Office of the Colorado State Auditor

Medicaid Fraud and Abuse Programs

Performance Audit
July 1999

Clifton
Gunderson L.L.C.
Certified Public Accountants & Consultants

LEGISLATIVE AUDIT COMMITTEE
1999 MEMBERS

Senator Doug Linkhart
Chairman

Representative Jack Taylor
Vice-Chairman

Senator Norma Anderson
Representative Ben Clarke
Senator Doug Lamborn
Representative Gloria Leyba
Senator Peggy Reeves
Representative Brad Young

Office of the State Auditor Staff

J. David Barba
State Auditor

Joanne Hill
Deputy State Auditor

Cindi Stetson
Legislative Auditor

Members of the Legislative Audit Committee:

This report includes the results of our performance audit of Medicaid fraud and abuse programs, which Clifton Gunderson L.L.C. conducted on behalf of the Office of the State Auditor. The audit was conducted pursuant to Section 2-3-103, C.R.S., which authorizes the State Auditor to conduct performance audits of all departments, institutions, and agencies of state government. This report presents our findings, conclusions, and recommendations, and the responses of the Department of Health Care Policy and Financing and the Department of Law, Medicaid Fraud Control Unit.

Clifton Gunderson L.L.C.

Denver, Colorado
July 22, 1999

Table of Contents

Page

REPORT SUMMARY 1

Recommendation Locator 7

CHAPTER ONE - DESCRIPTION AND OVERVIEW OF MEDICAID FRAUD AND ABUSE 9

Findings and Recommendations

CHAPTER TWO - DETECTING FRAUD AND ABUSE 19

Oversight of High Risk Areas Could Be Improved 19
Evaluate Resources Available for Fighting Fraud and Abuse 23
Review Programs for Weaknesses that Permit Payments for Fraudulent or Abusive Claims 26
Recover Prescription Credit Refunds from Pharmacies 27
Expand Nursing Facility Audits 29
Improve Oversight of Home Health Services 31
Require Prior Authorization for County Transportation Services 33
Increase Analytical Review of Claims to Identify Questionable Payments 34
Improve Management of "Explanation of Medicaid Benefit" Notices 36

CHAPTER THREE - DETERRING FRAUD AND ABUSE 39

Close Gaps in the Provider Application Process 39
Propose Legislation to Discourage Fraud and Abuse 44
Record Date of Death Timely 45
Improve Records Management 47
Update Authoritative Manuals 48

APPENDICES 51

Appendix A - Medicaid Fraud Schemes 51
Appendix B - Follow-Up on Prior Recommendations 59

REPORT SUMMARY

Medicaid Fraud and Abuse Programs
Performance Audit
July 1999

Authority, Purpose, and Scope

This report presents the results of our performance audit of Medicaid fraud and abuse programs. The audit was conducted on behalf of the Office of the State Auditor under the authority of Section 2-3-102, C.R.S. We gathered information through interviews, data analyses, document reviews, and county site visits. We obtained best practice information by contacting the federal government and other states. Audit work was performed between August 1998 and July 1999.

We gratefully acknowledge the assistance and cooperation extended by staff at the Department of Health Care Policy and Financing and the Medicaid Fraud Control Unit, Department of Law. Additionally, we acknowledge the participation of staff from county departments of social services.

Description and Overview of Medicaid Fraud and Abuse

Medicaid is a federal- and state-funded program that provides health care for children, adults, and families based on income level and medical or physical conditions. Managed by the Department of Health Care Policy and Financing (Department), the Medicaid program served more than 258,000 Colorado residents during Fiscal Year 1998. Medicaid expenditures, excluding mental health and developmental disabilities services overseen by the Department of Human Services, were about $1.09 billion.

Over the past five years, Medicaid expenditures at the Department have increased by $280 million, or 35 percent, while the number of Medicaid recipients has declined by over 8 percent. The magnitude of expenditures and volume of services increase the risk of Medicaid fraud and abuse. Fraud and abuse occur when program funds are used to provide services that are not necessary or appropriate or to pay for services that were not provided. Fraud is an intentional deception or misrepresentation resulting in an unauthorized benefit, such as when a provider intentionally bills Medicaid for a service that it did not provide. Abuse lacks intent, such as when a provider submits claims with errors. Dollars lost to fraud and abuse schemes can be significant. The federal government has estimated that at least 10 percent of the nation's Medicaid expenditures could be avoided if waste, fraud, and abuse were identified and eliminated.

Detecting Fraud and Abuse

Our audit found that the Medicaid program should improve its oversight of fraud and abuse. We identified over $3.3 million in potential recoveries resulting from fraud and abuse detection activities and weaknesses in program practices over a three-month period. We found that, when Medicaid recipients do not pick up their prescriptions, pharmacies are not consistently refunding the cost of the prescriptions to the Medicaid program. We identified backlogs in audits of billing practices and resident personal fund accounts (accounts that are managed by a nursing facility for the benefit of the resident) at Medicaid-licensed nursing facilities. We also found problems with oversight of transportation services provided by 3 metro area taxi companies and 33 mobility and wheelchair van companies. Finally, we found the Medicaid program could improve oversight of 1) Medicare cross-over claims (claims for about 53,000 recipients eligible for both Medicare and Medicaid where Medicaid pays the portion of the claim not covered by Medicare), 2) mental health and developmental disabilities services managed by the Department of Human Services and valued at about $334.5 million, and 3) county functions such as recording of recipient date-of-death. These are all high-risk areas. **We recommend the Department develop an overall framework to heighten accountability for fighting Medicaid fraud and abuse. This framework should include a strategic plan that identifies weaknesses in current program operations, integrates fraud- and abuse-fighting activities, and closes gaps that permit inappropriate payments.**

As part of its strategic plan, the program also needs to evaluate how its resources are deployed. **We recommend the Department, in conjunction with the Medicaid Fraud Control Unit and any other appropriate agencies, undertake a comprehensive evaluation of its resource distribution that 1) investigates the feasibility of leveraging current state general funds to obtain additional federal funds for qualified fraud-fighting activities; 2) identifies areas where the Department should expand its use of contingent fee arrangements; and 3) results in a plan for redistribution of resources and, if necessary, acquiring additional resources to intensify fraud-fighting efforts. The Department and the Medicaid Fraud Control Unit should also evaluate the impact and feasibility of retaining a portion of funds obtained from seizures and recoveries for expanded fraud-fighting activities.**

The Medicaid program has recently implemented new pharmacy procedures for tracking, recording, and refunding credits for prescriptions that were not picked up by recipients. However we estimate that, over the past six years, between $3 and $9 million in prescription refunds exist from prior weaknesses in pharmacy program controls. Further, the MFCU reports that, due to the lack of audit trails at small pharmacies, some of these funds will never be recovered. The Medicaid program must take aggressive steps to recover these funds. The program could set a percentage threshold, such as 1 percent, and require pharmacies that have not refunded prescription credits to submit the amount of the percentage threshold. **We recommend the Department work with the Medicaid Fraud Control Unit to recover past unrefunded prescription credits and monitor future prescription refunds to make sure**

its new pharmacy program controls are working as intended. The Department should also require pharmacies to obtain signatures from Medicaid recipients before giving the prescription to the recipient.

Only 18 of 191 nursing facilities received in-depth audits of their billing practices during Fiscal Year 1998, and every one of these audits resulted in recoveries. We estimate that, if all nursing facilities received in-depth audits on a systematic basis, the State would recover an additional $2 million per year. **We recommend the Department ensure all nursing facilities receive in-depth reviews of billing practices and personal needs funds on a systematic basis.** The Medicaid program will need to evaluate a number of options, including whether audits could be conducted in house, through its long-term care audit contractor, through a contingent fee arrangement, or through some combination of these approaches.

Home health services are skilled services ordered by a physician and provided in the recipient's home. During the past nine years, home health expenditures have increased at least 20 percent per year. However, the Medicaid program reviews few home health claims after payment is made. For a 36-month period beginning July 1, 1996, only 61 providers, or less than 15 percent annually, received post-payment review. Of these, over half owed money back to the State and recoveries totaled over $276,000. Given the explosive growth in home health expenditures, the Medicaid program's post-payment review must be more aggressive. **We recommend the Department extend oversight of home health agencies through increased post-payment reviews.**

The Medicaid program is not enforcing its regulations requiring transportation providers to receive authorization from counties before providing services and to bill counties for those services. Three metro area cab companies bill the Medicaid program directly, violating program regulations and avoiding the prior authorization process. Additionally, wheelchair vans provide services without prior authorization. The MFCU is currently investigating nine transportation providers and has identified over $100,000 in inappropriate payments from another four transportation providers. **We recommend the Department revise its regulations to allow transportation providers to bill the fiscal agent directly for transportation services. Additionally, the Department should require the fiscal agent to verify that counties authorized the transportation services, including wheelchair van services, before paying the bill.**

During our review, we identified questionable utilization patterns that had not come to the attention of Medicaid program staff previously. We accomplished this through basic claims analysis, performed through specialized audit software, specifically looking for inappropriate billing relationships. Although questionable billing relationships do not always result in problems or recoveries, ongoing review of these relationships is an important control for curtailing fraud.

Recently the Medicaid program acquired two new fraud-fighting systems that promise increased capacity to do expanded analytical review of questionable billing relationships.

However, as with any new system, the Medicaid program will need to evaluate the new systems' effectiveness in analyzing paid claims after it has been in place for a year or so. If there are weaknesses in some areas, the Medicaid program may need to work with the contractor to upgrade the system or obtain additional software—such as computer assisted audit technique (CAAT) software—to conduct ad hoc claims analysis as required. **We recommend the Department undertake a comprehensive review of high-risk programs that result in inappropriate payments and modify its policies and procedures to prevent payment of inappropriate claims. To achieve this, the Department should expand analytical review of paid claims to identify high-risk areas, acquiring additional computerized software if necessary.**

The Medicaid program sends out "Explanation of Medicaid benefit" notices (EOMBs) to a randomly selected sample of recipients each month. An EOMB sets forth Medicaid's service dates, the name of the provider, the type of service provided, and the amount paid. The EOMB samples are small—ranging between 450 to 550 recipients, or about 0.1 percent of the average number of paid monthly fee-for-service claims. We believe the EOMB can be a useful tool for fighting fraud and abuse and could result in more substantial recoveries if samples were targeted toward high-risk areas. **We recommend the Department target EOMB samples toward high-risk providers and services on a test basis.**

Deterring Fraud and Abuse

Fraud must be stopped before it has an opportunity to occur. Deterrence is vital since it is time-consuming and expensive to recover payments from a provider. Our review of the Medicaid program's practices for preventing fraudulent or abusive payments identified a number of areas where improvements are needed.

We found the current provider application process leaves the Colorado Medicaid program particularly vulnerable to fraud and abuse. Specifically, the program does not verify the documentation submitted by providers, conduct periodic site visits of high-risk providers to make sure they exist, conduct criminal background checks of providers before admitting them to the program, require surety bonds for high-risk providers, or ensure providers disclose related party arrangements. ("Related parties" are individuals or companies that also have ownership in the provider's business, and may receive kickbacks that cause service costs to be higher than necessary.) In contrast, Florida, whose fraud prevention practices have been held out as a model by the federal Health Care Financing Administration, has implemented almost all of these practices. **We recommend the Department, with the assistance of the Medicaid Fraud Control Unit, review and revise regulations, statutes, application materials, and provider agreements, using Florida's benchmark anti-fraud controls as a model to reduce fraud and abuse.**

Colorado lacks two crucial state statutes to aid the Medicaid program and the MCFU in prosecuting unscrupulous providers. Specifically, Colorado lacks a state false claims act, which permits recovery in civil rather than criminal court. Civil false claims acts require a less stringent level of proof and typically include harsh penalties for violators. Colorado also

lacks anti-kickback legislation. This legislation typically includes penalties for providers who receive a monetary award from another provider when referring a Medicaid recipient for services. Finally, the Medicaid program lacks anti-unbundling regulations. Unbundling occurs when providers bill for each service or lab test separately, instead of submitting a single charge for a group of services or tests. Unbundling results in a higher bill, and thus, a higher payment. **We recommend the Department work with the Medicaid Fraud Control Unit to propose legislation that establishes anti-kickback and civil false claims statutes. Additionally, we recommend the Department develop anti-unbundling regulations.**

When a Medicaid recipient dies, county staff record the date of death into the Client Oriented Information Network (COIN), which interfaces with the claims payment system (Medicaid Management Information System or MMIS). Currently, there are delays in county staff learning of a recipient's death and subsequently a delay in entering the date of death into COIN. If a provider bills for services after a recipient's death, it will receive payment. If the date of death is entered later, the system does not go back and recover those claims. As part of our testing, we obtained the dates of death for 13 clients from two counties. Of 13 clients, 8 had HMO capitation claims paid on their behalf subsequent to their dates of death. The average value of each claim was $50. Although this is a limited sample and the Medicaid program has subsequently recovered these claims, we were surprised by the high rate of occurrence.

The program needs stronger controls to make sure it identifies date of death in a timely manner. Additionally, the program needs to take steps to recover any inappropriate payments made after a recipient's date of death. **We recommend the Department pursue the most effective and efficient method to obtain date of death information. The Department should use this information to seek recoveries for past inappropriate claims and to prevent payment for services provided after date of death in the future.**

The Medicaid program needs to improve its document management. Of 19 provider application files, we found five missing documents, indicating a high error rate. Missing documents can impact the success of fraud and abuse cases. **We recommend the Department work with its fiscal agent to verify and document that all required application materials are included with the initial application and that application materials are filled out completely before enrollment into the Medicaid program.**

Finally, we identified two manuals that did not contain up-to-date information. **We recommend the Department update its Staff Manual for transportation policies currently in effect and keep it current with future program changes. We also recommend the Medicaid Fraud Control Unit update its Policies and Procedure Manual and keep it current.**

The Department of Health Care Policy and Financing and the Medicaid Fraud Control Unit, Department of Law agreed or partially agreed with all of the recommendations in this report. The full texts of their responses are contained in the body of the report.

