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Federal and State Leadership Needed to Control Fraud and Abuse

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Medicaid: Federal and State Leadership Needed to Control Fraud and Abuse

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you discuss ways to combat fraud and abuse in the Medicaid program. Some 40 million Americans—not only poor mothers and children but also poor elderly, blind, and disabled individuals—depend on health care services made possible by the Medicaid program. With total expenditures of over $177 billion in fiscal year 1998, Medicaid is the third largest social program in the federal budget and represents a significant share of individual state budgets as well.

Fraud and abuse drains away vital program dollars and exploits taxpayers and vulnerable beneficiaries. As we recently reported, consumers and legitimate health care providers have been victimized by the fraud schemes of career criminals and organized criminal groups.[1] While the Department of Health and Human Services (HHS) and the Department of Justice have recently augmented their program integrity activities for Medicare, the Congress is concerned that a similar emphasis be placed on fraud and abuse control in Medicaid. We have just launched a study to better understand the scope and effectiveness of Medicaid program integrity efforts at the federal and state levels and will report our results next spring. Today, my remarks will focus on a brief overview of the problem, several key components of fraud control, and the importance of federal and state cooperation. My comments are based on observations gleaned from our prior work addressing both Medicaid and Medicare program integrity issues and from our ongoing Medicaid study.

In summary, our body of work on health care fraud and abuse indicates that programs the size and structure of Medicaid are inherently vulnerable to exploitation. Fraud schemes often cross state lines and enforcement jurisdictions, entailing a number of federal, state, and local agencies that may have different or competing priorities in their efforts to investigate, prosecute, and enforce compliance. Experience shows that coordinating the efforts of the multiple players, investing in preventive strategies, and dedicating adequate resources to fraud control units are essential components of an effective program integrity strategy. Finally, our work shows that the Health Care Financing Administration (HCFA), the agency in HHS responsible for administering Medicaid federally, is in a position to work in partnership with the states to ensure an appropriate level of commitment in states' efforts to control Medicaid fraud and abuse.

[1]Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers (GAO/OSI-00-1R, Oct. 5, 1999).

Background

Medicaid is a jointly funded federal-state health insurance program for eligible low-income and needy people. Although it is one federal program, as a practical matter, it consists of 56 separate programs (including the District of Columbia, Puerto Rico, and the U.S. territories). Within broad federal guidelines, each state establishes its own eligibility standards; determines the type, amount, duration, and scope of services; sets the rate of payment for services; and administers its own program. For fiscal year 1998, federal Medicaid expenditures were over $101 billion, with the states contributing about $76 billion. For each state, the federal share varies according to a statutory formula. The federal government picks up at least half the cost for medical services, and in nine states, it pays for more than 70 percent.

Medicaid fraud and abuse control entails a complex mix of actors and entities. At the federal level, HCFA and the HHS Office of Inspector General (OIG) have program oversight responsibilities. The Federal Bureau of Investigation (FBI) and the U.S. Attorneys in the Department of Justice are responsible for enforcement under certain conditions. However, front line oversight and enforcement reside primarily with the states. Each state administers its Medicaid program through a state Medicaid agency—variously situated in departments such as health, welfare, or human services. In addition to paying claims and performing other administrative duties, the state Medicaid agencies conduct program integrity activities. Many state Medicaid agencies have a "data mining" unit—a surveillance and utilization review subsystem (SURS) unit—dedicated to reviewing paid claims to identify suspect billing practices or other aberrations indicating potential wrongdoing. Separate from the state Medicaid agency, 47 states have Medicaid Fraud Control Units (MFCU), generally located in the state's attorney general's office, which carry out investigations and prosecutions. For a composite view of the multiple agencies involved in Medicaid fraud and abuse control, see table 1.

