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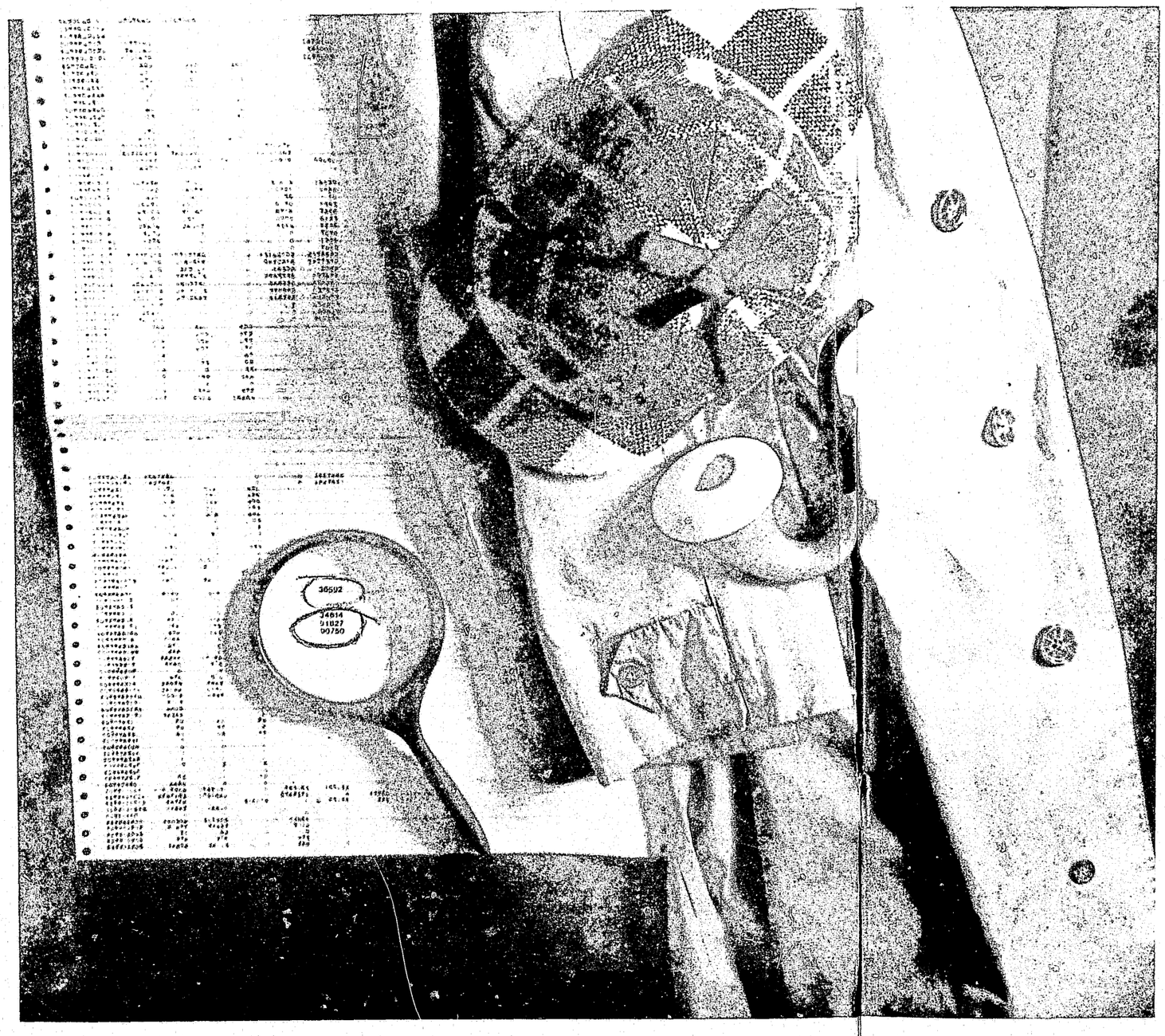

Fraud Control Units Gear Up To Detect Illegal Billings and Prosecute Offenders.

by Ann Slayton

Since the scandals of Medicaid Mills splashed across the country's newspapers and television screens in 1976, there has been an increased effort to curb fraud and abuse in both the Medicaid and Medicare programs.

The best estimates of federal and state funds lost annually to fraud and abuse in the two programs is $15 million for Medicare and $653 million for Medicaid. But so-called administrative waste and errors bring the total loss to $4.5 billion annually.

Officials have been understandably reluctant to make firm predictions about how much this loss will be cut once the anti-fraud, abuse and error campaigns are fully mobilized. One reasonable estimate for fraud and abuse is that for every dollar spent in reviews, investigations, and prosecutions, between 4 and 5 dollars will be recovered.

Between April 1975 and March 1978, the State of New York spent $12.4 million to ferret out fraud involving $113 million. Of this, the state expects to recover at least $65 million. What cannot be measured, however, is the deterrent value of these well publicized convictions.

