Controlling Fraud and Abuse in Medicaid:

Innovations and Obstacles

A Report from the
"Executive Seminars on Fraud and Abuse in Medicaid,"
Sponsored by HCFA: December 1998—May 1999

By
Malcolm K. Sparrow

Professor of Practice
John F. Kennedy School of Government
Harvard University

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A Report from the "Executive Seminars on Fraud and Abuse in Medicaid," Sponsored by HCFA: December 1998—May 1999

Executive Summary

During the winter of 1998 and spring of 1999 the Health Care Financing Administration (HCFA) sponsored and hosted a series of four regional seminars on the subject of Medicaid fraud and abuse control. Senior executives from 49 states, and other concerned agencies, attended the seminars. Each state attending was invited to select, in advance of the seminar, "one important innovation" and "one major obstacle" in their efforts to control Medicaid fraud and abuse, and asked to submit a short written summary description of these innovations and obstacles. Discussions on the second day of each seminar revolved around the topics raised by participants.

This report groups the innovations and obstacles by subject, and summarizes the issues raised. The purpose is to provide the participants themselves (each of whom could only attend one of the four sessions) an overview of what happened at the others; and to make available to non-participants the collective insights and wisdom of the attendees.

Three Major Themes:

Three themes stood out quite clearly. They were heavily represented in the written submissions for all four seminars and, between them, they dominated the second day discussions. These three subjects seemed to be the ones that carried with them the highest degree of consternation and confusion, where uniformity across states was most obviously lacking, and which fostered a wide variety of innovation. These three major themes were:

1) Building Commitment, Understanding, Support, and Resources for Fraud and Abuse Control Efforts
2) Technology Issues: Obtaining access to claims databases, Claims Analysis, Fraud & Abuse Detection
3) Managed Care: Controlling Fraud and Abuse in the Capitated environment.

In the first of these areas, reports were overwhelmingly negative, with 21 states selecting this issue for discussion, all of them doing so as an "obstacle." These submissions and ensuing discussions suggest that the nature and magnitude of the Medicaid fraud problem is, in many states, still not properly understood; or, if understood, is not treated as a serious or central issue in program administration.

The second area (technology) reflected a great deal of activity, with 24 states reporting technological innovations, most of which involved new data access systems, acquisition of decision support or utilization review systems, and/or new fraud and abuse detection tools. At the same time, 10 states raised this subject as an *obstacle*, many of them frustrated by inadequate technological infrastructures and a basic inability to interrogate their own claims databases efficiently.

The third area (fraud and abuse in the capitated environment) revealed a vast range of divergent opinion and initiatives, suggestive of some confusion as Medicaid agencies seek to understand the implications of capitation on fraud and abuse control. 11 states reported *innovations* in fraud and abuse control relating to capitated systems, and 10 reported *obstacles*. The two most common and most substantial obstacles reported were:

1) the apparent persistence across many states of the quite erroneous assumption that "managed care takes care of the problem," and the accompanying conclusion that Medicaid agencies who introduce capitated systems "don't have to worry about fraud and abuse anymore."

2) the inadequacy of *encounter data* as a basis for assessing quality of care issues.

The seminar discussions surrounding capitated systems also revealed a general failure among a significant number of state agencies to distinguish carefully enough between frauds committed *against* the Managed Care Organizations (by providers or recipients), from frauds committed *by* the MCOs themselves (involving improper diversion of capitation payments away from front line health care delivery, resulting in poor treatment for

recipients). The idea that the "MCOs have the financial incentive to control fraud" (with its natural corollary—that program officials therefore need worry *less* about it) clearly applies to the first category (to some limited degree), but doesn't touch the second category at all.

Also, six minor areas:

Participants' advance submissions and seminar discussion also revealed a number of other issues, each of them important enough in its own right, yet each of them lacking the degree of common concern, energy, or activity that the three major areas outlined above seemed to provoke. These somewhat less prominent issue areas were:

1) Measurement Programs for Overpayment Rates (formally conducted by 2 states so far)
2) External Validation techniques: checking that the claim was *true*, rather than just *billed properly* and *processed correctly*.
3) Provider Screening/Enrollment/Re-Enrollment Programs
4) Legislative Issues: Sanctions, Remedies. Civil and Administrative Sanctions.
5) Organizational and Administrative Arrangements: particularly focusing upon cross functional and inter-agency collaborative relationships.
6) Finally, states bought for discussion a few specific problems relating to fraud and abuse in specific industry segments, or focusing on specific abusive practices; and some presented innovations formulated in response to such specific issues.

Accepting that the information gathered through these Executive Seminars represents only a single "snapshot in time" (albeit a wide-angle one), one cannot draw many long range conclusions. The purpose of this report is merely to help spread the information around, and hopefully in a useful form.

However, it does seem clear that the principal focus areas for further regional and national efforts, in support of the states, should focus (or continue to focus) on the three major areas identified here. The priorities, for now, are:

1) continuing to build understanding of, and commitment for, fraud and abuse control among legislatures, governors' offices, and senior agency officials.
2) making sure that the significant sums of money that will spent over the next few years on fraud and abuse detection technology are spent wisely, and that purchasers develop a more sophisticated understanding of what technology can and cannot do for them.
3) clarifying, codifying and communicating effective fraud control strategies for the capitated managed care environment.

Immediate sources of encouragement, from this review, include a substantial number of new collaborative arrangements to coordinate fraud and abuse control efforts, growing acceptance of the need for *external validation* of claims in the fee-for-service environment, and the emergence of more sophisticated approaches to problem identification and reduction.

A Report from the "Executive Seminars on Fraud and Abuse in Medicaid," Sponsored by HCFA: December 1998—May 1999

1.1 Description of Workshops:

During the winter of 1998 and spring of 1999 the Health Care Financing Administration (HCFA) sponsored and hosted a series of four regional seminars on the subject of Medicaid fraud and abuse control.[1] Designed for high level state officials, the seminar series was coordinated by HCFA's Southern Consortium, which has the national lead for Medicaid Fraud and Abuse issues. Executives attending spanned the multiple functional areas that play a role in Medicaid fraud and abuse control. Attendees included Medicaid Directors, Directors of Program Integrity, SURS Officials, Audit Managers, Directors of Medicaid Fraud Control Units, and other senior officials in a position to discuss and affect policy.

Medicaid Officials from 49 states were able to attend, together with representatives from Washington D.C., Puerto Rico, American Samoa, and the Northern Mariana Islands. Other organizations represented included HCFA national and regional offices, the Office of Inspector General (DHHS), the Federal Bureau of Investigation, the Department of Justice, the Administration on Aging (DHHS), and the Executive Office for U.S. Attorneys.

The first day of the program used the case-discussion method as the basis for examining the nature of the fraud control challenge, and the particular characteristics of the problem in the context of major health care programs. The second day of the program revolved around discussion of issues raised by the participants themselves, sorted by subject and organized into thematic panel discussions.

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[1] The specific venues for the four sessions were as follows:

(a) Atlanta, Georgia: (Hosts, Southern Consortium): December 2nd-4th, 1998
(b) Monterey, California: (Western Consortium): March 10th – 12th, 1999
(c) Rockford, Illinois: (Midwest Consortium): April 13th – 15th, 1999
(d) Newport, Rhode Island: (Northeast Consortium): May 3rd – 5th, 1999

HCFA contracted with me, as an "independent expert," to help design the workshops and to facilitate all four of them.

1.2 Purpose and Scope of this Report

Each state attending was invited to select, in advance of the seminar, "one important innovation" and "one major obstacle" in their efforts to control Medicaid fraud and abuse. The states were asked to submit a written summary description of these innovations and obstacles (no more than one page for each), and then to make a short presentations about them during the discussions on the second day of the seminar. Virtually all states attending provided these materials; albeit several states interpreted "one" liberally, describing *several* innovations and obstacles rather than just one of each. In order to encourage candor and frankness in our discussions, states were invited to submit their "obstacles" anonymously, with the promise that the name of the state would not be attached to the "obstacle" in any subsequent report.

This report groups the innovations and obstacles by subject, and summarizes the issues raised. The purpose is to provide the participants themselves (each of whom could only attend one of the four sessions) an overview of what happened at the others; and to make available to non-participants the collective insights and wisdom of the attendees. Most of all, I and my collaborators in this project at HCFA hope that this document will assist in keeping federal and state officials up to date with who's doing what, and encourage them to stay in touch with each other and learn from each others' successes and frustrations.

There is no scientific method here, nor any statistical or other quantitative analysis of the states' submissions. I have taken the *number of states raising an issue* as only the crudest of indicators as to the issue's prevalence or importance. I have also taken into account the *response of other participants* (to the presentations) in determining what seemed to be major or minor concerns for the group as a whole.[2]

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[2] The 3rd day of the seminar provided opportunity for individual state consultations. These consultations were advertised as confidential, and thus this report makes no mention or use of matters raised there.