Table 1: Overview of Medicaid Fraud and Abuse Control Efforts

Agency	Responsibility	Related activities
Federal		
Department of Health and Human Services (HHS)		
Health Care Financing Administration (HCFA)	Oversees state Medicaid agencies	Among other activities, through its Medicaid Fraud and Abuse National Initiative, HCFA provides an ongoing forum and training for state officials on fraud control.
Office of Inspector General (OIG)	Oversees state Medicaid Fraud Control Units Investigates federal Medicaid fraud cases	The OIG can sanction fraudulent providers by imposing exclusions and civil monetary penalties. It refers investigative findings to Department of Justice.
Department of Justice		
U.S. Attorneys	Prosecute Medicaid fraud cases referred by FBI and HHS OIG	The U.S. Attorneys also indict, negotiate settlements, and make recoveries.
Federal Bureau of Investigation (FBI)	Investigates federal fraud cases but cannot impose sanctions	The FBI refers investigative findings to the U.S. Attorneys.
State		
State Medicaid agency (located in such departments as health, human services, and welfare)	Administers state Medicaid program and oversees Medicaid program integrity activities	The state Medicaid agency's activities may include conducting pre- and postpayment claims reviews and administering the provider enrollment process.
Program integrity/ surveillance and utilization review subsystem (SURS)[a] unit	Reviews claims data to detect and investigate aberrant payment patterns and conducts other types of integrity activities	SURS units refer suspected fraud cases to the state's MFCU and noncriminal cases to the state Medicaid agency's collection unit.
Medicaid Fraud Control Unit (MFCU)[b] (generally in state attorney general's office)	Investigates and prosecutes cases involving fraudulent Medicaid activities Investigates and acts on complaints of abuse or neglect of patients in facilities receiving Medicaid funding	The MFCU may refer cases that will not be prosecuted to the state Medicaid agency or other authority for administrative action.
Local		
District attorney	Prosecutes Medicaid fraud cases in states where MFCUs do not have prosecutorial authority	

[a]States vary in how their program integrity activities are organized and in what the units are called.

[b]Three states do not have MFCUs–Idaho, Nebraska, and North Dakota.

Fraud and Abuse Are a Persistent Problem in Medicaid Program

The magnitude of fraud and abuse in the Medicaid program has not been quantified. Nevertheless, similar fraud and abuse schemes crop up in different states, and states have problems with fraud and abuse under both fee-for-service and managed care payment methods. Medicaid is

vulnerable to fraud because of some intrinsic characteristics—such as its share of states' budgets and its vulnerable beneficiary population.

Several Types of Fraud and Abuse Are Common in Medicaid

Common Medicaid fraud and abuse schemes generally fall into three broad groups: improper billing practices, misrepresentations of professional or service qualifications, and improper business practices.[2] Improper billing practices include "upcoding," in which the provider misrepresents treatment provided and bills for a more costly procedure; "ghost" or "phantom" billing, in which a provider bills for services never provided; and delivering more treatment than is either necessary or appropriate for the patient's diagnosis. Misrepresenting qualifications encompasses such offenses as submitting false credentials to obtain a Medicaid provider number and performing treatments outside the bounds of what is permitted by one's license. Among the improper business practices found in Medicaid are kickbacks for referring or otherwise steering patients to a particular provider or product such as pharmaceuticals; self-referrals, in which providers, for example, may order and request lab tests from companies they own or have a financial interest in; and antitrust violations, in which companies collude with each other or with providers to improperly influence payments or fees. Table 2 contains examples of fraud and abuse cases from the files of state MFCUs.

[2]Fraud involves a willful act to deceive for gain, whereas abuse typically involves actions that are inconsistent with acceptable business and medical practices.

