BY THE COMPTROLLER GENERAL

Report To The Congress

OF THE UNITED STATES

Further Improvements Needed in Investigations of Medicaid Fraud and Abuse in Illinois

HEW and Illinois have progressed in investigating fraud and abuse in the Medicaid program within that State. More needs to be done.

Establishing a single program integrity unit for Medicare and Medicaid within the new Health Care Financing Administration should

--improve coordination between Medicaid and Medicare,

--enable each HEW regional office to review State efforts to control fraud and abuse,

--identify ways for States to improve detection of suspected fraud and abuse,

States needed assistance.

HRD-78-46
MARCH 10, 1978

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(4)

To the President of the Senate and the
Speaker of the House of Representatives

This report describes (1) Illinois' activities to identify and refer cases of Medicaid fraud for prosecution and the State's computerized system for processing Medicaid claims and (2) the Department of Health, Education, and Welfare's oversight role in Medicaid fraud and abuse matters.

Our review was made at the request of Senators Percy and Stevenson of Illinois to follow up on the findings and recommendations of our April 14, 1975, report to the Chairman, Subcommittee on Health, Senate Committee on Finance, entitled "Improvements Needed in Medicaid Program Management Including Investigations of Suspected Fraud and Abuse" (MWD-75-74).

Following the requestors' wishes, we did not take additional time to obtain written agency comments. However, we discussed the matters in the report with Federal and State officials and their comments are incorporated as appropriate.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and the Secretary of Health, Education, and Welfare.

Comptroller General
of the United States

COMPTROLLER GENERAL'S
REPORT TO THE CONGRESS

FURTHER IMPROVEMENTS NEEDED IN INVESTIGATIONS OF MEDICAID FRAUD AND ABUSE IN ILLINOIS

D I G E S T

INCREASED HEW EFFORTS TO IDENTIFY MEDICAID FRAUD AND ABUSE

Almost 3 years ago GAO reported on investigations of suspected fraud and abuse in the Medicaid program, particularly in Illinois. The Department of Health, Education, and Welfare (HEW) had no unit to investigate suspected Medicaid fraud and abuse or to help States develop necessary capability to investigate such activities. GAO concluded that HEW should better coordinate its Medicare and Medicaid fraud and abuse reviews.

In May 1975 HEW established a Medicaid Fraud and Abuse Unit for evaluating States' programs. This unit had 108 authorized positions in 1977. Subsequently, this unit and Medicare's Program Integrity Group were consolidated into the Health Care Financing Administration Program Integrity Office. This Office should improve the coordination of investigations between Medicare and Medicaid regarding the improper activities of those providing medical services--doctors, druggists, nursing homes, etc., hereafter referred to as "providers."

Further improvements needed

GAO identified some problems which the new Health Care Financing Administration should attempt to eliminate, including

--communication to Medicare of information on providers terminated from Medicaid for improper activities (see p. 12);

--the inability of HEW headquarters to assure that each region makes scheduled reviews of State efforts to control Medicaid fraud and abuse (see p. 10); and

--limited HEW evaluation of, and assistance to, Illinois' efforts to identify providers that may be involved in Medicaid fraud or abuse because HEW was building up its capabilities in this area. (See p. 9.)

FURTHER IMPROVEMENTS NEEDED IN ILLINOIS TO IDENTIFY SUSPECTED MEDICAID FRAUD AND ABUSE

Since GAO's earlier review on identifying suspected Medicaid fraud and abuse in Illinois, substantial progress has been made, and an organization to audit, investigate, and review such activities has been established.

During 1977, Illinois referred 60 providers to a U.S. attorney for prosecution, stopped 70 from participating in Medicaid, recovered $6 million in erroneous payments, and established a computerized system for identifying providers who most likely defrauded or abused the program.

GAO noted that

--much of the money recovered by Illinois was from payments for duplicate or other unallowable billings and

--most of Illinois' audit efforts pertained to payments made before December 1974. (See p. 21.)

Some erroneous payments might have been avoided had proper prepayment edits been made. Over $1.6 million in duplicate and unauthorized drug payments would have been avoided. This also would have allowed the Illinois audit staff more time to review (1) recent payments rather than those several years old and (2) unanalyzed pharmacies' payments.

FURTHER IMPROVEMENTS NEEDED IN ILLINOIS CLAIMS PROCESSING

Since April 1975 Illinois has improved its Medicaid Claims Processing System by reducing processing time for paying error-free

Medicaid claims. However, it has been slow to make the suggested improvements in GAO's prior report for

--reducing manual processing,

--reducing computer rejects, and

--improving accountability for processed claims.

In addition, Illinois has fallen behind about 3 years in its plans to fully implement a Medicaid Management Information System to better manage its Medicaid program. This system is only partially used now.

RECOMMENDATIONS

The Secretary, HEW, should direct the Administrator of the Health Care Financing Administration to require that

--information on terminated providers is exchanged between Medicare and Medicaid so that, as appropriate, providers are terminated from both programs; and

--each HEW regional office reviews State efforts to control fraud and abuse. (See p. 17.)

Specifically, with respect to Illinois, HEW needs to make sure that the State

--routinely reviews current information on all major provider groups and

--reviews the feasibility of coordinating Medicaid investigations of fraud and abuse with State licensing agencies to help determine if providers' medical licenses should be revoked. (See p. 31.)

In addition, HEW should assist Illinois in implementing fully a Medicaid Management Information System. Such implementation of this System should enhance Illinois' claims processing procedures and minimize payments for duplicate and other unallowable billings. (See p. 41.)

Contents

ABBREVIATIONS

FBI	Federal Bureau of Investigation
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
IDPA	Illinois Department of Public Aid
MMIS	Medicaid Management Information System
MSA	Medical Services Administration
SRS	Social and Rehabilitation Service

CHAPTER 1

INTRODUCTION

On April 14, 1975, we issued a report to the Chairman, Subcommittee on Health, Senate Committee on Finance entitled, "Improvements Needed In Medicaid Program Management Including Investigations of Suspected Fraud and Abuse." This report recommended several improvements in HEW's and Illinois' efforts regarding Medicaid fraud and abuse and for improvements in Illinois' claims processing system.

In November 1975 hearings before the Subcommittee on Long Term Care, Senate Special Committee on Aging, a former Illinois welfare employee alleged that seven computer runs had been withheld from us in our earlier review and that access to these documents would have changed our earlier review results and the related April 1975 report. Illinois Senators Percy and Stevenson requested a followup review with particular emphasis on the charges that efforts had been made to impede the earlier review.

In December 1975 we responded to these allegations and told Senators Percy and Stevenson that Illinois officials had kept us informed during our prior review on the nature, availability, and purpose of three of the seven computer runs. We also noted that the remaining four computer runs were not completed until we finished our fieldwork and that our prior review was directed to the causes of problems in the Illinois Medicaid program rather than to developing potential cases of fraud.

This review was directed at following up on our prior report findings, particularly with regard to:

--Department of Health, Education, and Welfare (HEW) efforts to strengthen its oversight role in identifying and preventing Medicaid fraud; and

--Illinois actions to better deal with Medicaid fraud and abuse and its computerized system for processing Medicaid claims.

THE MEDICAID PROGRAM

Medicaid--authorized by Title XIX of the Social Security Act, as amended (42 U.S.C. 1396)--is a grant-in-aid program under which the Federal Government pays part of the costs incurred by States in providing medical services to persons

unable to pay for such care. Based on per capita income in the State, the Federal Government pays from 50 to 78 percent of the States' costs for medical services under the program. The Medicaid program began January 1, 1966.

Services provided to Medicaid recipients vary among States. As a minimum, States participating in Medicaid must provide the following services: physician, inpatient and outpatient hospital, laboratory and X-ray, skilled nursing home, home health care, family planning, and early and periodic screening, diagnosis, and treatment of eligible individuals under age 21. Additional services such as dental care and prescribed drugs, may be included under a Medicaid program at a State's option.