I have taken the liberty of describing some innovations in greater detail than others, in order to make this document more readable and more useful in expanding horizons. In some cases I have highlighted programs because they seemed to be substantial and important; in other cases, because they were unique or particular and thus useful in stretching the imagination. Such selection is not intended as endorsement of particular programs or policies, either by me or by HCFA. If the actions of another state seem worthy of imitation or replication, I urge the reader to contact those involved directly to learn more of the strengths and weaknesses of their programs.[3]

HCFA, as sponsor of the project, has no responsibility for the framing of this report nor the selection of the subject areas. Please accept these comments as the observations of an 'outsider looking in,' simply hoping to feed back some of what I heard in a form that will prove stimulating and useful. The object is to promote continuing conversation and information exchange among the states.

1.3 Summary Observations: Three Principal Themes

Three themes stood out quite clearly. They were heavily represented in the written submissions for all four seminars and, between them, they dominated the second day discussions. These three subjects seemed to be the ones that carried with them the highest degree of consternation and confusion, where uniformity across states was most obviously lacking, and which fostered a wide variety of innovation. These three major themes were:

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[3] Current contact information for Program Integrity officials in MFCU's and Medicaid agencies, spanning all states, can be found on a new web site provided by HCFA, at: http://fightfraud.hcfa.gov/mfs (note: no "www")

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The second area (technology) reflected a great deal of activity, with 24 states reporting technological innovations, most of which involved new data access systems, acquisition of decision support or utilization review systems, and/or new fraud and abuse detection tools. At the same time, 10 states raised this subject as an *obstacle*, many of them frustrated by inadequate technological infrastructures and a basic inability to interrogate their own claims databases efficiently.

The third area (fraud and abuse in the capitated environment) revealed a vast range of divergent opinion and initiatives, suggestive of some confusion as Medicaid agencies seek to understand the implications of capitation on fraud and abuse control. 11 states reported *innovations* in fraud and abuse control relating to capitated systems,[4] and 10 reported *obstacles*. The two most common and most substantial obstacles reported were:

1) the apparent persistence across many states of the quite erroneous assumption that "managed care takes care of the problem," and the accompanying conclusion that Medicaid agencies who introduce capitated systems "don't have to worry about fraud and abuse anymore."

2) the inadequacy of *encounter data* as a basis for assessing quality of care issues.

The seminar discussions surrounding capitated systems also revealed a general failure among a significant number of state agencies to distinguish

[4] although in two of these cases, the *innovation* was the advent of managed care itself, with obvious consequences for fraud and abuse control. Thus, these two might just as easily have been presented as challenges, rather than innovations.

carefully enough between frauds committed *against* the Managed Care Organizations (by providers or recipients), from frauds committed *by* the MCOs themselves (involving improper diversion of capitation payments away from front line health care delivery, resulting in poor treatment for recipients). The idea that the "MCOs have the financial incentive to control fraud" (with its natural corollary—that program officials therefore need worry *less* about it) clearly applies to the first category (to some limited degree), but doesn't touch the second category at all.

1.4 Also, Six Minor areas:

Participants' advance submissions and seminar discussion also revealed a number of other issues, each of them important enough in its own right, yet each of them lacking the degree of common concern, energy, or activity that the three major areas outlined above seemed to provoke. These somewhat less prominent issue areas were:

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The remainder of the report explores these three major issue areas and six minor ones in greater detail.

2.0 Three Major Issue Areas

2.1 Commitment, Understanding, Support, Resources

No fewer than 21 of the states raised this subject area explicitly in their advance submissions, all 21 of them presenting the issue as an "obstacle" (although two of them reported some recent progress). Many other participants clearly empathized, although they had not raised the subject themselves, and discussions on this point were at times quite passionate. Expressed frustrations included participants' sense that:

- legislatures and senior management (particularly of the single-state agencies) appeared either not to recognize the problem of Medicaid Fraud and Abuse; or, if they did, they seemed not to treat it as a serious or central issue in program administration
- providers and provider associations exerted powerful political influence at the state level which effectively thwarted efforts to bring them into compliance or to implement sensible controls on billing behavior
- resources available for program integrity functions (including fraud detection and investigation) appeared miniscule compared to the potential losses to the program
- "separation of funds" (*program* funds from *administrative* funds) prevented consideration of the *returns on investment* available from investments in fraud and abuse control activities. This leaves program integrity funding at the mercy of other inescapable administrative requirements (in a zero-sum game), and normally last in line
- constrained capacity of the justice system: created backlogs, or abandonment, of significant cases
- the culture of social service agencies and claims processing operations appears to be adverse, and in some cases openly hostile, to the purposes and methods of effective fraud control

The following seven comments—a sample of the seminar participants' advance written submissions on this subject—give a flavor of these concerns. Each of these was presented by a different state:

- "We are a provider driven agency. Our agency operates directly under the governor's office and primarily by executive order and therefore is subject to political pressure by providers and associations. This creates difficulty in introducing new programs, new checks and balances, changing rates, policies and punitive actions. The agency's attitude for units within Medicaid that uncover mistakes or even potentially fraudulent behavior is negative."

- "Because most public health insurance programs are administered at a fraction of the administrative cost of private health insurance, there is a tremendous internal struggle over limited administrative resources. The program integrity budget is always at risk of the agency's other administrative needs. A long term budget commitment to program integrity is always a problem. The program integrity budget commitment tends to be crisis driven."

- "The most difficult obstacle to conducting fraud control in this state is the political and social and welfare culture of the sponsoring agency……The concept of program integrity is foreign to social workers……In a broader view of all state agencies, the program integrity and enforcement functions, and law enforcement, are prevented from being given information to perform those functions by other state agencies who hold useful information. The state licensing boards and Revenue Department seek information but refuse to share information with the SURS and MFCU."

- "The largest obstacle we have is top level management of the Division. The manager does not want anything to do with the fraud unit or referrals." [In presentation, later clarified: "The new Director does not tolerate the fraud unit. He has announced internally that there will be no referrals to the fraud unit."]

- "The most substantial obstacle facing Medicaid Program Integrity operations is the lack of awareness and understanding of the extent of the problem. Senior management have limited time and resources to deal with anti-fraud and abuse issues. Provider fraud and abuse issues take second place to productivity and service delivery priorities……over the

past several years the department's Program Integrity operation's resources were reduced in order to staff up [other] efforts.....[our state's] anti-fraud and abuse efforts are minute in relationship to the size of its program; [the state's] response is simply not proportional to the problem."

- "The most serious problem in combating fraud in [the state] is the loss of resources and the aging of the systems used to identify and combat fraud. With the advent of the managed care delivery system, many of the resources previously devoted to fraud and abuse detection have been diverted to support managed care."

- "The most serious obstacle to fraud control in our state is, I think, the single state agency's lack of interest in and commitment to it, despite the cordial and cooperative day-to-day working relationship which exists between our agencies.....This lack of concern manifests itself in myriad ways.....It could be fairly said that even if the single state agency were to direct more attention and resources to fraud detection, our MFCU would be hard pressed to cope with any substantial increase in the fraud caseload, and that this is ultimately a failure of the legislature to provide resources for either agency that are adequate to the task.....The plain fact remains that the MFCU does not get referrals from the single state agency and so our capacity to deal with an increased number of them has never been tested."

One might be tempted to dismiss such concerns as the predictable complaints of *specialists*, more attuned to their own program responsibilities than to others'. And one might reasonably expect officials who chose to attend a "fraud and abuse" seminar to care a lot more about the subject than other officials who chose *not* to attend. Some might draw comfort from such observations.

But, as an outsider, I would observe that the concerns expressed on these matters had an earnestness, a gravity, and a prevalence that would lead anyone who heard it all to conclude that those dedicated to controlling Medicaid fraud and abuse obviously feel, quite genuinely (and despite any recent improvements) that they are still "up against it" almost every way they turn.

I should also point out, as I have elsewhere,[5] that fraud control is, by its very nature, a miserable business, carrying with it a certain underlying pathology. Elements of that pathology include the fact that fraud is always *invisible unless detected*, which means that the majority of fraud remains invisible in perpetuity; that *finding integrity problems* is never good news, and can therefore be an unpopular occupation; and that massive under-investment in controls is *the norm* in almost any fraud control setting.[6] In this regard, therefore, I would interpret the widespread complaints about recognition of the problem, and commitment to controlling it, as ordinary and predictable, and by no means unique to the Medicaid environment. But that makes these concerns no less serious, or genuine, or distressing from the perspective of taxpayers. This reflects, perhaps, the central character of the fraud control challenge, as revealed through these seminars.

In any case, within the Medicaid setting, there clearly remains much work to be done in increasing awareness and building commitment.

2.1.1 Obtaining Resources: Particular puzzles

Participants pointed to some rather specific issues which bedevil efforts to obtain additional resources for fraud and abuse control:

- the savings from penalties, recoveries and cost avoidance cannot generally be fed back into additional controls, so there is no possibility of building resources based on returns on investment
- identifying or specifying the magnitude of potential overpayments (a normal part of the argument for increased resources) can backfire and hamper efforts, given a tendency of some state legislatures to strip those amounts identified from Medicaid appropriations, without offering any assistance in realizing those potential savings. It takes money to save money. Simply withdrawing funds seldom helps matters.
- Once overpayments are identified, current HCFA policy is to demand repayment of the federal portion within 60 days, regardless of

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[5] Sparrow, Malcolm K. , License to Steal: Why Fraud Plagues America's Health Care System, Westview Press, Denver, Colorado, 1996. page 18

[6] ibid. See particularly chapter 1: "The Pathology of Fraud Control."

whether or not the state effects a recovery. Where states choose to pursue criminal cases, or other serious sanctions such as exclusion, those state efforts may ultimately force a provider out of business and consequently diminish the prospects for monetary recovery. HCFA's policy provides a disincentive for states to identify overpayments and an incentive to focus only on easy, straightforward, recoveries—lest the state be left "holding the bag". (HCFA does not currently have discretion in this area. HCFA officials present at the seminars were aware of the problem, and assured state participants that they were continuing their efforts to have the policy altered.)

