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# HEALTH CARE FRAUD

# Types of Providers Involved in Medicare Cases, and CMS Efforts to Reduce Fraud

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Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee:

I am pleased to be here today to discuss our work regarding health care fraud in Medicare and to discuss strategies that could help reduce fraud. Since 1990, GAO has designated Medicare as a high-risk program, as its complexity and susceptibility to payment errors from various causes, added to its size, have made it vulnerable to fraud.[1] Although there have been convictions for multimillion dollar schemes that defrauded the Medicare program, the extent of the problem is unknown as there are no reliable estimates of the magnitude of fraud in the health care industry. Fraud is difficult to detect because those involved are engaged in intentional deception. According to the Department of Health and Human Services' Office of Inspector General (HHS-OIG), common health care fraud schemes include providers or suppliers billing for services or supplies not provided or not medically necessary, purposely billing for a higher level of service than that provided, misreporting data to increase payments, paying kickbacks to providers for referring beneficiaries for specific services or to certain entities, or stealing providers' or beneficiaries' identities.

Since 1997, Congress has provided funds specifically for activities to address fraud, as well as waste and abuse, in Medicare and other federal health care programs. In fiscal year 2011, the federal government allocated at least $608 million in funding to investigate and prosecute

[1]In 1990, we began to report on government operations that we identified as "high risk" for serious weaknesses in areas that involve substantial resources and provide critical services to the public. Medicaid is among those programs we have identified as high-risk and Medicare has been included since 1990. See GAO, *High-Risk Series: An Update*, GAO-11-278 (Washington, D.C.: February 2011). See also http://www.gao.gov/highrisk/risks/insurance/medicare_program.php. Medicare is the federally financed health insurance program for persons age 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease. Medicare Parts A and B are known as Medicare fee-for-service (FFS). Medicare Part A covers hospital and other inpatient stays. Medicare Part B is optional, and covers hospital outpatient, physician, and other services. Medicare beneficiaries have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—Medicare's managed care program—also known as Part C. All Medicare beneficiaries may purchase coverage for outpatient prescription drugs under Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan. Fraud involves an intentional act or representation to deceive with the knowledge that the action or representation could result in gain.

cases of alleged fraud in health care programs.[2] The Centers for Medicare and Medicaid Services (CMS)—an agency within HHS—oversees Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Along with its contractors, CMS works to reduce fraud. The HHS-OIG along with the Department of Justice (DOJ)—including its Criminal and Civil Divisions, the U.S. Attorney's Offices (USAOs) throughout the country, and the Federal Bureau of Investigation (FBI)—work together to investigate and prosecute cases of health care fraud.

My testimony today focuses on the types of providers that have been investigated for fraud and the outcomes of those investigations, and strategies that could be used to combat Medicare fraud. This statement is informed primarily by our September 2012 report on health care fraud and 8 years of prior work on fraud, waste, and abuse in health care programs.[3] A full list of the products that this testimony is based on is provided at the end of this statement.

These products were developed using a variety of methodologies, including analyses of fraud investigations and outcomes data obtained from federal agencies, review of public court records, examination of relevant policies and procedures, and interviews with agency officials.[4] The work on which these products were based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provided a reasonable basis for our findings and conclusions based on our audit objectives.

[2]See Department of Health and Human Services and Department of Justice, *Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2011*: February 2012. The program, which is under the joint direction of the Attorney General and the Secretary of the Department of Health and Human Services (HHS) is designed to coordinate federal, state, and local law enforcement activities with respect to health care fraud and abuse. Additional funds to combat health care fraud spent by HHS and the Department of Justice (DOJ) are not included in this figure.

[3]See GAO, *Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases;* GAO-12-820 (Washington, D.C.: Sep. 7, 2012).

[4]The products listed at the end of this statement contain detailed information on the methodologies used in our work.

## Medical Facilities Were the Most Frequent Subjects of Criminal Investigations, and Hospitals Were the Most Frequent Subjects of Civil Investigations

In recently completed work, we found that medical facilities (such as medical centers, clinics, and practices) and durable medical equipment suppliers were the most frequent subjects of criminal fraud cases in Medicare, Medicaid, and CHIP in 2010.[5] Hospitals and medical facilities were the most frequent subjects of civil fraud cases, including cases that resulted in judgments or settlements.