Administering Medicaid

Medicaid was administered federally by the Social and Rehabilitation Service (SRS) within HEW until March 9, 1977, when SRS was abolished and the Health Care Financing Administration (HCFA) was established to administer both the Medicaid and Medicare programs. HCFA began operations on June 20, 1977. Administration of State Medicaid programs has been further delegated to the HCFA Regional Medicaid Directors who administer the field activities of the program through HEW's 10 regional offices.

Each State has primary responsibility for administering its Medicaid program. The nature and scope of such a program is contained in a State plan which, after approval by the HCFA, Regional Medicaid Director, provides the basis for Federal grants to the State. The Regional Medicaid Directors must determine if State programs are administered in accordance with existing Federal requirements and the provisions of the State's approved plan.

The Illinois Medicaid program began in 1966 and is administered by the Illinois Department of Public Aid (IDPA), which makes policy decisions, establishes fiscal and management controls, and reviews program activities. In addition, it is responsible for approving, disapproving, or canceling the certification of providers to participate in Medicaid.

Costs of providing health care under Medicaid have increased greatly since the program began. In fiscal year 1967 the Federal and State cost of providing Medicaid services was about $2.3 billion. By fiscal year 1976 the cost had risen to approximately $15 billion nationwide. The fiscal year 1976 Medicaid costs in Illinois were about $800 million.

MEDICAID FRAUD AND ABUSE

Much attention has been focused on Medicaid fraud and abuse in Illinois and other States by newspapers, magazine articles, congressional hearings, and television. The following partially lists reported Medicaid fraud schemes:

--Kickbacks by laboratories and pharmacies to physicians and nursing homes, respectively, for Medicaid business.

--Billings by physicians for services not rendered.

--Charging for more expensive services than those actually rendered.

Persons successfully prosecuted for fraudulently obtaining payments under Medicaid may be subject to criminal penalties under statutes of either general or specific application. Section 286, Title 18, United States Code, provides for fines up to $10,000 or imprisonment of up to 10 years, or both. Sections 287, and 1001, Title 18, United States Code, calls for fines up to $10,000, or imprisonment of up to 5 years, or both. Section 1341 of Title 18 prescribes fines of up to $1,000, or imprisonment of up to 5 years, or both when U.S. mail is used for fraud. The Social Security Amendments of 1972, specifically section 242, provided for fines of up to $10,000, or imprisonment for not more than 1 year, or both for persons convicted of fraudulently obtaining payment under Medicaid.

In addition, Title 31, section 231, of the United States Code provides civil penalties of $2,000 and, in addition, double the amount of the damage which the United States may have sustained because of a fraudulent claim and the cost of the law suit.

In October 1977, Public Law 95-142, the Medicare-Medicaid Anti-Fraud and Abuse Amendments, was enacted making various forms of Medicaid fraud a felony and raising maximum fines to $25,000 and the maximum jail sentence to 5 years.

HEW regulations (45 CFR 250.80) (1976) state that a State's plan for medical assistance under Title XIX of the Social Security Act must

--provide that the State agency will establish and maintain (1) methods and criteria for identifying situations in which a question of fraud in the program may exist and (2) procedures developed in

cooperation with State legal authorities, for referring to law enforcement officials situations in which valid reason exists for suspecting fraud;

--provide for methods of investigation of situations in which a question of fraud exists that do not infringe on the legal rights of persons involved and are consistent with principles recognized as affording due process of law;

--provide that the State agency will designate persons responsible for referring situations, involving suspected fraud, to the proper authorities; and

--provide that the State agency shall establish and maintain procedures for reporting information to the Health Care Financing Administration at intervals prescribed in implementing instructions.

MEDICARE

Medicare--authorized by Title XVIII of the Social Security Act, as amended (42 U.S.C. 1395)--is a federally defined, uniform package of medical care benefits for most persons 65 and over. Effective July 1, 1973, the Social Security Amendments of 1972 extended Medicare protection to (1) individuals under 65 who have been entitled to social security or railroad retirement benefits for at least 24 consecutive months because they were disabled and (2) insured individuals or other dependents under age 65 with chronic kidney disease.

HEW's Social Security Administration administered Medicare until March 9, 1977, when HCFA was established. Medicare offers two forms of insurance protection. One form, Hospital Insurance Benefits for the Aged and Disabled (part A), covers inpatient hospital services and posthospital care in a skilled nursing facility or in the beneficiary's home (home health care).

The second form of protection, Supplementary Medical Insurance Benefits for the Aged and Disabled (part B), covers physicians' services and certain medical and health benefits, including home health care.

SCOPE OF REVIEW

Our review was made at HEW Headquarters, Washington, D.C., HEW's Region V Office, Chicago, Illinois, and IDPA

offices in Springfield and Chicago, Illinois. We visited Federal and local prosecutors identified as most involved in prosecutions of Medicaid fraud in Illinois.

We also visited the Illinois offices of the Departments of Health, Registration and Education, and Law Enforcement, and the Attorney General, the Comptroller, and the Legislative Advisory Committee on Public Aid.

At IDPA we followed up on the findings of our prior report including IDPA's actions to improve (1) its policies and procedures for managing its systems for processing and paying Medicaid claims and (2) its system for identifying and referring for prosecution potential cases for Medicaid fraud and abuse.

In addition we followed up on our prior report on HEW efforts to improve its (1) monitoring of States' Medicaid fraud and abuse activities, (2) investigating potential Medicaid fraud and abuse cases, and (3) better coordinating Medicare and Medicaid.

The offices of Senators Percy and Stevenson requested that we not obtain written comments on this report, but we have obtained informal HEW and State views through informal discussions with officials of these agencies whose comments were incorporated as appropriate.

CHAPTER 2

INCREASED HEW EFFORTS TO IDENTIFY MEDICAID FRAUD AND ABUSE

During the last 2-1/2 years, HEW has significantly increased its efforts to identify Medicaid fraud and abuse. As of November 1977, HEW's newly created Office of Inspector General had identified over 2,400 physicians and pharmacies which had presumably abused the Medicaid program. The most apparent violations appeared to be Medicaid fraud. The Office of Inspector General was arranging for Federal or State agencies to investigate this data further.

We identified problems in the exchange of information between Medicare and Medicaid on potential fraud and abuse by providers, as we did in our prior review. In June 1977, the Medicaid Division of Fraud and Abuse Control, formerly of the Medical Services Administration (MSA), SRS, and Medicare's Program Integrity Group were consolidated into the HCFA Program Integrity Office. Hopefully, this will improve the exchange between programs of fraud and abuse information about providers.

Also, establishing this unit should prevent (1) awarding a contract for a computer program to detect fraudulent and abusive practices of noninstitutional Medicaid providers by SRS staff without coordinating the award with Medicaid operating personnel, (2) the inability of headquarters staff to assure scheduled regional reviews are made of State efforts to identify Medicaid fraud and abuse, (3) limited HEW assistance to IDPA, and (4) limited HEW evaluation of IDPA's efforts to identify providers that may be defrauding or abusing the program.

The Department of Justice has been active in prosecuting Medicaid fraud in Illinois but had expressed concern about limited Federal penalties for Medicaid fraud before enactment of Public Law 95-142. As a result, a U.S. attorney has prosecuted Medicaid providers under the mail fraud statute. Public Law 95-142 made Medicaid fraud a felony rather than a misdemeanor.

OFFICE OF THE INSPECTOR GENERAL, HEW

Public Law 94-505, of October 15, 1976, created the Office of Inspector General in HEW which absorbed the HEW Audit Agency and HEW's Office of Investigations. The Inspector General is responsible for, among other matters, audit

and investigative activities relating to HEW operations and programs and the coordination of other Department activities for detecting and preventing fraud and abuse in its programs and operations.

In addition, the law provided that the Inspector General shall establish within his office a staff specifically responsible for anti-fraud and anti-abuse activities relating to Medicare, Medicaid, and other health programs authorized by the Social Security Act.

HEW Audit Agency

The HEW Audit Agency has developed a computer audit system for identifying selected providers and recipients suspected of abusing the Medicaid program. Since 1976 the Audit Agency has used these techniques in audits of several States and in cooperation with a New York U.S. attorney.