Table 2: Examples of Medicaid Fraud and Abuse

Type of fraud	Example
Billing fraud	A psychiatrist operated a "psychotherapy mill," in which parents were enticed to enroll their children in "free" enrichment programs such as after-school tutoring, field trips, and supervised recreation in exchange for their children's Medicaid numbers. Using these numbers, the psychiatrist billed Medicaid for psychotherapy services not provided. A psychologist he employed discovered the scam and negotiated a higher salary from him. The psychologist also set up her own copycat operation. State officials estimated that the two fraudulently obtained $421,000 from Medicaid. The defendants pleaded guilty, were ordered to pay fines and restitution, and received probation. *Source: Georgia State Health Care Fraud Control Unit.*
Business practices fraud	Two businessmen pleaded guilty to felony charges related to a complex scheme of submitting fraudulent nursing home cost reports to the state's Medicaid program. The scheme involved a nursing home chain and a shell corporation that the chain allegedly contracted with, enabling the owners to bill Medicaid for inflated expenses related to phony contracts with the nursing homes. Through a complex web of bank and investment accounts, the owners laundered payments. The scheme, which netted the owners nearly $10 million in excess Medicaid reimbursements, was discovered when a state auditor became suspicious of high payments to the shell company. One of the defendants received 50 months in prison and a $70,000 fine; the other, 36 months in prison and a $50,000 fine. Both received an additional 3 years of supervised release. As restitution, the pair agreed to pay about $6 million to the state Medicaid program and to forfeit an additional $2-million-plus in assets. *Source: Georgia State Health Care Fraud Control Unit.*
Fraudulent misrepresentation of qualifications	A woman, who had never attended, graduated, or received a degree from a nursing school, presented a false nursing license to several nursing homes that employed her. She also contracted with a county Board of Mental Retardation and Developmental Disabilities to provide nursing and counseling services. The misrepresentation was discovered when substandard care she provided led to complaints and a subsequent investigation. A state nursing board determined that the woman had posed as a nurse for at least 5 years. She was charged with felony Medicaid fraud, felony forgery, and misdemeanor practice of unlicensed nursing. She pleaded guilty and was sentenced to 5 years' probation and was ordered to either pay some $3,850 in restitution or perform 84 days of community service. *Source: Ohio Attorney General's Health Care Fraud Section.*

Fee-for-service providers do not have a monopoly on fraudulent and abusive health care practices. Under managed care, providers intending to exploit the program have adapted to new financial incentives. Whereas receiving a fee for each service enables providers to enhance revenues by ordering too many services, receiving a lump-sum payment in advance for each enrollee can encourage dishonest providers to enhance their profits by stinting on patient care. Consistent with this incentive are examples of Medicaid managed care fraud and abuse by prepaid health plans: avoiding expensive treatments, underfinancing plan operations, providing poor quality care, using deceptive marketing practices, and claiming phony enrollments. In a specific instance in Tennessee, a managed care plan used a homeless shelter as the address for nearly 4,500 fictitious enrollees—a

scheme that was generating nearly $450,000 a month in fraud losses to Medicaid. The scheme came to light once the shelter tipped off the state Medicaid agency. Managed care plans can also engage in fraudulent business practices similar to those in fee-for-service health care—such as providing kickbacks for referrals or having unqualified personnel provide services.

Fraud and abuse schemes also cross jurisdictional and program boundaries, complicating the task of pursuing the perpetrators. In our October 1999 correspondence on health care fraud, we noted that criminal groups have created interstate health care fraud schemes and have used associates in foreign countries to transfer ill-gotten proceeds out of the United States. For example, a group with ties to a New Jersey scheme purchased a lab in Illinois and began bilking Medicaid and Medicare there. In another case, two individuals investigated for Medicaid fraud in south Florida were tied to three individuals in North Carolina who used a similar scheme to falsely bill Medicare. Proceeds from this scam were laundered through associates in Mexico.

Medicaid Is Vulnerable to Fraudulent and Abusive Practices

Certain characteristics of the program make Medicaid an attractive target for exploitation, as follows:

- As a third-party payer, Medicaid pays for services provided by others and cannot, as a practical matter, police each claim for reimbursement submitted. In a state like New York, the very size of the program invites exploitation. In fiscal year 1998, New York's Medicaid program, covering roughly 2 million beneficiaries,[3] cost an estimated $27 billion. Medicaid consumes, on average, 20 percent of a state's budget.
- The impermanence of the population, owing to beneficiaries' changing eligibility status, makes the program a target for such schemes as billing for services provided to ineligible or deceased individuals.
- Because many states pay considerably less under Medicaid than providers' customary charges, Medicaid providers are often in short supply. Thus, program administrators are reluctant to impose controls that are perceived as burdensome for fear of discouraging provider participation.