### Medical Facilities and Durable Medical Equipment Suppliers Were the Most Frequent Subjects of Criminal Fraud Cases in 2010

According to 2010 data, about one-quarter of the 7,848 subjects investigated in criminal health care fraud cases were medical facilities or were affiliated with these facilities. Additionally, about 16 percent of subjects were durable medical equipment suppliers. Among the subjects investigated in criminal fraud cases, a small percentage (approximately 3 percent) were individuals who were beneficiaries of health care programs.

Most of the subjects investigated for criminal fraud in 2010 were not pursued—meaning that the HHS-OIG did not refer the subject's case to DOJ for prosecution. According to the 2010 data, 1,086 subjects were charged in criminal fraud cases and approximately 85 percent of them (925 subjects) were found guilty, pled guilty, or pled no contest to some or all of the criminal charges against them. Among those subjects that were found or pled guilty or no contest, the most frequent subjects were medical facilities (18.7 percent) or durable medical equipment suppliers (18.5 percent). See table 1 below for additional information on subjects who were found or pled guilty or no contest in 2010 criminal cases by provider type.

[5]GAO-12-820. We use the term "subjects" to refer to individuals and entities involved in fraud cases. These subjects can be individuals, such as a dentist or a nurse; an organization, such as a pharmaceutical manufacturer; or a facility, such as a hospital.

**Table 1: Number and Percentage of Criminal Health Care Fraud Subjects That Were Found or Pled Guilty or No Contest by Provider Type, 2010**

| | Number of subjects that were found or pled guilty or no contest | Percentage of total number of subjects that were found or pled guilty or no contest |
|---|---|---|
| Medical facilities | | |
| Medical centers or clinics[a] | 130 | 18.7% |
| Medical practices | 43 | |
| Durable medical equipment suppliers | 171 | 18.5 |
| Other centers, clinics, or facilities | 58 | 6.3 |
| Other | 49 | 5.3 |
| Home health agencies | 42 | 4.5 |
| Pharmacies | 40 | 4.3 |
| Management service providers | 33 | 3.6 |
| Nursing homes | 14 | 1.5 |
| Medical transportation companies | 14 | 1.5 |
| Pharmaceutical manufacturers or suppliers | 9 | 1.0 |
| Mental health centers, clinics, or facilities | 9 | 1.0 |
| Medical supply companies | 8 | 0.9 |
| Insurance companies | 5 | 0.5 |
| Dental clinics or practices | 4 | 0.4 |
| Government employees, contractors, or grantees | 3 | 0.3 |
| Hospitals | 2 | 0.2 |
| Unknown affiliation | | |
| Individuals[a] | 220 | 31.6 |
| Health care providers | 52 | |
| Data unavailable | 19 | |
| **Total** | **925** | |

Source: GAO analysis of Department of Health and Human Services' Office of Inspector General (HHS-OIG) and Department of Justice's (DOJ) U.S. Attorneys' Offices (USAO) data.

Notes: Data in this table are for calendar year 2010. For the subjects in the DOJ's USAO data, we identified the provider type using the court documents obtained from the Public Access to Court Electronic Records database. The data from HHS-OIG pertained only to health care fraud in Medicare, Medicaid, and the Children's Health Insurance Program; however, data from the USAOs may have also included other health care fraud.

[a]Among the 130 subjects affiliated with medical centers or clinics, 8 subjects were beneficiaries. Among the 220 individuals whose affiliation was unknown, 95 were beneficiaries. In total, there were 103 beneficiaries who were found or pled guilty or no contest to some or all of the criminal charges against them. This represents approximately 11.1 percent of all criminal subjects who were found or pled guilty or no contest.

Additionally, about 11 percent of the subjects found guilty or who pled guilty or no contest were beneficiaries of health care programs. Among the 925 subjects that were found or pled guilty or no contest, 103 subjects were beneficiaries—95 of whom are listed as individuals in Table 1 and 8 of whom were affiliated with medical centers or clinics. For example, in one of these criminal cases, a number of people associated with a medical clinic, including owners, an administrator, employees, a physician, and beneficiaries pled guilty or were convicted for their participation in a scheme to defraud Medicare. The fraud scheme involved recruiting beneficiaries through kickbacks for the purpose of submitting bills for injection and infusion treatments, which were not provided or not medically necessary.