In March 1977, the HEW Audit Agency began Project 500, an effort to use its computer techniques to identify the 500 physicians and pharmacies most likely involved in Medicaid fraud and abuse.

As of June 1977, this project--renamed "Project Integrity"--had identified over 1,400 physicians and pharmacies that had apparently defrauded or abused the program based on data developed by HEW.

As of November 1977, the Audit Agency analyzed computer information on selected providers and identified 2,434 physicians and pharmacists for further investigation. These cases were being screened by HEW's Office of Investigations, and arrangements are being made State-by-State to have Federal or State agencies further analyze, investigate, and prepare cases for prosecution. For example: California has agreed to do this based on the data developed by HEW.

Office of Investigations

During the past 2-1/2 years, HEW's Office of Investigations has increased in size and responsibilities. During our previous review, the Office had only 10 investigators. By March 1977, the staff had increased to 56, 6 of which were located in Washington, D.C., and the remaining 50 in HEW's 10 regional offices. The Office had only 2 professional investigators in 4 regions and as many as 10 in 1. One investigator in each of six regions is assigned to investigate Medicaid fraud full-time. The other four regions

had no full-time individuals assigned to these investigations. However, investigators in these regions are assigned to Medicaid fraud cases according to priorities established by the investigator-in-charge. As of August 1977, the Office of Investigations had 114 authorized positions.

Nationwide during calendar years 1975 and 1976, 27 convictions resulted in cases involving Medicaid fraud which had been handled by the Office of Investigations. One Medicaid fraud case resulted in a Federal grand jury indicting a dentist on 75 counts for defrauding the Government on $21,000 in Medicaid claims. The charges included illegal submission and reimbursement of claims for services not provided, such as claiming costly emergency treatment visits for routine office visits and claiming reimbursement for services provided without medical cause. The dentist was convicted of criminal fraud and received jail sentences totaling 3 years. Only a small portion of the Office of Investigations' workload is related to Medicaid, with 35 of 236 active cases, as of March 1977, involving Medicaid. In addition to Medicaid, the Office conducts internal HEW investigations and investigates fraud connected with all other HEW programs, including student loans, Aid to Families with Dependent Children, and Social Security.

The investigator in charge, in HEW Region V in Chicago, told us that as of April 13, 1977, his Office was not working on any major Illinois Medicaid fraud cases. As of April 13, 1977, this Office had five investigators for all HEW programs in the six States in Region V, and it was investigating a Medicaid fraud case in Ohio. The Director said that he expected to hire two investigators to work on suspected Medicaid fraud cases in Illinois.

MEDICAL SERVICES ADMINISTRATION'S DIVISION OF FRAUD AND ABUSE CONTROL

Since April 1975, MSA had increased the persons responsible for evaluating State Medicaid fraud and abuse activities. MSA's Division of Fraud and Abuse Control had not performed independent fraud and abuse investigation. However, it had

- --completed limited initial assessments of most States' Medicaid fraud and abuse activities,
- --analyzed in detail claims processing problems in seven States, and
- --awarded several contracts regarding Medicaid fraud and abuse matters.

Because these activities were still underway on completion of our field work, we did not attempt to evaluate their effectiveness.

In May 1975 the Fraud and Abuse Surveillance Branch was established in MSA's Division of Program Monitoring with an allocation of 11 full-time positions. Prior to May 1975, MSA had only one employee working part-time to monitor States' compliance with Medicaid fraud and abuse regulations and to provide technical assistance to States in carrying out their responsibilities in this area. On April 8, 1976, the Division of Fraud and Abuse Control was established in MSA with 108 authorized positions. This Division assumed the responsibilities of the Fraud and Abuse Surveillance Branch. As of March 30, 1977, the Division of Fraud and Abuse Control had 93 professional employees--53 in headquarters and 40 in regional offices. The Division's mission and functions included fostering integrity of the Medicaid program by (1) monitoring and reviewing States' compliance with Medicaid fraud and abuse regulations and (2) providing technical assistance to States involved in developing, evaluating, and referring Medicaid fraud and abuse cases.

Since its establishment in April 1976, the Division's major effort has been conducting onsite reviews of provider claims in seven States--Massachusetts, Ohio, Georgia, Idaho, Louisiana, Texas, and Oregon. These reviews involved sending a team of 15 to 20 to a State for 60 to 90 days to examine the records of a sample number of providers, to detect discrepancies in provider billings and the States reimbursement system, and to recommend State actions for improving program administration and further investigating information on specific providers. In June 1977, the Health Care Financing Administration became operational, and the Medicaid Division of Fraud and Abuse Control and Medicare's Program Integrity Groups were consolidated into the HCFA Program Integrity Office. As of December 1977, that Office had 283 professional employees--89 in headquarters, and 194 in regional offices.

As of May 1977, the Medicaid Fraud and Abuse Unit of each HEW regional office had made or scheduled onsite assessments of each of the 53 States' and jurisdictions' Medicaid fraud and abuse control activities. These assessments were an initial attempt to determine various States' needs in developing their fraud and abuse control programs. HEW Region V, was not responsible for investigating suspected fraud and abuse in Illinois but must

evaluate States' programs in its region. As of September 1977 the Medicaid Fraud and Abuse Unit (which had been consolidated into the HCFA Program Integrity Office) was completing a draft report on IDPA's Medicaid fraud and abuse activities. The organization's evaluation consisted of a 4-day visit to IDPA by five persons and obtaining information from IDPA on its Medicaid computer system and fraud and abuse activities. The HEW regional office, however, had not given technical assistance to IDPA.

In April 1977, the Director of the Fraud and Abuse Control Division told us that through the detailed State reviews, the Division was increasing its capability to provide such technical assistance.

The Division has also awarded several contracts concerning Medicaid fraud and abuse matters. A contract for $196,000 was awarded to the accounting firm of Touche Ross and Co. for developing manuals on procedures for detecting potential abuse in reviewing physician, pharmacy, and nursing home records. Another HEW contract for $352,774 was awarded to the accounting firm of Wolf and Co. to use the manuals in nursing home audits in Massachusetts, Ohio, and Florida.

The Division of Fraud and Abuse Control also awarded a $100,000 contract to Morris Davis/Coopers Lybrand to develop guides containing procedures for detecting potential abuse in hospitals. As of May 1977 a first draft of a manual had been developed and tested in Georgia and in nine hospitals in Ohio.

REGIONAL OFFICE NOT PERFORMING REQUIRED MEDICAID FRAUD AND ABUSE ACTIVITIES

The Fraud and Abuse Control Division's headquarters' staff did not control the allocation, selection, and use of authorized field staff. The field components of the Division reported directly to the former SRS Commissioner of each HEW regional office. Consequently, its possible that some personnel, recruited for positions authorized for Medicaid fraud and abuse control, were performing many functions which were unrelated to fraud and abuse control.

For example, the Chief of the Medicaid Fraud and Abuse Unit in Chicago told us that three professional staff members assigned to the Unit had only worked there for 1 month since August 1976. As a result the then MSA Commissioner sent a memorandum in December 1976 to the Regional Commissioner requesting that assigned staff members work on

fraud and abuse matters. In March 1977 the Chief told us that all members of the unit were working on Medicaid fraud and abuse matters.

In April 1975, HEW added a requirement that their regional offices evaluate States' Medicaid fraud and abuse efforts in their fiscal year 1976 workplans. Workplans for all regions, except New York, were on file at HEW Headquarters. MSA Central Office personnel disapproved the workplans submitted by three regional offices for the following reasons:

HEW region	Reason for disapproval of workplan
Region V (Chicago)	Low level of allocated manpower
Region IX (San Francisco)	Major required actions not addressed
Region X (Seattle)	Unclear description of resource application

No followup action was initiated by MSA on missing or disapproved workplans.

Although MSA approved six regional workplans, it did not adequately monitor implementation of these plans. MSA scheduled management conferences with regional offices to determine to what extent the regions had implemented fiscal year 1976 plans. However, only one of the three scheduled conferences was held.

The Region V workplan for 1976, which was eventually approved, included the following objectives:

--To develop and maintain a detailed understanding of the structure and operations of State fraud and abuse surveillance systems, and to update this information quarterly.