[3]Our data on New York's beneficiary enrollment reflect calendar year 1998.

Coordination, Prevention, and Adequate Resources Are Key Fraud Control Elements

Our prior health care program integrity work has shown that strong federal and state leadership is needed to ensure that three essential fraud control elements are in place. First, the multiple agencies involved must coordinate their efforts effectively. Second, HCFA and the states must focus on preventive strategies, since detection and prosecution efforts alone cannot stem program losses. Finally, state agencies need the administrative and technical tools and resources to accomplish their mission.

Coordination Essential, but Difficult to Achieve

Examples from our prior program integrity work underscore the importance of coordinating the efforts of multiple law enforcement and oversight agencies. One of our reports focused on Medicaid prescription drug diversion,[4] often referred to as "pill-mill" fraud, in which physicians, clinic owners, and pharmacists collude with willing beneficiaries by fraudulently prescribing and distributing prescription drugs. In some cases, pharmacists added medications to beneficiaries' orders and kept the extra for resale; clinics provided unneeded prescriptions to beneficiaries, who would trade them for merchandise; and providers gave beneficiaries prescriptions for drugs in exchange for their Medicaid number to bill for services not provided. We noted that a drug diversion case could typically involve five or more state, local, and federal agencies in its investigation, prosecution, and resolution. Network diversion schemes could involve third-party payers other than Medicaid, entrepreneurs, beneficiaries, middlemen, and physicians not enrolled in Medicaid. Handling such schemes could entail coordination between, for example, a MFCU in the state's department of law and other agencies with jurisdiction, such as an office of professional medical conduct in the state's department of health, an audit office in the state's department of social services, and an office of professional discipline in the state's department of education.

Two examples illustrate the payoff resulting from agency cooperation. One is the FBI's Operation Goldpill. Working with other federal agencies and with state MFCUs and regulators, approximately 1,000 FBI agents participated in the FBI's largest health care undercover operation at that time, involving 50 cities nationwide. This initiative reflected a new strategy focusing on multidefendant conspiracy indictments rather than single-defendant prosecutions. Through this effort, law enforcement agencies were able to charge 254 defendants; seize $10.8 million in assets, including 11 pharmacies; and levy $6.6 million in fines.

[4]Medicaid Drug Diversion Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

The second example—Operation Restore Trust (ORT)—represented a cornerstone in recent health care fraud coordination, which focused on Medicare and Medicaid fraud and abuse. ORT brought together the HHS OIG and other federal, state, and local agencies to target wrongdoing by home health, nursing home, and durable medical equipment providers, initially in five states. In its first 2 years of operation, ORT identified $188 million in inappropriate payments. Among the lessons learned was the importance of coordination among the various program and enforcement agencies involved at the federal, state, and local levels. For example, coordination between Medicare claims administration contractors and state licensing inspectors in the project states resulted in the decertification of many of the targeted home health agencies and the recovery of substantial sums in inappropriate payments. Through the Medicare contractors' efforts to train state inspectors on specific billing and beneficiary coverage issues, the inspectors were able to provide the contractors information they might not otherwise have been able to obtain on beneficiaries who were not eligible or home health agencies that billed for services not provided. Through this mutual exchange of information, contractors were able to identify an array of billing abuses costing the government millions of dollars.

As obvious as the benefits are from interagency coordination, several barriers exist that discourage such cooperative efforts. Among these are the following:

- Labor-intensity of building a case with uncertain outcome. The level of resources and interagency coordination required for case development can stall the pursuit of a case at many junctures and delay the resolution of a case for many years. The pursuit of fraud often begins with the state Medicaid agency, which, to refer the case to a MFCU, must typically prepare careful documentation through data analyses, claims audits, interviews with patients, and medical record reviews. The MFCU may reject cases because of its backlog, insufficient evidence, or estimated dollar losses below a certain threshold. At the time of our drug diversion study, one state's MFCU typically rejected more than 90 percent of the Medicaid agency's fraud referrals because of staffing constraints. For cases accepted, MFCU investigations can involve, among other things, additional interviews or analyses of medical records and subpoena of financial records. If the case enters federal jurisdiction, the MFCU may forward the case to a U.S. Attorney. If the case is prosecuted and convictions are obtained, further work also may be necessary to establish administrative sanctions and recover overpayments.