RECOMMENDATION LOCATOR

Recommendation Number	Page Number	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
1	23	Develop an overall framework to heighten accountability for fighting fraud and abuse. The framework should include a strategic plan that identifies weaknesses in current program operations, integrates fraud and abuse fighting activities, and closes gaps that permit inappropriate payments.	Department of Health Care Policy and Financing	Agree	December 1, 1999
2	25	Undertake a comprehensive evaluation of the distribution of statewide resources dedicated to curtailing fraud and abuse. Evaluate the feasibility of leveraging current state general funds to obtain additional federal funds for qualified fraud-fighting activities, propose legislation to retain a portion of funds from seizures, and expand use of contingency fee arrangements.	Department of Health Care Policy and Financing Medicaid Fraud Control Unit	Agree Agree	December 1, 1999 December 1, 1999
3	28	Recover past unrefunded prescription credits and monitor future prescription refunds to make sure new pharmacy program controls are working as intended. Require pharmacies to obtain recipient signature before giving the prescription to the recipient.	Department of Health Care Policy and Financing Medicaid Fraud Control Unit	Agree Agree	January 1, 2000 for rules; May 1, 2000 to start recovery activities Ongoing
4	30	Address gaps in current nursing facility audit practices by ensuring all nursing facilities receive in-depth reviews of billing practices.	Department of Health Care Policy and Financing	Agree	July 1, 2001 with legislative appropriation
5	32	Extend oversight of home health providers through increased post-payment review.	Department of Health Care Policy and Financing	Agree	December 1, 1999 for resource assessment and July 1, 2000 for contingency-based contract
6	33	Revise regulations to allow transportation providers to bill the fiscal agent directly for transportation services. Require the fiscal agent to verify that counties authorized the transportation services, including wheelchair van services, before paying the bill.	Department of Health Care Policy and Financing	Agree	July 1, 2001 with legislative allocation
7	35	Undertake a comprehensive review of high-risk programs that result in inappropriate payments and modify policies and procedures to prevent inappropriate claims.	Department of Health Care Policy and Financing	Agree	December 1, 1999
8	36	Target EOMB samples toward high-risk providers and services on a pilot basis.	Department of Health Care Policy and Financing	Partially Agree	January 1, 2000

RECOMMENDATION LOCATOR

Recommendation Number	Page Number	Recommendation Summary	Agency Addressed	Agency Response	Implementation Date
9	43	Using Florida's benchmark anti-fraud controls as a model, review and revise regulations, statutes, application materials, and provider agreements to reduce fraud and abuse.	Department of Health Care Policy and Financing	Partially Agree	July 1, 2000
			Medicaid Fraud Control Unit	Agree	July 1, 2000
10	44	Propose legislation that establishes anti-kickback and civil false claims statutes. Enact anti-unbundling regulations.	Department of Health Care Policy and Financing	Agree	January 2000
			Medicaid Fraud Control Unit	Agree	January 2000
11	47	Pursue the most effective and efficient method to obtain date of death information. Utilize this information to seek recoveries for past inappropriate claims and to prevent future payment for services provided after date of death.	Department of Health Care Policy and Financing	Agree	To start recoveries December 1, 1999
12	47	Verify and document that all required application materials are included with the initial application and that application materials are filled out completely before enrollment into the Medicaid program. Contact current providers for any missing application file documentation.	Department of Health Care Policy and Financing	Agree	August 1, 1999 for current records; July 1, 2005 for updating historical records
13	48	Update and keep current transportation policies maintained in the Staff Manual. Update and keep current the Medicaid Fraud Control Unit's Policies and Procedures Manual.	Department of Health Care Policy and Financing	Agree	January 1, 2000
			Medicaid Fraud Control Unit	Implemented	January 12, 1999

Description and Overview of Medicaid Fraud and Abuse

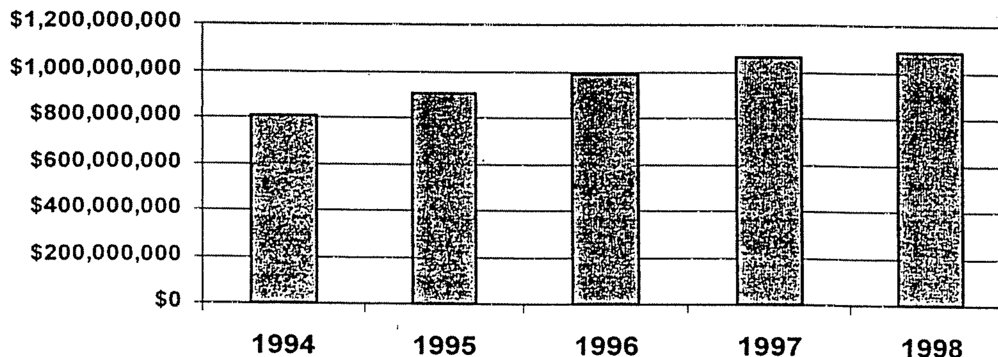
Chapter 1

Introduction

Medicaid is a federal- and state-funded program that provides health care for children, adults, and families based on income level and medical or physical conditions. Managed by the Department of Health Care Policy and Financing, the Medicaid program is one of the largest state programs in Colorado. In Fiscal Year 1998, the Medicaid program served more than 258,000 Colorado residents, or about 6.5 percent of the State's population. Medicaid expenditures for all services, including mental health and developmental disabilities services (which are overseen by the Department of Human Services) were $1.4 billion, of which 52 percent were federal funds and 48 percent were state general funds. Excluding mental health and developmental disabilities services, expenditures for Fiscal Year 1998 were $1.09 billion. Except where noted otherwise, analysis in this report focuses on expenditures for services managed by the Department of Health Care Policy and Financing and excludes mental health and developmental disabilities.

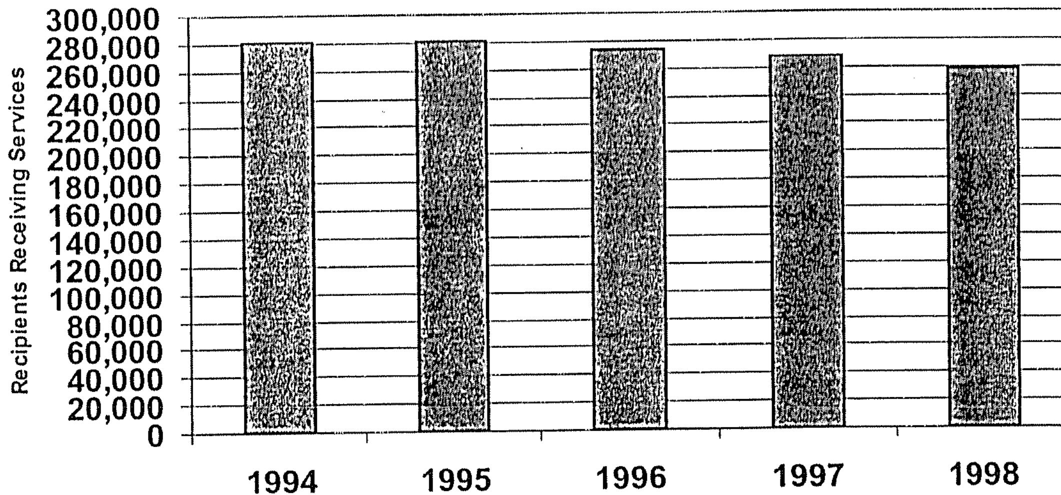
In Colorado, as in other states, Medicaid is a program whose growth continues even as the number of recipients has declined in recent years. Over the past five years, Medicaid expenditures at the Department of Health Care Policy and Financing have increased by $280 million or 35 percent while the number of Medicaid recipients has declined by over 8 percent, as shown in the following two charts.

Medicaid Expenditures FY 1994-1998



Source: Department of Health Care Policy and Financing

Note: Expenditures for Medicaid services managed by the Department of Health Care Policy and Financing, excluding mental health and developmental disabilities services.



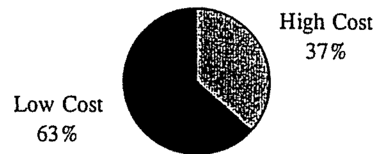
Source: Department of Health Care Policy and Financing

According to Department staff, expenditures have continued to increase because the Department increasingly serves more eligibles with serious illnesses, such as people who are elderly or disabled. The decline in recipients has occurred primarily in population groups that are less costly to serve, such as adults and children on welfare. Since Colorado's welfare caseload has declined significantly in recent years, the number of adults and children on Medicaid have also declined.

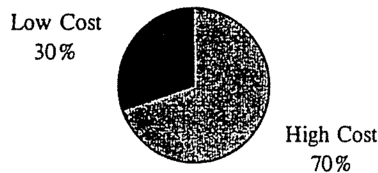
Our review of Department information on Medicaid caseloads and expenditures indicates that the number of eligibles in more costly population groups has increased by about 8 percent while the number of eligibles in less costly populations has declined by over 15 percent. In Fiscal Year 1994, expenditures for more costly population groups represented about 70 percent of total expenditures; however, by Fiscal Year 1998 expenditures for more costly population groups increased to about 76 percent of total expenditures. Changes in expenditures and number of eligibles for more and less costly eligibility groups are shown in the following charts. However, expenditures for all Medicaid population groups have increased overall, with the largest expenditure increases occurring for populations that are the most costly to serve.

Medicaid Eligibles In Low and High Cost Per Capita Eligibility Groups Fiscal Year 1994

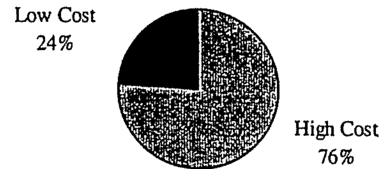
Medicaid Eligibles In Low and High Cost Per Capita Eligibility Groups Fiscal Year 1998



Total Expenditures For Low and High Cost Per Capita Eligibility Groups Fiscal Year 1994



Total Expenditures For Low and High Cost Per Capita Eligibility Groups Fiscal Year 1998



Source: Department of Health Care Policy and Financing

Note: High cost per capita eligibility groups include Old Age Pension, Aid to the Blind, Aid to the Needy Disabled, and Baby Care Adult. Low cost per capita eligibility groups include Aid to Families With Dependent Children, Foster Care, Baby Care Child, Undocumented Aliens, and Qualified Medicare Beneficiaries. Costs per capita exclude expenditures for mental health and developmental disabilities services. For 1994, there were 86,727 high cost eligibles and 191,336 low cost eligibles at a cost of $557,465,158 and $243,479,976, respectively. For 1998, there were 93,422 high cost eligibles and 161,698 low cost eligibles at a cost of $819,772,798 and $259,072,860, respectively.

During Fiscal Year 1998, the Colorado Medicaid Management Information System (MMIS) processed about 9 million Medicaid claims on behalf of Medicaid recipients. These claims covered a comprehensive package of health care services including hospital, physician, prescription, home health, durable medical equipment, mental health, assistance with daily living, and transportation. Children also received coverage for dental and vision services and immunizations.

Medicaid Programs Are Vulnerable to Fraud and Abuse

As Medicaid programs continue to grow, the magnitude of expenditures and the volume of services increase the risk of fraud and abuse. Fraud and abuse occur when program funds are used to provide services that are not necessary or appropriate, or to pay for services that were not provided. According to federal definitions, fraud differs from abuse. Fraud is an intentional deception or misrepresentation resulting in an unauthorized benefit. For example, the term "fraud" is used when a provider intentionally bills Medicaid for a service that was not provided. In contrast, the term "abuse" is used when there is a lack of intent. Abuse

occurs when a provider submits claims with errors. Abuse may occur in a single instance, or it may occur repeatedly.

Since Medicaid programs pay health care providers directly, fraudulent and abusive financial practices occur predominantly among providers rather than among Medicaid recipients. There are many types of providers, such as physicians, pharmacies, hospitals, clinics, home health agencies, nursing homes, laboratories, and therapists. Nationally, fraud and abuse schemes have been perpetrated or executed by every provider type. The examples below demonstrate some of the types of fraud schemes executed in various states around the nation during the past five years. The dollars lost to these schemes have been significant. A more comprehensive national list of over 140 known fraud schemes, by provider type, is also presented in Appendix A.

- A physician billed for two patient office calls even though only one took place, billed for office visits even though the patient missed the appointment, or billed for visits even though the office was closed or the physician was not in the office.

- A provider billed for expensive custom-made orthotics but provided the recipient with less expensive stock goods.

- A nursing facility billed and was paid by Medicaid for services allegedly provided to a resident after the resident had died.

- A laboratory billed for each test separately instead of charging one combined, lower fee, as was appropriate (unbundling).

- A provider retained its Medicaid overpayments rather than refunding them to Medicaid.

- A recipient received a kickback from a physician to use the recipient's Medicaid number to bill for services the physician did not provide.

The Growth of Medicaid Fraud and Abuse Is Costly

Federal and state governments are concerned about the growth of Medicaid fraud and abuse. The U.S. General Accounting Office (GAO) testified as follows regarding the proliferation of fraud and abuse in Medicare and Medicaid programs nationwide:

> "In summary, our work clearly demonstrated that Medicare - - serving the elderly and disabled - - and Medicaid - - serving the poor - - are overwhelmed in their efforts to keep pace with, much less stay ahead of, profiteers bent on cheating the system. Various factors converge to create a particularly rich environment for profiteers. For both programs, these include the following:
>
> - Strong incentives to overprovide services.

- Weak fraud and abuse controls to detect questionable billing practices.
- Few limits on those who can bill.
- Little chance of being prosecuted or having to repay fraudulently obtained money.

> [Nationally], Medicaid spent about $143 billion (of which $81 billion was federal aid) on behalf of 34 million recipients during fiscal year 1994. Its size, structure, target population, and state-by-state variations render the program especially vulnerable to false billings and other fraudulent activities." (Source: Medicare and Medicaid, Opportunities to Save Program Dollars by Reducing Fraud and Abuse, United States General Accounting Office Testimony Before the Subcommittee on Human Resources and Intergovernmental Relations, Committee on Government Reform and Oversight, House of Representatives, March 22, 1995.)

The cost of fraud and abuse in Medicare and Medicaid programs is difficult to estimate, although state and federal agencies have attempted to do so. Many of these estimates have been controversial. However, recent studies using statistically valid samples have provided more reliable estimates. For example, the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services estimated that, due to recent efforts to reduce Medicare fraud and abuse, the number of inappropriate Medicare payments has decreased to about 7.1 percent of claims. The federal government has estimated that at least ten percent of the nation's Medicaid expenditures (nearly $16 billion) could be avoided if waste, fraud, and abuse were identified and eliminated.

Recoveries Result from Fraud and Abuse Detection and Prevention Initiatives

Various reports prepared by the federal government indicate that, if resources are directed toward fraud and abuse prevention and recovery, the cost-benefit ratio can be exceptional. For example, Operation Restore Trust, a ground-breaking project aimed at coordinating federal, state, local, and private resources and targeting them on areas most plagued by fraud and abuse, identified $23 in overpayments for every $1 of project costs. Fraud and abuse detection and prevention cannot be a one-time effort if lasting results are to be achieved. Resources must be committed and diligent efforts to detect, recover, and prevent fraud and abuse must be persistent and ongoing.

Medicaid Fraud and Abuse Prevention, Detection, and Recovery in Colorado

The federal Health Care Financing Administration (HCFA) requires that all Medicaid programs have ongoing fraud and abuse detection activities carried out by staff trained specifically to detect fraud and abuse related to Medicaid health care services. In Colorado,

Medicaid fraud and abuse prevention, detection, and recovery is mainly the responsibility of the staff at the Department of Health Care Policy and Financing, the single state agency that administers the Medicaid program, and the Department of Law's Medicaid Fraud Control Unit. Local county departments of social services also have some responsibilities for preventing and detecting recipient fraud.