--To track individual cases of suspected fraud and abuse through recovery and action by State and local prosecutors.

--To improve the quality and completeness of State reporting of fraud and abuse investigations.

--To bring all States into compliance with applicable HEW regulations governing fraud and abuse control.

We determined that Region V made no effort, in fiscal year 1976, to accomplish the first two objectives listed above. We also found limited effort by Region V in

reviewing data the States used to develop their reports. Implementing the fourth objective was extremely limited due to staff shortages.

COMPUTER TECHNIQUES TO IDENTIFY SUSPECTED PROVIDERS

In addition to the HEW Audit Agency Computer Audit System, three other computer techniques, designed to identify providers suspected of Medicaid fraud and abuse, are in various stages of development.

HEW has developed the Medicaid Management Information System (MMIS) to improve States' processing of Medicaid claims and management of their Medicaid programs. One component of the system is the surveillance and utilization review subsystem which identifies physicians and recipients which deviate from selected statistical norms for medical care. As of October 1977, 12 States had certified Medicaid Management Information Systems.

During 1976 the Control Analysis Corporation developed a computerized audit package or guide for analyzing Medicaid expenditures, called the Automated Medicaid Overutilization and Erroneous Billings Auditor.

In September 1976, HEW awarded a $200,000 contract to Arthur Young for developing a computer program to detect fraudulent and abusive practices of noninstitutional Medicaid providers. The Director of the Division of Fraud and Abuse Control, MSA, told us that the SRS Office of Information Systems did not coordinate awarding this contract with the Division of Fraud and Abuse Control. A January 26, 1977, memorandum from the MSA Commissioner to the Associate Administrator of the Office of Information Systems stated that the proposed system would duplicate existing capabilities. The Director believed that, in the future, awarding such contracts will be better coordinated with program personnel in the new HCFA organization.

IMPROVED COORDINATION NEEDED BETWEEN MEDICARE AND MEDICAID

Our April 1975 report indicated limited coordination between the Medicaid and Medicare programs. Program integrity staff in both programs did not adequately share information on potential fraud and abuse cases which were under investigation. We recommended that HEW establish a single unit for systematically coordinating investigations

of suspected fraud and abuse under both programs. Regulations requiring Medicare to give States data on Medicare providers which were under investigation were issued January 19, 1977.

IDPA provides the HCFA Region V Office of Program Integrity with information on terminated providers. Prior to the March 1977 reorganization, this information was provided to the then SRS Regional Office whose staff informed us that they did not provide this information to HEW Medicare officials. As of July 12, 1977, the Office of Program Integrity had not provided IDPA with data on providers terminated from the Medicare program or being investigated for fraudulent activities. However, the Office was implementing methods and procedures and preparing an agreement, to be signed by the Director of Illinois' Medicaid program, authorizing exchange of information on Medicaid and Medicare providers.

As a result of the lack of coordination before the reorganization, we found that six of eight physicians who had been terminated from the Illinois Medicaid program during 1976 continued to participate in Medicare, and Medicare was unaware of their Medicaid terminations. 1/ For example, we identified a physician who received over $140,000 in Medicaid payments in 1975 and was terminated in April 1976 for

--billing for services without patient records to substantiate that services were rendered,

--billing for services without documentation in the patients' record to substantiate that specific services were rendered,

--billing for an initial office visit more than once,

--billing for services rendered by another physician, and

--billing for hospital visits which were included in payment of the surgical fee.

1/The lack of coordination at the regional office level between Medicare and Medicaid on fraud and abuse activities, before the March 1977 reorganization, is also discussed in our May 23, 1977, report to the Subcommittee on Health, Senate Committee on Finance (Investigations of Medicare and Medicaid Fraud and Abuse--Improvements Needed, HRD-77-19).

This physicians' Medicare payments increased from $3,070 in 1975 to $17,856 in 1976.

We believe Medicare should have been notified that these providers had been terminated from Medicaid. Section 1862(d)(1)(c) of the Social Security Act provides for excluding providers from Medicare when the Secretary determines such persons furnished services or supplies substantially in excess of the needs of individuals or of a quality which fails to meet professionally recognized care standards. Prior to October 1977, any provider referred to Medicare had to be judged on fraudulent or abusive activities in the Medicare program rather than Medicaid because no provision existed under Medicare to require suspension of a physician or other individual practitioner from Medicare after having been terminated from Medicaid. 1/

Coordination between Medicaid and Medicare programs should improve due to the establishment of one Program Integrity Unit for both programs in HCFA. Additionally, HEW's Office of Inspector General which will supervise and coordinate relationships between HEW and other Federal, State, and local agencies in audit and investigation matters relating to preventing and detecting fraud and abuse, should improve coordination between the Medicaid and Medicare programs.

DEPARTMENT OF JUSTICE

Since 1976 the Department of Justice has increased its efforts to investigate and prosecute Medicaid fraud in several areas of the country. By a letter of February 4, 1977, the Department told us that in November 1976, Federal investigative resources for combating fraud in the Medicare and Medicaid programs were sizably increased when the Federal Bureau of Investigation (FBI) agreed to take joint responsibility with HEW for these investigations. In addition, the Department later stated that the U.S. Attorney's Office, Northern District of Illinois, had about 49 Medicare/Medicaid cases involving over 400 individuals and firms being considered for prosecution.

1/ Under Public Law 95-142 of October 1977, HEW may suspend a physician or other individual practitioner from Medicare who has been convicted of a criminal offense related to his/her involvement in either Medicare of Medicaid.

The FBI team leader for Medicaid fraud in Chicago told us that prior to August 1976, HEW and the FBI had generally agreed that HEW would handle Medicaid fraud cases at the Federal level. The only exception to this agreement in Illinois was a case in Chicago involving the FBI's Organized Crime Unit. However, since August 1976 the FBI in Chicago has been responsible for investigating selected suspected Medicaid cases. As of April 1977, 12 Medicaid cases were being investigated in the FBI's Chicago Office. The FBI investigations were being coordinated very closely with the Chicago U.S. Attorney's Office. The team leader stated that IDPA's Medical Audit and Review Division had been extremely helpful and responsive to FBI information requests.

The Deputy Director of the Governmental Fraud Unit of the U.S. Attorney's Chicago Office stated that, as of September 1977, his unit had 8 attorneys working half time on Medicaid fraud. He stated that as of that same time, approximately 37 providers had either been convicted or pleaded guilty to mail fraud and/or Medicaid misdemeanors.

In one case involving kickbacks from pharmacies to nursing home administrators, 11 individuals pleaded guilty to 209 counts of mail fraud and 112 counts of Medicaid misdemeanors. They received sentences totaling over $1 million in fines, jail sentences ranging from 30 to 90 days (or up to 3-years probation). This investigation and subsequent conviction were initiated as a result of a review of three Illinois nursing homes by the former Medicare Program Integrity Unit in Region V, at the request of the Senate Committee on Finance.

The Deputy Director told us he was very pleased with the cooperation and data received from IDPA's Medical Audit and Review Division. He also stated that as of September 1977, IDPA was the leading source of referrals to this U.S. attorney's office. He further stated that U.S. Postal Service inspectors and HCFA personnel had also assisted the U.S. attorney in developing cases for prosecution.

STATES' EFFORTS TO CONTROL MEDICAID FRAUD AND ABUSE

Since our previous report, State efforts nationwide to control Medicaid fraud and abuse have increased considerably. As of March 1977, according to statistics reported by HEW,

about 2,000 State personnel were involved in identifying and investigating Medicaid fraud and abuse. Approximately 1,600 are located in 5 States--New York, Texas, Illinois, New Jersey, and California.

During fiscal year 1976, the States, according to HEW statistics, initiated 3,383 investigations. This was a 27 percent increase over fiscal year 1975 investigations. States' investigations into Medicaid fraud and abuse led to 56 convictions in fiscal year 1976, 41 more than in the previous fiscal year. The following table compares the results of States' activities during fiscal years 1975 to 1976.

