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

by Ann Slayton

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

The best estimates of federal and state funds lost annually to fraud and abuse in the two programs is $15 million for Medicare and $353 million for Medicaid. But so-called administrative waste and errors bring the total loss to $4.3 billion annually.

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

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

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

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

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

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

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

To attack the problem across a broad front, Congress established the office of Inspector General in HEW to coordinate the total program, and
HCFA established the Office of Program Integrity to combat fraud, with a three-pronged effort to take three major approaches: 

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

Before May 1975, Medicaid had 32 providers of providers, 55 had added services or investigative work, and the Government paid the providers. Medicaid and Medicare programs is considered the cornerstones for a successful fraud control program.

State fraud control units

In each state, the Medicaid agency and the fraud control unit are essential. New Jersey has developed the combination of investigative, attorneys, and auditors on a full-time basis. It also must employ or have access to personnel with Medicare experience.

A state fraud unit is comprised of investigators, attorneys, and auditors who are knowledgeable in medicine, pharmacy, and the Medicaid requirements under Title XIX.

The fraud unit and the Medicaid agency must have a written agreement which covers the procedures for referring cases of suspected fraud to the state attorney general, or with an agency that has the necessary authority. New Jersey has already have effective procedures for referring cases to appropriate prosecuting authorities.

The fraud control unit must have a combination of investigators, attorneys, and auditors. Having these personnel is expected to bring an average of 20 percent of the persons on the Medicaid roles eligible for payment. HCFA is proposing a regulation to help states set goals for reducing errors.

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

The reduction of unnecessary payments due to illegibility, claims processing errors and the uncollectible liabilities of other parties, such as insurance companies, is expected to save $272 million by October 1, 1979. HCFA also expects savings of $266 million, and by 1981 $259 million.

The state fraud control units are vital to the issues of curbing fraud by providers and reinstating fiscal integrity to the Medicaid program. By the beginning of 1979, it is anticipated that a majority of the states will have units in full operation. The data unit, along with HCFA, are the only units that have access to the Medicaid roles eligible for payment.
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