Nationally, during Fiscal Year 1977 the states reported that they referred 391 cases of suspected fraud to law enforcement officials for prosecution. Of these, 91 convictions were obtained, and an additional 149 providers were barred from participating in the Medicaid program. The total amount of payments for fraudulent claims in those cases was nearly $70 million.

HEW has been reviewing the claims of 26,000 physicians and pharmacists whose patterns of utilization and reimbursement appear to be improper when compared to established norms. To date some 600 of those have been referred for full-scale investigation. Thus far, 16 indictments have been returned, and there have been six convictions and one acquittal.

Don Nicholson, director of HCFA's Office of Program Integrity, is quick to point out that prosecutions are not sought on these data alone. "These data are useful only insofar as they provide an indication of potential fraud or overutilization," says Nicholson. A decision to prosecute for fraud cannot be made until a thorough investigation has been completed; this would include an examination of medical records to determine the type of services actually rendered.

While incidents of fraud and efforts to combat it have captured most of the headlines, work also has been underway to reduce administrative waste and error. Goals were set for states to reduce eligibility errors. States that achieved these goals would continue to receive their full share of federal funds; States that did not would lose a measure of funds.

Before the Medicare-Medicaid Anti-Fraud Amendments were passed in October of 1977, each state Medicaid agency was responsible for detecting, investigating, and developing suspected cases of fraud. There were great variations in the states' capabilities to control fraud. Some had no programs of control at all, and a few, like New York, Texas, California and New Jersey, had programs which had been in operation for several years.

To attack the problem across a broad front, Congress established the office of Inspector General in HEW to coordinate the total program, and

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HCFA established the Office of Program Integrity. The combined effort took three major approaches:

- Increasing the number of field investigators
- Assisting the states to more effectively develop cases of Medicaid fraud, particularly provider fraud
- Developing management and reporting systems which would help them identify errors and overpayments

Before May 1975, Medicaid had 32 program personnel involved in fraud and abuse and HEW had 10 professional investigators. Today, HCFA has 280 program integrity specialists around the country and the Office of Inspector General has about 65 professional investigators, with another 70 authorized. States whose fraud control units are certified have added a total of 690 investigators, lawyers and auditors. In the effort to counteract fraud, the Government pays 90 percent of the costs of these state operations.

Training

HEW has conducted training programs for its own staff since 1969. Now the responsibility is shared by the Institute of Medicaid Management, the Inspector General's Office of Investigation, and HCFA's Office of Program Integrity. Training is given in investigative techniques, legal grounds for prosecution, and developing a case for prosecution.

First, a general introduction to the Medicaid and Medicare programs is given so that investigators will know how to question providers effectively and how to locate and quickly check records for irregularities.

Second, trainees are given an introduction to criminal law, including an explanation of statutes pertaining to mail fraud, false statements and claims, embezzlement and theft, perjury, conflict of interest, bribery, and graft by Government employees.

The third stage of the program concerns gathering evidence. Investigators and auditors learn what constitutes evidence, what evidence is admissible in court and the correct procedures used to obtain evidence.

State fraud control units

To some extent, the present effort to curb Medicaid fraud is not a continuation of the old game, but a different game altogether. During the period when the states each ran their own fraud control activities—or didn't—the game was much like a casual summer afternoon drive. Now, not only has the pace of the drive picked up, but the drivers are more skilled and are driving high-performance cars.

A state fraud control unit is composed of investigators, attorneys, auditors and other specialists whose combined skills create a vigorous team. The units are viewed by the Congress as vitally needed to restore public confidence in the Medicaid program and to deter providers from committing fraud.

HEW pays 90 percent of the cost of these units for up to three years. After this period, the states are expected to support their own operations.

To date 16 states have received certification for their units, and an equal number have expressed a strong interest in establishing units. The three general requirements for states to receive funding of their anti-fraud units are:

- The unit must be "separate and distinct" from the state Medicaid agency.
- The unit must be located either within the office of the state attorney general, or with an agency that has statewide prosecution authority or within an agency with a formal working relation with the state attorney general, approved by HEW.
- All procedures must be developed and memoranda of understanding written, and the applicant must show that there is sufficient staff to properly investigate, prepare, and prosecute suspected fraud cases.

The capability for prosecution and a thorough grounding in Medicaid are considered the cornerstones for a successful fraud control program.

One barrier to certification is that in several states, the attorney general does not have statewide prosecution authority. To gain certification, some states are seeking legislation to give them the necessary authority. Other states may be able to show that they already have effective procedures for referring cases of suspected fraud to all appropriate prosecuting authorities.

The fraud control unit must have a combination of investigators, attorneys, and auditors on a full-time basis. It must also employ or have access to other professionals knowledgeable in medicine, pharmacy, and the Medicaid requirements under Title XIX.

The fraud unit and the Medicaid agency must have a written agreement which covers the procedures for referring cases of suspected fraud to the unit, a guarantee of access to Medicaid files, and assurance of confidentiality.

In addition to handling all aspects of abuse, the Medicaid agency continues to review suspected provider fraud. Those cases which are questionable are referred to the fraud unit for investigation.