Summary of activities	1975	1976
Number of investigations initiated	2,657	3,383
Number of cases closed		
Referred to law enforcement officers	86	269
Without referral to law enforcement officers	358	2,372
Number of convictions	15	56
Number of providers terminated or suspended	Not Available	414

CONCLUSIONS

During the last 2 years, and particularly during 1977, HEW has significantly increased its efforts to identify providers that are committing Medicaid fraud or abuse. During 1977, the Office of the Inspector General began a nationwide effort in this regard. In addition, in June 1977, the Medicaid Division of Fraud and Abuse Control and Medicare's Program Integrity Group were consolidated into one HCFA Program Integrity Group for both programs.

Our review, which was conducted primarily during 1976, disclosed the following:

(1) Inadequate exchange of information between Medicare and Medicaid on terminated providers.

(2) The inability of HEW Headquarters' staff to assure that each region conducted scheduled reviews of State efforts to control Medicaid fraud and abuse.

(3) Limited HEW evaluation of, and technical assistance for Illinois' efforts to identify

providers involved in improper activities because HEW had not yet built up its capabilities in this area.

(4) The award of a Medicaid fraud and abuse contract by a staff group which did not coordinate the award with Medicaid personnel having program responsibility.

RECOMMENDATIONS

We recommend that the Secretary, HEW, direct the Administrator, HCFA, to require that the new Medicare/Medicaid Program Integrity Group:

--Coordinate the exchange of information between Medicare and Medicaid on terminated providers and make recommendations to the Secretary to terminate providers from both programs as appropriate.

--Follow up on regional work plans to assure that objectives are achieved, including scheduled reviews of State efforts to control fraud and abuse.

In addition, we recommend that the Secretary, HEW, direct the Administrator, HCFA, to require that contracts involving the operational aspects of identifying fraud and abuse awarded by staff groups be coordinated, prior to award, with cognizant personnel having program responsibility.

CHAPTER 3

FURTHER IMPROVEMENTS NEEDED IN ILLINOIS TO IDENTIFY SUSPECTED MEDICAID FRAUD AND ABUSE

Since our prior review, IDPA has progressed substantially in identifying suspected fraud and abuse. In addition, IDPA has established an organization to audit, investigate, and review such activities. IDPA has increased investigations, referrals for prosecution, terminations of providers, and recoveries of questionable payments made to providers. IDPA has also established a computerized system to identify providers most likely to have defrauded or abused the program.

However, substantial amounts collected by IDPA resulted from payments for duplicate or other unallowable billings. These payments might have been prevented by improved prepayment edits. This matter is discussed more fully in chapter 4.

IDPA also needs to coordinate with other State agencies on the necessary investigations of providers to determine if their medical licenses should be revoked.

If cost-effective, installing prepayment edits would reduce erroneous payments to be reviewed on a postpayment basis. IDPA staff could review more recent payments and payments to providers, such as pharmacies, whose payments had not yet been analyzed.

RESULTS OF MEDICAID TASK FORCE

In August 1974 the Governor of Illinois ordered the Director of the Office of Special Investigations to assume control of all State investigative efforts and to establish an effective investigative process using State resources as necessary to determine the extent of fraud and overuse of services in the Medicaid program. As a result, on September 1974, a Medicaid Task Force was established with personnel from the Illinois Bureau of Investigation, State Police, Department of Revenue, Department of Finance, and IDPA. The task force was under the daily operational direction of a special counsel to the former director of IDPA.

Under the direction of the former director of IDPA, the special counsel and IDPA staff developed computer programs to produce recipient and provider profiles so that data from IDPA payment records could be used to investigate potential Medicaid fraud and abuse.

By using information from provider and recipient profiles, the special counsel referred three cases to a U.S. attorney for prosecution. These were the first cases of potential Medicaid fraud ever referred by Illinois officials to a U.S. attorney for prosecution since Illinois' Medicaid program began in January 1966.

At the end of our earlier review, the special counsel told us he was still investigating several other cases, some involving "factors," 1/ to be referred to the U.S. attorney for prosecution, if warranted. See pp. 24 to 25 for further information on factors.

The Medicaid Task Force completed its activities in March 1975, and the efforts of the Task Force gave momentum to IDPA to strengthen its system for dealing with Medicaid fraud and abuse. These efforts included:

--Referring nine cases of potential Medicaid fraud to prosecutors, of which seven were closed without prosecution.

--Developing an audit manual, procedures for sampling claims, and selecting providers for audit.

--Completing 24 provider audits and identifying $329,000 in overbilled services.

1/ To define a "factor," for the purposes of this report, we used HEW Regulations (45 C.F.R. 249.31(a)(3)), which define "Factor" as an organization, that is, collection agency or service bureau, which, or an individual who, advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred, including transfer through the use of power of attorney, to such organization or individual for an added fee or a deduction of a portion of such accounts receivable. The term factor does not include business representatives, such as billing agents or accounting firms, which render statements and receive payments in the name of the individual provider, provided that compensation of such business representative for such service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

--Establishing procedures to insure due process to providers who might be terminated from the program or otherwise administratively disciplined for practicing in a way not consistent with the Department's requirements or for overbilling.

While the Medicaid Task Force's activities were an important step forward in dealing with Medicaid fraud and abuse in Illinois, much remained to be done by IDPA in March 1975 when the task force completed its activities.

INCREASED ILLINOIS ACTIONS TO IDENTIFY SUSPECTED MEDICAID FRAUD AND ABUSE

As of June 30, 1977, IDPA's increased efforts to identify suspected Medicaid fraud and abuse during fiscal years 1976 and 1977 have resulted in:

--Temporary suspension of 58 providers.

--Termination of 70 providers. 1/

--Identification of about $13 million in erroneous payments.

--Recovery of $6 million in erroneous payments.

--Implementation of a formal provider appeals program.

--Use of computer techniques to identify suspected Medicaid fraud and abuse.

1/ In October 1977, the Illinois State Supreme Court ruled that health care providers found guilty of fraud may not be removed from the Medicaid program by the Illinois Department of Public Aid. The court said that IDPA lacks statutory authority to terminate or suspend but does have authority to investigate allegations of welfare fraud and to turn the results over to a court prosecutor for further action. In December 1977, the Illinois State Legislature enacted legislation giving the Director, Illinois Department of Public Aid, authority to terminate and suspend health care providers from Medicaid.

The Chief, Bureau of Medicaid Audit and Review, estimated that, as of May 1977, IDPA had referred 60 cases to the U.S. attorney for prosecution.

IDPA has used and refined computer techniques developed by the task force to identify providers to be audited, investigated, or sent recoupment letters.

IDPA analysis of all physicians paid in excess of $2,500 from July 1, 1973, to December 31, 1974, used a composite system of 12 indicators to identify physicians who might be defrauding or abusing the program. The analysis identified 429 physicians for further review because they exceeded the norms established by IDPA. By April 1976, 307 physicians were either sent letters requesting repayment of funds or scheduled for audit. Fifty-three physicians scheduled for audit were deleted from the audit schedule in October 1976 and were sent letters requesting repayments because of insufficient staff and time to investigate for disciplinary action. We noted that one physician, deleted from the audit schedule, had received $17,596 in overpayments from IDPA for submitting 15 duplicate billings and using 1,800 questionable procedural codes. In April 1977, the remaining 122 physicians identified for further review were scheduled for audits.

IDPA has also used computer techniques to analyze payments to dentists, laboratories, optometrists, and other individual practitioners, including podiatrists. These analyses have resulted in identification of (1) duplicate payments to laboratories of $22,781 and billing irregularities by dentists of $247,495. In addition, 11 laboratories and 23 dentists have been identified for further review.

IDPA has not used computer techniques to identify other providers for further review, such as pharmacies and ambulance services.

The Chief, Bureau of Medical Audits and Review, told us that IDPA refined its computer techniques for 1977 to evaluate billings by, and payments to, providers from January 1, 1975, to June 30, 1976. He also stated that IDPA could use 14 indicators, rather than 12, of potential fraud and abuse for identifying deviant billing practices in analyzing physicians' billings.