2.1.2 Building Commitment: Particular Ideas

Through the seminar discussions, a number of suggestions surfaced for building commitment and obtaining increased resources for fraud and abuse control:

- the use of formal *measurement studies* to provide statistically valid estimates of overpayment rates. Such estimates can help justify allocation of control resources commensurate with the size of the problem.
- stressing, in discussions with the legislature, the availability of federal matching funds for additional investments in fraud and abuse control
- the use of pilot or demonstration projects by fraud detection technology vendors, as a low cost way of finding and establishing the existence of illegitimate billing patterns. Such discoveries can help prove the existence of larger problems, otherwise invisible, that the state has not yet addressed.
- dedication of a small proportion of investigative and data analysis resources (say, 5%) to *proactive* investigation and intelligence gathering, and prohibiting them from working on the cases they uncover. Their role would be to *find out* about patterns of fraud and abuse, deliberately building an impressive pile of cases for which investigative resources are obviously and demonstrably inadequate. Such a putting aside of *proactive* resources counteracts the normal dynamic, where *reactive* work (i.e. case development) always takes

precedence and drives out nearly all proactive work (i.e. case discovery)

- cooperating with journalists seeking to educate the public about the nature and prevalence of Medicaid fraud and abuse. (One state credited a recent series of articles on local Medicaid fraud, by one journalist, with boosting awareness and commitment, and producing a subsequent increase in staffing for the Program Integrity unit from 16 to 60.)
- deliberately sending reporters, who are engaged in reporting criminal convictions for Medicaid fraud, to the relevant provider association to ask for *their* comment on the case. This can help force the provider associations to adopt more publicly responsible positions (i.e. something other than concerted opposition) on the issue of fraud and abuse control.

2.2 Technology, Claims Access & Analysis, Fraud & Abuse Detection

2.2.1 Obstacles Reported:

In the area of technological support for fraud and abuse control, 10 states chose to identify specific obstacles that they knew impeded them in their ability to identify and control fraudulent and abusive billing practices. Of those ten, five states reported an inadequate underlying information technology infrastructure, preventing them from gaining access to their own claims data on a timely basis. Four states specifically recognized the inadequacy of their fraud detection, utilization review, and claims edit systems. One state chose to write about the need for improved information sharing among Medicaid agencies, Medicare, Licensing Boards, Revenue Departments, and so on.[7]

2.2.2 Establishing goals/requirements

The presentations by the technology panels, at all four seminars, showed a high level of activity surrounding the issue of fraud and abuse detection. Many states reported recent procurements; many had Requests For Proposals (RFPs) scheduled; others were in the earlier formative and planning stages. Clearly the commercial technology sector had begun to recognize fraud and abuse detection as a new market opportunity, and a number of vendors, including several selling *data-warehouses*, had been quite active in marketing systems to different states.

In our discussions, therefore, we sought to establish more clearly the nature of the goal for technology support. As more and more states look to buy, we sought to ensure some measure of common understanding as to what sophisticated consumers in this field should be asking for.

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[7] an issue which is only partly about *technology,* and more about *partnerships* and *cooperation.* Considerable progress in the area of cross-functional and inter-agency collaboration is revealed through innovations described under the heading "Organizational and Administrative arrangements." See section 3.5

License to Steal, published in 1996, suggested that *claims access* was a prerequisite for fraud detection, but never sufficient by itself. That underlying access needed to be overlaid with a range of analytic tools enabling analysts and investigators to launch their own searches—searches constructed from their own analytic insights and investigative knowledge regarding the nature of fraud scams. In other words (and in the language of the science of pattern recognition), the detection apparatus had to embody a great deal of "domain specific knowledge and insight," in addition to generic database query capabilities.

> "Instead of focusing upon state-of-the-art analytical methods, the industry should focus on providing its fraud control teams a broad range of flexible, user-friendly, claims analysis tools. These teams should be able to construct their own searches quickly and easily, slicing and dicing the claims data in many different ways, inserting and deleting different types of search as different fraud threats wax and wane. And the people operating the systems should not need to be technical wizards to get what they want. The most important tools in the fraud detection toolkit are timely and easy access to claims data (including pre-payment data); friendly, easy to use, non-technical interfaces; and a broad range of analytical tools which can be easily sequenced to answer complex ad-hoc inquiries." [8]

Through the seminar discussions, these requirements/specifications were codified a little more precisely. In order to provide the broadest possible range of detection opportunities, and to be effective in the dynamic business of fraud and abuse control, we should expect fraud and abuse detection technologies to provide all of the following capabilities:[9]

1) **Flexible and easy access to claims data**. Claims history databases should span at least two years, preferably more. They should include *claims denied* as well as *claims paid*, because claims denied provide a rich source of information about efforts by fraud perpetrators to test, and then game, a payment system. Simple logical queries, initiated and launched by users, should run almost real-time, producing results within

[8] License to Steal. page 201

[9] these requirements apply equally whether a state chooses to purchase a fraud detection service from a commercial vendor, or to develop its own capability in house.

minutes (maybe *hours* in some cases; but certainly not *days* or *weeks* as some participants report.)

2) **A Broad Range of Detection Algorithms,** built on top of that underlying data access capability, generating periodic reports to reveal a range of fraudulent and abusive billing practices. Provider-profiling and beneficiary profiling techniques, alone, are not enough. Particular attention needs to be paid to the detection of higher level fraud scams, where perpetrators spread their activities broadly across multiple provider numbers and hundreds or thousands of patients.[10]

3) **A Broad Range of Different Analytic Techniques**, all available through a common interface. There are a great many analytic tools that have relevance to fraud detection. These include simple statistical summaries and comparisons; anomaly detection; geometric ratios; trends over time; acceleration rates; cluster analysis; regression analysis; discriminant analysis; artificial intelligence, rule-based and expert systems; neural networks; similarity profiling; alias detection; network analysis; and geographic analysis (perhaps using GIS tools). Avoid systems and vendors that seem to rely on a single underlying technology or analytic approach. Analysts should be able to *pick the right tool for the job*—which means having the broadest set of tools at hand, and knowing how to use them.

4) **Continuous and Dynamic Updating of Detection Tools**, based on intelligence received from other agencies and sites, from analytic and investigative insights developed locally, and from news regarding emerging fraud schemes elsewhere in the country. Fraud control is a dynamic game played against intelligent opponents, who adapt continuously. Effective fraud control relies upon early recognition of emerging fraud problems, coupled with the technical capacity to design and implement new searches quickly and easily. Therefore states should look for an *adaptive fraud detection service,* rather than a *static fraud detection system*.

[10] See License to Steal, chapter 9, for a discussion of the multiple levels of fraud detection required in the health care setting.

2.2.3 Innovations in Uses of Technology and Analysis

Various aspects of the technology goal, laid out above, are reflected in the technology innovations described by 24 different states—although virtually none of them claimed to be quite where they wanted to be on this front, recognizing further work still to be done. Among the innovations presented, three seem quite unique, and worth elaborating.

- **Illinois: Creation of a Fraud Detection Working Group**. The Medicaid Agency and the Office of Inspector General took the joint decision to adopt a proactive approach to the development of new fraud detection tools. Rather than simply acquire what others offered, they established a cross-functional working group that meets monthly to generate lists of detection ideas related to specific fraud schemes, to prioritize them, and then to supervise the testing and implementation of new algorithms. The group, under the joint chairmanship of the Deputy Medicaid Administrator and Deputy Inspector General, gathers information from a variety of sources about fraud and abuse problems; surveys the private sector and financial world for relevant analytic methods and tools; researches academic methods; as well as debriefing the state's own analysts, investigators, and other Medicaid personnel.

- **Kentucky: Fraud and Abuse Detection and Recovery on a Contingency Basis.** In order to increase the effectiveness of overpayment detection, despite limited resources, Kentucky has let a contract to a commercial vendor for the detection of overpayments and subsequent recovery on a contingency basis. The contingency rate initially set at 25% has since been reduced. The vendor provides lists of suspect claims/overpayments, and then state officials review the list and decide how to dispose of each. The vendor is not permitted to proceed with recovery efforts until authorized. The vendor will provide analytic and investigative support to the state through any resulting appeals and hearings. [This project is still in its early stages. At the time of the seminar presentation, no recoveries had yet been effected under this contract. The obvious advantages of contingency based work lie in the initial *no-cost* and *no-risk* for the state. Potential disadvantages include the perception of "bounty hunters," which (if not managed carefully) could provide a symbolic target for provider associations and political

opponents. States contemplating such arrangements might consider the use of declining royalty schedules in order to provide sufficient incentive to the vendor up front, but avoiding the potential embarrassment of gigantic sums being paid to them over the long term. Longer term difficulties include the fact that vendor incentives based on recoveries do not align proper with a strategy of prevention or control. The vendor's profitability depends upon there being *plenty* of overpayments, preferably easy to recover. Such arrangements would therefore need to be thoughtfully embedded within a broader control strategy.]