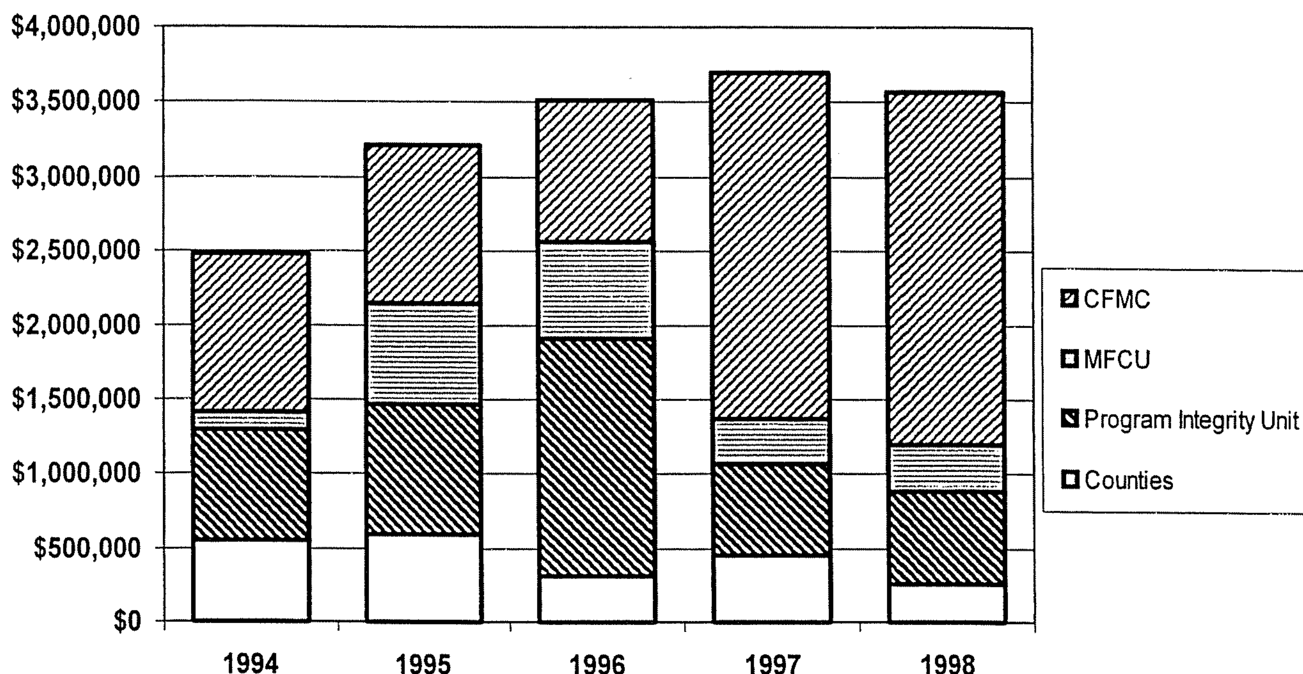
At the Department of Health Care Policy and Financing (Department), the duties of the Program Integrity Unit relate directly to reducing fraud and abuse. With a staff of four reviewers, the Program Integrity Unit reviews fee-for-service providers' billings for allowability. The Unit applies historical standards established by the federal Health Care Financing Administration and reviews about 60 of 25,232 providers per quarter, or about 1 percent of providers per year. The Unit selects providers for review through one of two methods: 1) referrals (the Unit reviews 100 percent of referrals received) and 2) analysis of claims to identify aberrant claims or "outliers." Once a provider is selected for review, it may receive either a desk (in-office) or field (on-site) review. If the review determines erroneous payments were made, the Department can request a refund of monies and impose sanctions against the provider. If the Unit determines that fraud may be involved, it refers the case to the Medicaid Fraud Control Unit. The Program Integrity Unit recovered $619,641 and $624,425 from providers in Fiscal Years 1997 and 1998, respectively. For Fiscal Years 1997 and 1998, 17 percent of referrals to the Medicaid Fraud Control Unit came from the Program Integrity Unit.

The Department also contracts with the Colorado Foundation for Medical Care (CFMC) to provide retrospective payment review of inpatient hospital claims. CFMC reviews claims for inappropriate or unnecessary treatment and excessive length of stay. During Fiscal Year 1997 and Fiscal Year 1998, CFMC reported savings to the Medicaid program of $2,329,607 and $2,365,031, respectively.

The Medicaid Fraud Control Unit (MFCU) includes a staff of attorneys, investigators, and an auditor who prepare criminal and civil cases against offenders suspected of committing Medicaid fraud. The MFCU obtains referrals from a variety of sources including federal and state agencies and the general public. In the past three years, the unit has maintained an average caseload of 40 to 50 cases. Recoveries by the MFCU were $299,846 for Fiscal Year 1997 and $311,593 for Fiscal Year 1998.

In addition to efforts by the Department and the MFCU, each county department of social services has a program integrity unit that is mainly responsible for preventing recipient abuse of the Medicaid program. During Fiscal Years 1997 and 1998, these county agencies recovered $450,370 and $263,601 respectively from recipients.

Medicaid recoveries for the past five years, by source of recovery, are displayed in the chart below.



Source: Health Care Policy and Financing and Medicaid Fraud Control Unit

The Medicaid Program Has Recently Intensified Efforts to Reduce Fraud and Abuse

Recently, the Department of Health Care Policy and Financing implemented a new Medicaid Management Information System (MMIS) managed by its new fiscal agent, Consultec. Included in the new MMIS system are many more tools for preventing and detecting fraud than existed on the former MMIS system. The Department plans to use these tools to intensify efforts to identify and curtail fraud and abuse. These tools are not yet fully implemented and will need to be monitored on an ongoing basis after implementation. Evaluation of these tools and their implementation was not included in the scope of this audit.

Two relevant footnotes to Long Bills also required the Department to 1) complete an external study of fraud and abuse and 2) evaluate the growth of home health expenditures. The Department, through the Footnote 39 study completed in 1997, developed a number of recommendations for reducing fraud and abuse. These recommendations and their current status of implementation, as reported by the Department, are included in Appendix B of this report. On the basis of the Department's response, full implementation of most of the recommendations is still in process. The Department, in its 1998 evaluation of home health

expenditure growth (Footnote 49 Study), also made numerous recommendations for improvement to home health services. The Department reports these recommendations have been adopted and that the growth in home health expenditures will slow.

We recognize the effort the Department has taken in recent years to increase its focus on curtailing fraud and abuse. These efforts reflect trends occurring nationally and in other states, as government agencies nationwide focus more intensely on detecting and preventing health care fraud. Almost without exception, increased recoveries and significant taxpayer savings have rewarded these fraud-fighting efforts.

Fraud and Abuse in Fee-for-Service and Managed Care Environments

In Colorado, Medicaid services are delivered and reimbursed according to a model that combines fee-for-service and managed care approaches. During Fiscal Year 1997, the General Assembly passed legislation requiring that 75 percent of Medicaid recipients be enrolled in managed care programs by Fiscal Year 2000. The legislation includes both the HMO and Primary Care Physician (PCP) programs in its definition of "managed care." Although the PCP program requires recipients to receive services and referrals from a single primary care physician, all services provided under the PCP program are reimbursed on a fee-for-service basis (under fee-for-service the provider bills for each service provided). Therefore, the majority of Medicaid services, including nursing facility and other long term care services, are still provided under a fee-for-service payment system. During Fiscal Years 1997 and 1998, about 72 percent of Medicaid eligibles received services through fee-for-service, including the PCP program.

Fee-for-service payment systems present risks that providers will deliver more services than necessary or bill for services they did not provide. Managed care presents risks that providers will deliver fewer services than appropriate to reduce costs and retain profit. Under both fee-for-service and managed care approaches, there are opportunities for providers to abuse the system at the expense of taxpayers and recipients. As the managed care model for delivering health care services continues to evolve, those in the health care industry, as well as the Medicaid program, will continue to identify ways that fraud and abuse are committed and—more importantly—how those practices can be detected and prevented.

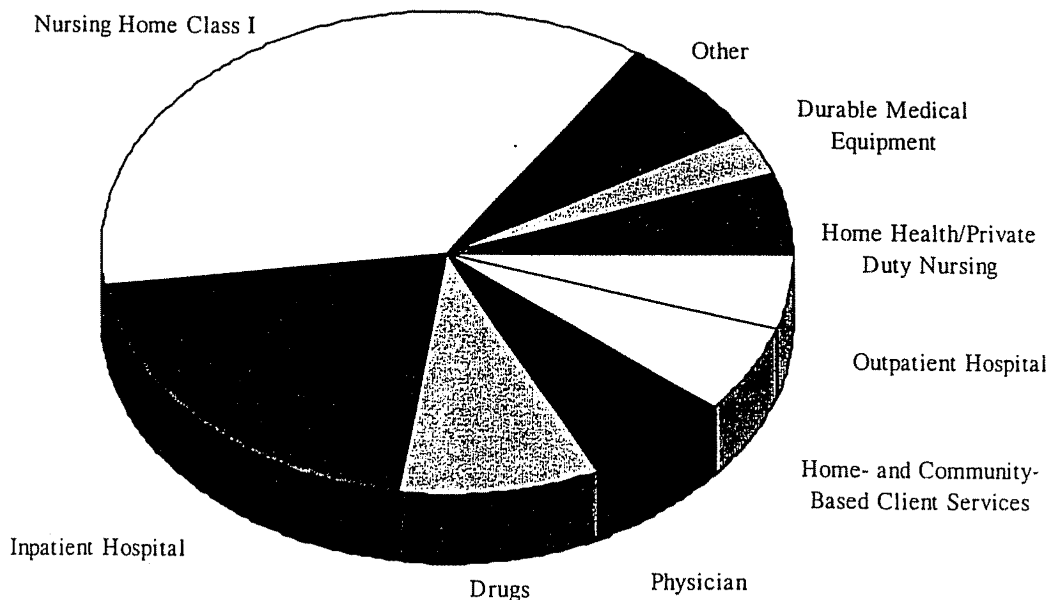
Audit Scope and Methodology

This audit reviewed the fraud and abuse activities related to health care (this includes medical transportation and home care costs) delivered under a fee-for-service approach. In Fiscal Year 1998, fee-for-service accounted for about $899 million or about 83 percent of Colorado Medicaid program expenditures directly managed by the Department of Health Care Policy and Financing. This includes the types of services and programs displayed in the following two charts.

Medicaid Fee-For-Service Program Expenditures Fiscal Year 1998	
Nursing Home Class I	$ 327,011,076
Inpatient Hospital	182,655,664
Drugs	84,185,364
Physician	59,876,905
Home- and Community-Based Client Services	51,630,924
Home Health/Private Duty Nursing	48,831,769
Outpatient Hospital	44,383,874
Durable Medical Equipment (DME)	26,209,321
Other	73,986,002
Total	$ 898,770,899

Source: HCPF Eligibility and Service Category Detail

Medicaid Fee-For-Service Expenditures



During the audit, we utilized our Medicare and Medicaid consulting experience in other states to review the Colorado Medicaid program's effectiveness in preventing fraud and abuse. We reviewed the program's policies and procedures for preventing and recovering inappropriate payments. We analyzed three months of actual paid claims data using computer assisted audit technique (CAAT) software, looking for anomalies in the data that could indicate fraudulent or abusive claims or a need for increased program oversight. We compared Colorado's practices to other states that have aggressive programs for preventing fraud and abuse—primarily Indiana and Virginia for nursing facilities and Florida for provider agreements.

Where appropriate, we recommended that Colorado adopt many of the best practices found in other states. We estimated potential recoveries for Colorado by either extrapolating from other state recoveries (when programs were similar) or from Colorado data (when limited review was already occurring).

This report discusses our review of Medicaid fraud and abuse in fee-for-service claims through two avenues: 1) methods for detecting and recovering fraudulent and abusive payments and 2) methods for deterring fraud and abuse. Our findings and recommendations follow.

Detecting Fraud and Abuse

Chapter 2

During Fiscal Year 1998, the Medicaid program provided services to 258,000 recipients at a cost of $1.09 billion. This amount excludes mental health and developmental disabilities services provided through the Department of Human Services. Both the General Assembly and the Medicaid program want to be sure that, as health care costs continue to increase, all Medicaid services and payments are appropriate and misuses and inefficiencies are identified promptly. Effective, comprehensive strategies to identify, recover, and deter inappropriate services and payments are the key to providing this assurance to taxpayers.

This chapter reviews the Medicaid program's efforts to detect and recover inappropriate payments and compares Colorado's efforts with best practices in other states. Overall, we found the Medicaid program should improve its oversight of fraud and abuse and strengthen practices for identifying and pursuing recoveries. Over a three-month period, our audit identified over $3.3 million in potential recoveries resulting from gaps in fraud and abuse detection activities and weaknesses in program practices. On the basis of estimates prepared by the federal government and recoveries obtained by other states, we estimate Medicaid fraud and abuse in Colorado could exceed $20 million per year or 1.8 percent of total expenditures. In contrast, Colorado's Medicaid program recovered an average of $3.3 million per year during the past 5 years. By applying successful practices used by other states, the Colorado Medicaid program can reduce inappropriate payments and increase recoveries. Time is of the essence since, as statutes of limitation run out and records are discarded, older fraudulent or abusive payments will be unrecoverable.

Oversight of High-Risk Areas Could Be Improved

Our audit identified gaps in the Medicaid program's oversight of several high-risk areas. Specific problems we identified include:

- **Prescription credits.** The Medicaid Fraud Control Unit (MFCU) has evidence indicating that Medicaid recipients do not pick up between 2 to 3 percent of prescriptions. Our analysis found that refunds for these prescriptions are not occurring. Of 636,701 paid claims for 656 pharmacies over a three-month period, only 735 claims, or 0.1 percent, were refunds. Of these pharmacies, 27—each having more than 2,500 paid claims—had no refunds. Medicaid rules require providers to maintain records for a minimum of six years. Therefore, if only 1 percent of all pharmacy claims over the past six years should have been refunded, recoveries would be over $3 million. If 3 percent should have been refunded, recoveries over a six-year period would be over $9 million. The Department should work with the Medicaid Fraud Control Unit to recover these funds.

- **Nursing facility audits.** Current oversight of long-term care facilities is not as comprehensive as it should be. Additionally, in-depth audits of nursing facility billing practices are backlogged. Of 191 Medicaid-licensed facilities, only 18 received in-depth reviews of billing practices and resident personal fund accounts (accounts which are held and managed by nursing facilities for the benefit of the resident) during Fiscal Year 1998. Under these circumstances it is unlikely that fraud schemes—such as 1) billing Medicaid when the resident is not at the facility, 2) billing both Medicaid and Medicare for the same covered services, or 3) failing to deduct the correct patient resource amount from the bill—will be detected. Every one of the 18 in-depth audits completed during Fiscal Year 1998 resulted in recoveries. Total recoveries for the State and for nursing facility residents were $153,310 and $18,833, respectively. If backlogs were eliminated and all nursing facility billing practices and resident personal fund accounts were audited on a systematic basis, we estimate the State could recover an additional $2 million per year (this includes testing for Medicaid credit balances and discount billing). Further, we estimate nursing facility residents would recover an additional $50,000 per year. As we discuss later in this chapter, there are additional costs for obtaining these recoveries which will depend on the Medicaid program's methods for eliminating the backlog and conducting systematic audits.

- **Questionable utilization patterns.** The Medicaid program has not systematically conducted some basic and important claims analyses. Although the Department conducts claims analysis through its Surveillance and Utilization Review Subsystem (SURS) and ad hoc reporting, its analysis does not include evaluating certain billing relationships such as 1) payments for "out-of-hospital" services provided while a recipient was hospitalized, 2) services provided on holidays, or 3) services provided after a recipient has died. Analyzing basic provider billing relationships and patterns identifies questionable service utilization. (Providers include the organizations or individuals that provide the recipient with services, including physicians, hospitals, pharmacies, laboratories, nursing facilities, and home health agencies, among others.) Although basic claims analysis does not always indicate a problem exists, it is the key to identifying high-risk practices that may be highly vulnerable to fraud and abuse.

- **Unauthorized transportation services.** The county departments of social services are required to authorize certain types of transportation for recipients, such as private vehicle mileage, taxi charges of less than $50 one way, bus, mobility van, ambulance, and air or train transportation, in advance. Medicaid regulations require counties to pay for the transportation they authorize and then seek reimbursement from the Medicaid program. Medicaid regulations prohibit county transportation providers from billing the Medicaid program directly. However, we found that 3 metro area taxi companies and 33 mobility and wheelchair van companies are billing the program directly, and the Medicaid program is paying these claims. This avoids the county authorization process, making transportation services vulnerable to fraud and abuse. Additionally, it prevents the counties from ensuring, according to Medicaid regulations, that recipients use the least expensive transportation method. The Medicaid Fraud Control Unit (MFCU) is currently investigating nine transportation providers who may have billed for inappropriate

transportation services. The MFCU has filed charges against another four transportation providers. The MFCU has identified over $100,000 in inappropriate transportation payments from these four providers.

