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MEDICAID

A Program Highly Vulnerable to Fraud

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SUMMARY

The Medicaid program cost state and federal governments over $150 billion in 1993 for health services and supplies. It is highly vulnerable to fraud because of its size, structure, target population, and coverage. The ensuing drain on program funds is difficult to gauge, but state Medicaid officials believe it can be as high as 10 percent of program expenditures.

Prescription drugs--one of Medicaid's covered services--are one appealing target. Diversion of these drugs is lucrative, widespread, and difficult to control. Schemes include pharmacists routinely adding medications to customers' orders and clinics inappropriately providing Medicaid recipients with completed prescription forms, or scrips, that may be sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy have been resold for as much as $85. In Florida, some pharmacies have also accepted the scrips in exchange for lottery tickets, TV sets, and even a grandfather clock. The drugs--for which the pharmacy billed Medicaid as though they had been dispensed to the recipient--may have been shipped to Cuba.

Medicaid drug diversion frequently occurs in conjunction with other fraud involving clinics and labs. For example, one group of providers billed Medicaid more than $3,000 for office visits, 85 prescriptions, and the same three lab tests five times, for the same recipient over one 18-day period.

States are addressing the problem of Medicaid fraud and meeting with some success. Recent initiatives focusing on prevention or early detection include the use of improved identification and utilization monitoring procedures and prescription-filing systems that can instantly link orders to the filing physician. To enhance pursuit and punishment of offenders, interagency task forces now target health care fraud, and harsher sanctions have been approved. Introduction of managed care for Medicaid recipients also offers some promise of decreasing fraud related to overbilling or provision of unnecessary services.

Nevertheless, the problem persists. Officials in many states told us that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. Most say that lack of adequate resources limits oversight, investigative, and prosecutorial efforts. We feel that a lack of federal leadership has kept states from making the best use of the resources they do have. The Health Care Financing Administration should develop an overall strategy to address Medicaid fraud and provide guidance and technical assistance to the states struggling to control these schemes.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here this morning to discuss fraud in the Medicaid program. My comments draw heavily on findings from our recent investigation--conducted at your request--that focused on the diversion of prescription drugs paid for with Medicaid funds. Although we reviewed cases of such diversion and associated types of fraud in a number of states,[1] we found that the problems associated with Medicaid fraud nationwide are equally, if not more, pervasive in Florida.

MEDICAID IS VULNERABLE TO FRAUD AND ABUSE

As you know, Medicaid is the largest government health program for the poor. The Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) estimates that 1993 program expenditures for health care services and supplies exceeded $150 billion on behalf of almost 32 million recipients. Medicaid's size, structure, target population, and coverage make it highly vulnerable to false billings and other fraudulent activities.

Program Size and Structure Contribute to its Vulnerability

Medicaid is a federally aided, state-administered medical assistance program.[2] The federal government provides a share of each state's payment for services--between 50 and nearly 80 percent--depending on the state's per capita income.

Several characteristics of Medicaid's structure invite fraud:

-- It is a large program, with costs anticipated to reach $161 billion in 1994. It generates a correspondingly large number of provider claims, which creates difficulty in examining them closely for abusive practices.

-- Eligibility is income-dependent and thus constantly changing. Many states, including Florida, issue their Medicaid recipient ID cards monthly. This complicates verifying who is eligible and for what services as well as controlling the possession and use of Medicaid cards.

-- Providers are often in short supply, and program administrators do not want to discourage participation by imposing controls that could be perceived as unduly burdensome.

-- Because it has traditionally been a fee-for-service system, with nominal if any significant copayments, Medicaid offers no financial disincentives to heavy use by honest recipients, much less those who may participate in dubious schemes.

Medicaid fraud is widespread. The ensuing drain on program funds is hard to estimate, but state officials believe the loss is significant, perhaps as high as 10 percent of total program expenditures.

Such fraud frequently involves providers that bill for services not rendered or not medically necessary. Schemes take many forms. A snapshot of recent cases is provided in table 1.

Table 1: Examples of Recent Medicaid Fraud Cases

Dentist	Physician
A Minnesota dentist was charged with defrauding Medicaid over a 4-year period by billing for services to nursing home residents who were already dead or who were absent from the nursing home at the time he claimed to treat them there. Cost to Medicaid: $25,242	A Massachusetts physician was indicted for submitting fraudulent bills to Medicaid, claiming to have treated patients with fractured bones and other injuries never sustained. Cost to Medicaid: $30,000
Nursing Home	**Psychiatrist**
The owner of a New York nursing home, himself a former federal prosecutor, was convicted of inflating construction and operating costs to improperly obtain increased Medicaid reimbursement. Cost to Medicaid: $1,173,694	A psychiatrist in Harlem was convicted of illegally selling prescriptions on demand for cash. Over an 18-month period, he may have pocketed over $1.2 million in cash from his patients. Pharmacies billed the prescriptions to Medicaid. Cost to Medicaid: $1.8 million

PRESCRIPTION DRUGS ARE ONE TARGET OF FRAUD

In studying Medicaid fraud, we focused on the diversion of prescription drugs. This type of fraud, which involves diversion of drugs paid for by Medicaid, is lucrative, widespread, and difficult to control. Some drugs have psychological or physical effects similar to those of illicit drugs, and others have substantial monetary value. When Medicaid pays for the prescriptions, profiteers can divert them for resale through illicit channels.

