b>Initiatives Focusing on Deterrence</b>				
Mandatory time requirements placed on professional disciplinary process	Medical board only	No	Different requirements for medical, pharmacy boards	No
Mandated professional sanctions	No	Immediate suspension of physicians convicted of felony	No	No
Referring physician held responsible for unnecessary or excess care	Yes, but not actively enforced	No	Yes	No

(continued)



**Appendix IV  
Selected Initiatives in Four States Visited**

Initiative	Status			
	California	Florida	New York	Texas
<b>Initiatives Focusing on Detection</b>				
Explanations of Medical Benefits (EOMBs) sent to physicians as well as recipients <sup>d</sup>	No	No	Yes	No
Enhanced analytical capability	Pilot projects targeting high-volume providers	Targets suspect physicians and pharmacies	Based on on-line verification systems	Manual comparison of records
<b>Initiatives Focusing on Prosecution</b>				
State laws making prescription drug diversion or Medicaid fraud a felony	For most drugs except opiates, first offense is misdemeanor. Medicaid fraud can be a felony, depending on dollar amount	Medicaid fraud is a felony	No	Controlled substances only <sup>e</sup>
Provider agreements viewed as contracts, cancelable without cause	No	Plan to view as contracts does not allow "arbitrary or capricious" cancellation	Yes, upheld by courts	Yes, but not actively enforced
Interagency task forces addressing Medicaid drug fraud	Southern California	In all three federal court districts	New York City only	State-wide
<b>Initiatives Focusing on Restitution</b>				
Performance bonds or other financial security required of enrolling providers	Not relating to prescription drugs	No	High-volume pharmacies and certain other providers	For some pharmacies only provisionally enrolled
State Civil Monetary Penalties Law	Yes	No	Yes	Yes
Applicable state asset forfeiture law	Yes	No	No	Yes
HHS permits MFCU affidavits to substitute for court documents	No	No	As basis for Medicare exclusion <sup>f</sup>	No

(Table notes on next page)

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**Appendix IV**  
**Selected Initiatives in Four States Visited**

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<sup>a</sup> In all states, certain exceptions may apply.

<sup>b</sup> Prescribing physician electronically "posts" his scrip, later "cleared" by pharmacist. See appendix I.

<sup>c</sup> Prescribing physician must use prenumbered, multiple-copy prescription forms or equivalent control mechanism, thus creating a clear audit trail. See appendix III for definition of Schedule II drugs.

<sup>d</sup> HCFA regulations require that EOMBs be sent to all or a sample group of recipients. See appendix V.

<sup>e</sup> See appendix III for definition of controlled substances.

<sup>f</sup> CMPL action is not limited to cases that are criminally prosecuted. However, in criminal cases, such action is postponed until official court documents are received by HHS. An affidavit is not accepted in these circumstances.

# Federal Initiatives Relevant to Prescription Drug Diversion

Federal regulations require most states to have Medicaid Management Information Systems (MMIS).<sup>1</sup> These are computerized systems designed to process claims and give state Medicaid agencies information for internal program management. In 1988, we recommended that HHS and the Department of Justice test the usefulness and cost of analyzing controlled substance data from MMIS and providing it to regulatory, licensing, and law enforcement agencies for addressing sources of drug diversion. HCFA agreed that this approach should be tested.

The Surveillance and Utilization Review Subsystem (SURS), also federally required, was developed in part to identify providers and recipients most likely to abuse the Medicaid program. It establishes, measures, and compares provider and recipient utilization patterns to identify those who show unusual patterns of practice or utilization. States have flexibility in deciding what form specific screens should take. We were told in all the states we visited that MMIS data are not timely and that SURS reports are not configured to facilitate ready identification of potentially fraudulent providers.<sup>2</sup>

Building on MMIS data, HHS has also developed and made available to states the Medicaid Abusable Drug Audit System (MADAS), which analyzes Medicaid prescription drug claims submitted by pharmacies. MADAS can identify aberrant prescription drug dispensing and prescribing patterns for all providers in a specific area. This program has been run successfully in New Mexico and Maryland and has recently been implemented in Florida.

Federal regulations require that all or a sample group of recipients be sent notifications (EOMBS) for verification of claims' accuracy. When aggressively pursued, this process can detect improper claims, but estimates of its effectiveness vary. The response rate is said to be low. But a recent case in New Hampshire illustrates that it can be very productive—a single routine EOMB led to the exposure of the largest fraud case in the state's history, with losses exceeding \$330,000 to Medicaid and other insurers. Also, New York has sufficient faith in this approach to have adopted a variant aimed at providers, targeting those with a high volume of services or prescriptions.

The Omnibus Budget Reconciliation Act of 1990 required a drug utilization review system for Medicaid recipients to be in place by January 1, 1993.

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<sup>1</sup>Several of the smallest states are exempt from this requirement.

<sup>2</sup>We commented to this effect in an earlier report, Controlled Substances: Medicaid Data May Be Useful for Monitoring Diversion (GAO/HRD-88-111, Aug. 1988).

While the primary purpose of this legislation was to improve the monitoring of pharmacological treatments, its provisions are likely both to serve as a deterrent and to provide early warning of violations. They include screening for clinical abuse/misuse and optional electronic claims processing. They call for both prospective and retrospective medication assessments; unless states establish electronic drug claims management (ECM) systems with prospective DUR components, individual pharmacies are responsible for prospective screening. Nineteen states will have established ECM systems by January 1994, of which 15 will be used for prospective DUR.

The Department of Justice is encouraging states to set up cooperative efforts among health care agencies to address fraud. One of these is in West Virginia, and the MFCU credits much of its success to its informal, informational monthly meetings with representatives from the Black Lung Organization, the Blue Cross and Blue Shield Association, Aetna Insurance, the Department of Labor, workman's compensation program, Bureau of Mines, DEA, FBI, HHS regional office, and the state Medicaid agency. Joint efforts were initiated at these meetings and—according to MFCU officials—were aggressively pursued. One problem noted is that such cooperative efforts depend critically on the leadership of the Department of Justice officials (U.S. attorneys) and how much emphasis they place on this approach.

A federal task force recently recommended legislative actions designed to curb health care fraud and abuse, many of which would have relevance to drug diversion.<sup>3</sup> They include

- improving antikickback laws;
- expanding the list of health care fraud schemes punishable by civil monetary penalty statutes;
- establishing a database for final adverse actions and another for active investigations;
- increasing the severity of quality of care sanctions;
- enhancing provider responsibility and accountability for electronic media claims; and
- instituting asset forfeiture for health care fraud.

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<sup>3</sup>The task force consisted of the Department of Health and Human Services, the Office of Management and Budget, and the Department of Justice. See Health Care Anti-Fraud and Abuse Recommendations, Health Care Fraud and Abuse Action Team (Washington, D.C.: 1993).

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