- **Puerto Rico: Information Exchange across State Agencies**. The Puerto Rico Medicaid program employs an information exchange system (called "SWICA") for cross matching data from 87 state agencies, including the Treasury Department and range of social Service agencies. The focus is upon recipient fraud, and the purpose is to identify inconsistencies in information provided by recipients to different government agencies for different purposes (e.g. failing to report income during the Medicaid qualification process.)

Other innovations and developments in the technology area, reported by the states, include the following. Please bear in mind, though, that the lists of innovations in this area (and any other lists in this report) are probably not in any sense *complete*. This report is not based upon comprehensive survey data; these are simply the topics that *some* states chose to present. Other states, active in the same areas, may have chosen to present different issues.

- **Specific Detection Methods Aimed at Particular Problems.** States presented a fascinating collection of new fraud detection techniques, developed in response to specific fraudulent or abusive billing practices.

    - Hawaii: Trend analysis, with accompanying charting techniques for visualization purposes. A specific focus on the detection of computerized billing schemes.
    - Illinois: A "Spike Billing" detection system to detect rapid acceleration of business volume, as often happens with *bust-out* or *hit-and-run* schemes. This algorithm was the first formal product of the new Fraud Working Group (described above).

- Kentucky: A new Pharmacy Monitoring System, given traditional problems in that sector.
- Maryland: A detection system for possible instances of child abuse. Detection logic is based upon the observation that repeat child abusers tend to shop around for medical treatment in order to prevent one physician from seeing multiple instances and becoming suspicious.
- Montana: A search capability to identify common addresses from different providers. The purpose is to identify possibly fraudulent 3rd party billers. Another version of the search looks for Medicaid checks from multiple providers being routed to common bank code destination numbers.
- New York: Use of "Intersect" Reports to detect kickback schemes, identifying instances where a physician's patients used one "filler" of ordered services (e.g. a particular pharmacy, or lab) almost exclusively, indicating the possibility of patients being steered to that one provider in exchange for kickbacks. [In addressing the same problem, New York State also promulgated a new regulation allowing the state to recover the amount paid for unnecessary orders from the *orderer*, even though payment went to the *filler*. Officials credit this program with substantial reductions in costs for ordered services, particularly lab services.]

- **Enhancements to MMIS/Claim Edit and Audit Procedures/Basic Claims Access and Review Capabilities.** Reported by the following states:

  - Alabama: New MMIS. Possible addition of commercial claims edit software package, and/or claims utilization review software.
  - New Hampshire: Recently obtained on-line access to Medicaid claims data.
  - Washington State: New Claims Extract Capability. MFCU can now receive claims data on discs useable in their PCs. Flexible, desktop analysis of provider billing patterns.

- **Acquisition of Systems described as "Decision Support Systems**." Reported by the following states:

  - Kansas: New Decision Support System.

- Rhode Island: Installation of new software for analysis of historical claims data. Also gained increased flexibility for the SURS quarterly reports.
- West Virginia: SURS unit, use of new Decision Support System.
- Wisconsin: New Decision Support System for audit selection. Capacity for geographic analyses, amongst others. Also a new "Automated Audit" Tool, with facility to download provider's claims and information into laptops for use by auditors on site. Based on record review findings, this system tabulates the overpayments. Use of these systems is reported to have reduced preparation time, time on site, and report production time.

- **Acquisition of Systems for Utilization Review.** Reported by Michigan, Montana, and South Carolina.

- **Acquisition of "Data Warehouses."** Reported by Minnesota. Being considered by many others.

- **Acquisition of "Fraud and Abuse Detection" capabilities (recent, or pending)**. Reported by Louisiana, North Carolina, Pennsylvania, Texas (using Neural Network technology), & Utah (developed in house). Utah was also developing new fraud-specific front-end edits to be built into the claims processing system.

- **New Approaches to Claims Selection and Examination.** Reported by:
  - Georgia: Adoption of an "Aggressive Prospective Approach" to claims review. Data analysis highlights the top 25 providers in each category of service, and reviews their billing and treatment patterns for aberrancies. That data analysis is followed up, where indicated, by claims review and referral for investigation or audit.

2.3 Managed Care: Fraud and Abuse in the Capitated Environment

Seminar discussions surrounding this issue revealed a vast range of divergent opinion and initiatives, as Medicaid agencies sought to understand the implications of capitation on fraud and abuse control. In the workshop evaluations (completed by seminar participants and later tabulated) this was the subject where the greatest number of participants asked for further help, and wished that we had had more time for it during the sessions.[11]

11 states reported *innovations* in fraud and abuse control relating to capitated systems,[12] and 10 reported *obstacles*. Despite this apparently even split, the discussions that followed the state presentations suggested, overall, that the residual confusion and difficulties outweighed the limited progress that a handful of states had made. The pervasive impression from seminar recipients was that they did not feel their agencies had really grasped this issue yet.

This sense of widespread uncertainty resonates with the findings of a recent (June 1999) report from the Office of Inspector General (HHS).[13] That report, entitled "Medicaid Managed Care Fraud and Abuse," examined the first ten states to obtain Medicaid Section 1115 Waivers for Managed Care.[14] It describes vast differences in perception among states about the *possibility and nature* of fraud and abuse in a capitated setting, the *need* for control, the *locus* for control, the nature of detection and referral systems, and the necessary elements of a control strategy. The report's findings include the observation:

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[11] This despite the fact that, by the 4th seminar, we were already spending nearly half a day on this one subject.

[12] although in two of these cases, the *innovation* was the advent of managed care itself, with obvious consequences for fraud and abuse control. Thus, these two might just as easily have been presented as challenges, rather than innovations.

[13] "Medicaid Managed Care Fraud and Abuse." Department of Health and Human Services, Office of Inspector General. Report no. OEI-07-96-00250. Washington D.C. June 1999.

[14] That is, those that had the waivers in place when the study commenced in July 1996: Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee, & Vermont.

> "There is no general agreement about roles and requirements to detect and refer fraud and abuse in the managed care setting." [15]

Examining case detection and referral mechanisms, the OIG report found that two states, out of the ten examined, now had "active programs which result in case detection and referral of fraud and abuse; others do not." And these two (Arizona and Tennessee), which both employed proactive outreach mechanisms, accounted for 490 out of the 504 cases of managed care case referrals, or 97% within the group during the period studied.[16] However, despite the concentration of cases, neither in Arizona nor in Tennessee did the fraud units receive *any* case referrals from the Managed Care Organizations.[17]

In survey responses, three of the ten Medicaid State agencies indicated that they did not think they were any longer responsible for detection and referral of cases; and two others indicated that, since the monies were capitated, there was no longer any reason to worry about fraud and abuse.[18]

The overall impression one gets from that OIG report is that Arizona and Tennessee—as pioneers in the introduction of capitated managed care within the Medicaid Program—have learned certain lessons the hard way, through their early, and somewhat bitter, experience. Unfortunately it appears that many other states, following along later, have not been quick to learn the same lessons; or—if they have—that *they too are learning them the hard way*, beset by scandal, uncertainty, and confusion. As the OIG report puts it:

> Overall, there is confusion and disagreement on how to address fraud and abuse and there is limited activity in developing or actively pursuing and referring cases in the Medicaid managed care program.[19]

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[15] "Medicaid Managed Care Fraud and Abuse." OIG, DHHS, June, 1999. page i.

[16] ibid. The "period studied" was Calendar Year 1996.

[17] ibid. page 7. Note that in Arizona the requirement for the MCO's is to report instances of fraud and abuse to the Medicaid Agency, rather than to the MFCU directly.

[18] ibid. page 9.

[19] ibid. page ii.

In other words, the body of law, policy, and operational knowledge required for effective control in this environment has apparently not yet been sufficiently well codified and communicated to give states, moving their programs in this direction, a sound basis upon which to construct effective controls.[20]

During our seminars, several participants stressed the need for HCFA, or others, to provide greater assistance in this area; particularly with the business of educating state legislators and senior program officials about the nature of the risks involved.

2.3.1 Obstacles Reported by States: The seminar discussions (involving 49 states) validate and extend the findings of the OIG study (which examined only 10 states, but in a much more rigorous fashion). States, presenting this issue area as a major *obstacle* for them, drew attention to the following central problems:

- the apparent persistence of the assumption that "managed care takes care of the problem," and the accompanying conclusion that Medicaid agencies who introduce capitated systems "don't have to worry about fraud and abuse anymore." As one participant put it:

  > "Program managers of the State's managed care program believe that there is no fraud and/or potential fraud in their programs.....Although the managed care program reviews quality of care issues, it believes fraud is unlikely and if existent, the problem of the contracted entity."

- the inadequacy of *encounter data* as a basis for assessing quality of care issues.

