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MEDICAID DRUG FRAUD

Federal Leadership Needed to Reduce Program Vulnerabilities

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SUMMARY

Medicaid prescription drug fraud is widespread in the United States. Directors of Medicaid fraud control units, in 20 states and the District of Columbia, identified significant problems with such schemes. For example, some pharmacists routinely added medications to customers' orders, keeping the extras for themselves or to sell to others. Clinics 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. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

A common scheme is the so-called "pill mill" in which physicians, clinic owners, and pharmacists collude to defraud Medicaid by prescribing and distributing drugs for the primary purpose of obtaining 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. GAO's own investigation revealed an organized network of colluding physicians, pharmacists, owners of clinical labs, patient brokers, and other middlemen, many of whom transferred money overseas through the notorious Bank of Credit and Commerce International.

Prescription drugs cost Medicaid $5.5 billion in 1991--more than it paid for physician services or any other noninstitutional benefit--and real spending per user for prescriptions tripled between 1975 and 1990. Drug fraud contributes significantly to these expenditures. Though nationwide data are not available, New York's social services department estimated that, in 1990, pill mills and related schemes cost them at least $75 million--about 10 percent of the state's Medicaid prescription drug expenditures.

States--struggling to curb diversion schemes--have instituted both up-front controls and measures intended to facilitate pursuit, punishment, and financial recovery. Some progress has been achieved. New York, for example, has experienced 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.

Nevertheless, the problem persists. State officials told us that most leads are not pursued, cases take too long to resolve, and penalties are light even for those convicted. Most blame lack of adequate resources--a situation unlikely to be resolved in today's budget environment. Consequently, it is imperative to help the states use their resources as effectively as possible. The Health Care Financing Administration should display more leadership in developing an overall strategy to address prescription drug diversion and heighten states' sensitivity to the financial benefits of effective preventive measures.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss Medicaid prescription drug diversion. At your request, we have been examining the extent of the problem, the reasons it persists, and initiatives to address it in the four most populous states: California, Florida, New York, and Texas. We have found that Medicaid, the primary source of health care funding for the poor, is vulnerable to drug diversion and that the difficulties involved in combating it are substantial. Recent initiatives in several states show positive signs of stemming financial losses, but federal leadership and support can help assure broader implementation of these initiatives to deal more effectively with this problem.

BACKGROUND

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 for the primary purpose of obtaining 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 is a logical target of drug diversion because it typically includes prescription drugs in its covered services.[1] It accounts for 80 percent or more of all federal spending on prescription drugs.[2] According to the Congressional Budget Office (CBO), real payments per user tripled for this benefit between 1975 and 1990.[3] In 1991, prescription drugs accounted for 7 percent of Medicaid spending--more than physicians' services and more than any noninstitutional program benefit.[4] By 1996, prescription drug benefits are expected to reach $10 billion, nearly double the 1991 figure of $5.5 billion.[5] In Florida and Texas, the recent rate of increase has been even greater, with expenditures more than doubling between 1987 and 1991.[6]

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.

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) administers and monitors the program. However, HCFA has no organizational unit dedicated to curbing fraud and abuse, nor is HCFA 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. When fraud or some other 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 them to local, county, state, or federal prosecutors. Court probation offices can become involved to collect court-ordered fines, costs, and restitution.

Providers convicted of crimes involving Medicaid drug diversion are subject to various sanctions.[7] 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.

EXTENT OF THE PROBLEM

Directors of MFCUs in 20 states and the District of Columbia identified significant problems involving drug diversion (see fig. 1).[8] For example, some pharmacists routinely added medications to customers' orders, keeping the extras for themselves or to sell to others. Some clinics 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. Some pills costing 50 cents at the pharmacy were resold for as much as $85.

Moreover, in some cases, the schemes displayed characteristics typical of pill mills, involving conspiracy among several providers. For example, our own investigation revealed an organized network of colluding physicians, pharmacists, clinical lab owners, patient brokers, and other middlemen, many of whom transferred money overseas through the Bank of Credit and Commerce International. Figure 2 shows the structure of such a network.

Program losses from this type of fraud can be significant. Though nationwide data are not available, New York's social services department estimated that, in 1990, pill mills and related schemes cost them 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.

WHY DIVERSION PERSISTS

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. Routinely generated reports fail to identify even obvious problems. For example, in California, a pharmacist was billing and being reimbursed by Medicaid for dispensing large volumes of drugs. For more than 3 years the volume of prescriptions was improbably high--in many cases more than 20 prescriptions a day for a single recipient--yet the state's reporting system triggered no investigation of the pharmacist or any recipients. A tip eventually revealed the scheme.