- **Oversight of Medicare crossover claims.** There are about 53,000 Medicaid recipients who are eligible for both Medicare and Medicaid. Medicaid claims for these recipients are frequently "crossover claims," that is, Medicaid pays the portion of the claim that Medicare does not cover. Medicaid may contribute as much as 50 percent for certain types of claims. The Medicaid program typically pays all Medicare crossover claims without investigating appropriateness. During our review, we identified 8 psychologists with 2,325 fee-for-service claims totaling over $100,000 during a two-month period. Of these eight psychologists, six had the same billing address. We found that about 74 percent of the claims (1,731 claims) filed by these 8 psychologists were Medicare crossover claims for services to Medicaid recipients between the ages of 70 and 99 years. About 13 percent (295 claims) were crossover claims for 56 Medicaid recipients between the ages of 90 and 99. Additionally, we identified 34 Medicare crossover claims for psychologists' services provided on Memorial Day and 19 Medicare crossover claims for a single psychologist's services on Easter Sunday. According to Medicaid Fraud Control Unit staff, the dollar value of the Medicaid program's portion of these Medicare crossover claims (in this case, 50 percent) is greater than what the Medicaid program would have paid for the service under its own rate structure. Upon further review, we also found that, for recipients who received at least 7 psychologist's services during the 2-month period, 146 were also covered for capitated mental health services through Mental Health Assessment and Service Agencies (MHASAs). The Medicaid program paid monthly capitation fees to these MHASAs on behalf of these recipients at rates ranging between $7.49 and $93.05 per month, in addition to paying for individual psychologist's services on a fee-for-service basis. The Medicaid program and the Medicaid Fraud Control Unit have reviewed some of these claims and believe that the psychologists provided these services. However, these claims have not been reviewed for medical necessity or appropriateness. Federal regulations require that all services be medically necessary. The Medicaid program needs to evaluate the medical appropriateness of these claims. Changes to program practices within the Medicaid program or at the federal Health Care Financing Administration may be warranted.

- **Oversight of services provided by other state agencies.** Medicaid program staff could be better informed about Medicaid services provided by other state agencies. Almost 100 percent of recipients are eligible for Medicaid mental health services managed through the Department of Human Services. A significant number of recipients with developmental disabilities also receive home-based support services managed by the Department of Human Services. The Department of Health Care Policy and Financing has a Memorandum of Understanding (MOU) with the Department of Human Services to address the management of these programs. The total cost of these programs is approximately $334.5 million. According to statutes, the Department of Health Care Policy and Financing is the single state agency for administering the Medicaid program, and is ultimately responsible for all Medicaid-funded services. Federal rules also require

the Department of Health Care Policy and Financing to be accountable for all Medicaid services. Currently the Department provides little oversight of MOU requirements. As the single-state agency for Medicaid services, the Department must be diligent in assuring that recipients served by multiple programs are receiving necessary services at an appropriate cost.

- **Oversight of county functions.** By statute and Medicaid program policy, counties perform a number of functions on behalf of the Medicaid program, including determining eligibility and monitoring for recipient fraud. Counties are also responsible for recording date of death for Medicaid recipients. Currently the Medicaid program has serious concerns about the accuracy of date of death information recorded by counties and the Medicaid program is querying counties about recording practices. Our audit work identified a number of instances where the Medicaid program paid claims for services provided after a recipient's date of death. The Medicaid program needs to be more involved in oversight of county operations that impact program services and payments.

- **Implementation of prior recommendations.** In its internal study of Medicaid fraud and abuse, completed as required by Footnote 39 of Senate Bill 98-216, the Medicaid program made a number of recommendations for improving its oversight of fraud and abuse in Colorado. Out of 10 recommendations, we noted three important recommendations that have not been implemented. According to the Medicaid program, resource constraints have postponed implementation of one of the recommendations. Development of a new request for proposal and implementation of the new Consultec system have postponed implementation of the other two recommendations. These recommendations address controls to determine if lab tests, prescriptions, hospital billing adjustments, and emergency care practices are appropriate. Implementation of these recommendations should be a high priority. The Medicaid program should take steps to implement them as soon as possible.

The professional literature and a review of best practices from other states indicate that, to curtail fraudulent and abusive practices and increase recoveries, the Medicaid program must intensify its fraud-fighting efforts and expand its oversight of high-risk programs. This should include heightening accountability and improving the coordination of all fraud-fighting functions, including those performed by counties, other state agencies, and contractors such as the Colorado Foundation for Medical Care and private auditing firms. Specifically, the Medicaid program must implement a comprehensive fraud-fighting plan that 1) reviews all aspects of the Medicaid program for weaknesses, 2) integrates all fraud and abuse oversight functions, and 3) closes gaps that permit inappropriate payments. Additionally, the program needs to evaluate and reallocate resources available for fighting fraud and abuse, increase analytical claims review, and intensify fraud prevention efforts as discussed later in this chapter and in Chapter 3. With program costs of over $1 billion annually, accountability for preventing and curtailing fraud and abuse should be among the Medicaid program's highest priorities.

Recommendation No. 1:

The Department of Health Care Policy and Financing should develop an overall framework to heighten accountability for fighting Medicaid fraud and abuse. This framework should include a strategic plan that identifies weaknesses in current program operations, integrates fraud and abuse fighting activities, and closes gaps that permit inappropriate payments.

Department of Health Care Policy and Financing Response:

Agree. Although the Department submitted a fraud and abuse plan to the federal government on December 19, 1997, and updated the federal Health Care Financing Administration on that plan in June 1998, it does not contain the level of depth that is referenced in the auditor's report. We are currently developing a formal overall framework and will complete it by December 1, 1999. As part of its strategy, the Department will continue to utilize prior authorization as a fraud, abuse, and waste deterrent.

Evaluate Resources Available for Fighting Fraud and Abuse

As discussed in Chapter 1, the professional literature indicates that significant resources must be committed to detecting and deterring fraud and abuse in public-funded health programs. Further, experts indicate that if resources are committed, taxpayers benefit from substantial savings. Federal efforts to find and recover fraudulent and abusive payments have been highly cost-beneficial. Operation Restore Trust, which targets anti-fraud efforts to areas most plagued by abuse, has identified $23 in overpayments for every $1 invested. Similarly, a Medicare demonstration project found that increased efforts to review claims reduced program losses by half.

The Medicaid program has not undertaken a comprehensive, system-wide evaluation of its resources committed to fighting fraud. These resources include the Program Integrity Unit, the fiscal intermediary Consultec, the Medicaid Fraud Control Unit, the Colorado Foundation for Medical Care, audit contractors, and county and Department of Human Services monitoring staff, among others. As part of its strategic plan, the Medicaid program needs to evaluate how its resources are deployed, determine whether resources should be redistributed to increase their fraud- and abuse-fighting potential, and whether additional resources are needed.

In the past, the Medicaid program has reviewed its resource requirements for fraud-fighting activities on an ad hoc, as needed basis. Department staff note that they have looked for creative ways to use staff more efficiently and made efforts to obtain additional resources

with little or no impact on state general funds. We believe the program should expand these efforts through a broad, system-wide resource analysis including the steps below.

First, the program should consider the feasibility of reallocating current state dollars to leverage additional federal funds for intensifying oversight of fraud and abuse. For example, the Medicaid Fraud Control Unit (MFCU) is funded by 75 percent federal funds and 25 percent state general funds. Similarly, nurse claim reviewers, located in the Program Integrity Unit, are funded through 75 percent federal funds. Additionally, services performed by contract through the Department's Peer Review Organization, Colorado Foundation for Medical Care (CFMC), are also funded by 75 percent federal funds. In contrast, effective October of 1999, most other Medicaid functions and services will be funded by 50 percent federal funds and 50 percent state general funds. If the Medicaid program identifies resources in one area that could be reallocated to intensify fraud-fighting activities—such as taking dollars from programs funded by a higher percentage of state general funds and using them to fund MFCU investigators or nurse claims reviewers—it could bring in significantly more federal funds. For example, under most Medicaid functions and services, $50 in general funds brings in $50 in federal funds. By applying the same general funds to nurse auditors or the MFCU, $50 brings in $150 in federal funds—or three times the previous amount. Similarly, by replacing program activities that receive a $50-to-$50 match rate with activities that can be appropriately contracted through CFMC, the Medicaid program can receive $150 for the same $50 general fund contribution. To increase federal funds and retain the original general fund appropriation, the Medicaid program requires the approval of the General Assembly through the appropriation process. With the General Assembly's approval, this is one way the Medicaid program could expand the resources available for investigating and prosecuting fraud and abuse without increasing the state general funds required to do so.

Second, the Medicaid Fraud Control Unit should seek legislative approval to retain a portion of the funds it recovers through seizure of funds and property. Currently all funds obtained through seizures are returned to the federal government and the State General Fund. Other state agencies, such as the Colorado State Patrol and Colorado Bureau of Investigation, are permitted to retain funds from seizures and use them to improve or increase operations. The MFCU could use the funds to address resource needs and enhance fraud-fighting activities. Similarly, the Medicaid Program Integrity Unit could evaluate the impact and feasibility of retaining a portion of its fraud and abuse recoveries for expanded fraud-fighting efforts. However, since the Program Integrity Unit is responsible for both preventing and recovering fraudulent and abusive payments, the Medicaid program would need to provide the General Assembly with strong evidence that adequate, state-of-the-art fraud prevention controls are in place before seeking approval to retain a portion of recoveries. We discuss the Medicaid program's fraud prevention efforts in more detail in Chapter 3.

Third, the Medicaid program plans to expand its use of contingent fee arrangements to detect and recover inappropriate payments. However, additional work is needed to identify the areas where expansion is most appropriate. Under a contingent fee arrangement, the Medicaid program contracts with a firm to pursue a recovery and the contractor receives a

percentage of the actual recovery as its fee. The Department of Health Care Policy and Financing currently has one contingent fee arrangement with a law firm to pursue inappropriate payments in federal court. Contingent fee arrangements offer a number of advantages to the Medicaid program:

- **Efficient use of resources.** Significant staff resources are required to pursue recoveries in neglected areas, especially if the payments are several years old. Both the Medicaid program and the MFCU believe they lack staff for an effort of this magnitude. Under a contingent fee arrangement, the State hires an outside contractor to pursue recoveries. The State receives the benefit of additional recoveries without hiring additional staff. The arrangement is budget-neutral because the contractor is paid a percentage of the recovery and receives payment only if the recovery is successful.

- **Flexibility.** Contingent fee arrangements provide the Medicaid program with flexibility to determine how many contracts it needs and adjust the number of contracts as circumstances change. Typically, recoveries are larger at the outset but decline as recovery efforts continue. Therefore, fewer contingent fee arrangements may be needed as time passes. As scrutiny increases, providers become less careless and are more likely to comply with program requirements.

Fourth, the Department needs to determine which resource options are best for pursuing recoveries in specific program areas. For example, contingent fee arrangements may be most feasible for programs where high recoveries are likely and intensive efforts are necessary to curtail abusive practices. Home health and nursing facilities, discussed later in this chapter, may be good examples of these types of program areas. Redistribution of resources or leveraging of federal funds may be an appropriate option for expanding analytical reviews, investigations, and on-site utilization reviews.

Finally, the Department may determine that additional resources are required in some areas to provide appropriate levels of oversight, curtail abusive practices, and increase recoveries. If so, the Department should conduct an appropriate workload analysis to substantiate its need for resources and develop a plan for acquiring them. A comprehensive plan addressing the acquisition and distribution of resources, as we have discussed, is key to ensuring adequate resources are available and committed to curtailing fraud and abuse.

Recommendation No. 2:

The Department of Health Care Policy and Financing should, in conjunction with the Medicaid Fraud Control Unit and any other appropriate agencies, undertake a comprehensive evaluation of the distribution of statewide resources dedicated to curtailing fraud and abuse. The evaluation should:

1) Investigate the feasibility of leveraging current state general funds to obtain additional federal funds for qualified fraud-fighting activities.

2) Identify areas where the Department should expand its use of contingent fee arrangements.

3) Result in a plan for redistributing resources and, if necessary, acquiring additional resources to intensify fraud-fighting efforts.

Additionally, the Department should seek the approval of the General Assembly for federal fund leveraging through the appropriation process. The Department and the Medicaid Fraud Control Unit should evaluate the impact and feasibility of retaining a portion of funds obtained from seizures and recoveries for expanded fraud-fighting activities, upon evidence of strong fraud prevention controls.

Department of Health Care Policy and Financing Response:

Agree. Over the past two to three years, the Department has assessed resources, resulting in the request to pursue contingency fee-based contracts, requiring little to no General Fund dollars. This Fiscal Year 2000 Budget Request Decision Item was approved and we are currently drafting a Request for Information for interested vendors based on that authorization. In addition, the Department has acquired new state-of-the-art MMIS fraud-fighting tools and an advanced provider profiling system to improve the efficiency of staff resources. We agree that resource evaluations are important.

The Department agrees to conduct a comprehensive review of resources, in light of the apparent resources necessary to implement the recommendations in this report. The Department aims through its analysis to identify where current resources can be reapplied and where requests for resources need to be forwarded to the General Assembly.

Medicaid Fraud Control Unit Response:

Agree. The Medicaid Fraud Control Unit will work with the Department of Health Care Policy and Financing as requested.

Review Programs for Weaknesses that Permit Payments for Fraudulent or Abusive Claims

On the basis of our review, the Medicaid program needs to undertake a comprehensive review of its programs with an eye toward identifying policies and practices that encourage fraud and abuse. Areas we specifically identified through our audit work are discussed below.

Recover Prescription Credit Refunds from Pharmacies

According to Department staff, the problems with pharmacy credit refunds, discussed previously in this chapter, resulted from gaps in procedures for tracking, recording, and refunding credits for prescriptions that were not picked up by recipients. The cumbersome manual method for the pharmacies to process credits also contributed to the problem. The Department has recently taken steps to address these gaps, including:

- **Establishing time frames for returning prescriptions to inventory.** In the past, there were no time limits to determine the point when a prescription should be returned to inventory. The Department has now established a 15-day limit for this purpose. If the recipient does not pick up the prescription within 15 days, the pharmacy must return the prescription to inventory and establish a prescription credit due the Medicaid program.

- **Increasing the time frame for pharmacies to refund prescription credits to the Medicaid program.** Formerly, pharmacies were required to complete paper work and refund prescription credits to the Medicaid program within 24 hours of returning the prescription to inventory. If the pharmacy was busy, staff were not able to complete the refund within the required time and, as time passed, the paper work was never completed and the refund never occurred. Pharmacies now have a 15-day time limit to execute the refund. Refunds executed after the 15-day time limit are not in compliance with program policies.

- **Requiring pharmacies to track prescription credits through inventory logs.** Until recently, pharmacies were not required to maintain accurate inventory logs. Pharmacies are now required to maintain this information. However, pharmacies are not required to have Medicaid recipients sign for prescriptions before picking them up. Most insurance programs require their clients to sign for prescriptions. Requiring recipients to sign for prescriptions would provide an audit trail and help pharmacies maintain accurate inventory records.

- **Establishing automated procedures to prevent payment for the same prescription twice.** In the past, recipients who did not pick up their prescriptions could return to their physician, request another prescription, and get the prescription filled at a different pharmacy. If the first pharmacy did not execute a refund, the Medicaid program paid for the same prescription twice. The Medicaid program recently established automated procedures preventing payment for the same prescription more than once during a thirty-day period. If recipients do not pick up their prescriptions and decide later to do so, they must return to the first pharmacy to obtain the prescription.