- the lack of any awareness within MCO's, or cooperation from MCOs, regarding fraud and abuse detection and referral.

[20] HCFA, and others, are clearly well aware of this abiding need. HCFA plans to release a report during the fall of 1999 entitled "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care."

- the loss of Program Integrity resources within Medicaid agencies, as these are transferred over to help manage capitated programs.

- absence of relevant performance measures for fraud and abuse controls. (The traditional measures from the Fee-For-Service environment—dollars recovered or payments prevented—are clearly not relevant here.[21])

- the difficulties of establishing and maintaining an investigative capacity for fraud under managed care (with few referrals or sources, unfamiliar investigative environment, little cooperation, etc.)

- the absence of model fraud *statutes* for the managed care setting.

One MFCU Director, during his presentation, explained that many legislators and policymakers within his state did not seem to think that the shift in financial structure (from FFS to Capitation) would significantly alter medical practice. He countered this by describing a particular physician's office that had been under surveillance by a team of investigators within his unit at the time the transition took effect. Before the change (i.e. under FFS) investigators reported that the physician was *always* at his office, working extremely long hours, every day, with the parking lot always full. From the date when his reimbursement shifted to capitation, he was henceforth *hardly ever* at his office, with the patients being seen by nurse assistants and, if really sick, referred to the County Clinic. Thus this one physician's behavior changed *immediately and substantially* in response to altered incentives. The MFCU Director expressed the wish that high level policy makers could better appreciate the street-level realities of the business.

One of the most basic points of confusion, reported by seminar participants, was the general failure to distinguish carefully enough between frauds committed *against* the Managed Care Organizations from frauds committed *by the MCOs themselves*. Frauds committed against the MCOs, by providers or recipients, would hurt the MCOs bottom line. Thus one might expect them to have a natural incentive to control these. [That's the basis

[21] These measures, even within a fee-for-service environment, are *output* measures, not *outcome* measures; and therefore potentially problematic within the context of a fraud and abuse *control* strategy.

for the widespread assumption that "managed care takes care of the problem."]

But fraudulent or abusive practices *by the MCOs themselves* principally involve improper diversion of capitation payments away from front line health care delivery, resulting in poor treatment for recipients, and enriching the MCOs and their affiliates. The idea that the "MCOs have the financial incentive to control fraud" (with its natural corollary—that program officials therefore need worry *less* about it) clearly applies to the first category (to some limited degree), but doesn't apply to the second category at all.

2.3.2 Potential frauds committed by providers, provider networks, against plans:

The first category of abuses includes inaccurate billing, unbundling, upcoding, billing for services not provided, kickback schemes, false claims, balance billing or double billing, excessive utilization, and falsification of diagnoses to support such behaviors. These are traditional fee-for-service frauds, which occur at the expense of the MCOs, or at the expense of any MCO subcontractor that is paid on a capitated basis.

Seminar participants observed (as does the OIG report) that—*even in this area*—the managed care organizations seem either unconcerned, ineffective, or uncooperative. They generally seem reluctant to appear hard-nosed, preferring to shuffle any troublesome providers quietly out of the system, or to constrain them administratively. MCOs seem more willing to report fraud by *recipients* than they are to impugn any part of their valuable *provider* networks.

The consequent failure to control even this kind (the traditional kind) of fraud, results in diminished profits for the MCOs. Dwindling profit margins may, in turn, lead to

1) lack of adequate competition for MCO contracts,[22]
2) MCOs pulling out of the business,

[22] Which, in turn, diminishes any leverage the Medicaid Agency might have had over these organizations.

3) MCO bankruptcies, and
4) higher capitation rates in the future.

All four of these phenomena damage the Medicaid program, and all four seem to be occurring with increasing frequency. Hence the inadequacy of a control strategy that relies too heavily on the natural propensities and capabilities of MCOs in this domain.

2.3.3 Potential fraudulent or abusive schemes committed by plans:

The much greater and more pervasive failing, however, is in failing to understand the myriad ways in which MCOs and their corporate affiliates can take advantage of lax systems for control and accountability. Many of these methods have already been observed and chronicled by organizations such as the National Association of Medicaid Fraud Control Units, the National Health Care Antifraud Association, the President's Task Force on Health Care Reform, the General Accounting Office, the OIG (HHS), and others.[23] Such practices include:

- withholding or unreasonably delaying payments to subcontractors, providers, or provider networks
- destruction of claims
- embezzlement of capitation funds paid by the state
- theft of funds, equipment, and services
- fraudulent subcontracts (for example, where no services are provided, or phony management contracts)
- fraudulent related-party transactions
- excessive salaries and fees to owners or their close associates
- "bust-outs" (money goes in, no money goes out to the vendors, then the entrepreneur claims bankruptcy or simply disappears)
- collusive bid-rigging (between plans, and potentially involving collusion with state personnel)
- improper enrollment practices (attracting good risks or refusing bad risks)
- improper dis-enrollment practices (deliberately eliminating bad risks—persuading or forcing sicker patients to leave)

[23] For example, see Chapter 7 of License to Steal.

- or, conversely, presenting bureaucratic obstacles to prevent dissatisfied patients from dis-enrolling
- falsification of new enrollee registrations (either fictitious patients, or fictitious enrollments)
- kickbacks for primary care physicians for referrals of sicker patients to "out-of-network" specialists.
- arbitrarily excluding identifiable groups of beneficiaries (e.g. those with mental health problems, children, infants, elderly) from service
- regularly denying treatment requests without regard to legitimate medical evaluation
- establishing policies that require an appeal before treatment will be given
- measuring performance only in terms of absence of specific breaches of the contract language
- failing to notify assigned beneficiaries of their rights, yet retaining the capitation payments
- failing to procure health practitioners, so no service is ultimately provided
- retaining exorbitant "administrative fees", leaving inadequate provision for services
- assigning unreasonably high numbers of beneficiaries to providers of service, making adequate service impossible.

Most of these methods center on diversion of capitation fees into the pockets of entrepreneurs. None of them involve *false claims* in the traditional sense. Most of them are *corporate* frauds, committed somewhere within the complex layers of intervening businesses which now separate payers (the Medicaid Agencies) from front line providers and their patients. The existence of so many abusive practices, which have been uncovered and reported all around the country, rebuts the notion that Medicaid agencies no longer need to pay attention, and demonstrates quite convincingly that the kinds of detection and investigative capacities developed under fee-for-service simply do not match the nature of these corporate abuses. A very different kind of monitoring, different forms of accountability, and a new set of investigative skills must be established in order to ensure the integrity of these contracts.

At the same time that these new forms of fraud appear harder to detect and control, they may be much more damaging to human health, as

they result in insufficient or inadequate medical treatment. Their traditional counterparts under fee-for-service—which, by nature, were largely *financial* crimes—often did not actually affect medical treatment, with many patients whose identities were used in fraudulent billing schemes remaining oblivious to the schemes' existence.

Assistant U.S. Attorney Jim Sheehan[24] joined us at the 4th seminar[25] to share his experiences in bringing cases against managed care organizations and providers paid on a capitated basis. In his presentation he emphasized the following points:

- the change in the investigative environment: Rather than monitoring thousands of individual providers, agencies now had to monitor a relatively small number of large, and quite powerful, corporations. These issues of *corporate compliance* required quite different control strategies.

- the most blatant "bust-out" schemes (where MCOs just take the money up front and run), witnessed in the early development of managed care programs, seemed now to be relatively well controlled. He surmised that the next problem might well be bust-outs at a slightly lower in the corporate food-chain, among the multiple sub-contractors who focus on specific services or segments.

- the potential for MCOs to make money improperly by deliberately doing a lousy job of claims processing—losing claims, destroying them, or denying them willy-nilly.

- the importance, in this environment, of whistle-blowers, insiders, and other informants who can accurately describe company policy and practice.

Of course, no one in their right mind would expect a Managed Care Organization to *report itself* for any of these practices. So the need for Medicaid Program Integrity units and MFCUs to focus on these issues, and to develop a broad range of *other methods* for uncovering such abuses,

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[24] Chief, Civil Division, Eastern District of Pennsylvania.

[25] held in Newport, Rhode Island. May 3-5th, 1999.

seems clear enough. Even as MFCUs and Program Integrity units work *with* the MCOs to improve performance with respect to provider fraud, they also need to develop their capacity for monitoring the *behaviors of the MCOs and their agents*. Thus the institutional arrangements necessary to promote control of fraud committed *against* the MCOs will be quite different (and maybe organizationally separate) from the apparatus developed to control fraud committed *by the MCOs and their corporate affiliates.*

There is still much work to be done in this area, both in defining and communicating the nature of those oversight arrangements. HCFA plans to disseminate a new report on this subject, entitled "Guidelines for Addressing Fraud in Medicaid Managed Care." (Forthcoming, August, 1999.) That report, a product of the "National Medicaid Fraud and Abuse Initiative," describes in some detail different types of managed care fraud and abuse, lays out recommended protocols for fraud referral systems, and elaborates on the multiple sources of data and multiple methods for monitoring relevant in this new environment. Hopefully, that report will contribute to the task of elevating the general level of understanding of these issues to a more reassuring level. But for now, there clearly remains much intellectual and practical work to be done here.