We found that some pharmacists routinely added medications to customers' orders, keeping the extras to use themselves or to sell to others. Clinics inappropriately provided Medicaid recipients with completed prescription forms, called scrips, that recipients

then sold on the street to the highest bidder. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

Florida law enforcement officials described to us one type of scheme particularly prevalent in Miami and probably also in Tampa. This involved Medicaid recipients who obtained scrips on demand from obliging doctors. Pharmacies colluding in the scheme gave store credit for some percentage of the scrip's value. Examples of merchandise obtained in this manner included tennis shoes, TV sets, toaster ovens, and a grandfather clock. In some cases the scrips were even exchanged for lottery tickets or the payment of utility bills. The pharmacy billed Medicaid for the drugs, some of which may have been shipped to Cuba, others sold over the counter on demand, one pill at a time. Investigators told us that they believe such schemes persist, with some pharmacies billing Medicaid for more than $1 million a year--50 percent of which may be fraudulent.

Prescription drug diversion frequently occurs in conjunction with other fraudulent schemes. Our analysis of Medicaid claims data in New York revealed one typical example involving a recipient who was the subject of considerable billing activity by a group of suspect providers. Using the Medicaid number of one recipient, for one 18-day period, providers billed Medicaid more than $3,000 for office visits and associated claims for 85 prescriptions and the same three lab tests five times.

WHY ABUSES PERSIST

Drug diversion in the Medicaid program persists for a variety of reasons. These include ineffective use of data, inadequate resources, and a complex administrative structure, as well as light penalties for convicted offenders, and poor follow-up of their subsequent involvement in the health care system.

Data to Detect Fraud Are Not Effectively Used

State Medicaid agencies have paid claims data and other records that can be used to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care. However, we found that, due in large part to the unreliable and incomplete nature of these data, state Medicaid agencies generally do not rely on analyses of their data to identify potential drug diversion. Instead, we found that most alleged abuses investigated by the Medicaid Fraud Control Units (MFCUs) are identified through tips or other fortuitous means. Others are referred by the Medicaid agency, but even those are seldom revealed by routine analysis of existing claims data.

In California, we found that 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. A tip ultimately revealed the scheme.

Resources Are Inadequate

State law enforcement and program officials that we talked to expressed a belief that far more potentially fraudulent offenses were occurring than they had the resources to pursue. Florida's Medicaid agency estimates that 90 percent of its referrals are rejected by the MFCU for lack of resources. Even when cases are opened, preparing them for prosecution is slow and resource intensive.

Our own analysis of Florida drug diversion cases leading to conviction revealed that, from the time they were reported to the MFCU, half of the cases took almost 3 years (32 months) before offenders were excluded from Medicaid and more than 5 years (62 months) before professional licensure action--if any--was completed. None of the cases we reviewed resulted in more than a 1-year probation. Sixty percent led to no action by the cognizant state licensing agency.

Complex Administrative Structures Result in Need for Extensive Coordination

It is not unusual for a drug diversion case to involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. In a case of provider abuse, state Medicaid agencies are authorized to take certain administrative actions. When fraud or some other form of intentional wrongdoing is suspected, cases in most states are referred for investigation to the organizationally separate MFCUs.

At the federal level, HCFA funds and oversees the Medicaid program. However, no organizational unit within HCFA is dedicated to curbing fraud and abuse, and HCFA is not directly involved in drug diversion cases.

Financial and Other Penalties Are Light

To compensate for limited resources, many cases are settled short of conviction. Plea bargaining is common, and most first offenders in Florida are subject to "pretrial diversion," in which their court records are sealed if they abide by the terms of judicially approved probation for 1 year.

With regard to financial penalties, in more than half the cases we reviewed across the four states, restitution amounts were nominal--$5,000 or less. Providers usually paid these amounts. But in cases in which courts set restitution at $20,000 or more, the

Medicaid agency recovered only a small percentage of the dollar amount established. In one Florida case in which restitution was set at $220,000 on March 5, 1991, only $4,000 had been repaid as of the close of our inquiry on July 12, 1993.[3]

Little Follow-up of Convicted Providers

Providers convicted of Medicaid fraud are generally excluded from the program. However, offenders frequently retain some connection with health care delivery and have subsequent opportunities to commit further violations. Although federal laws are in place to exclude previously convicted providers from program participation, it appears that no one with authority and adequate resources is following up on these individuals. In the Florida cases we reviewed, we found that

-- of nine individuals charged with Medicaid fraud in 1990, five--including a pharmacist excluded from program participation--were employed (as of July 1992) in pharmacies that served Medicaid recipients, and

-- of five pharmacies charged with fraud in 1990, three were excluded from Medicaid participation. One pharmacist-owner sold his store but is still employed there as a pharmacist, and the other two re-enrolled in Medicaid under new ownership. One of the new owners is married to the convicted former owner.[4]

Faced with such problems in following up on crimes within their own borders, it is not surprising that state officials cannot prevent incursion by offenders from out of state. Our investigation found that several providers in New York, suspected or convicted of fraud, were associated with Florida health care facilities: a clinical lab, and a nursing home that reportedly receives both Medicare and Medicaid funds.