## Hospitals and Medical Facilities Were the Most Frequent Subjects of Civil Fraud Cases, Including Cases That Resulted in Judgments or Settlements

Hospitals constituted nearly 20 percent of the 2,339 subjects of civil fraud cases investigated in 2010, and other medical facilities accounted for about 18 percent of the subjects. Less than 1 percent of subjects involved in civil health care fraud cases were beneficiaries of health care programs.

Not all of the subjects investigated in 2010 civil cases were pursued; by pursued, we mean that the USAO or DOJ's Civil Division received the case and took some sort of action. Approximately 47 percent of subjects were involved in civil cases that were pursued and the remaining 53 percent were involved in cases that were not pursued for a variety of reasons, including lack of resources or insufficient evidence as reported by the HHS-OIG. According to the 2010 data, 1,087 subjects were involved in civil fraud cases that were pursued, and among those, 602 subjects were involved in cases that resulted in a judgment or settlement for the government or the relator.[6] Twenty-seven percent of the subjects in cases that were pursued were hospitals, and about 17 percent were medical facilities. None of those 602 subjects were beneficiaries of health care programs. See table 2 for additional information on provider types for

[6]Individuals, known as relators, can bring civil health care fraud suits in the name of the government under the False Claims Act (FCA). The FCA prohibits certain actions, including the knowing presentation of a false claim for payment by the federal government. 31 U.S.C. § 3729(a)(1)(A). In these cases, known as qui tam cases, the relator can receive a portion of a monetary settlement, and reasonable expenses and attorneys' fees and costs. 31 U.S.C. § 3730(b),(d).

subjects where the case resulted in a settlement or judgment for the government or relator.

**Table 2: Number and Percentage of Subjects in Civil Health Care Fraud Cases with Judgment for Government or Relator, Settlement, or Both by Provider Type, 2010**

| | Number of subjects with judgment, settlement, or both | Percentage of total number of subjects with judgment, settlement, or both |
|---|---|---|
| Hospitals | 165 | 27.4% |
| Medical facilities | | |
| Medical practices | 65 | |
| Medical centers or clinics | 35 | 16.6 |
| Other centers, clinics, or facilities | 41 | 6.8 |
| Home health agencies | 34 | 5.6 |
| Nursing homes | 26 | 4.3 |
| Durable medical equipment suppliers | 25 | 4.2 |
| Management service providers | 21 | 3.5 |
| Dental clinics or practices | 21 | 3.5 |
| Pharmaceutical manufacturers or suppliers | 19 | 3.2 |
| Insurance companies | 15 | 2.5 |
| Pharmacies | 13 | 2.2 |
| Medical transportation companies | 11 | 1.8 |
| Mental health centers, clinics, or facilities | 5 | 0.8 |
| Other | 5 | 0.8 |
| Medical supply companies | 3 | 0.5 |
| Government employees, contractors, or grantees | 2 | 0.3 |
| Unknown affiliation | | |
| Data unavailable | 58 | |
| Health care providers | 34 | |
| Individuals | 4 | 15.9 |
| **Total** | **602** | |

Source: GAO analysis of Department of Health and Human Services Office of the Inspector General (HHS-OIG), Department of Justice's U.S. Attorneys' Offices (USAOs), and DOJ's Civil Division data.

Notes: Data in this table are for calendar year 2010. For the subjects in the USAOs and DOJ's Civil Division data, we identified the provider type using the court documents obtained from the Public Access to Court Electronic Records database. The data from HHS-OIG pertained only to health care fraud in Medicare, Medicaid, and the Children's Health Insurance Program; however, data from the USAOs and DOJ's Civil Division may also include other health care fraud.

## CMS Has Made Progress in Implementing Strategies to Prevent Fraud, but Further Actions are Needed

CMS has made progress in implementing strategies to prevent fraud, and recent legislation provided it with enhanced authority. However, CMS has not implemented some of the key strategies we identified in our prior work to help CMS address challenges it faces in preventing fraud. Among others, these strategies include strengthening provider enrollment processes and standards, improving pre- and post-payment claims review, and developing a robust process for addressing identified vulnerabilities.