Staff shortages, in the face of lengthy and complex case preparation, hamper investigative agencies. Even for those cases pursued as fraud, the outcome is often neither timely nor satisfactory: few providers go to prison or lose their license, and a very small percentage of program losses are recovered. Consider the outcomes of 39 drug diversion cases settled in 1990 or 1991 in the four states we reviewed:

- Most cases took almost 2 years to be adjudicated, once they were referred to the MFCU. Four cases took 4 years or more.

- Professional sanctions were minimal and slow. Thirty-two cases involved providers with professional licenses. Six had their licenses revoked, three had them suspended, and four experienced only a 1-year probation. Almost one-third of these cases were still unresolved by licensing boards, an average of 44 months after first being reported to the MFCU. In one case, the entire scenario took 6 and 1/2 years--and the licensure action consisted of just a 1-year probation.

- Financial penalties were light: in more than half the cases, restitution amounts were nominal--$5,000 or less. Providers usually paid these amounts. 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. For example, in a case where restitution was set at $220,000 on March 5, 1991, only $4,000 had been repaid as of July 12, 1993.[9]

Both state and federal agencies have other legal options for seeking recoveries. State Medicaid agencies can take civil action to recover estimated overpayments, but we found that they rarely do so when criminal charges are involved. Also, 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 Medicaid claims. State and federal officials cited similar reasons for such inaction: scarce resources and the poor prospect of recovering substantial funds.

In addition, offenders frequently retain some connection with health care delivery, with the consequent opportunity for future violations. The most telling statistics come from the Florida Medicaid drug diversion cases.[10]

-- 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 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 the spouse of the convicted former owner).

Although federal laws are in place to exclude previously convicted providers from program participation, no one with authority and adequate resources is following up on these individuals.

STATE INITIATIVES ARE MEETING WITH SOME SUCCESS

States are taking steps to address these problems. All states have up-front controls designed to prevent Medicaid fraud. Since these are never 100 percent effective, states 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.

Recent initiatives emphasizing up-front controls include the use of identification 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 establishing multiagency task forces to coordinate case development, implementing stronger state laws and administrative procedures to expedite disciplinary actions, and improving recovery of monetary losses by requiring high-volume providers to post performance bonds or other financial security as a condition of program participation.[11] These measures appear to be achieving some success, particularly in New York. Moreover, these state initiatives are effective against both prescription drug diversion and other associated types of Medicaid fraud.

Some federal measures also support states in these endeavors. Regulations require states to engage in various monitoring activities. Most recently, the Omnibus Budget Reconciliation Act of 1990 required states to develop a drug use review system for Medicaid recipients and implement it by January 1, 1993. While the primary purpose of this legislation was to improve the quality of health services through counseling and prospective and retrospective medication assessments, it will likely deter fraud and provide early warning of violations. The law provides for screening for clinical abuse/misuse and optional electronic claims processing.

In at least one state, the combination of up-front controls and "pay-and-chase" initiatives--aimed at facilitating pursuit and punishment--has been linked to measurable reduction in abuse of Medicaid's prescription drug benefit. New York has experienced 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.

EFFORTS INSUFFICIENT WITHOUT ADDED SUPPORT

Drug diversion continues, however, in many areas of the United States. Both state and federal officials cite lack of adequate resources as the primary reason their efforts have failed to control this type of fraud or to recoup the dollars lost to the program. While some states claim partial success, most leads are still not pursued. In Florida, for example, the MFCU rejects more than 90 percent of the state Medicaid agency's referrals because of its own staffing constraints. 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 MFCU officials are more likely to reject ill-prepared cases because of the additional burden imposed on their own limited staff. In each state we visited, officials expressed frustration at how long it

takes to resolve each case, at the poor and uncertain outcome, and at the prevalence of repeat offenders and resilient schemes. As I pointed out earlier, cases drag on for years, almost no one goes to prison, and many offenders retain their connection with the health care system--sometimes even continuing as Medicaid providers--with consequent potential for further violations.

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 could use help from HCFA in controlling prescription drug fraud and related abuse.

Many of the problems we found stem in large measure from severe resource constraints in the state and federal oversight, investigative, and prosecutorial organizations. In the current budget environment, additional funding may be difficult to achieve. Consequently, it is imperative to make the best use of available resources. Although no single entity is orchestrating states' efforts to curb drug diversion, we believe HCFA should assume this responsibility. In a report issued today, we recommended that the Administrator of HCFA develop an overall strategy to address prescription drug diversion, an action that would highlight the importance of lessons learned from state initiatives.[12] 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.

