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MEDICAID PRESCRIPTION DRUG DIVERSION

A Major Problem, But State Approaches Offer Some Promise

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SUMMARY

The fraudulent reselling of drugs obtained through prescription is a prevalent type of Medicaid fraud that state Medicaid agencies are beginning to address more actively. A common fraud scheme involves "pill mills,"--that is, a doctor's office, a clinic, or a pharmacy in which a principal business of that facility is the illegal diversion of prescription drugs. Three parties are involved in each transaction, and at least two are fraudulent participants. A physician, enrolled in the Medicaid program, provides a medically unnecessary prescription--a "scrip"--to a Medicaid recipient. Depending on the set-up of the scheme, the recipient may sell the scrip to a pharmacist or intermediary for cash or merchandise; alternatively, recipients or pharmacists resell the drugs "on the street."

Officials in 21 states cite such drug diversion as a problem. A recent initiative by the Federal Bureau of Investigation targeting pill mills and other drug diversion schemes led to about 100 arrests in 50 cities. Though no-one knows how much Medicaid loses to drug diversion, the potential financial impact is considerable: Medicaid prescriptions cost $5.5 billion in 1991, and likely will approach $10 billion by 1996.

Pill mills remain particularly resistant to enforcement efforts. Reasons for their resilience include delayed detection due to limitations in current information systems; poorly conceived provider enrollment procedures; constrained state resources for imposing additional controls and pursuing and prosecuting cases; concerns that legitimate providers could be deterred from participating in the program; the time-consuming process of pursuing such cases; and a perceived lack of incentive for the state to do so, in view of limited financial recoveries.

Recent state initiatives offer considerable potential for overcoming these stumbling blocks, curbing diversion, and recovering financial losses. These include the use of state-of-the-art automated systems, more stringent enrollment procedures, and strong financial recovery measures. New York state cut its Medicaid payments to pharmacies for the top 30 abused drugs by over 50 percent in one year, and state officials believe this is largely due to their implementation of these approaches.

Mr. Chairman and Members of the Select Committee:

I am pleased to be here today to discuss Medicaid prescription drug diversion. At your request, we have been examining the extent of the problem, and initiatives to address it in New York State, and are just beginning to expand the scope of our investigation to other states. We have found that Medicaid, the primary source of health care funding for the poor, is vulnerable to drug diversion, and that the difficulties involved in combatting it are substantial. Recent initiatives in several states show positive signs of stemming financial losses, but additional state actions are needed to bring the problem under control.

BACKGROUND

Vulnerability of Medicaid

Medicaid's prescription drug benefits cost the program $5.5 billion in 1991, and are expected to approach $10 billion within 5 years. The potential to abuse these benefits is considerable: some prescription drugs have psychological or physical effects similar to those of illicit drugs; others have substantial monetary value and can be diverted for resale through illicit channels by those who seek monetary profit.

In 1977, the Congress authorized states to establish Medicaid Fraud Control Units charged with investigating and prosecuting (or referring for prosecution) providers suspected of fraud. Forty-two states have such units, which--as a condition of federal certification and funding--are required to be organizationally separate from the agency administering the Medicaid program. Most are situated within the office of the State Attorney General.

The Nature of Drug Diversion

The term "pill mill" applies to a whole range of illegal schemes involving drug diversion. It refers to a facility--a doctor's office, a clinic, or a pharmacy--in which a principal business of that facility is prescription drug diversion. These are the focus of our testimony today. Three parties--at least two of them fraudulent--are generally involved in pill mill transactions. The participants are the physician or physician's assistant, the Medicaid recipient, and the pharmacist. The physician, enrolled in the Medicaid program, provides a medically unnecessary prescription--a "scrip"--to a Medicaid recipient. Typically, this is for a drug with a high street value. The recipient sells the scrip to a pharmacist or street dealer for cash or merchandise. Alternatively, the dispensed drugs may be resold on the street.