- **Strengthening provider enrollment processes and standards**—As we have reported in the past, strengthening the standards and procedures for provider enrollment could help reduce the risk of enrolling providers intent on defrauding Medicare.[7] Although CMS has taken some important steps to identify and prevent fraud, including implementing provisions in Patient Protection and Affordable Care Act (PPACA), such as screening providers by risk level, more remains to be done to prevent making erroneous Medicare payments because of fraud.[8] In particular, we have found CMS could do more to strengthen provider enrollment screening to avoid those intent on committing fraud, such as requiring a surety bond for certain types of at-risk providers and additional disclosure of information such as previous payment suspensions from other federal programs.

- **Improving pre- and postpayment review of claims**—As we have reported in the past, having robust controls in claims payment systems to prevent payment of problematic claims can help reduce loss.[9] Effective prepayment edits that deny claims for ineligible providers and suppliers depends on having timely and accurate information about them, such as whether the providers are currently enrolled and have the appropriate license or accreditation to provide specific services. In prior work, we found weaknesses in the database that maintains Medicare provider and supplier enrollment information related to the frequency with which CMS's contractors update

[7]See GAO, *Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers,* GAO-12-351, (Washington, D.C.: Apr. 10, 2012).

[8]Pub. L. No. 111-148, 124 Stat.119 (2010), as amended by Health Care and Education Reconciliation Act of 2010 (HCERA), Pub. L. No. 111-152, 124 Stat. 1029, which we refer to collectively as PPACA.

[9]See GAO, *Medicare: Progress Made to Deter Fraud, but More Could Be Done*, GAO-12-801T, (Washington, D.C.: June 8, 2012).

enrollment information and the timeliness and accuracy of information.[10] Although CMS is working to improve the timeliness and accuracy of the provider and supplier information, it is too soon to tell if these efforts will better prevent payments to ineligible providers and suppliers. Additionally, further actions are needed to improve use of CMS technology systems that could help CMS and program integrity contractors identify fraud both before and after claims have been paid.[11] For example, we recently examined CMS's new predictive analytics system—the Fraud Prevention System—and found that although it has been implemented and is in use, it is not yet fully integrated with existing information technology systems. This level of integration would allow for the prevention of payments until suspect claims can be investigated and determined to be valid.[12] To ensure that the implementation of the Fraud Prevention System is successful, we recommended to CMS that it define quantifiable benefits expected and mechanisms for measuring the results of using the system. In response to our report, HHS officials agreed with our recommendation and noted that CMS intends to establish outcome-based performance targets based on the first year of the system's implementation.

- **Developing a robust process for addressing identified vulnerabilities**—As we have reported in the past, having mechanisms in place to resolve vulnerabilities that lead to improper payments is critical to effective program management and could help address fraud.[13] For example, fraud in the Medicare program can be reduced by making it more difficult for thieves to steal beneficiaries' Social Security numbers (SSN), which are printed on beneficiaries' Medicare cards. In recent work, we found that CMS had not committed to a plan for removing SSNs from Medicare cards, and that CMS's cost estimates for options it explored to remove SSNs were not well documented or reliable. We recommended that CMS select an approach for removing the SSN from the Medicare card that best

[10]GAO-12-351.

[11]See GAO, *Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*, GAO-11-475 (Washington, D.C.: June 30, 2011).

[12]See GAO, *Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness,* GAO-13-104 (Washington, D.C.: Oct. 15, 2012).

[13]GAO-12-801T.

protects beneficiaries from identity theft and minimizes burdens for providers, beneficiaries, and CMS; we also recommended that CMS develop an accurate, well-documented cost estimate for such an option using standard cost-estimating procedures.[14] CMS agreed with our recommendation and indicated that it would take steps to revise its cost estimates on the basis of concerns we highlighted.

Although CMS has taken some important steps to identify and prevent fraud, including implementing provisions in PPACA, more remains to be done to prevent making erroneous Medicare payments because of fraud. It is critical that CMS implement and make full use of new authorities granted by recent legislation, as well as incorporate recommendations made by us, and the HHS-OIG in these areas. Moving from "pay and chase" to effective deterrence that prevents fraud from occurring in the first place is key to ensuring that federal funds are used efficiently and for their intended purposes.