Mr. Chairman, this concludes my testimony. I will be happy to answer any questions that you or members of the Subcommittee may have.

Figure 1: State Medicaid Fraud Units Citing Pill Mill Problems

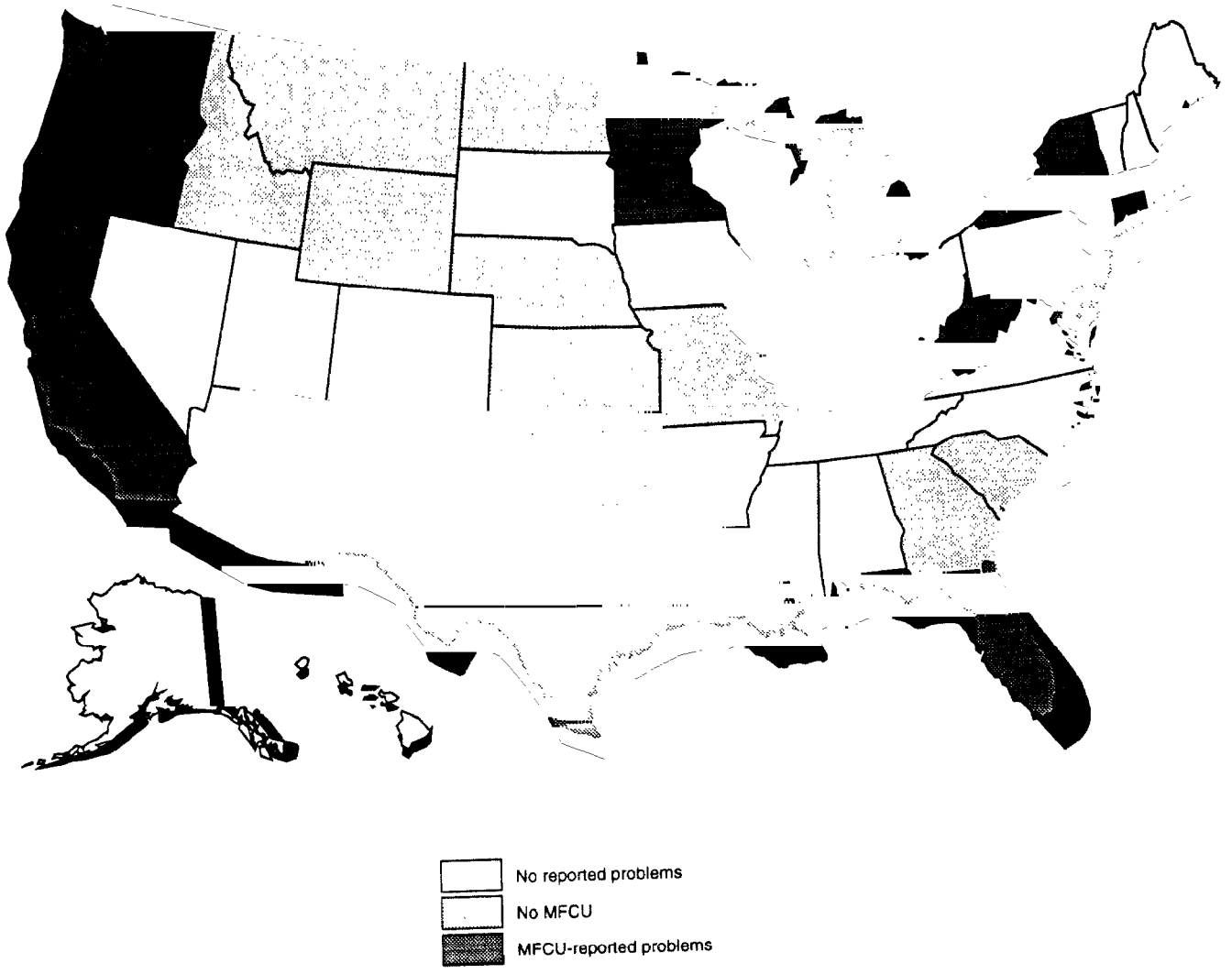
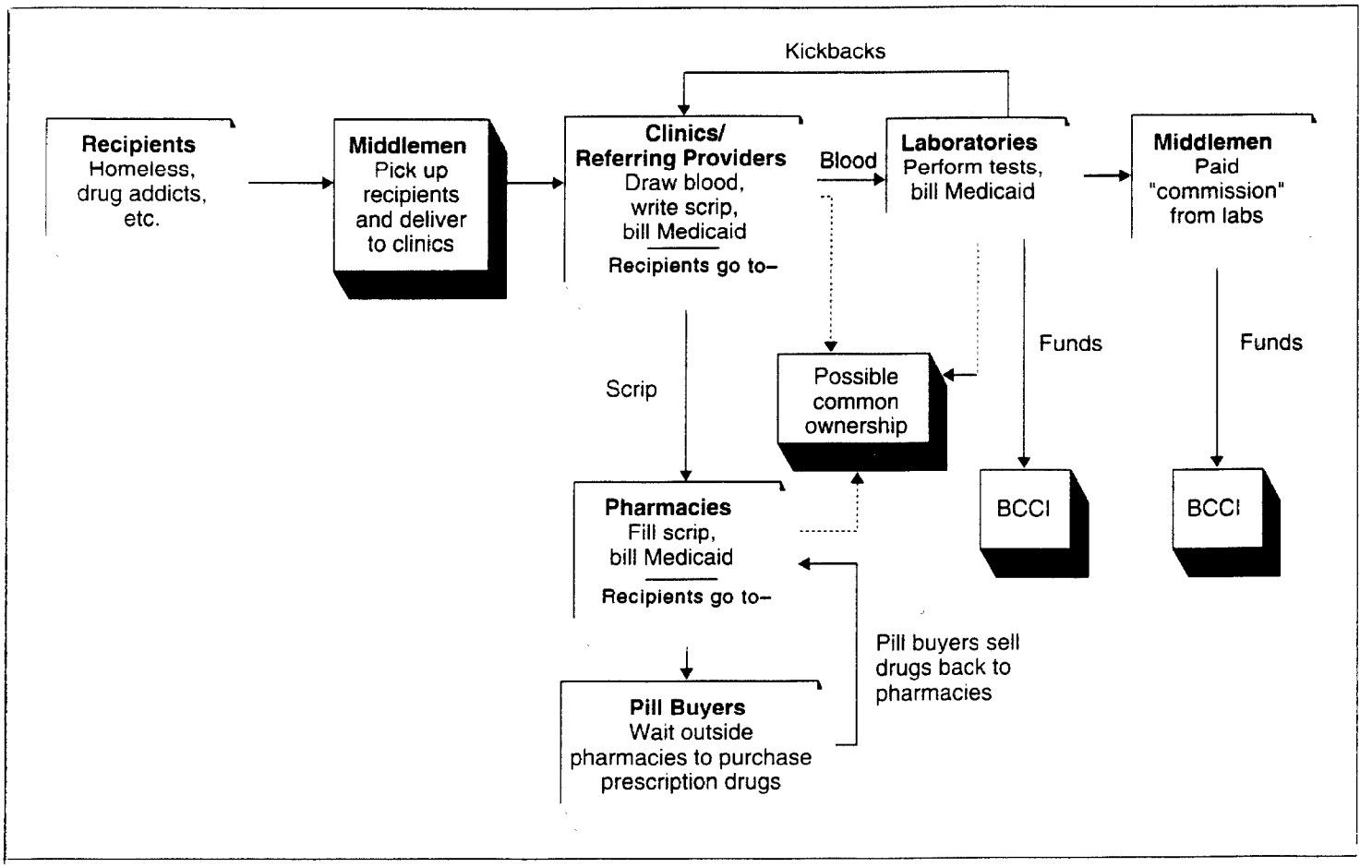