- Timing of actions to maximize administrative as well as criminal sanctions. In our drug diversion study, we reported that the state agencies and MFCUs made little effort to time audits and criminal investigations so that civil recoveries could be made without compromising criminal prosecution. When poor communication exists between a MFCU and the state Medicaid agency, the state agency may be delayed in taking civil action before the statute of limitations has expired. In such cases, the agency may have to forgo the opportunity to assess monetary penalties or obtain recoveries that can restore financial losses to the Medicaid program.

- Competing productivity goals between agencies. One state's MFCU officials told us that a state Medicaid agency's SURS unit, for example, may be reluctant to classify cases as fraud. Fraud cases must generally be referred to the state MFCU. Cases classified as overpayments generally remain the within the SURS' jurisdiction, and recoveries are credited to the SURS' performance results.

- Federal payback rules. Federal law creates a fiscal incentive for states to avoid finding fraud.[5] The law requires that the state pay back the federal share of these overpayments within 60 days of discovery, regardless of whether the state has recouped its losses.[6]

We are currently reviewing states' efforts to enhance coordination in our ongoing study for the Committee. In Georgia, the MFCU has established working teams consisting of members from three state agencies—prosecutors from the Attorney General's office, investigators from the Georgia Bureau of Investigation, and auditors from the Department of Audits.

Prevention Is Key to Avoiding Program Losses

Preventive strategies designed to stop improper activity before Medicaid incurs losses is another essential control. Our observations on coordination difficulties demonstrate that efforts to detect and prosecute wrongdoing are important but are typically expensive and labor-intensive, sometimes with little financial recovery to show for the effort. Consistent with this view is HCFA's philosophy "to pay it right" instead of paying and chasing.

[5]42 U.S.C. 1396b(d)(2)(C).

[6]While this requirement may be appropriate under ordinary circumstances so that states are encouraged to seek recovery, it may not be appropriate in criminal cases in which recovery efforts could damage the investigation by alerting the suspect.

Preventive strategies can be embedded in the design of provider enrollment procedures, payment methods, coverage policies, and beneficiary eligibility verification. As we concluded from previous work, states' emphasis on developing preventive measures were well-placed because efforts to recover losses were often unsuccessful. In our ongoing study, we will examine states' approaches to fraud control prevention. One example—provider enrollment controls in the Medicare program—illustrates how such approaches help avert fraud.

Until recently, when new requirements were established, Medicare procedures for certifying home health agencies were seriously flawed. For example, in a 1997 report,[7] we noted that becoming a Medicare-certified home health agency had been too easy, particularly in light of the number of problem agencies that had been identified in past years. There had been little screening of those seeking Medicare certification. For example, Medicare certified an agency owned by an individual with no home health experience who turned out to be a convicted drug felon and who later pleaded guilty with an associate to having defrauded Medicare of over $2.5 million. Rarely did new home health agencies fail the program's certification requirements. HCFA has since developed procedures to better scrutinize the qualifications and background of home health agency applicants.

Adequate Resources Include Qualified Staff and Modern Technology

An investment in adequate resources, consisting of qualified staff and modern payment safeguard technology, is a third element essential to effective Medicaid fraud and abuse control. Over time, health care fraud schemes have become increasingly complex, frequently involving networks of people, sophisticated computer techniques, and multiple geographic locations. In a 1994 Medicare report,[8] we focused on the results of a HCFA demonstration examining the effect of additional program safeguard funding. We found that the "demonstration" contractors had achieved higher medical review savings than the control group contractors because they committed more resources to improving their analytic tools and hiring qualified technical staff.

