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HEALTH CARE FRAUD

Types of Providers Involved in Medicare, Medicaid, and the Children's Health Insurance Program Cases

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Highlights

Highlights of GAO-12-820, a report to congressional requesters

Why GAO Did This Study

GAO has designated Medicare and Medicaid—which are administered by the Centers for Medicare & Medicaid Services (CMS), an agency of HHS—as high-risk programs partly because their size and complexity make them vulnerable to fraud. Several federal agencies conduct health care fraud investigations and related activities, including HHS-OIG and DOJ's Civil Division, and the 93 U.S. Attorney's Offices (USAO). In fiscal year 2011, the federal government devoted at least $608 million to conduct such activities. Additionally, state MFCUs investigate health care fraud in their state's Medicaid and CHIP programs.

GAO was asked to provide information on the types of providers that are the subjects of fraud cases. This report identifies provider types who were the subjects of fraud cases in (1) Medicare, Medicaid, and CHIP that were handled by federal agencies, and changes in the types of providers in 2005 and 2010; and (2) Medicaid and CHIP fraud cases that were handled by MFCUs. To identify subjects of fraud cases handled by federal agencies, GAO combined data from three agency databases—HHS-OIG, USAOs, and DOJ's Civil Division—and removed duplicate subject data. GAO also reviewed public court records, such as indictments, to identify subjects' provider types because the USAOs and DOJ Civil Division data did not consistently include provider type. To describe providers involved in fraud cases handled by the MFCUs, GAO collected aggregate data from 10 state MFCUs, which represented the majority of fraud investigations, indictments, and convictions nationwide.

View GAO-12-820. For more information, contact Kathleen M. King at (202) 512-7114 or kingk@gao.gov.

What GAO Found

According to 2010 data from the Department of Health and Human Services' Office of the Inspector General (HHS-OIG) and the Department of Justice (DOJ), 10,187 subjects—individuals and entities involved in fraud cases—were investigated for health care fraud, including fraud in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). These subjects included different types of providers and suppliers—such as physicians, hospitals, durable medical equipment suppliers, home health agencies, and pharmacies—that serve Medicare, Medicaid, and CHIP beneficiaries. For criminal cases in 2010, medical facilities—including medical centers, clinics, or practices—and durable medical equipment suppliers were the most-frequent subjects investigated. Hospitals and medical facilities were the most-frequent subjects investigated in civil fraud cases, including cases that resulted in judgments or settlements.

- **Subjects of criminal cases**: Many of the 7,848 criminal subjects in 2010 were medical facilities or durable medical equipment suppliers, representing about 40 percent of subjects of criminal cases. Similarly, in 2005, medical facilities and durable medical equipment suppliers accounted for 41 percent of criminal case subjects. Data from 2010 show that most of the subjects were in cases that were not referred by HHS-OIG to DOJ for prosecution (85 percent). Of the subjects whose cases were pursued, most were found guilty or pled guilty or no contest.

- **Subjects of civil cases**: Over one-third of the 2,339 subjects of civil cases in 2010 were hospitals and medical facilities. In 2010, about 35 percent more subjects were investigated in civil fraud cases than in 2005. Nearly half of the subjects of 2010 cases were pursued. Among the subjects whose cases were pursued, 55 percent resulted in judgments or settlements.

Additionally, data from HHS-OIG show that nearly 2,200 individuals and entities were excluded from program participation for health care fraud convictions and other reasons, including license revocation and program-related convictions. About 60 percent of those individuals and entities excluded were in the nursing profession. Pharmacies or individuals affiliated with pharmacies were the next-largest provider type excluded, representing about 7 percent of those excluded.

According to data GAO collected from 10 state Medicaid Fraud Control Units (MFCU), over 40 percent of the 2,742 subjects investigated for health care fraud in Medicaid and CHIP in 2010 were home health care providers and health care practitioners. Of the criminal cases pursued by these MFCUs, home health care providers comprised nearly 40 percent of criminal convictions and 45 percent of subjects sentenced in 2010. Civil health care fraud cases pursued by these MFCUs in 2010 resulted in judgments and settlements totaling nearly $829 million. Pharmaceutical manufacturers were to pay more than 60 percent ($509 million) of the total amount of civil judgments and settlements.

GAO provided a draft of the report to DOJ and HHS. DOJ provided technical comments, which have been incorporated as appropriate.