Also, IDPA was analyzing the data on providers, to determine if common data characteristics (such as the ratio of amount paid to charges and average dollar amount per bill)

between providers' billings can be identified. IDPA plans to use the results of this analysis to improve its techniques for identifying providers suspected of Medicaid fraud and abuse. We believe HEW should assist IDPA in these efforts.

IDPA's efforts have been successful in using and improving computer techniques to identify potential fraud and abuse. However, IDPA needs to do more, as discussed in chapter 4, to improve prepayment edits to reduce (1) erroneous payments made and (2) time needed to analyze these payments on a post-payment basis. Further, IDPA has not analyzed payments to pharmacies and has only recently started analyzing payments made to most providers after January 1, 1975.

INCREASED ILLINOIS AUDITS AND INVESTIGATIONS

As of June 30, 1977, IDPA had performed 364 audits during fiscal years 1976 and 1977, and within 1 year conducted 125 investigations of Medicaid providers. The staff assigned to Medicaid audits had generally increased over the past 2 years until a hiring freeze in May 1977. The staff assigned to specific types of Medicaid investigations has fluctuated greatly.

Medicaid audits

As of April 1977, the IDPA Bureau of Medical Audit and Review had 82 assigned staff, including 64 professionals. This division had three main components:

(1) A research and program development section to develop computer techniques for identifying providers suspected of Medicaid fraud and abuse.

(2) A professional review section to examine suspected overuse or other instances of questionable medical care.

(3) A review and organization section to perform desk and field audits of Medicaid providers.

As of June 30, 1977, this bureau had audited 223 practitioners, 38 laboratories, 31 pharmacies, and 72 nursing homes. Providers are identified for audit primarily by tips or referrals from persons outside of IDPA and by analysis of provider computer profiles.

Our analysis of erroneous payments identified by IDPA's computer techniques showed that many erroneous payments, that is, duplicate payments for the same service, could have been prevented by improved prepayment edits. This matter is discussed on pp. 33 to 36.

This bureau has referred approximately 60 cases to the U.S. attorney's office for prosecution. The deputy attorney of the Government Fraud Unit in the U.S. Attorney's Chicago Office stated that the bureau had been helpful in providing information for prosecution of Medicaid fraud cases. He further stated that IDPA's Bureau of Medical Audit and Review currently is the major source of referring potential Medicaid fraud cases.

Medicaid investigations

In August 1975, IDPA's Bureau of Special Investigations established a medical vendor unit, with a staff of 7, to investigate Medicaid fraud. As of April 1977, this bureau had 30 full-time investigators. Fifteen of them are members of a Cook County unit, and the other 15 work in other parts of Illinois.

The number of investigators working on specific types of Medicaid cases has varied considerably. For example, we were advised that 30 investigators were initially assigned to the January 1976 clinical laboratory project because of the "60 Minutes" television special on this topic. However, within a month, only seven investigators were still assigned.

The bureau's responsibilities encompass more than Medicaid vendor investigations. Most of its investigative efforts are directed toward recipient abuse. During calendar year 1976, the bureau investigated 125 Medicaid provider cases. The chief of the bureau estimated that 75 of these cases were direct referrals from other sections of IDPA and that 50 were public referrals. Public referrals include hotline telephone calls and letters from citizens. As of April 1977, the bureau had 50 open Medicaid vendor cases.

The former director of IDPA instructed bureau officials that Medicaid investigative efforts should be directed to developing cases for referral to IDPA's audit section for recoupment or referral to the U.S. attorney's office for prosecution.

FACTOR-RELATED AUDITS AND ANALYSIS

A primary emphasis of the Medicaid Task Force (see p. 18) was using automated techniques to focus on relationships between factors and providers.

In July 1974, IDPA issued an administrative order to stop the mailing of payments to factors. IDPA was concerned that the arrangements between providers and factors could result in possible fraud. IDPA officials reasoned that providers might not know what charges had been submitted and paid on their accounts and that bills could be submitted for a higher fee than actually charged by providers. Factors initiated legal action to prevent execution of IDPA's July 1974 administrative action. An injunction was issued and was in effect until August 1976 when the factors' suit was dismissed.

The task force developed computer programs to identify factors and the providers who used their services. At the same time, it established criteria to select providers for audit.

Task force audits were heavily oriented to one factor. The information on this factor, which was developed during the task force audit, was forwarded to the U.S. attorney. The task force special counsel told us that the information presented warranted the convening of a grand jury. However, the U.S. attorney's office disagreed, and no prosecution resulted.

The task force also studied the assumption that factors had received preferential treatment from IDPA employees in processing claims. The study compared processing actions on provider claims submitted through two factors with claims submitted by providers who did not use those factors. The task force concluded the study results did not support the hypothesis that the factors had received preferential treatment from IDPA employees in processing their claims. Our subsequent inquiry led IDPA to perform a followup analysis, and IDPA also concluded that factors were not receiving preferential treatment.

We analyzed the scope of both studies and concluded that neither could be considered conclusive on the issue of preferential treatment because

--needed data was incomplete, or missing entirely,

--sample selection was not representative, and

--variables analyzed were subject to multiple interpretations.

According to the special counsel, the validity of the task force study was unimportant because it did not alter task force plans for investigating factors. He stated the task force had not completed investigating factors, and he assumed that IDPA would continue where the task force left off.

Starting in May 1976 IDPA audited five factors. From September to November 1976, IDPA gave the results of four audits to the Illinois Department of Registration and Education. In addition one case was given to the U.S. attorney in March 1977.

The chief, Bureau of Medical Audit and Review, told us that several providers discovered one factor was submitting higher bills than the providers had intended to charge. The audit report on this factor was referred to the U.S. attorney. The IDPA audit also identified the other factors as charging excessive interest rates. IDPA officials believed the factors violated the Illinois Collection Agency Act (usury law) and referred these findings to the Illinois Department of Registration and Education.

Public Law 95-142 provides for clarifying existing law to insure that a power of attorney cannot be used to circumvent the prohibition in existing law against using factoring arrangements in connection with payment of provider claims by the Medicare and Medicaid programs.

OTHER STATE INVESTIGATIONS OF MEDICAID FRAUD

Other organizations and agencies, including the Illinois Legislative Advisory Committee on Public Aid, the Illinois Attorney General's Office, the Illinois Department of Public Health, the Illinois Department of Registration and Education, and the Illinois Department of Law Enforcement have reviewed and investigated suspected Medicaid fraud and abuse in Illinois.

Illinois Legislative Advisory Committee On Public Aid

During 1976 the committee gave information on several providers to IDPA. Examples of such data concerning one medical center were:

--Sixteen billings for pregnancy tests performed within 2 weeks of an abortion on the same woman.

--Repeat billings for blood typing.

--Eighty-six billings, totaling $19,600, in which two doctors both saw patients on the same day, and both indicated on their bills that no other physician had rendered service to these patients.

IDPA Medicaid Audit and Review Groups researched and evaluated each finding and forwarded a memorandum to the deputy director regarding the review.

As a result of this referral, two physicians and the medical center pharmacy were suspended from Medicaid. As of April 1977, their cases had been appealed and were being evaluated as a part of IDPA's administrative review process.

Illinois attorney general

The Illinois attorney general hired a former IDPA employee as a consultant to work for the Illinois attorney general's and comptroller's offices for 7 months and to further investigate providers suspected of committing Medicaid fraud and abuse.

On April 14, 1977, an official of the Illinois attorney general's office told us that as a result of these investigations:

--One physician has been indicted.

--Many allegations involving factors, physicians, and IDPA employees were investigated, but insufficient evidence existed to warrant prosecutions.

--Information on the income of one factor's employee was turned over to the Internal Revenue Service.

--The statute of limitations ran out on an investigation of IDPA employees charged with giving factors preferential treatment.

--Coordination has taken place with the U.S. attorney's office.

One investigation identified an unlicensed physician (medical student) who provided services to Medicaid patients and billed and received payments from IDPA by forging the signature of another physician.

Staff of the Illinois attorney general's office in Chicago informed us that four attorneys in that office spend about 20-percent of their time defending IDPA in suits brought by suspended or terminated Medicaid providers.