2.3.4 Difficulties with Detection of Under-utilization

In their presentations, many states focused on the analysis of *encounter data* as a principal mechanism for finding and establishing patterns of under-utilization. A few sought to feed encounter data through the same sets of edits and audits used for fee-for-service claims. Most reported that the encounter data that they currently received (if any) was simply unreliable as a basis for monitoring anything. The following difficulties surfaced:

- In order to establish under-utilization, a broad pattern of encounters (or absence of encounters) has to be established. A case can no longer be built around any one *false claim*.

- MCOs generally fail to submit encounter data as required by their contracts. Data is often late, poor quality, incomplete, or totally missing.

Falsification of encounter data is generally not a crime, as it does not act as the basis for payment.[26]

- Even where contracts clearly require submission of encounter data, most MCOs do not comply. Medicaid agencies seem unable or unwilling to press the issue too hard, worried about losing yet another MCO.

- Encounter data that is not processed through MMIS (even if submitted in the same form as FFS claim), is subsequently not available through SURS.

- Analytic tools developed in the SURS environment are not suitable for detecting the kinds of anomalies one might expect to represent under-utilization. Tools tailor-made for this task have been slow to emerge on the market, and would in any case be useless given the current quality of encounter data submission.

- Investigators of managed care fraud have few natural complainants or allies. The MCOs' corporate world will remain a closed system with respect to useful information, and difficult for investigators and auditors to penetrate.[27]

- Proving fraud or abuse is inextricably intertwined with questions of medical quality—a poorly developed field even amongst medical experts.

- Investigative units lack some of the investigative skills required in this domain, which include: the ability to explore complex webs of contractual arrangements, to "follow the money," and to understand the effects of complex incentive and financial systems.[28]

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[26] Most Medicaid Managed Care Contracts now state the requirements for submission of encounter data quite explicitly, and many deem failure grounds for contract termination.

[27] Disgruntled providers may be the most likely source of information, albeit many of them fear being blacklisted by the MCOs. Also a few astute patients, who recognize improper policies being exercised.

[28] The Internal Revenue Service, within the context of federal inter-agency cooperation on Health Care Fraud, offers the services of its Revenue Agents, Special Agents, and Auditors in this field. These IRS officers have considerable experience in unraveling complex corporate contractual arrangements, uncovering improper or related-party subcontracts, and "following the money." Their experience may assist states

In light of all these difficulties, and in light of all the current inadequacies of encounter data as a basis for monitoring service quality, some participants questioned the usefulness of continuing to fight this particular battle, which already appears utterly lost. In one of the most interesting exchanges, one participating Medicaid Director expressed the conviction that there was absolutely no point continuing to press on this front, and recommended agencies diligently pursue alternative mechanisms for measuring and monitoring service quality.

For the time being at least, HCFA continues to *require* the submission of encounter data; and efforts to improve the quality, completeness, and timely submission will undoubtedly continue. Nevertheless, with these persistent difficulties, this avenue seems unlikely to provide effective monitoring anytime soon. Hence the importance of developing a much broader range of monitoring methods.

Meanwhile, many states remain utterly frustrated by the poor quality of encounter data; perhaps—at least in part—because they rely upon it so heavily.

[Rhode Island offered, during discussion, that they already use a range of techniques to gather data on MCOs' policies and practices, including: focus groups, satisfaction surveys, grievance procedures, and record reviews.]

2.3.5 Fraud & Abuse Control in the Capitated Environment: Innovations

Encouraging signs on this front, amidst an otherwise bleak picture, came in the form of particular state innovations:

- Arizona: Creation of a new "Program Compliance Audit Team." This team consciously adopts an "up front" approach to proactively assess vulnerabilities, conducting audits both in areas where problems are known, and in others where not. The team sponsors quarterly "Fraud and

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considerably in undertaking complex managed care fraud investigations. To obtain such help, and to identify the local IRS resources available, contact the IRS Health Care Fraud Coordinator, Steve Pregozan, at IRS Headquarters: 202-622-5755.

Abuse Work Group" meetings for Fraud & Abuse Coordinators from the MCOs, representatives of AHCCCS (the Medicaid agency), the MFCU, other State agencies, HCFA, and others.

- Maryland: Instituted "Episode of Care" Analysis, both for FFS and MC recipients, using their SURS system.

- Michigan: Structural changes have been made to eliminate the possibility of certain improper practices by the MCOs. Health plans do not enroll or dis-enroll members (this work being done by a separate contractor); direct marketing is prohibited; plans are required to submit HEDIS data as well as encounter data; Medicaid members are permitted and encouraged to appeal directly to the state, without having to go through the plan first; imposition of co-payments is not permitted. Michigan also created controls to monitor plans' use of suspended or terminated providers; and routinely analyses vital statistics data to identify capitated payments continuing after a member's death.

- New Mexico: Recently passed a new statute to cover criminal fraud in the managed care arena. [Those interested in reviewing this, or relevant legislation from any other state, are invited to examine the new Web-Site created by HCFA explicitly for this purpose.[29]]

- Oregon: State officials took the view that, as encounter data was used as the basis for setting capitation rates and for monitoring utilization rates, that "it had to be accurate." The state contracts with an external contractor to validate encounter data from managed health and dental plans. The 1st year study of this kind found a 32% discrepancy rate between services represented on medical charts and services reflected in encounter data. (The medical records showed *more* services than the encounter data.) The state plans to repeat the program both within the fee-for-service and managed care sides of their program.

- South Dakota: Instituted "Provider Profiling" within their managed care program, comparing rates of referrals for primary care physicians. Anomalies detected may help identify physicians claiming case management fees without providing services.

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[29] available at: http://fightfraud.hcfa.gov/mfs (note: no "www")

- Texas: Imposed a new requirement for all MCO's to submit Fraud and Abuse Compliance Plans.

3.0 Six Minor Areas:

This final section summarizes the remaining obstacles and innovations: those that did not fit any of the major issue areas above. They fall roughly under six subject headings:

- **Measurement Programs**: (to estimate or establish overpayment rates).
- **External Validation Techniques**: to examine the truthfulness of claims submitted, rather than merely ensuring they are presented and processed correctly.
- **Provider Screening/Enrollment/Re-Enrollment** Programs
- **Legislative Issues and Developments**: Sanctions, Remedies. Civil/Administrative Methods.
- **Organizational and Administrative Arrangements**: Collaboration/Relationships, etc.
- **Specific Fraud or Abuse Problems**: this final section describes a range of specific problem areas, observed and reported by individual states.

3.1 Measurement Programs

Two states—Texas and Illinois—have performed formal measurement studies to assess the overpayment rates within their Medicaid programs.

The Texas study was required by statute[30] and performed by the State Comptroller's Office. The study, completed in the fall of 1998, examined likely overpayments and fraud in Medicaid acute care, medical worker's compensation for state employees, and health insurance for state employees and retirees during fiscal 1997. The report, issued as a draft in December 1998, was hotly contested by some of the agencies concerned, and is no longer available publicly.

Illinois has made a commitment to biennial measurement. The first study, based on a sample of over 1200 claims, examined claims paid for services during November 1997. The claims review protocol employed a four

[30] Senate Bill 30.

part claims examination procedure: (1) medical record review, (2) client interview, (3) review of patient history 7 days before and after the service, and (4) special review to make sure the diagnosis made sense given the patient's prior and post history. The findings from this first measurement study, extrapolated to the whole program, suggested 13.5% of the services paid being in error, at least in part. The Payment Accuracy rate overall was 95.28%, suggesting an annual rate of roughly $113 million misspent in the FFS part of the Illinois Medicaid Program. One provider, who surfaced through the sample, could not substantiate *any* of his claims. Officials also noticed, among the claims pulled for transportation providers, that an unnaturally high proportion of their transportation customers had suffered mental health problems, exacerbating the difficulties associated with claims verification. The Illinois report is available through the OIG's internet site.[31] Illinois officials described how their initial apprehension at the prospect of the study (which carries with it the possibility of producing very bad news) had abated, particularly since the results had turned out not too alarming. Also, the relatively low overpayment rate (4.7%) had not provoked complacency, as senior officials had at first feared.

The Texas study, at least in draft form, produced significantly higher overpayment rate estimates. For the sake of any others contemplating such studies, and unclear about the appropriate methodology, it is worth pointing out some differences between the protocols used by Texas and Illinois.

1) Texas used *patient days* as the sampling unit, rather than *claims*. Starting from randomly selected claims, analysts extracted all other claims for the same patient for the same day, and added them to the sample. Thus duplicate submissions from different providers could be identified, as could incompatible services apparently delivered on the same date.
2) Texas used external consultants to review the claims and conduct patient interviews; Illinois used existing state employees (principally within the Medicaid agency).
3) The task for the Texas' Comptroller's Office was to find "certifiable savings," rather than just to set the baseline for future performance measurement. Hence they were required to show how various categories

[31] at http://www.state.il.us/agency/oig

of overpayments (which the study identified) might be prevented, and at what cost.