In a case where it is clear that providers have received funds to which they are not entitled, the fraud unit will ask for restitution, or refer it back to the state agency for recovery. In either event, the fraud unit follows the case closely to see that some action is taken quickly.

Obviously, good working relations and good communication between the Medicaid agency and the fraud control unit are essential. New Jersey has had its fraud control unit housed within the attorney general's office for more than three years. Referral and administrative guidelines were worked out between the state Medicaid agency and the attorney general's fraud unit in 1977.

Before the two offices established guidelines for the timely processing of cases, the cases "would sit in the Medicaid agency for years," says Robert Sturges, chief of the attorney general's fraud unit. Now the average turn-around time is 30 days.

During this 30-day period a case is referred to the fraud unit for review and is either prepared for investigation and prosecution or sent back to the Medicaid agency for administrative disposition.

Administrative sanctions include suspension of the suspected provider while the fraud unit is preparing a case for prosecution. Respresentatives of the two offices meet twice a month to inform each other of progress in each case.

Evaluating success

The anti-fraud approaches of states vary considerably. Oklahoma, for example, has long emphasized prevention through good relations with the provider community and through tight program management. The state conducts a training program for providers, closely screens and verifies all claims, and widely publicizes its convictions of fraud. Montana also has a rigorous claims screening process and reports a low number of prosecutions. In these two cases, dollar recoveries have little meaning in assessing the programs' successes.

How, then, is a state's fraud control activity assessed? Says Don Nicholson, director of the Office of Program Integrity, "Our evaluation of a state's efforts is determined by a variety of factors: the state's commitment of resources to fraud and abuse control; its workload, including investigations, convictions, sanctions, and prosecutions; its demonstrable efforts to improve operations; and the basic characteristics of its program."

How is the success of states' efforts measured in national terms? The picture is incomplete because, until now, states have not been required to systematically report data on prosecutions, overpayments, or recoveries.

The Office of Program Integrity has established uniform reporting requirements, which will produce a continuous flow of information from the states. These reports will help HCFA construct a national picture of both the problems and the progress in controlling fraud and abuse.

The status of each case being prepared for prosecution is monitored by HCFA, including where the case was referred for prosecution and its final disposition.

Each year state fraud units must report the number of:

- Investigations initiated, completed and closed
- Cases prosecuted or referred for prosecution and the outcomes
- Complaints received on abuse and neglect of patients in health care facilities, and the number investigated or referred
- Recovery actions initiated by the unit and the Medicaid agency, and the total dollar amounts recovered

Management and data systems

In 1977 it was estimated that eligibility and payment errors by state Medicaid agencies were responsible for some $600 million misspent federal dollars, and that perhaps 20 percent of Medicaid recipients were ineligible for assistance.

In an effort to disseminate to all states the most successful error-reduction techniques developed in any one state, the Institute for Medicaid Management was established. The institute's claims processing and information retrieval system is designed to eliminate errors and to spot patterns of billings that may be improper.

To date 17 states have installed this system and are receiving 75 percent federal funding for operating them. HCFA also pays the states 90 percent of the cost to develop the system. Recently, the system developed by the State of Indiana was adopted by Alabama, thus saving more than $3 million in the cost of designing and implementing a new system. The system was slightly modified and became operational in 9 months for a total cost of $500,000. This is a typical example of the savings that can be achieved by sharing.

Another new computer program intended for eventual installation in the states is the Medicaid Exception Reporting System. It checks for excesses in:

- Encounters between single patients and providers
- Encounters between patients and multiple providers
- Number of services provided
- Number of certain types of diagnoses

The first application of the Exception Reporting System in New Jersey identified 50 providers for investigation. Of the 50 only 17 had been selected by state Medicaid personnel for review.

A quality control program was launched in the states to ensure that only persons eligible for benefits receive them. An analysis showed that about 20 percent of the persons on the Medicaid roles were not eligible.

HCFA is proposing a regulation to help states set goals for reducing errors. The regulation, which is expected to become effective by the end of this year, requires states to set goals for reducing error levels at the median of their current error rate or, if set above the median, reduce the error rate by at least 18 percent by October 1, 1979.

The reduction of unnecessary payments due to ineligibility, claims processing errors and the uncollected liabilities of other parties, such as insurance companies, is expected to save $272 million by October 1, 1979. By October 1, 1980, the projected saving is $266 million, and by 1981 $259 million.

Secretary Califano has said, "This department has no more challenging or important task than instilling confidence in the American taxpayer that the vast sums expended by HEW each year are managed with fiscal integrity and responsibility."

The state fraud control units are vital to the issues of curbing fraud by providers and reinstating fiscal integrity to the Medicaid program. By the beginning of 1979, it is anticipated that a majority of the states will have units in full operation. The data uniformly reported to HCFA by the units together with data from the new management systems now being installed in state Medicaid agencies will bring into focus, for the first time, a clear and complete picture of the progress toward curbing fraud and abuse. ■

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