Medicaid program staff believe that these steps will significantly increase the number of prescription refunds and reduce abusive pharmacy practices. However, we estimate that over the past six years, between $3 and $9 million in unrefunded pharmacy credits exist from prior weaknesses in the pharmacy program. The Medicaid Fraud Control Unit reports that, due to

the lack of audit trails at small pharmacies, some of these funds will never be recovered. The Medicaid program must take aggressive steps to recover prescription refunds from larger pharmacies where audit trails still exist. Further, Medicaid Fraud Control Unit staff report that some states have set percentage thresholds, such as 1 percent, for recovering prescription refunds. These states are notifying pharmacies that have made few refunds over several years and are requiring them to refund the amount of the percentage threshold. Colorado's Medicaid program could consider a similar approach. Finally, the Medicaid program must provide ongoing monitoring in the future to make sure prescription refunds are occurring as expected under the newly established practices.

Recommendation No. 3:

The Department of Health Care Policy and Financing should work with the Medicaid Fraud Control Unit to recover past-unrefunded prescription credits. Additionally, the Department should monitor future prescription refunds to make sure its new pharmacy program controls are working as intended. Finally, the Department should require pharmacies to obtain signatures from Medicaid recipients before giving the prescription to the recipient.

Department of Health Care Policy and Financing Response:

Agree. The Department will work with the Medicaid Fraud Control Unit (MFCU) to obtain the uncollected funds from prescriptions that were billed to Medicaid but not picked up by the recipient when documentation is available. Smaller pharmacies may not and often do not keep records of returned-to-stock items. Recovery in these circumstances is not possible. If a determination is made that the Department is the appropriate agency to pursue this matter, investigative materials will be transferred from MFCU to the Department for completion of recoveries. The Department may enter into a contingency contract with an outside contractor as a method of collecting these recoveries. This will require the submission of a request for information, a request for proposals, coordination with the Medicaid Fraud Control Unit, and contract negotiations; hence the May 1 date.

By rule, the Department will require all Medicaid pharmacy providers to:

1. Require that all prescriptions billed to Medicaid, but not picked up within 14 days, will be credited back to Medicaid on the 15th day, and

2. Obtain the signature of the Medicaid recipient in the chronological log at the time of dispensing a prescription.

Medicaid Fraud Control Unit Response:

Agree. The Medicaid Fraud Control Unit will work with the Department of Health Care Policy and Financing to recover past-unrefunded prescription credits.

Expand Nursing Facility Audits

Previously, we discussed how very few nursing facilities receive in-depth reviews of their billing practices or personal needs funds. Our review of best practices in other states indicates that substantial recoveries occur when all nursing facilities receive in-depth audits on a systematic basis. For example:

- **Billing practices.** The states of Virginia and Indiana perform detailed reviews of billing practices at all nursing facilities on a two-to-three year cycle and have made sizeable recoveries for their respective Medicaid programs. However, due to a backlog, Colorado is currently only performing in-depth billing reviews when a facility changes ownership. If backlogs continue, and a facility does not change ownership, there is little likelihood that they will receive an in-depth review of their billing practices. We estimate that, if the rate of recovery for all Colorado facilities were the same as those receiving in-depth audits, the Medicaid program could recover an additional $1.2 million per year.

- **Personal needs funds.** The state of Virginia also systematically reviews personal needs fund accounts at all nursing facilities on a two-to-three-year cycle. In the past year, Virginia identified fraud involving personal needs accounts at 10 facilities. The Colorado Medicaid program reviews very few personal needs fund accounts. We estimate that by reviewing all of these accounts on a systematic basis, resident accounts could be refunded a minimum of $50,000 per year.

- **Discount billings.** State regulations require the Medicaid program to pay the lowest rate at any nursing facility. In other words, the program should never pay a rate that is higher than any other payor (other payors could include the patient, his or her family members, or an insurance company). The Medicaid program requires facilities to self-report the rates they are billing their various clients. Program staff monitor these on a monthly basis. However, the Medicaid program never verifies that it is actually paying the lowest rate, as reported by nursing facilities. One way the program could verify this would be to review for discount billings through nursing facility audits. The state of Indiana tests for discount billings at nursing facilities on a three year cycle, with high-risk providers being reviewed more frequently. It has recovered $1.8 million over three years, an average of $13 per bed per year. We estimate that, by systematically auditing discount billings at all Colorado nursing facilities, the Medicaid program could recover a minimum of $225,000 per year.

- **Credit balances.** A credit balance occurs when a nursing facility owes money back to the Medicaid program for services it billed, but did not provide, or was paid in error. For example, a nursing facility may have billed the Medicaid program for services when a recipient was discharged. The facility corrects this by showing a credit balance on the patient's account in its accounting system. Although the credit balance appears "on paper," the nursing facility may not have actually returned the funds to the State. The

state of Virginia recovered almost $6.7 million over five years, an average of about $46 per bed per year, by monitoring credit balances. We estimate that, by systematically reviewing credit balances at all Colorado nursing facilities, the Medicaid program could recover a minimum of $850,000 per year.

To improve recoveries and deter abusive practices at nursing facilities, the Medicaid program should perform comprehensive reviews of all nursing facility billings on a systematic basis. This would include reviewing high-risk providers on an annual basis, while lower risk providers would be reviewed every two to three years. Contracts for in-depth audits could cost up to $10,000 per facility. Depending on how frequently the Medicaid program determines in-depth reviews are necessary, these costs could be significant. Therefore, the program will need to evaluate a number of options for ensuring systematic in-depth audits occur. For example, the Medicaid program could reevaluate the activities of its current audit functions to determine whether more comprehensive, systematic reviews could be conducted in-house, through its long-term care audit contractor, through a contingent fee arrangement, or through some combination of these approaches. Since recoveries typically drop after intensive review processes are in place and abusive practices have been curtailed, a contingent fee approach may be the most feasible alternative.

Recommendation No. 4:

The Department of Health Care Policy and Financing should address the gaps in current nursing facility audit practices by ensuring all nursing facilities receive in-depth reviews of billing practices—including review of discount billings and credit balances—and personal needs funds on a systematic basis. In evaluating its resources, the Department should determine whether to use contingent fee arrangements for this purpose.

Department of Health Care Policy and Financing Response:

Agree. The Department will review the feasibility of incorporating the recommended changes in the existing audit program for nursing facilities. This would change the scope of work of the contract auditors and require some additional resources to implement, which will require a legislative appropriation. The Department will also include nursing facilities in the contingency based contracting initiative underway in the Quality Assurance section to increase in depth analysis of billing practices. The Department has added features to the new MMIS to highlight those provider billing practices which indicate high risk for erroneous billings. The plan is to target these high-risk providers for in-depth reviews. Through these plans, the Department will enhance its efforts to find additional savings that are relative to the Colorado program.

Improve Oversight of Home Health Services

Home health services are skilled services ordered by a physician and provided in the recipient's home. Currently 151 providers deliver home health services to Medicaid recipients in Colorado. Home health services are easily confused with Home- and Community-Based Services (HCBS)—services which are also provided to recipients in their homes. HCBS services differ from home health services, however. HCBS services are unskilled services that typically assist recipients with tasks of daily living (for example bathing, cleaning, or meal preparation). In contrast, home health services are provided by skilled staff, such as nurses, nurse aides, and physical, speech, or occupational therapists, who attend to the recipient's medical needs. Private agencies, located in communities, typically offer both home health and HCBS services. Home health and HCBS services are both intended to avoid costly nursing facility or inpatient hospital care.

During the past nine years (Fiscal Years 1990 through 1998), home health expenditures have increased dramatically. Expenditure growth has been at least 20 percent per year, with 30 percent expenditure increases occurring during the past 4 years. Colorado home health expenditure growth rates have been similar to home health expenditure growth in Medicare programs nationwide. Home health expenditure increases for Medicare have averaged 27 percent annually between 1990 and 1997.

These expenditure increases greatly concerned members of the Joint Budget Committee. As a result, the Committee introduced Footnote 44 to House Bill 98-1401 (Long Bill) requiring the Department of Health Care Policy and Financing to report on the growth of home health programs. The footnote also asked the program to report on changes to home health services resulting from actions taken by the federal government and to make recommendations for improving the home health program. In response to the footnote, the Department performed a comprehensive review and reported back to the Joint Budget Committee in the fall of 1998. The Department's study concluded that:

- Home health services have been very effective in preventing hospitalizations.
- Some home health services, specifically the "assess and teach" nursing visits, appear to be overutilized.
- Not all home health recipients evaluated in the sample were actually homebound as required by program rules.
- Home health providers are unbundling (i.e., billing separately) for a combination of home health aide and HCBS personal care/homemaker care visits occurring on the same day.

The Department's study recommended strong action to prevent abuse and curtail the growth of home health expenditures, including:

- Limiting reimbursement for "assess and teach" nursing visits.
- Strengthening record keeping requirements.
- Strengthening and increasing monitoring of Single Entry Point agencies.

- Enacting new rules to facilitate termination of problem providers.
- Convening a Home Health Reimbursement Task Force to review findings and advise the Department in decisions regarding changes in reimbursement methodology.

The report indicates the recommended changes have been adopted and that home health expenditure growth should slow. However, we believe that, unless the Department further expands its post-payment review of home health services, growth containment will be hampered.

Post-payment review, which reviews a sample of claims after payment occurs, is the Medicaid program's only method of making sure home health payments and services are appropriate. However, the Medicaid program reviews few home health agencies. For the 36-month period beginning July 1, 1996, only 61 providers, or less than 15 percent annually, received post-payment review. Of these, over half owed money back to the State and recoveries totaled over $276,000. Given the explosive growth in home health expenditures, the Medicaid program's approach to post-payment review must be more aggressive. Medicare has seen a decline in home health expenditure growth in recent years. It has attributed the decline to a number of factors, including increased scrutiny of home health claims and implementation of new anti-fraud measures.

The Medicaid program needs to take immediate steps to increase post-payment review for home health providers and to attempt recovery of past inappropriate payments, especially those identified in the Footnote 44 study. Contingent fee contracts could be used for this purpose. Increased post-payment review, along with the recommendations in the Footnote 44 study, will reduce this program's vulnerability to fraud and abuse.

Recommendation No. 5:

The Department of Health Care Policy and Financing should extend oversight of home health agencies through increased post-payment reviews.

Department of Health Care Policy and Financing Response:

Agree. Beginning in 1997, the Department, in concert with the desire of the General Assembly, embarked on focused review and policy revision relating to home health. We endorse the auditor's affirmation of our continued focus in this area. If resources can be re-allocated or if contingency-based contracting is an effective avenue, the Department will expand its post-payment review of home health.

Require Prior Authorization for County Transportation Services

As we discussed earlier in this chapter, the Medicaid program is not enforcing its regulations requiring transportation providers to receive prior authorization from counties and to bill the counties for transportation services. Statewide, the program pays about $4 million per year for county-authorized transportation. However, to expedite payment, the program is allowing three metro area cab companies to bill the Medicaid program directly. This practice avoids the prior authorization process. Additionally, the program allows wheelchair van companies to provide services without prior authorization. Recently, several instances of billing abuse by wheelchair van companies have been reported. These instances are currently under investigation by the MCFU.

It may be more efficient for the Medicaid program to allow certain transportation providers, such as the three metro cab companies, to bill directly for services. However, the program needs to revise its regulations accordingly, and provide an alternative mechanism for ensuring transportation services, including wheelchair van services, are authorized by counties. The Medicaid program should require transportation providers to include a prior authorization number, obtained from counties, on their billing statements. The fiscal agent should then verify with counties that the authorization number and corresponding services are correct before paying the bill.

Recommendation No. 6:

The Department of Health Care Policy and Financing should revise its regulations to allow transportation providers to bill the fiscal agent directly for transportation services. Additionally, the Department should require the fiscal agent to verify that counties authorized the transportation services, including wheelchair van services, before paying the bill.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees that when transportation services are billed directly to the fiscal agent, there should be a check for the prior authorization. The Department will review and clarify the rule as necessary. The Department agrees to pursue the submission of all reasonable bills to the fiscal agent and will analyze the system costs associated with the increased efforts. A Budget Request Decision Item will be prepared and submitted if it is found necessary. It should be noted that tying payment to prior authorizations for payment may cause reimbursement delays for providers who are not accustomed to completing these steps and will cause an additional strain on claims processing.

Increase Analytical Review of Claims to Identify Questionable Payments

During our review, we conducted a variety of queries on a subset of Medicaid claims data and identified questionable utilization patterns that had not come to the attention of Medicaid program staff previously. One example we discussed earlier in this chapter was the volume and nature of claims paid to psychologists for services provided to a small segment of Colorado Medicaid recipients. We have suggested the Medicaid program look into the medical necessity of these claims. Without further investigation by the Medicaid program, other providers may adopt similar practices and utilization of and expenditures for these services will increase. If the Medicaid program determines these services are not appropriate, it should aggressively initiate edits, prepayment reviews, or post-payment reviews to stop or recover inappropriate payments.

One way the Medicaid program can become better aware of high-risk areas is to expand its analytical review of paid claims looking specifically for inappropriate billing relationships. Using specialized audit software, we performed analytical reviews of questionable billing relationships observed in paid claims. Although questionable billing relationships do not always result in problems or recoveries, ongoing review of these relationships is an important control for curtailing fraud.

Recently the Medicaid program acquired two new fraud-fighting systems through its new fiscal agent, Consultec. These automated subsystems, the Rapid Surveillance and Utilization Review Subsystem (Rapid SUR System) and the Services Tracking, Analysis, and Reporting System (STARS) generate reports identifying questionable service and billing patterns. The Medicaid program also has an interim reporting system called CRYSTAL. Program staff review these reports and when warranted, conduct further investigations.

These new systems promise increased capacity to do the types of analytical claims review we are suggesting. However, it is too early to determine whether these subsystems will deliver all of the fraud-fighting potential promised by the contractor. As with any new automated system, it will be important for the Medicaid program to evaluate the system's effectiveness in analyzing paid claims after it has been in place for a year or so. If there are weaknesses in some areas, the program may need to work with the contractor to upgrade the system or obtain additional software—such as computer assisted audit technique (CAAT) software—to conduct ad hoc claims analysis as required. CAAT software is relatively inexpensive and can be purchased for as little as $2,000. This software can also be used to supplement claims review in creative ways, such as comparing data maintained on the Consultec system to data maintained on other computer systems.

Finally, the professional literature indicates that computerized review of claims alone is not enough to reduce the prevalence of fraud and abuse. Expanded review of claims and problem areas, as we have suggested earlier, is also necessary. A recent study completed by the U.S. Department of Justice states:

> "However artfully constructed, automated defenses can never substitute for human common sense and will never be able to spot suspicious patterns that have not been seen before and for which they were not looking. . . effective fraud control systems must deal with . . . sophisticated, well-educated criminals, some medically qualified, some technologically sophisticated, all determined to steal as much and as fast as possible."

In the end, the Medicaid program will need to use a combination of automated and manual techniques to expand its review of programs and address the problem areas we have identified. This could include expanding claims analysis through automated techniques and increasing post-payment review and auditing functions. A comprehensive effort will both increase recoveries and curtail fraudulent and abusive practices occurring in vulnerable programs.

Recommendation No. 7:

The Department of Health Care Policy and Financing should undertake a comprehensive review of high-risk programs that result in inappropriate payments and modify its policies and procedures to prevent payment of inappropriate claims. To achieve this, the Department should expand analytical review of paid claims to identify high-risk areas, acquiring additional computer software if necessary. The Department's review should include, at a minimum, pharmacy claims, psychologists' fee-for-service payments, nursing facility payments, home health payments, and county transportation services, as discussed above. Where the Department finds appropriate heavy utilization in one portion of the State but not in others, it must anticipate the additional expenditures that will be required as the providers take those services to additional communities.