Several other states are now considering some form of measurement program—partly as a way of establishing the parameters of the fraud and abuse problem; partly as a way of determining appropriate investments in detection and control; and partly in order to establish benchmarks for performance monitoring with respect to their current and future fraud reduction programs. HCFA may soon *require* states to conduct such studies, as a condition attached to Federal funds. So, despite a somewhat slow start in this area, we might anticipate much greater attention being paid to this issue over the next few years. In due course, states will need some assistance in establishing protocols for overpayment measurement studies, and guidance on handling the difficult politics of the issue.

3.2 External Validation Techniques

Three states reported specific initiatives in the use of external claims validation techniques:

- Mississippi: Use of Recipient EOMBs (Explanations of Medical Benefits), mailed quarterly to *every* FFS recipient, detailing *every* service. The notices give a toll-free number, which the program has established solely to receive recipients' calls and queries. Officials report the program has so far been effective in identifying overbillings, the most common form of which is *billing for services never rendered.*

- South Dakota: As part of Quality Assurance, recipients are surveyed to determine their degree of satisfaction with care received. These surveys occasionally result in recipients indicating services were not provided, or that they were unsatisfactory.

- Texas: Introduced a pilot program of random, on-site reviews of providers within specific segments of the industry.[32] The segments for the pilot are DME, Home Health, Therapists and Laboratories.

[32] The segments were specified in legislation: Senate Bill 30.

- Wyoming: Introduced *focused* use of EOMBs with select recipient groups, based upon the types of service received.

3.3 Provider Screening/Enrollment/Re-Enrollment Programs

Five states reported initiatives in the area of provider screening, stricter enrollment procedures, and re-enrollment programs. All states using such techniques report significant reductions in the numbers of providers seeking to enroll, and a surprisingly high number not bothering to re-enroll. States have faced political resistance in getting such programs established; but relatively little resistance in the form of appeals once the program is established.

- Connecticut: Implemented a new Provider Enrollment Procedure, complete with extensive background checks. The program is designed to keep undesirable providers out, particularly those associated with previously barred providers. The procedure employs a questionnaire asking for the owners' names, SSNs, DOBs, and their histories; and requiring declaration of the business' directors and officers. All information provided is subject to verification and further background checks. Connecticut uses a vendor of information services (with access to multiple public and private data sources) to develop background knowledge of each applicant. So far the program is reported to have weeded out 4000 DME and lab providers prior to enrollment. Also, inquiries revealed hospital ownership (undeclared) of several DME companies.

- Florida: Implemented a new Provider Enrollment Process. All providers receive on-site visits and get criminal background checks. $50,000 surety bonds are required for certain provider types. Providers, as a condition of enrollment, are now required to assent to new contract termination provisions, where either party can terminate the contract with or without cause upon 30 days written notice. Lying on application forms results in permanent exclusion. The Re-enrollment component of this program reduced the number of Medicaid providers from 80,000 to 50,000. Many simply did not reapply.

- Kentucky: Implemented a new Provider Screening program. The principal object was to keep sanctioned providers out. Kentucky also required re-enrollment of existing providers (with more comprehensive information provision), and has partnered with contiguous states to deal with problems of overlapping service areas.

- Mississippi: Implemented a new Provider Screening program, involving credential checks. They also sample new providers for unannounced site inspections, and will walk into existing providers' offices with claims submitted to verify, without notice.

- Texas: Implemented a Provider Screening and Re-Enrollment Program; all providers are required to re-enroll by August 1999. The earlier pilot program did not uncover any false applications, but fewer applications were received than expected.

3.4 Legislative Issues and Developments

On the legislative front, two states complained that providers' right to Administrative Review substantially delayed, and in some cases undermined, the preparation of criminal cases against them. Such reviews, they felt, burdened the agency with unnecessary process, tied up the case, and sometimes even required disclosure of evidence before investigators had concluded their investigation. Many other states echoed these concerns.

Another state noted the willingness of certain provider groups to argue "Medical Justification," even in the most egregious cases. Further, they noted that some associations received valuable political support as they did so.

Legislative Changes reported by the states included:

- Florida: Introduction of Affirmative Civil Enforcement. State law was altered to mirror the federal False Claims Statute, with a corresponding range of civil penalties and remedies. Particularly effective, officials

reported, was the lowering of the standard of proof from "acting with intent" to "acting with reckless disregard."

- Louisiana: Recently passed new comprehensive Program Integrity laws. State officials admitted to piggybacking on the work of another state, highlighting the value of sharing information (and draft statutes) among states. [Hence the importance of the new HCFA website, as described above, and at footnote 29.]

- Mississippi: New regulations recently elevated the status of MFCU investigators to sworn law enforcement officers, and removed the Statute of Limitations for prosecuting Medicaid fraud.

- New Mexico: Recent legislation has introduced tougher sanctions, and some new exclusionary provisions for Medicaid fraud and abuse.

3.5 Organizational and Administrative Arrangements

Obstacles raised, in the general category of organizational and administrative arrangements, were relatively few. One state reported great difficulty in conducting joint investigations with other programs and agencies. Another bemoaned the lack of information sharing and coordination across the Medicaid/Medicare divide—observing that often they were going after the same providers, but without knowing it. A third state reported persistent difficulties in the relationship between federal prosecutors (the local U.S. Attorney's Office) and the office of the state Attorney General—pointing to differing priorities, staff shortages, and deficiencies of information exchange.

3.5.1 Cooperative and Coordinating Structures, Enhanced Information Sharing:

Quite encouraging, however, was the fact that a considerable number of states reported recent establishment of new cooperative arrangements, designed to address precisely these kinds of issues, and to provide an opportunity for more broadly coordinated and concerted action against fraudulent and abusive practices. The states listed below all reported such new arrangements. In reviewing these, one gets a sense of a growing maturity in this field. Partnerships tend to be established, in the first instance, around protocols for referral and for case development. The more mature (and organizationally complex) versions provide a forum for identification of fraud and abuse *problems* or *issues* (as opposed to just *cases*), and a platform for the subsequent design and implementation of multi-functional, and inter-agency, interventions.

- Illinois: Reports a new cooperative environment; officials said they felt real progress had been made on "attitude." Different units cooperate and are happy to educate each other about their own roles and responsibilities. A significant contributing factor has been the creation of the "Central Illinois Health Care Fraud Task Force", which meets every month to share information and develop larger scale cases cooperatively. Also the "Fraud Working Group," formed to get parties in the same room and cut across physical and organizational boundaries, develops new detection algorithms and analytic approaches as a component of coordinated interventions.

- Hawaii: Reports much improved inter-agency communication and information sharing. Also, their investigators regularly use FinCEN[33] for case support when they need to check people's assets, records, and affiliations.

- Idaho: Created a joint state "Health Care Fraud Task Force" in 1994. Members include MFCU, Dept. of Insurance, State Tax Commission, Board of Medicine, Board of Pharmacy, Attorney General's Office, FBI,

[33] The U.S. Treasury's "Financial Crimes Enforcement Network," set up by the Customs Service in 1990. FinCEN specializes in money laundering and asset tracing, and has access to a vast range of law enforcement, intelligence, public and commercial data sources. They offer case support to *any law enforcement agency*—federal, state or local. That would certainly include MFCUs and other health care fraud investigators or auditors. FinCEN can be reached on 1-800-SOS-BUCK (767-2825), and they value your business.

US Attorney's Office, Department of Defense, IRS. Law Enforcement members meet regularly to discuss problem areas.

- Indiana: Reports enhanced mechanisms for coordination of fraud control functions. Coordination between agencies/functions is now aided by routine monthly meetings, around problem areas, focusing resources, preventing duplication, allocating responsibilities, and working collaboratively.

- Kansas: The MFCU, fiscal agent, and Medicaid agency now meet twice monthly to review cases and review policies and procedures.

- Mississippi: Reports an improved relationship between the MFCU and the SURS unit.

- Nebraska: Their Health Care Fraud Task Force now has over 65 members, including private insurers, Medicare intermediaries, law enforcement agencies, state agencies, Department of Defense (for Champus), the OIG (DHHS), Department of Defense, Drug Enforcement Agency, Food and Drug Administration, IRS, Postal Service, etc. The Task Force is chaired by the U.S. Attorney's Office, with funding for clerical support and expert witnesses provided by the Department of Justice. State officials report that formation of the Task Force provides members with numerous methods of obtaining information and gives them all a much "bigger picture"; also, together they can identify much bigger cases, and devote more manpower resources to them. Also, the multi-agency involvement provides multiple avenues for disposition of cases, depending upon their nature and seriousness.

- New Jersey: The state MFCU and Single State Agency solved a specific information sharing problem in a creative fashion. The problem was that providers under criminal investigation remained in the system, often setting up other companies to keep stealing and to fund their legal defense. The MFCU was not at liberty to disclose evidence to the Medicaid agency, who therefore kept paying the claims. The appearance of impunity, even when under criminal investigation, had detrimental effects on broader compliance. To deal with this situation the MFCU initiated more frequent use of search warrants and undercover

investigations. Evidence seized through *these* mechanisms could be shared immediately with the single-state agency to allow civil and administrative procedures to commence, even while criminal investigations continued. Collaboration between the parties was greatly facilitated through monthly dialog meetings. In the words of one senior official, "we took the risk of trusting each other". As a result, the MFCU gets prepayment information on a timely basis, and the Medicaid Agency gets early warning about providers under investigation, so it can stem the flow of funds.