Let me give you a real example. Florida's Medicaid agency identified and referred to the state's Medicaid Fraud Control Unit

a pharmacy that appeared to be overbilling the program. The unit subsequently conducted a year-long undercover investigation revealing the existence of a pill mill operation. Investigators found that Medicaid recipients went to certain physicians who would prescribe drugs for their use. Two physicians in particular accounted for nearly a third of all the pharmacy's Medicaid claims. In some instances these patients requested specific drugs, in others they complained of symptoms that they knew would obtain for them a prescription for those drugs. The pharmacy used by these recipients did not fill the prescriptions but billed Medicaid anyway. Instead, the pharmacy offered recipients either store merchandise or store credit slips for merchandise. On the basis of their experience in other cases, the investigators concluded that the pharmacy then resold the drugs through illicit channels.[1]

Our work thus far has focused on pill mill fraud in New York state, examining its nature and extent, and actions taken to address the problem. We are now widening our scope to include other states. We recently conducted a telephone survey of all the state Medicaid Fraud Control Units to obtain their assessment of the problems involving drug diversion. We also met with state Medicaid and fraud unit officials in Florida and West Virginia. This testimony is based on our preliminary findings concerning Medicaid drug diversion problems.

Extent of the Problem

Pill mills operate in many states. Half of the 42 State Medicaid Fraud Control Units we contacted reported having this problem, as you can see from our first chart. This list includes seven of the 10 most populous states. The fraud appears in locations as diverse as New York City (population 7.3 million), Miami (population 374,000) and Buckhannon, W.V. (population 6,600). The New York state Department of Social Services has estimated that, in 1990, pill mill schemes cost at least $75 million--about 10 percent of the state's total Medicaid expenditures for prescription drugs. In late 1990, the Department convened a Medicaid Pill Mills Task Force in New York City that initiated 114 investigations resulting in 64 exclusions of providers in the first year.

A recently publicized initiative by the Federal Bureau of Investigation, "Operation Goldpill," confirmed the continued existence in 1992 of such fraud in New York and other states. A variety of schemes was found, including the illegal diversion of individual prescriptions, the repackaging and distribution of medications obtained through bulk purchase, and overbilling by pharmacies of Medicaid and other insurers. An estimate of losses resulting from the Operation Goldpill schemes is still being developed. In New York, where 70 arrests were made and 40 facilities closed, the Department of Social Services told us these facilities billed Medicaid for almost $8 million in 1991. How much of this was fraudulent remains to be determined.

WHY PILL MILLS PERSIST

State Medicaid agencies have data that can be used to identify providers and recipients likely to be involved in diversion activities, but drug diversion schemes remain resistant to enforcement efforts. The reasons for this are already emerging from our ongoing work.

First, Medicaid agencies do not always have relevant data soon enough to prevent recipients from receiving an excessive number of prescriptions. For example, prior to implementation of improved utilization controls, one New York Medicaid recipient received 416 prescriptions in 1 month before the state became aware of the situation.

Second, provider enrollment procedures and ownership data are often not sufficient to ensure that providers previously involved in fraudulent schemes are barred from continuing to bill Medicaid. Medicaid agencies often have little information regarding the relationships between a pharmacy corporation's new and previous owners and officers. The practical effect of this absence of information is that pharmacies are sometimes able to continue operations through the new owners and officers that have ties with the prior fraudulent corporation.

Third, once committed, prescription drug fraud--like other fraud within the health care sector--is difficult to pursue, prove, and punish. In the amount of time involved in investigating, documenting, and prosecuting suspicious activity, Medicaid can incur substantial losses that often are never recovered. The Florida case mentioned earlier, for example, took over 3 years to resolve. During this period the pharmacy billed Medicaid over $1.5 million. In the end, virtually nothing was recovered and there is little assurance that the fraudulent providers have ceased operations. This case, and many of the 14 other pharmacy cases in Florida that have been investigated by the Medicaid Fraud Control Unit over the last 4 years, have a key element in common. That is, the entities under investigation were corporations that avoided Medicaid efforts to recover losses by going out of business, declaring bankruptcy, or simply reincorporating. Enforcement agencies frequently do not investigate the corporate structure to identify and pursue individual owners and financial backers, though the corporations are believed to be often little more than fronts for the illicit activities. Such investigative actions, known as "piercing the corporate veil," are necessary in order to hold responsible individuals personally liable for the losses.

STATE INITIATIVES OFFER POTENTIAL FOR IMPROVED PROGRAM SAFEGUARDS

States are experimenting with approaches aimed at reducing losses due to fraud. Our second chart lists the major initiatives we will focus on today. State innovations include automated systems and state-of-the-art identification technology that flag suspicious activity immediately, more stringent enrollment requirements, and strong financial recovery measures.