Department of Health Care Policy and Financing Response:

Agree. The Department appreciates the validation of our continued emphasis of high-risk areas provided in the auditor's recommendation. The Department has already conducted a continuous, significant, and productive informal review that resulted in our targeting of high-risk providers such as home health, pharmacy, durable medical equipment, transportation, and Home- and Community-Based Services. The Department agrees to conduct a formal comprehensive review of high-risk programs by December 1, 1999, and make that information available to the Legislative Audit Committee by January 31, 2000.

Improve Management of "Explanation of Medicaid Benefit" Notices

Currently the Medicaid program sends out "Explanation of Medicaid Benefit" notices (EOMBs) to a randomly selected sample of recipients each month. An EOMB is similar to the statements many policyholders receive from their insurance companies. It sets forth Medicaid's service dates, the name of the provider, the type of service provided, and the amount paid. The EOMB samples are small—mailed to between 450 to 550 recipients, or about 0.1 percent of the average number of monthly fee-for-service paid claims. In contrast, private insurance companies send benefit notices for 100 percent of paid claims. Medicaid recipients are asked to review their EOMB and mail it back to the Medicaid program, identifying any services that were paid for, but not provided.

Medicaid program staff indicate the EOMB is an ineffective tool for identifying fraudulent or abusive payments. Response rates are low. Depending on the month, the program may receive responses from as little as 7 percent of the sample. The Medicaid program does follow up on any questionable services identified through the EOMBs; however, it has achieved few recoveries.

We believe the EOMB can be a useful tool for fighting fraud and abuse and could result in more substantial recoveries if used to target high-risk areas. In the past, the Medicaid program selected its EOMB sample randomly. Given the small sample size and the variety of services and providers included in the sample, it is not surprising that recoveries were low. Under its new fiscal agent the Medicaid program now has the capability to target its EOMB sample toward certain types of procedures, services, or providers. The Medicaid program should use EOMBs to target high-risk services to identify problem providers.

Medicaid program staff continue to doubt the usefulness of EOMBs even when targeted toward high-risk areas. Therefore, the program should target EOMBs on a pilot basis and determine if recoveries improve. If targeting EOMBs proves ineffective, the Medicaid program can always discontinue using them.

Recommendation No. 8:

The Department of Health Care Policy and Financing should target Explanation of Medicaid Benefit samples toward high-risk providers and services on a test basis.

Department of Health Care Policy and Financing Response:

Partially agree. In its years of experience in sending EOMBs, the Department has not seen EOMBs as a cost-effective way to identify recoveries and curb fraud and abuse. To send EOMBs is a requirement of the federal government, but HCFA staff admit that states do not tend to find this as a useful tool and do the minimum requirements to

meet their conditions for certification of the MMIS. However, the Department will target a sample of providers to identify whether targeting improves the usefulness of the responses.

Deterring Fraud and Abuse

Chapter 3

In Chapter 2 we discussed how, by expanding efforts and redirecting resources to detect and recover fraudulent and abusive payments, the Colorado Medicaid program could recover an additional $3.3 million dollars annually. Through intensive efforts to recover inappropriate payments made during the past six years, recoveries could be significant. (Medicaid rules require providers to maintain records for a minimum of six years.) However, it is not sufficient to limit fraud control efforts to recovery of past payments; fraud must be stopped before it has an opportunity to occur. Deterrence is vital since it is time-consuming and expensive to recover payments from a provider. Further, if a provider has filed bankruptcy or disappeared, funds may never be recovered. (Providers are the organizations or individuals that provide the recipient with services, including physicians, hospitals, pharmacies, laboratories, nursing facilities, and home health agencies, among others.)

This chapter focuses on the Medicaid program's practices for preventing fraudulent or abusive payments. Again, we found the program needs to further strengthen efforts to deter fraud and abuse. Specific improvements to provider application and records management processes are needed. Additionally, the program needs new legislation to curtail abusive practices and facilitate prosecution and recovery. Our suggestions for addressing these issues follow.

Close Gaps in the Provider Application Process

The current provider application process leaves the Colorado Medicaid program particularly vulnerable to fraud and abuse. We found significant weaknesses in Colorado's process when compared to provider application practices in Florida. Florida enacted new, stringent enrollment guidelines in December 1995. Although information is not available to precisely estimate the savings that would result by addressing these gaps in the application and enrollment process, Florida has estimated substantial savings from implementing its fraud prevention actions. The federal Health Care Financing Administration has held out the Florida program as a model for the rest of the nation to emulate. The chart that follows highlights some of the differences between Florida and Colorado's application and enrollment practices.

Comparison of the Florida and Colorado Provider Application and Enrollment Requirements

Requirement	Florida "Model Program"	Colorado
Site reviews for high-risk providers.	Yes	No
Criminal background checks.	Yes	No
Surety bonds for high-risk providers.	Yes	No
Detailed disclosure of related party arrangements.	Yes	No
Re-enrollment of existing providers.	Yes	No

The chart shows a number of gaps in Colorado's application and enrollment processes. We discuss these gaps, along with other weaknesses we identified through our review, in more detail below:

- **The program does not verify documentation submitted by providers.** Once a prospective provider completes and submits the required forms to the fiscal agent, the provider is admitted to the Medicaid program. The program does not verify the accuracy of the forms before admission and thus, cannot be sure that the provider has submitted accurate information. For example, a prospective provider must include a photocopy of its current license or certification when applying for enrollment. Since the program does not verify the validity of the license, a provider could produce a fraudulent out-of-state medical license and be enrolled into the Medicaid program. Colorado licensing agencies do not monitor or oversee these out-of-state providers. It is possible some providers may not be legitimate. Following up with the appropriate licensing agency in another state would confirm the accuracy of these providers' representations, ensure that providers have appropriate qualifications, and highlight problems that could otherwise expose the Medicaid program to fraud and abuse.

- **The program does not make sure all high-risk providers receive periodic site visits.** Certain types of providers, such as hospitals, nursing facilities, and home health agencies, receive periodic site visits by the Department of Health, the licensing agency. Other provider types, such as physicians and durable medical equipment suppliers, do not receive site visits. Without a periodic site visit, even if brief, there is no guarantee that a provider physically exists. Florida requires site visits for high-risk providers (including durable medical equipment suppliers, private transportation companies, home health agencies, non-physician-owned clinics, and independent laboratories) to reduce fraud and abuse. Colorado's Medicaid program should establish a similar approach and visit high-risk providers before admission and upon reapplication (discussed later in this chapter). To reduce costs, it may be possible to work with county agencies to perform these site visits.

- **The program does not conduct criminal background checks of providers before admission to the program.** Colorado's application forms also do not request key information, such as social security numbers and date of birth for owners and officers, so that a criminal background check can be completed. Adequate criminal background checks, if in place, would furnish assurance that a provider has not been convicted of a felony, made false representations or omissions of material fact, or been excluded, suspended, terminated, or involuntarily withdrawn from Colorado's Medicaid program or any other state's Medicaid program. New Jersey recently implemented criminal background checks on new Medicaid laboratory providers when it was inundated with sham laboratories. The New Jersey Medicaid Fraud Control Unit reviewed each laboratory's application before admission. Similarly, Florida requires all applicants to submit fingerprints with their applications. These fingerprints are checked against the Florida Department of Law Enforcement and FBI criminal databases. Through background checks, Florida identifies potential problem providers before they are admitted, protecting both taxpayer dollars and vulnerable clients. In Colorado, the Judicial Branch maintains an automated system for tracking court cases which the Medicaid program could use to verify backgrounds of potential providers at minimal cost.

- **Program regulations do not require surety bonds for high-risk providers.** Surety bonds serve as financial screens to discourage the enrollment of unscrupulous and undercapitalized providers. Further, bonds protect the State should a provider be unable or unwilling to refund monies owed back to the program. Finally, bonding companies perform background checks before issuing a bond, which further serves to curb fraud and abuse. Florida requires a $50,000 surety bond for durable medical equipment suppliers, private transportation providers, home health agencies, non-physician-owned clinics, and independent laboratories. When first implemented, Florida's stricter requirements, including the surety bond requirement, resulted in 62 percent of its durable medical equipment providers resigning from the Medicaid program. Florida welcomed the reduction in durable medical equipment providers; it wanted only the most reputable companies to provide services to its Medicaid recipients. Colorado's Medicaid program should consider a similar approach.

- **Application procedures are not adequate to ensure providers disclose related party arrangements.** "Related parties" are individuals or companies that also have ownership in the provider's business. In some instances, related parties may receive kickbacks that can cause service costs to be higher than necessary. Current provider application packets do not request the provider to identify officers, directors, and principal owners in its business or in financial arrangements with other health care providers. Although the provider agreement does require providers to "disclos[e] ownership...as is required," specific disclosure requirements are not stipulated in the agreement. In contrast, Florida's application form states, "Please identify all officers, directors, and principal owners in your business (5 percent or more). List their names and social security numbers on a separate sheet on company letterhead. The list must be signed and dated by the chief officer of the business." The lack of adequate information on related parties in Colorado renders the Medicaid program highly vulnerable to additional and unnecessary

charges for services. More stringent related party disclosure requirements must be instituted on provider applications immediately.

- **Contract language covering billing requirements and suspension must be more stringent.** The current contract agreement states only that a provider may be suspended or administratively sanctioned for failure to comply with federal and state rules and regulations. In contrast, Florida's agreement outlines specific billing requirements and limits provider due process rights. The agreement specifically states that all Medicaid payments in error or in excess of the amount to which the provider was entitled must be refunded within 90 days. The agreement allows either side (Medicaid or provider) to terminate the agreement with 30 days notice without cause. The agreement also states that a provider has no property right in a Medicaid provider number (i.e. the provider cannot sell its provider number when it sells its business), that the courts in one county shall have jurisdiction in all equitable matters, that the Medicaid agency shall have discretion to resolve all other matters by informal hearing, and that in the event of overlapping jurisdiction, the Medicaid agency shall determine the proper forum. As a result of these provisions, Florida has greater latitude than Colorado to recover inappropriate payments or eliminate problem providers from the program. Additionally, Florida conducts weekly reviews of provider claims and suspends payments if it suspects a provider is submitting false claims. Colorado should revise its agreement to include more stringent language to limit the provider's due process should the program withhold payments on suspect claims. Additionally the program, with the assistance of the MFCU, should review suspect claims on a weekly basis and suspend payments until investigated. This will allow the Medicaid program to review claims before they are paid, significantly reducing the program's exposure to fraud and reducing the time and effort required to recover erroneous payments after they have been made.

- **Re-enrollment of existing providers rarely occurs.** In effect, once a Colorado provider submits an application and signs the provider agreement, that provider remains enrolled in Medicaid until the provider decides to discontinue. As a result, there is little chance that any changes in a provider's status will be disclosed to the Medicaid program. During our review, we identified provider agreements that had not been updated since originally submitted to the program. Further, the MFCU is aware of one instance where a Colorado provider used a retired physician's Medicaid provider number to bill Medicaid for services. If agreements had been terminated periodically and providers were required to reenroll, erroneous payments could have been prevented. Florida's provider agreement automatically terminates after three to five years, depending on the provider type. Providers must re-enroll to continue providing Medicaid-funded services. When Florida implemented this practice, it also required all existing providers to re-enroll using the new enrollment forms. The re-enrollment process eliminated many providers who had not provided Medicaid services for many years. A prudent step for Colorado would be to require all existing providers to re-enroll. The re-enrollment process would utilize new, stringent provider enrollment forms including the requirements mentioned above, and would assist in updating the information originally submitted.

Florida is not the only state that has recently implemented more stringent application processes and contractual provisions. The Texas Legislature recently required its Medicaid program to develop a new provider contract with more stringent provisions directed toward reducing fraud. All Medicaid providers are required to reenroll under the new agreement or be terminated from the program.

Although information is not available to precisely estimate the savings that would result by addressing these gaps in the application and enrollment process, Florida has estimated substantial savings from implementing its fraud prevention actions. Florida estimates it has saved $81 million and $111 million for Fiscal Years 1997 and 1998 respectively. The Florida Medicaid program is much larger than Colorado, with expenditures totaling over $7 billion per year. We cannot extrapolate Colorado savings based on Florida's experience because the programs and providers are different. However, we do believe that if the Colorado Medicaid program were to implement the changes we are suggesting, the potential savings would be substantial.

Recommendation No. 9:

We recommend the Department of Health Care Policy and Financing, with the assistance of the Medicaid Fraud Control Unit, review and revise regulations, statutes, application materials, and provider agreements, using Florida's benchmark anti-fraud controls as a model to reduce fraud and abuse.

Department of Health Care Policy and Financing Response:

Partially agree. The Department agrees that we can improve the provider application to include more detailed disclosure of related party arrangements. The Department had also considered re-enrollment of providers as we went to the new MMIS system with the 1995 request for proposals. However, this was delayed until after the new MMIS system could be successfully launched. The Department will now continue with its development of a rollout plan for reenrollment of existing providers.

The Department does not plan to implement site reviews, background checks, and surety bonds because we have determined they are not cost effective.

Medicaid Fraud Control Unit Response:

Agree. The Medicaid Fraud Control Unit will work with the Department of Health Care Policy and Financing as requested.

Propose Legislation to Discourage Fraud and Abuse

Many states have specific statutes to aid their state Medicaid agencies in prosecuting unscrupulous providers. However, not all of these crucial state statutes are in place in Colorado. As a result, it is more difficult for Colorado to prosecute fraud and achieve recoveries than for many other states. Legislation is lacking in the following areas:

- **False Claims Act.** A state false claims act, modeled after the Federal Civil False Claims Act, permits recovery in civil rather than criminal court. Therefore, the level of proof is less stringent. Additionally, a false claim act typically includes harsh penalties for violators. Under the federal law, the abuser receives a fine ranging between $5,000 and $10,000 for each false claim filed, plus treble damages. However, the federal law allows treble damages only for the portion of the claim paid from federal funds. A state false claims act would allow the State to receive treble damages for state-funded dollars, increasing recoveries. Florida has a state false claims act which it uses to aggressively pursue and prevent abusive payments.

- **Anti-kickback legislation.** This statute would make it illegal for one provider to receive a monetary award from another provider when referring a Medicaid recipient for services. The legislation typically includes penalties for violators.

Additionally, Colorado lacks anti-unbundling regulations. These regulations would penalize providers that purposely unbundle items, such as lab tests, when billing Medicaid. Under correct billing practices, the provider should submit one charge for a series of lab tests conducted for a single specimen. Unbundling occurs when the provider bills for each individual test separately. This results in a higher bill, and thus, a higher payment.

Enacting anti-kickback and false claims legislation and anti-unbundling regulations will facilitate the pursuit of abusive providers and increase recoveries. Additionally it will deter fraudulent and abusive practices, reminding providers that Colorado is serious about preventing fraud and abuse and will take strong steps to prevent it.

Recommendation No. 10:

We recommend the Department of Health Care Policy and Financing work with the Medicaid Fraud Control Unit to propose legislation that establishes anti-kickback and civil false claims statutes and anti-unbundling regulations as discussed above.

Department of Health Care Policy and Financing Response:

Agree. The Department does believe that these new laws are important to successful prosecution of Medicaid fraud and abuse. In early 1999, all substantial legislation (including the 1998-drafted civil monetary penalties language) was pulled back due to the change in administration and the legislature. The Department is prepared to

propose language for the state civil monetary penalties statute for false claims for the year 2000 legislative session. The Department will work closely with the MFCU who is likely to take the lead on anti-kickback legislative proposals. The Department and the MFCU are currently discussing the possibility of addressing anti-unbundling through state rule.