As the authorities and requirements in recent legislation become part of Medicare's operations, additional evaluation and oversight will be necessary to determine whether they are implemented as required and have the desired effect. We are investing significant resources in a body of work that assesses CMS efforts to refine and improve its fraud detection and prevention efforts. Notably, we are assessing the effectiveness of different types of prepayment edits in Medicare and of CMS's oversight of its contractors in implementing those edits to help ensure that Medicare pays claims correctly the first time. Additionally, we have a study underway that is examining how federal agencies—such as CMS, HHS-OIG, and DOJ—are allocating funds received from the Health Care Fraud and Abuse Control Program to reduce fraud, as well as the effectiveness of such efforts. We are also examining a number of issues concerning CMS's oversight and management of its Zone Program Integrity Contractors—the contractors responsible for detecting and investigating potential fraud—including how they prioritize their work and are evaluated by CMS. In addition, we are examining CMS's oversight of some of the contractors that conduct reviews of claims after payment. These studies are focused on additional actions for CMS that could help the agency more systematically reduce fraud in the Medicare program.

[14]See GAO, *Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards,* GAO-12-831 (Washington, D.C.: Aug. 1, 2012).

Because of the amount of program funding at risk, fraud will remain an inherent threat to Medicare, so continuing vigilance to reduce vulnerabilities will be necessary. Individuals intent on defrauding Medicare will continue to develop new approaches to try to circumvent program safeguards and investigative and enforcement efforts. Although targeting certain types of providers that CMS has identified as high risk may be useful, it may allow other types of providers committing fraud to go unnoticed. We will continue to assess efforts to fight fraud and provide recommendations to CMS, as appropriate, that we believe will assist the agency and its contractors in this important task. We urge CMS to continue its efforts as well.

Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee, this concludes my prepared statement. I would be happy to answer any questions you or other members of the subcommittee may have.

If you or your staff have any questions about this testimony, please contact me at (202) 512-7114 or kingk@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Martin T. Gahart, Assistant Director; Christie Enders; and Drew Long were key contributors to this statement.

# Related GAO Products

*Medicare Fraud Prevention: CMS Has Implemented a Predictive Analytics System, but Needs to Define Measures to Determine Its Effectiveness*. GAO-13-104. Washington, D.C.: October 15, 2012.

*Health Care Fraud: Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases*. GAO-12-820. Washington, D.C.: September 7, 2012.

*Medicare: CMS Needs an Approach and a Reliable Cost Estimate for Removing Social Security Numbers from Medicare Cards*. GAO-12-831. Washington, D.C.: August 1, 2012.

*Medicare: Progress Made to Deter Fraud, but More Could Be Done*. GAO-12-801T. Washington, D.C.: June 8, 2012.

*Medicare Program Integrity: CMS Continues Efforts to Strengthen the Screening of Providers and Suppliers*. GAO-12-351. Washington, D.C.: April 10, 2012.

*Improper Payments: Remaining Challenges and Strategies for Governmentwide Reduction Efforts*. GAO-12-573T. Washington, D.C.: March 28, 2012.

*2012 Annual Report: Opportunities to Reduce Duplication, Overlap and Fragmentation, Achieve Savings, and Enhance Revenue*. GAO-12-342SP. Washington, D.C.: February 28, 2012.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Expand Efforts to Support Program Integrity Initiatives*. GAO-12-292T. Washington, D.C.: December 7, 2011.

*Medicare Part D: Instances of Questionable Access to Prescription Drugs*. GAO-12-104T. Washington, D.C.: October 4, 2011.

*Medicare Part D: Instances of Questionable Access to Prescription Drugs*. GAO-11-699. Washington, D.C.: September 6, 2011.

*Medicare Integrity Program: CMS Used Increased Funding for New Activities but Could Improve Measurement of Program Effectiveness*. GAO-11-592. Washington, D.C.: July 29, 2011.

*Improper Payments: Reported Medicare Estimates and Key Remediation Strategies*. GAO-11-842T. Washington, D.C.: July 28, 2011.

*Fraud Detection Systems: Additional Actions Needed to Support Program Integrity Efforts at Centers for Medicare and Medicaid Services*. GAO-11-822T. Washington, D.C.: July 12, 2011.

*Fraud Detection Systems: Centers for Medicare and Medicaid Services Needs to Ensure More Widespread Use*. GAO-11-475. Washington, D.C.: June 30, 2011.

*High-Risk Series: An Update*. GAO-11-278. Washington, D.C.: February 16, 2011.