In recent interviews, officials in several states have expressed concerns that the lack of effective data systems has hampered their efforts to identify fraud. For example, one state official said that the state's Medicaid

[7]Medicare Home Health Agencies: Certification Process Ineffective in Excluding Problem Agencies (GAO/HEHS-98-29, Dec. 16, 1997).

[8]Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

automated detection system is 15 years old and not well designed for the types of analysis needed today. Another official noted that the state lacked a system to perform electronic prepayment screening of claims, a tool that we have reported on in Medicare reports as a fundamental payment safeguard. Reflecting these concerns, a MFCU official stated that service data, staff capable of mining them, and state-of-the-art detection software are important tools for fraud control. Our ongoing study will examine the extent of states' capacity to identify fraud or abuse.

HCFA's Role in Medicaid Fraud Control

In recent years, HCFA has taken steps to improve its program integrity efforts in both Medicare and Medicaid. For Medicaid in particular, HCFA's role to date has been largely to facilitate training and information-sharing efforts for the states.

In 1997, HCFA established the Medicaid fraud and abuse national initiative designed to bring different components among and within states together at meetings and to provide training, share information, and address common concerns. As part of the initiative, individual committees have been created to work on specific problems and solutions. For example, a state legislation committee developed a database on a Web site that all states can access that catalogues states' program integrity legislation. This serves states seeking models for anti-fraud-and-abuse legislation and contacts for further information. A federal legislation committee has developed proposals to increase state effectiveness that have been added to HHS' legislative proposals. HCFA has also formed and funded a technical advisory group that meets regularly to discuss Medicaid program integrity issues.

Despite HCFA's positive efforts to facilitate states' activities, we are concerned about the agency's efforts to ensure that all states have effective program integrity strategies. In our June 1999 testimony on Medicaid payments for school-based services, we raised concerns about HCFA's role as steward of Medicaid funds. We noted that the agency's regional offices, lacking specific guidance, were inconsistent in their determinations of whether a given state's practices for claiming administrative costs were appropriate. Practices that HCFA had allowed in one state had not been allowed in others, resulting in confusion. It also created an environment in which school systems "pushed the envelope" into the realm of questionable billing practices.

From this particular work we made observations that apply to Medicaid fraud and abuse control in general. First, striking a balance between the

stewardship of Medicaid and the need for flexible approaches in dealing with 50-plus Medicaid programs is difficult. However, mindful of that balance, HCFA is in a position to explore, in partnership with states, the appropriate level of commitment to preventing and detecting fraud and abuse. We think this is important because both have a fiduciary responsibility to administer Medicaid efficiently and effectively.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or the Subcommittee Members may have.

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call Sheila K. Avruch on (202) 512-7277. Key contributors to this testimony include Barrett W. Bader, Bonnie L. Brown, Hannah F. Fein, and Robert L. Lappi.

Related GAO Products

Financial Management: Increased Attention Needed to Prevent Billions in Improper Payments (GAO/AIMD-00-10, Oct. 29, 1999).

Health Care: Fraud Schemes Committed by Career Criminals and Organized Criminal Groups and Impact on Consumers and Legitimate Health Care Providers (GAO/OSI-00-1R, Oct. 5, 1999).

Medicaid: Questionable Practices Boost Federal Payments for School-Based Services (GAO/T-HEHS-99-148, June 17, 1999).

Fraud, Waste, and Abuse: The Cost of Mismanagement (GAO/AIMD-98-265R, Sept. 14, 1998).

Nursing Homes: Too Early to Assess New Efforts to Control Fraud and Abuse (GAO/T-HEHS-97-114, Apr. 16, 1997).

Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers From Federal Health Programs (GAO/HEHS-97-63, Mar. 31, 1997).

Fraud and Abuse: Providers Excluded From Medicaid Continue to Participate in Federal Health Programs (GAO/T-HEHS-96-205, Sept. 5, 1996).

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Medicaid Drug Fraud: Federal Leadership Needed to Reduce Program Vulnerabilities (GAO/HRD-93-118, Aug. 2, 1993).

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