Medicaid Fraud Control Unit Response:

Agree. Language for an anti-kickback statute must be carefully considered to be sufficiently comprehensive to address known and anticipated conduct that should be prohibited, narrowly tailored to withstand a constitutional challenge, yet allow providers to engage in legitimate business arrangements.

Record Date of Death Timely

When a Medicaid recipient dies, county staff are required to enter the information into the Client Oriented Information Network (COIN). COIN interfaces with the claims payment system (the Medicaid Management Information System or MMIS) and is accessible at each county department of social services. Once the date of death is entered into the system, all future claims submitted for dates of service after the date of death are denied by MMIS.

Currently, there are delays in county staff learning of a recipient's death and subsequently a delay in entering the date of death into COIN. If a provider bills for services after a recipient's death, but before the date of death is entered into COIN, the provider will receive payment. If the date of death is entered later, the system does not go back and recover those payments.

As a part of our testing, we obtained the dates of death for 13 clients from two counties. Of 13 clients, 8 had HMO capitation claims paid on their behalf subsequent to their dates of death. The average value of each claim was $50. Although this is a limited sample, we were surprised by the high rate of occurrence.

The Medicaid program became aware of problems with accurate date of death information in August of 1998 and is currently conducting a study of claims paid for services after date of death. The program has also found instances of payments made after date of death and questions about date of death data in general. Issues of payments after date of death are not limited to the Medicaid program, but also occur with the Food Stamp and Social Security programs.

Our findings are consistent with a study performed by the Texas Comptroller of Public Accounts. As a part of its 1998 Fraud Measurement Study, the Comptroller's office compared the November 1997 Texas Department of Human Services' Medicaid eligibility file to the 1996 and 1997 Department of Health's vital statistics files. As a result of its review,

the State found 3,395 Texans eligible for fee-for-service Medicaid programs 30 or more days after they had died, with 100 recipients still eligible a year or more after death. They also noted several of these deceased recipients were charged for services after dying, including one who was charged for services more than a year after date of death.

Upon further review of the claims included in our sample, we found the Medicaid program has since recovered all 10 of the claims paid after date of death. However, this requires resources for both paying the claim and recovering funds that should not have been paid. The program needs stronger controls to make sure it identifies date of death before payments are made. In the future, the program needs to take steps to match claims with Social Security records. Social Security records contain up-to-date, accurate date of death information because all morticians are required to inform Social Security when a person dies. The state of Florida is currently working on a project to link Medicaid information with Social Security records.

One avenue the Medicaid program should consider for obtaining accurate date of death information from Social Security databases is to link efforts with the Department of Human Services' food stamp agency. On November 12, 1998, President Clinton signed Public Law No. 105-379, dealing with providing food stamps to deceased individuals. The law directs each state food stamp agency to enter into a cooperative arrangement with the Commissioner of Social Security to obtain information on individuals who are deceased.

In the short term, the program needs to take steps to make sure it identifies and recovers any inappropriate payments made after a recipient's date of death. There are at least two methods that the Department could consider to obtain this information.

- **Match claims against vital records.** The Medicaid program could initiate a computerized match of past paid claims against vital records maintained at the Department of Health. This would serve to identify claims that have been paid for services after date of death, and therefore, may be inappropriate.

- **Match claims against burial assistance.** The State has a program for burial assistance for the indigent. The Medicaid program could crosscheck dates of death from this program against the COIN system to identify inappropriately paid claims. This could be a simple match of electronic files.

The Medicaid program should use whichever method obtains up-to-date death information most effectively. Currently program staff indicate they plan to initiate a match with the vital records database.

If the computer match of past claims identifies inappropriate payments, the program will need to seek recoveries. If resources are not available internally, the program should consider a contingent fee contract. However, a method for identifying date of death before claims are paid is needed in the future. As we have stated, access to up-to-date death information through Social Security records, before claims are paid, provides a more effective solution.

Recommendation No. 11:

The Department of Health Care Policy and Financing should pursue the most effective and efficient method to obtain date of death information. The Department should use this information to seek recoveries for past inappropriate claims and to prevent payment for services provided after date of death in the future.

Department of Health Care Policy and Financing Response:

Agree. The Department was pursuing necessary activities to address the billing of services after the client's date of death prior to this audit. The Department encountered the inadequate data and has already negotiated fees to coordinate data sources with the vital statistics data from the Department of Public Health and Environment. The Department identified the issue in August of 1998 and it was referred to the Program Integrity Unit for investigation. We agree to continue our progress to utilize an effective method to validate dates of death and to pursue recovery once inappropriate payments have been identified. We expect to initiate recoveries in December of this year, depending on the success of this first-time data match.

Improve Records Management

In any organization, proper management of documents is vital. When records are not managed properly, there are concerns that staff are not following required procedures. To verify that required documentation was submitted with provider applications and that the application materials were filled out completely, we sampled provider files at Blue Cross/Blue Shield, the fiscal agent during our audit. Out of 19 files reviewed, Blue Cross/Blue Shield was unable to locate one non-institutional Medicaid provider application, one provider agreement, and three Electronic Data Interchange (EDI) agreements. EDI agreements allow the provider to file claims electronically. The Medicaid program could not explain why these files were misplaced. This raises concerns about the accuracy of the application process. Five missing documents for 19 providers represents a high error rate. Missing documents can impact the success of fraud and abuse cases. Without all provider documents, a case may be difficult to prove.

Recommendation No. 12:

We recommend the Department of Health Care Policy and Financing work with its fiscal agent to verify and document that all required application materials are included with the initial application and that application materials are filled out completely before enrollment

into the Medicaid program. Current providers should be contacted for any missing application file documentation.

Department of Health Care Policy and Financing Response:

Agree. We will instruct the current fiscal agent by August 1, 1999, to continue to do a quality assurance check on all provider application documents submitted since December 1, 1998, and in the future. Updating the approximately 25,000 historical provider files transferred from the previous fiscal agent and contacting those providers will take some time. We plan to update one fifth of those files each year until all have been reviewed and updated by July 1, 2005, starting with higher-risk providers.

Update Authoritative Manuals

Both the Department and the Medicaid Fraud Control Unit maintain manuals to guide the operations of various aspects of the Medicaid program. We identified two manuals that did not contain up-to-date information:

- **Department of Health Care Policy and Financing Staff Manual Volume 8.** This manual contains the rules for carrying out the Medicaid program, including county-authorized transportation, discussed previously. The portion dealing with transportation was last updated in 1990, although a number of changes in transportation policies have since been made. As we discussed in Chapter 2, the Medicaid program now permits certain metro cab companies to bill the program directly, avoiding the county approval process.

- **Medicaid Fraud Control Unit's Policies and Procedures Manual.** The MFCU is aware that its policies and procedures manual is not up-to-date. The updating of this manual has been mentioned as a goal in the MFCU's last three annual reports.

Out-of-date manuals create confusion with regard to policies and practices, cause inefficiencies as staff search for guidance, and imply an inefficient organization.

Recommendation No. 13:

We recommend the Department of Health Care Policy and Financing update the Staff Manual for transportation policies currently in effect and keep it current with future program changes. We also recommend the Medicaid Fraud Control Unit update its Policies and Procedures Manual and keep it current.

Department of Health Care Policy and Financing Response:

Agree. The Department agrees to review policies and regulations and update them to reflect actual practice by January 1, 2000.

Medicaid Fraud Control Unit Response:

Implemented January 12, 1999.

Appendix A - Medicaid Fraud Schemes

The following are known schemes that have been perpetrated to obtain inappropriate reimbursement from Medicaid Programs nationally during the past five years:

Alcohol and Drug Clinic	Billing for office visits on days the patients were not present, charging for unbillable services, and counseling sessions conducted by telephone.
Billing Clerk	Continued to bill Medicaid for services after the provider had left the state.
Dentist	Falsified dates of service, characterize restorative procedures as emergencies, misstate the amount and type of services provided.
Dentist	Submitting hundreds of false Medicaid claims for dental surgical procedures which had not been performed.
Dentist	Billing for Nitrous Oxide (NO2) when patients weren't given gas.
Dentist	Submitted Claims for services either not performed or services performed by non-licensed staff.
Dentist	Submitted claims indicating he conducted more work (fillings, crowns, root canals, etc) than actually performed.
Dentist	Charging for emergency visits for treatments scheduled for weeks, procedures not rendered, altering patient files to make one visit look like several.
Dentist	Claims for services while on vacation.
Dentist	Billed for dental procedures not performed and dispensed Schedule III narcotic controlled substances to increase his Medicaid patient numbers.
Dentist	Billing for services provided by non-licensed staff.
Dentist	Billing for periodontal scaling and root planing procedures when only a routine cleaning performed.
Dentist	Billed for fluoride treatments provided by non-licensed dental assistants.
Dentist	Submitting claims after license was revoked.
Drug and Alcohol Clinic	Continued to use provider number of physician no longer connected with the clinic to bill for services not provided.
Durable Medical Equipment	Recipients were never patients of the physicians who allegedly signed the Certificates of Medical Necessity for the equipment.
Durable Medical Equipment	Billed for female external urinary collection device (pouch) while supplying an adult undergarment (diaper with elastic).
Durable Medical Equipment	Billed for medical equipment services never provided.

Durable Medical Equipment	Phony body brace billed for patients in nursing homes.
Durable Medical Equipment	Billed for supplying oxygen concentrating equipment to patients who were never patients of the physician alleged to have authorized the equipment.
Durable Medical Equipment	Providing durable medical equipment to nursing home residents as orthotics when residents were either bedridden or in advanced stages of contraction.
Durable Medical Equipment	Billed for equipment never supplied using unsuspecting physicians as the physicians prescribing the medical supplies.
Durable Medical Equipment	Requiring recipient to take out a loan for a wheel chair subsequently billed to Medicaid.
Durable Medical Equipment	Falsified signatures of physicians on prescriptions and then billed for services not medically necessary.
Durable Medical Equipment	Provided more medical supplies than were needed to relatives of recipients and then billed Medicaid under the names of the recipients.
Funeral Home Director	Submitted claims for funeral expenses previously paid by family members of deceased Medicaid recipients.
Group Home	Billed for providing direct care to patients when they were only providing administrative functions.
Group Home	Billing for direct care services to residents of adult care homes, when those services were not provided.
Hearing Aid Company	Billing for more expensive hearing aids than provided, billing Medicaid for testing after telling recipient it was free, not telling recipients of their eligibility and selling them hearing aids on contract at high prices.
Home Health Care	Claimed services provided at school to recipient on days when recipient was absent from school.
Home Health Care	Service actually provided to grandson of alleged recipient.
Home Health Care	Aides billing for services to daughter and granddaughter which were never provided.
Home Health Care	Fraudulent home health aide certificate.
Home Health Care	Did not report death of recipients and continued to claim hours.
Home Health Care	Billing for services to recipients who were not home bound.
Home Health Care	Client continued to receive money for chore worker after chore worker quit.
Home Health Care	Continued to bill for services after recipient was admitted to medical facility.
Home Health Care	Billed for services when client was in medical facility, jail, or dead.
Home Health Care	Billing for more time than spent in the home.
Home Health Care	Billing for services rendered by registered and licensed practical nurses when not provided by individuals so licensed.

Home Health Care	Billed for time spent with individual when that individual was in hospital.
Home Health Care	Two individuals being paid for taking care of the same recipient at the same time.
Hospital	Billing for patients' food supplements already paid through the per diem patient rate and charging for drugs at the high hospital rates.
Hospital	Billing wholesale prices for drugs while getting up to 50% discount.
Laboratory	Billing for tests the lab did not have the equipment to perform.
Laboratory	Kickbacks to medical clinics to refer blood specimens for expensive and unnecessary tests.
Laboratory	Bought blood, prepared fictitious laboratory request forms, and billed Medicaid.
Laboratory	Recipients subjected themselves to medically unnecessary tests including providing a blood sample in exchange for the physician writing them a prescription for drugs of their choice.
Laboratory	Splitting blood specimen to create two sets of billable tests with one being labeled as from a recipient selected randomly from the computer records.
Managed Care	Enrolling clients without the clients' knowledge or consent.
Medical Clinic	Phantom tests for range of motion, EKG, blood, skin, tuberculosis, ultra-sound, breathing, hearing and other medical services and supplies.
Medical Clinic	Claims for lengthy and complicated office visits resulting in claims for total service hours in excess of clinic's hours of operation.
Medical Clinic	Obtained health care provider numbers from non-existent medical facilities and billed for medical services supposedly performed by these phantom clinics.
Medical Clinic	Billing for services provided by non-licensed physician assistants.
Medical Clinic	Adding Lincomycin injections to claims.
Medical Clinic	Used contract physicians' Medicaid number to disguise funds collected.
Medical Clinic	Billing for highly expensive procedures (colonoscopy, mediastinoscopy, and three types of upper gastro intestinal endoscopies) which were not provided and for which he didn't have the equipment.
Medical Clinic	Clinic staff would generate fake patient charts for those beneficiaries who never visited the clinic and bill Medicaid for services never rendered.
Medical Clinic	Billing the Medicaid program for blood gas not performed and for which the clinic did not have the necessary equipment.
Medical Clinic	Paid kickbacks for each billable test ordered.

Medical Clinic	Provided community service programs to get Medicaid card numbers and then submitted massive billings for services never provided including psychotherapy, physical therapy and complex medical consultations.
Medical Transportation	Claims for unwarranted ambulance transports and for transports for which they could not produce documentation.
Medical Transportation	Billed Medicaid for transporting recipients when services had not been provided.
Medical Transportation	Billing for service provided after patient's death and billing for second attendant when never more than a driver.
Medical Transportation	Billed trips for deceased patient.
Medical Transportation	Recipients never heard of doctors where they were supposedly transported.
Medical Transportation	Billed for transportation by stretcher when not transported by stretcher.
Medical Transportation	Billing for medically unnecessary ambulance trips.
Medical Transportation	Billed a uniform number of miles to common destinations instead of actual miles.
Medical Transportation	Billed for grossly inflated mileage.
Medical Transportation	Billed for ambulance transportation for individuals who did not need it and then billed for wheelchair services to make it appear an ambulance was needed.
Medical Transportation	Transported people in private cars and then billed Medicaid.
Medical Transportation	Overbilling for mileage and waiting time and billing for wheelchair van services when transporting ambulatory patients.
Medical Transportation	Billed for transportation of nursing home residents on days they never left the nursing home.
Mental Health Center	Conducted group therapy sessions but billed Medicaid as if each client had been seen in a one-on-one therapy session. Billed for services on dates when therapist was out of town on vacation.
Mental Health Center	Phantom billing and upcoding - group therapy sessions billed as individual sessions.
Nurse	Forged prescriptions for cash.
Nursing Home	Invoices submitted by a facility and paid by the Medicaid Program while a nursing facility resident was discharged to a hospital or home.
Nursing Home	Invoices submitted by a facility and paid by the Medicaid Program for residents who have not been determined to be Medicaid eligible for long term care.
Nursing Home	Invoices submitted by a facility and paid by the Medicaid Program for deceased residents.
Nursing Home	Duplicate payments made by the Program.
Nursing Home	Overpayments made by the Program due to co-payment errors.