Figure 2: A Composite Pill Mill Network in New York



NOTES

1. Although coverage of prescription drugs under Medicaid is optional, all states provide the service, albeit with some restrictions. Some states require a nominal copayment.

2. HCFA officials cited a figure of 80 percent. Independent calculations led to a value of 86 percent for 1991, but, since these involved data from two different sources, we have presented the lower estimate here.

3. Factors Contributing to the Growth of the Medicaid Program, CBO Staff Memorandum (May 1992).

4. This is based on HCFA data quoted in an article by John K. Iglehart, "The American Health Care System: Medicaid," The New England Journal of Medicine, Vol. 328, No. 12, March 25, 1993. "Total computable" Medicaid data released by HCFA would lead to a lower value of 6.2 percent. This still exceeds all other noninstitutional spending categories.

5. These figures are based on HCFA's "total computable" Medicaid data, relative to total Medicaid spending of $88 billion.

6. GAO computation based on HCFA data.

7. Some civil sanctions may be applied even when the offender is not convicted of a criminal offense. A lesser burden of proof may apply in such instances.

8. We surveyed 42 MFCU Directors from 41 states and the District of Columbia. Other states lack separate units dedicated to the pursuit of Medicaid fraud.

9. This was revealed during the course of our investigation. State Medicaid officials and court probation officers said they lacked sufficient personnel to keep track of payments due.

10. 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.

11. 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.

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

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