Illinois Department of Law Enforcement

The Illinois Department of Law Enforcement investigates suspected fraud against the State of Illinois.

From January 1, 1976, to April 27, 1977, the department began 18 Medicaid investigations involving 26 investigators from the Illinois Bureau of Investigation, the Office of Investigations, and Illinois State Police. Four investigations involved assisting IDPA. During the same period, five providers were indicted because of the department's investigations. One case was referred to the FBI, and another was referred to the Illinois Department of Registration and Education. An additional case, involving three part owners of different pharmacies, was referred to the State attorney general, who presented the case to a grand jury. The individuals were indicted on 103 counts of forgery, 2 counts of theft, and 5 counts of conspiracy to commit theft. They had allegedly billed and received payments from IDPA by using patients' names and ID numbers to forge prescriptions.

No agreements on exchanging Medicaid fraud and abuse information exist between the department and IDPA. However, department officials are satisfied with the informal arrangements for exchanging information between the two agencies.

As of December 1977, the Department of Law Enforcement was working jointly with IDPA staff in assessing IDPA's capability to identify all fraud.

PROVIDERS TERMINATED FROM THE MEDICAID PROGRAM CAN STILL PRACTICE IN ILLINOIS

Most providers terminated from participating in the Medicaid program have not had their licenses revoked in Illinois. Some convicted of Medicaid fraud also have not had their licenses revoked. IDPA needs to coordinate its investigations with the Illinois departments responsible for licensing medical providers.

Illinois Department of Public Health

The Illinois Department of Public Health licenses clinical laboratories and nursing homes in the State. In November

and December 1976, seven nursing home owners, convicted of mail fraud and/or Medicaid misdemeanors, pleaded guilty to charges of receiving kickbacks from pharmacies. In return for kickbacks, pharmacies were given the nursing homes' business, which includes prescriptions and medical supplies. Four of these individuals were also nursing home administrators and the Illinois Department of Registration and Education is responsible for issuing licenses for nursing home administrators.

A department official told us that rather than revoking nursing home licenses, the department generally requested owners to divest their ownership interest in nursing homes to assure new management control of them.

From January 1, 1976, to February 10, 1977, IDPA gave the department data on laboratories and nursing homes terminated from Medicaid.

On July 26, 1976, IDPA notified the Illinois Department of Public Health that 24 providers' eligibility to participate in Medicaid had been suspended or terminated.

IDPA notified one medical laboratory of its intention to terminate the laboratory's eligibility based on its:

--Billing and receiving payment for services which were not rendered by the laboratory and which were, in fact, rendered by another provider of medical services.

--Billing and receiving payment for laboratory tests which were billed under a procedural billing code that included the performance of two tests when, in fact, only one was performed.

--Soliciting specimen referrals by and through its agent, on or about December 16, 1975, in a way which implied or offered rebates, kickbacks, or fee-splitting inducements.

Department officials informed us that IDPA's information was insufficient to revoke licenses and that the department must make its own detailed investigations before revoking a provider's license.

Illinois Department of Registration and Education

The Illinois Department of Registration and Education is responsible for licensing 33 professions, including physicians, dentists, pharmacies, and nursing home administrators in Illinois.

In November and December 1976 four nursing home administrators and five pharmacists were convicted of mail fraud and/or Medicaid misdemeanors.

As of May 1977, three of the four nursing home administrators' licenses had been revoked. In June 1977, the Department of Registration and Education Board of Pharmacists recommended that the department director revoke the licenses of three of the five pharmacists and suspend another pharmacist's license until January 1979.

In addition, as of March 15, 1977, IDPA had been referring to the department data on physicians terminated from Medicaid. For example, in September 1976, IDPA notified the department that four providers had been terminated or suspended, seven had either been reinstated or placed on probation, and eight voluntarily withdrew from Medicaid. One provider received a notice of intent to terminate for (1) submitting bills and being paid for eye examinations and prescription glasses that were not provided to public aid recipients and (2) accepting additional payments from patients for eyeglasses already billed and paid for by IDPA. Department officials informed us that IPDA's information was insufficient to revoke medical licenses, and the department must make an independent, detailed investigation to determine if a medical license should be revoked.

We obtained information which showed that six physicians continued to be eligible to participate in the Medicare program as much as 1 year after termination from Medicaid. (See p. 13.) As of July 1977, the department had revoked one physician's license and was investigating four others. The department's investigation of another physician revealed no violations to justify revoking his license.

A department official informed us that one physician had his license suspended for 60 days from December 1976 to February 1977 and was placed on 2-years probation in Illinois for having problems with Illinois' Medicaid program. The physician, part owner of a nursing home, had received kickbacks from a pharmacy. He pleaded guilty to the kickback

charges to a Federal grand jury and was convicted of a misdemeanor. As a result, the department filed charges against him under the "Illinois Medical Practice Act."

We were also informed by department officials that in June 1977, its Medical Disciplinary Board held hearings on two other physicians against whom the department had filed complaints. The board charged 1 physician with 10 counts of false billing and recommended that the department director censure him. The other physician was charged with 30 counts of billing for initial visits when less expensive services were provided. The board recommended that the department director suspend the physician's license for 60 days. The department director was expected to have acted on these recommendations by the end of 1977.

CONCLUSIONS

IDPA has improved substantially since our last review in identifying and investigating suspected Medicaid fraud and abuse. However, IDPA has not used its computer capability to analyze payments to certain provider groups, particularly pharmacies.

Also, most of IDPA's efforts to date have involved sending letters requesting repayment and auditing providers suspected of abusing the Medicaid program for the 18 months ended December 31, 1974. Only in April 1977 did IDPA start analyzing more current payments.

As discussed in chapter 4, improved prepayment edits would reduce erroneous payments made. As a result, IDPA would have to review, identify, and collect fewer erroneous payments on a postpayment basis, and could devote more resources to analyzing more current payments and additional provider groups.

In October 1977, the Illinois State Supreme Court ruled that IDPA did not have statutory authority to terminate or suspend health care providers from Medicaid. However, in December 1977, the Illinois State Legislature gave the Department of Public Aid authority to terminate and suspend health care providers for defrauding or abusing the Medicaid program.

Some providers convicted of Medicaid fraud or terminated from the Medicaid program continue to be licensed in Illinois and continue to participate in Medicare. IDPA also needs to coordinate with other State agencies in performing necessary

UNITED STATES
GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

--The computer was not programed to identify and tabulate all errors before rejecting a claim; thus claims were repeatedly entered and rejected until all errors were identified.

--Automated recipient eligibility files were not promptly updated or accurately maintained.

--The need for training of, and assistance to, providers to properly prepare claims to alleviate problems in processing claims.

CLAIMS PROCESSING IMPROVEMENTS

IDPA has reduced the average time to process and pay pharmacist claims and physician claims having no errors from 35 and 60 days to 18 and 22 days, respectively, for the 18 months ended June 30, 1976.

Since our last review, IDPA added personnel and equipment to increase resources applied to precomputer processing operations. IDPA has reduced rejects through increased provider education, improved response to provider inquiries, and return of ineligible claims before computer processing. Also, IDPA reduced record maintenance problems by replacing redundant and inconsistent eligibility files with one record containing all pertinent eligibility data for each public assistance case.

CLAIMS PROCESSING PROBLEMS PERSIST

While IDPA has improved its claims processing system several problems identified in our prior review still exist, including

--extensive manual processing,

--number of computer rejects, and

--inadequate accountability for processed claims.

Extensive manual processing

Our April 1975 report discussed IDPA's extensive manual processing of Medicaid claims. We reported that if IDPA furnished preaddressed envelopes to providers submitting many claims, it would not be necessary to sort claims manually by provider type, and this should reduce overall claims processing time.

During our prior review, the former director of IDPA said that it was evaluating the feasibility of furnishing preaddressed envelopes to providers to eliminate manual claims sorting. He also said he was considering minimizing or eliminating manual review of claims before entry into the computer.

Our earlier review also pointed out that manually kept records, dealing with the eligibility of providers to participate in Medicaid, duplicated records kept in IDPA's computer files. IDPA officials agreed that the manually maintained files duplicated existing computer files and were unnecessary.