Nursing Home	Unreported third party payors, who are often billed after the Program has been billed and paid.
Nursing Home	Inappropriate charges to recipients for covered items and services.
Nursing Home	Variances in patient fund accounts caused by anything from posting errors to embezzlement.
Nursing Home	Charged residents for diapers which were included in rate.
Nursing Home	False cost report including inflated costs for nursing staffing services provided by a co-conspirator.
Nursing Home	Gaining power of attorney over wealthy residents with no close relatives, looted their savings, and put them on Medicaid.
Nursing Home	False invoices from supply companies to increase costs
Nursing Home	Nursing home chain received free equipment and discounts on pharmaceuticals in exchange for ordering goods and services.
Nursing Home	Overbilling for medical supplies given to nursing home residents.
Optometrist	Billed for scheduled patients who were no-shows.
Personal Care Attendant	Billing for services not provided.
Pharmacy	Stole Medicaid cards and paid Medicaid recipients for their cards, illegally obtained doctors' prescription pads and wrote prescriptions and forged doctors' names for drugs using recipient names and Medicaid numbers.
Pharmacy	Billing of primarily high-priced drugs which were never prescribed or provided to Medicaid patients. Rocephin was heavily billed.
Pharmacy	Dispensed drugs, including controlled substances, without a doctor's prescription, then claimed to Medicaid he had a prescription requiring brand drugs. He then informed a doctor so the doctor could falsely bill Medicaid for a 25 minute patient visit.
Pharmacy	Generated false prescriptions which were used to submit numerous claims.
Pharmacy	Failed to give credit for prescriptions returned unused and were reusable. Billed for Neupogen not furnished after patient quit using the drug.
Pharmacy	Falsely inflated its prices for products billed to Medicaid program.
Pharmacy	Handling and crediting of returned medications, billing of dispensing fees, and billing arrangements with nursing facilities.
Pharmacy	Billed high priced drugs - Mevacor, Zantac, Ceclor, etc. - which were fraudulent claims.
Physical Therapist	Claim forms signed by physician who was not the physician for the recipient and submitted in a manner to avoid need for providing services in the physician's office in conjunction with other services.
Physician	Sold use of provider number.
Physician	Soliciting and paying Medicaid recipients to frequent the facility under guise of obtaining medical treatment.

Physician	Billing Medicaid twice for the same service - once to the KidMed program, and once as a high-level office visit.
Physician	Billed for visits that did not occur and prescribed controlled substances for no legitimate need.
Physician	Bookkeeper filed false claims and deposited funds into personal bank account.
Physician	Double billing (2 programs) and billing DPT while only giving DT shots.
Physician	Taking money from patients in exchange for narcotic prescriptions absent medical necessity. Treatment in absence of the physician; billing as an office visit.
Physician	Billing for services provided by non-licensed individual.
Physician	Billed laboratory tests that were not medically necessary - on-site rapid strep tests and amylase tests.
Physician	Billing for therapy by individual not licensed.
Physician	Billed for services never rendered and patients never seen by buying Medicaid numbers from black market dealers.
Physician	Billing for an allergy injection and office visit for each Medicaid patient being treated for allergies.
Physician	Submitted two invoices for every one visit by a patient; submitted invoices for treatment of patients who missed their appointments, submitted invoices for treatments when office was closed or he was not in the office.
Physician	Over-prescribed narcotic painkillers such as Vicodin, Darvocet, and Talacen.
Physician	Billed Medicaid for vaccine provided free under the Childhood Immunization Initiative.
Physician	Billing diagnostic tests for dead patients and sophisticated tests for which equipment was not available.
Physician	Billed for non-existent medical visits when patient merely renewed their prescriptions.
Physician	Physician paid $2,000 per month to allow clinic to use his provider number for phantom office visits and prescriptions.
Physician	Excise a skin lesion and bill for a large, malignant lesion.
Physician	Instructed patient to sign Medicaid claim form for self and all children. Claims subsequently submitted for treating patient and children.
Physician	Posing as a physician to submit claims and write phony prescriptions.
Physician	Coding laser surgery and varicose vein treatment as compensable procedure codes.
Podiatrist	Prescribing controlled and non-controlled medications without a medical license.

Podiatrist	Provided debridements to both feet when one or both had been amputated. Provided debridements to patients absent from the facility on that date. Provided debridements to patient who had previously died. Billed comprehensive or extended visits when number seen exceeded hours available.
Podiatrist	Offered free food and sometimes sneakers to get Medicaid numbers of the "patients" to bill for prescriptions, x-rays, and podiatry services.
Podiatrist	Billed for matrisectomies and flexor tenotomies never provided.
Podiatrist	Billing for surgical procedures (avulsion) when nail trimming (not covered) was performed - also billed for performing matricectomy when only providing nail trimming.
Provider Address	Changed provider address to P.O. Boxes or unfurnished office facilities.
Psychiatric Clinic	Misrepresenting the type of service rendered for family therapy and inflating the number of individual psychotherapy sessions.
Psychiatrist	Billed for more than 24 hours worth of visits per day.
Psychiatrist	Billed for "medication visit (approximately 30 minutes required) but spent only a few minutes with each patient.
Psychiatrist	Required Medicaid patients obtain a second medically unnecessary medication as a prerequisite to the pharmacist filling the controlled substance prescription.
Psychiatrist	Providing controlled drugs without medical indication.
Psychiatrist	Billed for services when not in the geographical area, billed for therapy provided to deceased recipients, and billed for services actually provided by a therapist.
Psychiatrist	Saw patients for 10 minutes and billed for half-hour or one-hour psychotherapy sessions.
Psychiatrist	Billing for both medical and psychiatric services on the same visit to require working far in excess of 24 hours a day.
Psychologist	Billed for services not provided by a licensed psychologist and for non-covered services.
Psychologist	Billed for hours and services not provided.
Psychologist	Used Medicaid provider number of other licensed therapists to bill for services after his license was revoked. Billed under those numbers for services provided by unlicensed therapists.
Social Worker	Billed for counseling children (some as young as 3) and elderly (some had died) exceeding 24 hours per day.
Social Worker	Billed for services never provided.
Social Worker	Forged documents from fictitious medical professionals that own children needed personal care attendants.

Appendix B - Follow Up on Prior Recommendations

In completing the performance audit, we noted the following report that contained recommendations that impacted fraud and abuse prevention with the Colorado Medicaid program:

Medicaid Fraud, Footnote 39 Report, Senate Bill 97-216 (Long Bill). To the Colorado State Joint Budget Committee.

We requested the current status of implementation of these recommendations from the Department of Health Care Policy and Financing. Below are their responses to the specific recommendations made in this report.

Continued Training for Colorado Foundation for Medical Care and Consultec

Colorado Foundation for Medical Care and Consultec are Health Care Policy and Financing contractors. Colorado Foundation for Medical Care reviews hospital billings and medical necessity of acute and long term care admissions and continued stays, and could benefit from additional training on how to identify possible fraud issues, how to prepare cases, and how to coordinate with Health Care Policy and Financing and Medicaid Fraud Control Unit for referrals. Consultec is the State's new fiscal agent as of July 1, 1998, and is directly involved in the claims that are submitted. They could benefit from training on how to identify and refer possibly fraudulent cases. Although initial training has begun, Health Care Policy and Financing and the Medicaid Fraud Control Unit plan to continue this effort. A one-day in-service was attended by the Medicaid fraud Control Unit, the Quality Assurance Section, and Colorado Foundation for Medical Care in October 1997.

Current Status of Implementation: **The Medicaid Fraud Control Unit (MFCU) met with the Colorado Foundation for Medical Care (CFMC) for a full day training and information exchange. The whole unit was involved in this training. Communication has remained open and individual referrals have been discussed with CFMC staff on at least two occasions. A joint forum was held in May between State Agencies and contractors which included the CFMC and the MFCU to identify billing, loopholes, waste, or reporting problems. Outreach efforts to the new Fiscal Agent will take place after implementation, when key staff are in place.**

Colorado Foundation for Medical Care to Review Adjustments

Currently, Colorado Foundation for Medical Care reviews only initial final bills from hospitals, but does not review any adjustments made to those initial bills. Dollars are recouped from hospitals, once a billing error has been identified or a medical necessity denial has been made. But hospitals also have the potential to adjust the bill, submit it for the same reason or with the same error, and receive payment again. Since Colorado Foundation for Medical Care does not review adjustments, potentially fraudulent claims may be paid and never recouped. Efforts are under way to change this procedure so that adjustments are reviewed and tracked. If it appears that a hospital may be intentionally resubmitting claims that are not justified, then referrals will be made to the Medicaid Fraud Control Unit.

Current Status of Implementation: **Attempts to design new acute care reviews were met with obstacles. Efforts to improve acute care procedures have been postponed due to the advent of a new bid being published for that work. We will reconsider the role of the adjustments when the contractor has a direct line to Consultec and once the design of the reviews has been decided.**

Continue to Educate Individual Physicians

More information and education could be provided to physicians about consequences of misbilling, mistreating, and ignoring Medicaid rules and regulations. Physicians may be more willing to report peers if they understand the negative impacts to the system and their patients. These professionals are often closest to the system and can yield the most productive referrals.

Current Status of Implementation: **A professional fraud and abuse conference was held at the downtown (Denver) Marriott on October 23, 1998. Multiple provider types were invited and speakers addressed issues of misbilling and ignoring rules and regulations. Provider education continues on an ongoing basis through individual Program Integrity reviews, which can include recovery or provider education efforts.**

State Civil Monetary Penalties Law

Several states have adopted false claims acts much like the federal law, which provide for substantial monetary penalties for submission of false claims. The Medicaid Fraud Control Unit staff is reviewing these laws to determine whether such an additional civil remedy would be beneficial to efforts in Colorado.

Current Status of Implementation: **We have developed some proposed language to address this in the 1999 legislative session. The concept basically centers around specific civil penalties for each violation of the law. It is modeled after states who have similar laws in effect.**

Pharmacy and Laboratory Fraud

With additional staffing, Health Care Policy and Financing could initiate a phone investigation program for pharmacies and laboratories. At random, or guided by claims analyses, staff could call physicians to determine if the prescriptions and tests were actually ordered. In certain parts of the country, pharmacies have been found to forge prescriptions, and laboratories have been found to add tests that have not been ordered. If providers believe they are not being audited in these areas, the problem may perpetuate. New Jersey employs approximately 10 nurses to perform this activity and benefits from a productive outcome.

Current Status of Implementation: **With the current staffing level, we have not been able to perform this to date. However, we plan to consider this project in January when less staff are working on the MMIS transition.**

Emergency Care Review by Colorado Foundation for Medical Care

Health Care Policy and Financing is currently considering adding emergency room claims to the hospital claims reviewed by Colorado Foundation for Medial Care. This would allow better monitoring of the billing and quality of care problems associated with emergency rooms. As most of the care in emergency rooms is high cost, this may result in significant recoveries of dollars.

Current Status of Implementation: **As was mentioned previously, attempts to design new acute care reviews were met with obstacles. Efforts to improve acute care procedures have been postponed due to the advent of a new bid being published for that work. We will reconsider the role of emergency care review when the contractor has a direct line to Consultec and once the design of the reviews has been decided in the RFP. In the meantime, the Program Integrity Unit does review and has recovered from emergency room physician billings.**

Transportation

Both Departments should work collaboratively to continue review of transportation providers for unbundling issues through special computer runs directed toward specific codes with the most potential for abuse. It also has come to our attention that there is software that allows mileage verification. The Departments will investigate the cost and feasibility of such programs.

Current Status of Implementation: **The Department has developed a task force to address transportation rules. Mileage variations should be a component of our new Decision Support System through STARS.**

New Criminal Statutes

The Medicaid Fraud Control Unit, in cooperation with Health Care Policy and Financing's Quality Assurance Section and the Managed Care Division, will review the model criminal enforcement statutes for managed care, developed by the National Association of Medicaid Fraud Control Units, to assess their applicability to the Colorado Medicaid program.

Current Status of Implementation: **The National Association of Medicaid Fraud Control Units offered a model managed health care fraud statute for states' adoption. Some states have adopted managed care statutes, but to date no cases of actual managed care fraud have been prosecuted under the statutes. Because managed care is an emerging model of health care provision, it is uncertain whether the model or any states' statutes are the best possible tool to prosecute managed care fraud. Colorado's theft statute might be better suited to managed care fraud prosecutions than to traditional fee-for-service fraud prosecutions. The Colorado MFCU is closely monitoring managed care and other states' use of relevant statutes in order to be prepared to offer the best possible draft bill.**

The MFCU worked with the Colorado Department of Health Care Policy and Financing to draft a civil false claims statute. The MFCU fully supports such a statute as an effective prospective deterrent and as a remedy for fraud as it is discovered.

Parallel Civil and Criminal Proceedings

The Justice Department, in its effort to step up prosecution of Medicare provider fraud, has issued a directive to United States Attorneys to have the civil and criminal divisions of their offices coordinate the prosecution of cases against Medicaid providers engaged in fraudulent activities. The purpose is to maximize the benefit of these investigations and to bring these matters to a conclusion with the imposition of criminal sanctions, civil penalties, and administrative exclusions from the program as quickly as possible.

The Medicaid Fraud Control Unit is exploring, with Health Care Policy and Financing, and the Assistant Attorneys General who represent that Department, the feasibility of proceeding simultaneously when it appears that such action would lead to a swifter and more effective conclusion to the case.

Current Status of Implementation: **In the past, and especially within the past year, the MFCU and the Medicaid and Public Assistance Unit of the Attorney General's Office (which represents the Department of Health Care Policy and Financing) have worked together to exchange information so that each unit could pursue available action to combat Medicaid fraud and/or overbilling. Two significant cases have been worked in parallel fashion. One case remains under investigation with insufficient evidence at this point for either unit to commence legal action. In another case, the Medicaid and**

Public Assistance Unit has engaged in litigation while the MFCU is still conducting a criminal investigation.

Enactment of a civil false claims statute similar to the federal statute and those of other states would be extremely beneficial in undertaking parallel proceedings. Such a statute would be an extremely effective tool which could be used unilaterally by the Medicaid and Public Assistance Unit or in a parallel with criminal actions by the MFCU.

Systems Performance Review Requirements Formally Changed

Health Care Policy and Financing is constrained on how it performs its reviews by Federal requirements contained in the systems performance review. State Medicaid agencies have been approaching Health Care Financing Administration for some time on this matter. It is largely felt at a national level that if Health Care Financing Administration formally retracted the systems performance review requirements, then states would have more flexibility and opportunity to creatively tailor their methods and processes. Colorado concurs with this position.

Currently, the systems performance review requires a certain number of cases to be "opened" in a certain way, in a certain time frame. Instead of opening new types of cases or proceeding with a fewer number of large cases, Health Care Policy and Financing is restricted to meeting the structure requirements rather than focusing on outcomes. Health Care Financing Administration's Regional Office has agreed to consider a "Systems Performance Review Replacement Plan," and Health Care Policy and Financing is proceeding with this plan, but recommends that adjustment occur on a national and consistent level.

Current Status of Implementation: **HCFA did respond in writing that the SPR was no longer required. A copy of our proposed SPR replacement, which was approved by HCFA, was provided to the auditors.**

Distribution

Copies of this report have been distributed to:

Legislative Audit Committee (12)

Department of Health Care Policy and Financing (25)

Department of Law, Medicaid Fraud Control Unit (10)

Joint Budget Committee (2)

Department of Treasury (1)

Department of Personnel
d.b.a. General Support Services
Executive Director (2)
State Controller (2)

Honorable Bill Owens, Governor

Office of State Planning and Budgeting (2)

Depository Center, Colorado State Library (4)

Joint Legislative Library (6)

State Archivist (permanent copy)

National Conference of State Legislatures

Legislative Oversight Committee

Legislative Legal Services

Auraria Library

Colorado State University Library

Copies of the report summary have been distributed to:

Members of the National Legislative Program Evaluation Society

Members of the Colorado General Assembly

National Association of State Auditors, Comptrollers, and Treasurers

Report Control Number 1050

Report Control Number 1050