STATE EFFORTS ARE MEETING WITH SOME SUCCESS

States have some systematic controls designed to prevent drug diversion and other types of Medicaid fraud. Some are also establishing new initiatives that hold promise in curbing fraud. Since even the best controls are never 100-percent effective, states also have procedures for pursuit, punishment, and financial recovery.

Prevention and Early Detection Are a High Priority

Advanced identification technology and automated systems that can flag suspicious activity can prevent or detect fraud early on. Recent initiatives in some states include the use of identification cards that resemble credit cards and monitor utilization, prescription-filing systems that can instantly link orders to the filing physician, and data analysis techniques that can promptly

identify physicians and patients prescribing and receiving high volumes of drugs.

Florida had already instituted several such measures at the time we did our field work: prescriptions were limited to six per month; a pilot program was under way for on-line eligibility verification; and the state Medicaid bureau had enhanced its analytical capability to target suspect physicians and pharmacies. Florida's MFCU also supported the use of Medicaid photo ID cards, an approach already adopted in parts of New York state.

Other Initiatives Focus on Pursuit and Punishment

One approach to swifter and more certain pursuit of offenders uses multiagency task forces to coordinate case development. In Florida, interagency task forces addressing Medicaid fraud exist in all three federal court districts, and penalties have been strengthened. Mandated professional sanctions include immediate license suspension for physicians convicted of a felony. An assistant U.S. attorney in South Florida is dedicated to Medicaid fraud and supports a new 10-person Federal Bureau of Investigation task force on health care fraud. Alternatively, the authorities can bypass the criminal pursuit process through innovative administrative remedies such as Florida's guidelines and sanctions matrix, now part of state law.

Recovery of program losses is also receiving more attention. Stronger tools are available, such as requiring certain high-volume providers to post performance bonds or other forms of collateral as a condition of program participation.[5] Florida's MFCU officials favor such an approach, already adopted in New York and, on a smaller scale, elsewhere. Subsequent to our study, Florida demonstrated its confidence in the cost effectiveness of spending money to recover even more: the legislature approved a supplemental appropriation to substantially increase staff resources for pursuing aberrant Medicaid providers. Florida also made changes that transferred these responsibilities to the Inspector General as of July 1993.

Although hard evidence of the success of prevention and detection measures and harsher sanctions is generally lacking, encouraging signs exist. For example, a combination of initiatives in New York is associated 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.

Structural Changes Hold Promise

Many fraud schemes arise from a fee-for-service based system, which has an incentive to overserve or to bill for more services than are provided. Nearly all states are responding to this incentive, spiraling program costs, and problems of poor access by

establishing a different structure for health care delivery--managed care approaches that use primary care physicians to provide, or arrange for, health care in a cost-conscious manner.

Last year, to review states' efforts to implement managed care, we performed a nationwide survey of state Medicaid programs and detailed work in six states.[6] Our work did not focus specifically on the success of Medicaid managed care initiatives in preventing and detecting program fraud. However, Medicaid experts told us that managed care programs substantially discourage both provider and recipient fraud schemes often found in fee-for-service Medicaid.

CONCLUSIONS

Many of the problems we found result from ineffective use of data, complex administrative structures, inadequate financial and other penalties, and poor follow-up of convicted providers. While all jurisdictions have severe resource constraints that limit oversight, investigative, and prosecutorial efforts, an absence of federal leadership has kept states from making the best use of the resources they do have. For this reason, we have recommended that the Administrator of HCFA develop an overall strategy to address Medicaid fraud. This strategy should include evaluating existing state initiatives and providing guidance and technical assistance tailored to individual state problems.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you may have.

NOTES

1. We performed our field work in California, Florida, New York and Texas, and spoke with law enforcement officials in the majority of states.

2. Medicaid was established under the 1965 amendments to title XIX of the Social Security Act (42 U.S.C. 1396-1396u).

3. This came to light as a result of our case review. State Medicaid officials and court probation officers said they lacked sufficient personnel to keep track of payments due.

4. 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 circumstances, an excluded individual may be connected with a participating facility in a limited capacity.

5. 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.

6. The six states were Arizona, Kentucky, Michigan, Minnesota, New York, and Oregon.

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