New York's efforts appear to be achieving some success. Its Medicaid payments to pharmacies for the top 30 abused drugs, as identified by the state agency, dropped by over 50 percent--from $36.8 million in the third quarter of 1990 to $16.7 million in the last quarter of 1991. Though it is not possible to ascribe these reductions to any specific action, state officials believe that a combination of actions significantly reduced the state's vulnerability to both prescription drug diversion as well as many other provider and recipient fraud schemes. Such actions, taken by New York and other states we visited, sought to:

-- obtain more timely information on services provided to recipients and identify excessive levels of service;

-- better control provider enrollment procedures and enhance the ability to exclude providers expeditiously; and,

-- ensure quicker prosecutions and more certain recoveries.

Now I would like to discuss these actions in greater detail.

Obtain Timely Information

Automated information systems and state-of-the-art identification technology can help Medicaid agencies promptly detect suspicious activity. New York State has an Electronic Medicaid Eligibility Verification System that resembles the use of credit cards for retail sales. Although the federal Department of Health and Human Services has encouraged all states to implement point-of-service claims management systems for prescription drug claims,[2] New York is one of the few states where such a system is currently operational.[3]

In mid-1991 New York added caps--utilization thresholds--on the use of Medicaid services. The combination of service utilization caps with the eligibility verification system offers a powerful deterrent against abuse. The Medicaid-eligible individual's electronically coded card is used to track receipt of each covered service or prescription at the time of service. If the recipient has already reached a yearly service utilization threshold, the

provider must obtain a waiver from the Medicaid state agency in order to provide the service. Other states apply utilization thresholds, but only to known overusers. These programs are known to be cost-effective, though not widely used.[4]

New York also uses, for certain providers, an adjunct to its Electronic Medicaid Eligibility Verification System called "post and clear." When a physician orders medication on a prescription form for a given patient, the order is electronically "posted" in the system and subsequently "cleared" by the pharmacy rendering the service. This system thus detects any attempt by the pharmacist to add items to the prescription form, once posted, or to bill Medicaid for more prescriptions than the physician ordered--common problems in pill mill schemes.

Better identification procedures can also provide information early to avert the illegal sale, purchase, and rental of Medicaid ID cards, or the use of stolen cards. Certain areas in New York State now issue Medicaid recipients with photo ID cards. In April, the legislature approved a pilot project to use fingerprint identification cards, an approach already adopted by the Los Angeles welfare agency.

The federal Department of Health and Human Services has noted the use by some states of improved analytical tools to provide a quicker "first cut" at identification of potential abuse and to focus on specific benefit categories. Florida, for example, uses an extensive database and very sophisticated procedures for tracking the existence of logical linkages between patient services.

Enrollment

Medicaid agencies have several means for controlling provider enrollment procedures that bear directly on drug diversion. For example, New York

-- Limits the number of pharmacies participating in the Medicaid program by geographic area; pharmacies enrolled prior to December 1990 are allowed to continue operations, but additional enrollments are precluded unless a need is demonstrated.

-- Screens provider applicants prior to enrollment (or re-enrollment) by requiring (and verifying) more information than before, including provider ownership of medical facilities.

-- Requires new provider enrollees, in order to be certified, to attend orientation sessions informing them about Medicaid requirements.

-- Makes site visits to facilities to check for questionable or fraudulent activities.

-- Requires enrollment and closer monitoring of physicians' assistants, who in some instances actually hand out the previously signed prescription forms.

Prosecution and Recovery

Initiatives that focus on prevention and early detection do not preclude the need for actions that enhance prosecution and financial recovery. New York State has the largest Medicaid Fraud Control Unit in the country, but still is not able to pursue all cases.

Federal or state legislative changes that would increase penalties and ease the requirements for conviction are seen as one means of encouraging higher priority for pill mill investigations. Some states have enacted felony statutes addressing pill mill fraud and related kickbacks.[5] Others seek such legislation. The federal Civil Monetary Penalties Law (which has parallels in some states) and amendments to the False Claims Act have also helped states pursue these cases.

Agencies also need measures to help collect overpayments, fines, and other financial penalties. States' restitution initiatives vary. New York, for instance, now requires high-volume Medicaid pharmacies to post performance bonds to improve the chances of financial recovery if fraud is detected. New Jersey permits freezing of a provider's bank account or other assets under certain circumstances. In a Michigan case currently under appeal, the state seized a Medicaid pill mill operator's real estate, cash, bank accounts, and other assets.[6] According to investigators and state officials, much of the drug diversion in New York, and some in California, is by individuals able to move assets out of the country, and therefore states need the ability to identify and freeze assets before jurisdiction is lost.