- Oregon: Members of Oregon's "Health Care Work Group" include Medicaid, Medicare, licensing and regulatory bodies, worker's compensation programs, and other insurers. This group has met every other month for the past five years to talk about abuses, scams, problem providers, and fraud. Participants cite, as one benefit, the support received from the group by individuals who otherwise feel professionally isolated within their own organizations as a result of their orientation towards "rooting out the bad guys."

- Texas: The new "Office of Investigations and Evaluations" takes central responsibility with respect to fraud and abuse for coordination, staffing, referrals, outreach and training.

- Virginia: Reports increased collaboration between the U.S. Attorney's Office and the State Attorney General's Office, particularly regarding the use of civil fraud investigations. Increased use of civil recourse comes as a response to the experience and perception that providers who were not convicted criminally had little or no action taken against them.

3.5.2 Emergence of Problem-Solving Approach to Fraud and Abuse Control:

Two other states described initiatives that reveal emergence of a problem-solving approach to fraud and abuse control, even though they did not explicitly place this strategy within the context of a new partnership or new cooperative arrangements.

- Michigan: Reported a deliberate focus on development of systemic solutions and policy changes (as well as "reactive controls") in response to identified problems. Plans for 1999 include the development of "problem scenarios" through outside research, reading, MFCU national information sharing, interviews of key administrative players, data-mining, brainstorming, and analysis of trends.

- Ohio: Reported increased use of SURS-initiated policy changes (where policies are either obsolete or ambiguous), stemming from data analysis and problem identification.

3.5.3 Extended or Focused Uses of Prior Authorization and Pre-Payment Review:

Three states reported considerable success using either extended, or carefully focused, systems of *prior authorization* or *prepayment review*.

- California: Adopted a system for focused use of Prior Authorization. They use data analysis from a range of systems to identify specific providers with unusually high rates of utilization for specific diagnostic tests/procedures. Prior Authorization requirements are then imposed, selectively, for those providers. In the first 6 months of the program, officials report cost savings of $5.9 million from just 7 identified providers (their claims paid dropping from $6.5 million to $657,000.) During that period, these providers only filed 6 Treatment Authorization Requests between them, all of which were denied. No appeals were filed. The program has now moved beyond the pilot phase, with providers being placed on P.A. as a result of data analysis, desk reviews, or field audits. The range of procedure codes now subject to the program has been extended to include Otorhinolaryngologic (speech and swallowing) and Neuromuscular procedures.

- New Jersey: The state now employs extended use of Prepayment Review, including validation of claims with other providers and prescribers. Once a problem with a particular provider is indicated, the provider will be put on pre-payment review for a period of 4-6 weeks. Some or all of their claims may be pended, and referred to nurse reviewers for examination and verification. Two units of 'temp' nurses conduct these reviews. In some cases, providers will be asked to submit supporting documentation with their claims. Since the program was implemented, 10 labs have reportedly closed up shop leaving $10m in pending claims. Officials say that non-legitimate providers do not complain, and that the return on investment on an initial investment of $2 million has been roughly 16:1. In 1998 the savings were estimated at $46.9m, with $32.6m attributed to pre-payment avoidance of incorrect payments. This program now includes a 12 week intensive review for new laboratories, which has proven to be an effective deterrent for bad actors. The program manages to pay all its costs from its savings.[34] The review period can be extended if necessary beyond six weeks, and adverse findings from prepayment monitoring can result in denial of payments, withholding of payments, exclusion, referral for licensure action or criminal investigation.

- Ohio: The state uses a program of Selective Prior Authorization. Overutilizers are identified and placed on P.A. for 3 months, or until they re-establish the credibility of their billings.

3.5.4 Other Miscellaneous Innovations:

A number of other innovations, in the general area of organizational and administrative arrangements, do not fall neatly into any of the above categories. They are nevertheless worth noting.

- South Carolina: Has adopted the use of enhanced "Letters of Determination" for providers, containing "findings" (which describe aspects of their prior billing history), policy and rule references, and recommendations for correction of the problem.

[34] A rare instance of the "separation of funds" problem being overcome.

- South Dakota: Has contracted out review of inpatient hospital claims, and reports significant success in identifying inappropriate claims.

- Wyoming: Has implemented a system of Case Management oversight for *recipients* who "except out" in analysis by SURS unit. The focus of this program is upon education, and encouraging more appropriate use of medical services.

3.6 Specific Fraud and Abuse Problems

Several states described the emergence of specific fraud and abuse problems, control of which presented a considerable challenge. These problems included the following:

- **Organized Crime groups**, presenting themselves as "Medicaid Billing Experts," who approach naïve Medicaid providers offering a flat monthly salary in exchange for use of their provider number to fraudulently bill for services not rendered. Elaborate networks have recently appeared, perpetrating extensive fraud through creation of false documents, misuse of provider and recipient numbers, illegal incentive payments, and abusive billing practices. Providers often remain unaware of what is being done in their names.

- **Home Health Care Agencies** using questionable definitions of "homebound" status; overusing *assess and teach* visits; duplicating services; unbundling multi-person care delivery; and delivering services of questionable medical necessity. This problem is exacerbated by the volume of care delivered in unsupervised circumstances, poor documentation, and lack of established standards.

- **Community Based Care**: In some states *Personal Care Assistants* are not being required to enroll as distinct providers, but billing agencies are permitted to bill for them (without employing them). Such arrangements raise doubts about adequate accountability, as personnel seem to come and go very quickly.

- **Counties as providers** (particularly under managed care): issues with oversight and accountability.

- **Recipient Fraud**. Perception in some states that recipient fraud can become quite expensive, but investigators are constrained from pursuing the problem by the attitude of some that "the poor will do what they can to survive", so action against recipients is fraught with political difficulties.

- **Barred providers**, who keep reappearing under different company names, using new provider numbers. This problem demands effective tracking of barred and sanctioned providers.

3.6.1 Innovations in response to Specific Fraud and Abuse Problems

Finally, a number of states described specific fraud and abuse problems which they had identified, and for which they had devised responses:

- Arkansas: **Problem**—Extensive improper billing practices within the transportation segment of the industry. **Remedy**—Introduction of Capitated Transportation contracts on a regional basis. Designated regions across the state were contracted to individual providers to provide transportation services. The contractors are reimbursed a monthly fee, eliminating individual FFS claims from multiple providers. This structural change has been resisted by providers and recipients alike. State officials report their current challenge is to find adequate capacity for effective oversight of these new contracts.

- Maryland: **Problem**—prevalence of billing problems within the DME and Pharmacy segments. **Remedy**—a deliberate focus on these areas by the SURS unit.

- Montana: **Problem**—Lack of accountability for billing agencies, hitherto almost completely unregulated. **Remedy**—Requirement for billing agencies to enroll just like providers, in order to enable the SURS unit to track their billings, and so they can be excluded if necessary.

- Rhode Island: **Problem**—Lack of accountability for Home Health providers, especially working remote from supervision. **Remedy**—A Demonstration Project on time-keeping by telephone, currently in the pilot phase. The purpose is to cut down on "no-shows" that still result in billed visits, by requiring service providers to call in from the patient's home, once when they arrive, and again just before they leave.[35]

- Oklahoma: **Problem**—Behavioral Health Providers employing therapists lacking relevant qualifications. **Remedy**—Changes in the certification standards and enrollment procedures for this group.

4.0 Conclusion

Reviewing this very substantial collection of activities and innovations, one is immediately struck by some fundamental realities of this business. First, no two state Medicaid programs are alike. Second, there is an *enormous* amount of activity in this field. Keeping track of the changes and experiments underway is obviously valuable, and obviously difficult on any continuing basis.

Accepting that the information gathered through these Executive Seminars represents only a single "snapshot in time" (albeit a wide-angle one), I would hesitate to draw many conclusions. The purpose of this report, after all, is merely to help spread the information around, and hopefully in a useful form.

However, it does seem clear that the principal focus areas for further regional and national efforts, in support of the states, should focus (or continue to focus) on the three major areas identified early in this report. The priorities, for now, are:

1) continuing to build understanding of, and commitment for, fraud and abuse control among legislatures, governors' offices, and senior agency officials.

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[35] Such systems may be broadly useful; but they may also not be technologically foolproof. Another state reported discovering providers, within a similar program, using 3-way linking of cellular phones to mimic calling in from patients' homes.

2) making sure that the significant sums of money that will spent over the next few years on fraud and abuse detection technology are spent wisely, and that purchasers develop a more sophisticated understanding of what technology can and cannot do for them.
3) clarifying, codifying and communicating effective fraud control strategies for the capitated managed care environment.

Immediate sources of encouragement, from this review, include a substantial number of new collaborative arrangements to coordinate fraud and abuse control efforts, growing acceptance of the need for *external validation* of claims in the fee-for-service environment, and the emergence of more sophisticated approaches to problem identification and reduction.

Finally, let me thank all the seminar participants for their evident commitment to public service, their energetic engagement in these seminars, and for their candid discussion, without which this report would be utterly empty. It has been a pleasure working with you all.

This series of Executive Seminars may have ended; but this conversation has a long way yet to run.