Initiatives have also been taken to obtain more decisive action against abusive physicians and pharmacists. State licensing authorities and professional associations have been traditionally reluctant to act against their professional colleagues. New York has recently mandated tight timeframes for initiating and completing disciplinary actions by the state's professional licensing authorities, which have the power to suspend or revoke a provider's license to practice.[7] In West Virginia, the state Board of Medicine, which has its own staff of investigators, routinely imposes licensure restrictions on physicians convicted of Medicaid fraud.

CONCLUSIONS

Medicaid's prescription drug diversion problem is widespread. The initiatives we have seen in New York and a few other states appear to be achieving some success, making it easier to prevent drug diversion, detect suspicious activity early on, and recover program dollars lost to fraud. Promising approaches include tighter controls on provider enrollment, electronic verification of claims, and earlier and more sophisticated analysis of provider and recipient profiles.

While these safeguards can reduce Medicaid's vulnerability to current prescription diversion fraud, schemes continue to be invented that evade immediate detection. As a result, support for the investigative, prosecutorial, and financial recovery efforts of federal and state authorities remains crucial to combatting fraudulent activity. Initiatives that some states are taking include (1) the enactment of state laws making Medicaid fraud a felony, (2) stronger pursuit of responsible parties, involving the investment of sufficient investigative and law enforcement resources, (3) greater penalties for convicted providers, such as the mandatory suspension or revocation of their practitioner's license, and (4) increased attempts to recover losses through piercing the corporate veil and through such practices as requiring the posting of performance bonds and the freezing of assets.

ENDNOTES

1. State officials suspect that some may have been shipped to Cuba, others sold over the counter, on demand, one pill at a time. Alternatively, the drugs may never have been purchased from the manufacturer.

2. This is a provision of the Omnibus Budget Reconciliation Act of 1990 (P.L.101-508).

3. Officials in Florida told us they were in process of implementing a point-of-service system. According to a May 1992 report from the Department of Health and Human Services, New York and Massachusetts were the only states with such a system in 1991, and only 10 states had definite plans to introduce one.

4. New York's thresholds are not unduly restrictive: 14 physician visits; 43 prescriptions, refills or over-the-counter drugs; and 18 laboratory tests a year. The prescription limit is increased to 60 for children, the elderly, certified disabled or blind individuals, or the single caretaker of a child under 18. Some services are also exempt from the limits.

5. Kickbacks consist of monetary or other forms of recompense passing between colluding physicians and pharmacists.

6. This is permitted only where controlled substances are involved. A bill (H.R.4930) is currently pending in the U.S. House of Representatives to provide for forfeiture of property involved in the commission of federal health care offenses.

7. A New York law, effective July 1991, requires the Board of Professional Medical Conduct to follow strict time requirements in taking action in cases involving misconduct of physicians and eliminates several time-consuming steps. In addition, since April 1991, the New York State Board of Regents has begun using a summary suspension procedure against selected pharmacies, on the grounds that their continued operation "presented an imminent danger to the public health, safety and welfare." This allows action within 8 days of the time a statement of charges is filed.

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CHART 1

STATE MEDICAID FRAUD CONTROL UNITS
CITING PROBLEMS WITH PILL MILLS
(Ranked by Population)

California
New York
Texas
Florida
Illinois
Michigan
New Jersey
Massachusetts
Indiana
Washington
Maryland
Minnesota
Louisiana
Kentucky
Oklahoma
Oregon
West Virginia
New Mexico
Rhode Island
Delaware
District of Columbia

CHART 2

EXISTING STATE INITIATIVES WITH POTENTIAL TO CURB FRAUD

Recipient-Oriented

- More stringent ID: photos or fingerprints
- On-line eligibility verification
- Establishment of utilization limits including number of prescriptions
- On-line utilization review using plastic ID "credit" card

Provider-Oriented:

All

- Intensified checking of background upon enrollment
- Enrollment contingent upon attending informational seminar
- Site visits by Medicaid agency

Pharmacies

- Number of facilities limited by geographic area
- Required posting of performance bonds for high-volume providers

Physicians

- Establishment of tight timeframes for disciplinary proceedings