Our current review showed that extensive manual processing of Medicaid claims still prevails at IDPA. We also determined that, except for pharmacists, IDPA did not provide preaddressed envelopes to providers and did not minimize or eliminate manual claims' review before entry into the computer.

As designed, the MMIS includes features to minimize manual processing operations and further reduce claims' processing time. In September 1977, IDPA officials stated that the MMIS, when implemented, would use preaddressed envelopes to reduce hand sorting of claims by provider type on receipt, and expanded computer edits would be used to replace manual review. They also stated that the above actions have been implemented for processing drug claims.

Further improvements needed in reducing computer rejects

Our April 1975 report recommended that IDPA improve claims input and reduce computer rejects by using preprinted provider and recipient identification data. In our current review, we learned that IDPA had not implemented this recommendation because an IDPA study had shown that using preprinted provider and recipient identification data would be too expensive.

In March 1976 about 294,000 claims were awaiting review by IDPA's Error Correction Unit. At least 90,000 of these claims had been rejected initially because of possible recipient ineligibility.

In addition, our prior review showed that IDPA's prepayment duplicate payment edit did not include a test for the services' type. Claims for different services by the

same providers to the same recipient on the same day were erroneously assumed duplicate and were returned to providers.

A December 1975 HEW Audit Agency report concluded, and we agree, that a more sophisticated computer routine could almost completely eliminate rejecting claims incorrectly identified as duplicates.

During the 18 months ended June 30, 1976, IDPA's computer rejected 4 million claims, or about 10 percent of all the claims received. About 60 percent, or 2.4 million claims, were rejected because of possible duplication of payments or questionable recipient eligibility.

An IDPA study showed total processing time to reject, reprocess, and pay validated claims as between 5 and 6 months. This did not include the provider's time to process and resubmit the claim or any time used by IDPA to assist the provider.

IDPA Error Correction Unit personnel told us they have insufficient staff to process the backlog of rejected claims. IDPA hired outside help to reduce backlogged drug claims.

As of September 1977, IDPA was planning additional measures, generally for implementing an MMIS, to minimize rejects and process claims in a more timely way. Specifically, IDPA planned to require provider submission of claims within a year from the service date, and implement automated error control and correction procedures. Further, the Illinois' MMIS was designed to include more sophisticated computer edits to eliminate rejection of claims incorrectly identified as possible duplicates.

In September 1977 IDPA officials told us that claims awaiting corrections by the Error Correction Unit had been reduced, and the department planned to allow high volume providers to submit billing information on tapes.

Inadequate accountability for processed claims

Our April 1975 report recommended that IDPA assign control numbers to claims on receipt. The former director of IDPA agreed to this and stated that a suspense file would be established to control claims rejected by the computer. He also stated that all claims would be microfilmed on receipt.

As of September 1977, IDPA had not implemented our recommendation for provider claims other than drugs, and, as a

result, neither IDPA nor its local offices had adequate records to account for claims received and processed. Accordingly, it was not possible to determine if all incoming claims were processed or if all corrected claims were properly validated for payment.

In September 1977 IDPA told us that, as part of its MMIS, IDPA will assign control numbers to claims on receipt, establish a suspense file to control rejected claims, and microfilm all incoming claims.

Lack of control over use of override codes

Using an override code permits a claim to bypass one or more computer edits that might cause repeated rejection of the claim. IDPA justified such use based on the premise that reviewers who validate claims would have more accurate or complete data than that in the computer.

IDPA does not monitor or otherwise account for using these codes. IDPA's Bureau of Medical Audit and Review has identified $309,563 in paid duplicate claims, some of which resulted from the use of override codes.

During this review, we randomly sampled 50 duplicate paid bills from a universe of 4,085 paid bills. We identified $2,441 in duplicate paid bills, of which over $1,700 resulted from using override codes.

On September 14, 1977, IDPA officials told us that now they prepare monthly reports on the use of override codes and procedures and have also implemented controls on such use. The officials also stated that for the 3 months, June to August 1977, override codes were used for 135,366 of the 6-million claims processed. The claims paid through use of override codes amounted to $11 million, or about 5 percent of the total amount of claims processed for the same period, or $239 million.

INADEQUATE COMPUTER PREPAYMENT EDITS

The IDPA Claims Processing System has inadequate computer edits for preventing invalid payments. Effective prepayment edits would have prevented erroneous IDPA payments of about $3.5 million to physicians and pharmacists. Additional invalid payments are likely to have occurred because IDPA has not used computer prepayment edits on nursing home claims since June 30, 1974, to check for duplicate claims or for services provided to ineligible recipients.

Physician claims

On a postpayment basis, IDPA's Bureau of Medical Audit and Review found over $1.9 million in improper payments to physicians from July 1973 to December 1974. Many of these would have been prevented if prepayment computer edits and associated paid claims history files were complete and accurate when claims were originally processed.

The audit detected improper payments by using the computer to identify certain common characteristics between separate billings. The improper payments included duplicates for the same service to the same recipient on the same date. The computer also detected the following incorrect payments:

--Those for more than one initial office visit. Rates for initial office visits can be higher than for followup visits. IDPA regulations allow only one initial office visit charge per recipient per physician.

--Those for postoperative care within 30 days of an operation. These charges are normally part of the fee for the surgical procedure, and IDPA routinely disallows them when identified.

The IDPA prepayment computer operation includes a review for identifying and rejecting duplicate claims. However, this operation did not compare all elements needed to identify a duplicate. Kind of service had to be identified by a later manual review since it was not in the paid claims history file used in the prepayment computer operation. In contrast, the audit group's postpayment computer operation compared and identified the type of service.

Also, the postpayment operation established that the history file used in the prepayment operation contained inaccuracies and omissions and that later manual review was not always effective. A prepayment review comparable in completeness and accuracy to the postpayment review mentioned above would have identified the same duplicates prior to claims payment, but such a review can work effectively only if IDPA maintains an up-to-date paid claims history file.

No prepayment computer review occurred for the other two types of improper payments--multiple initial visits and postoperative care. We believe more sophisticated and complete prepayment edits could also have detected and prevented these

unallowable payments from occurring. In September 1977, IDPA officials told us that when implemented the Illinois MMIS will expand prepayment physicians' review to detect unallowable multiple billings for initial office visit charges and postoperative care, and to compare services provided on separate claims so that duplicate claims are more accurately identified.

Pharmacists' claims

We estimate that IDPA incorrectly paid at least $1.6 million for duplicate claims and unauthorized prescription refills to pharmacists during the 20 months before June 1976. IDPA had no prepayment computerized review for routinely detecting these payments. We identified them by comparing data in separately submitted billings.

IDPA procedures require authorization of prescriptions and prescription refills by a doctor or dentist and evidence of such authorization to be provided to IDPA by the pharmacist. Also, IDPA procedures provide that

--no more than two refills of a prescription can be authorized and

--no refill can be honored more than 3 months after the original prescription date.

Using IDPA's paid claims history file, we identified, on a random sample basis, the number of duplicate payments and unauthorized refills improperly paid by IDPA. The file contained about 26 million claims for prescriptions provided after September 1974 and paid for before June 1976 and costing IDPA $113 million. Based on our sample, we estimate that IDPA incorrectly paid at least $1.6 million--$0.8 million for duplicate claims and $0.8 million for unauthorized refills.

IDPA officials told us in September 1977 that the MMIS, which is operational for drug claims, includes a prepayment edit for duplicate payments. However, they stated that unauthorized refills, except for more than three over 3 months, will only be checked on a postpayment basis.

Nursing home claims

IPDA paid over $10 million a month in Medicaid claims to nursing homes from January 1975 to April 1976. In December 1975 the HEW Audit Agency reported that these

claims were not screened by the computer before payment to identify claims previously paid or claims for services to ineligible persons. The absence of such screens increased the possibility that duplicate or ineligible claims had been paid.

HEW auditors also noted that before July 1974, IDPA had such screens in place. The screens consistently resulted in the rejection of 10 percent of total nursing home claims, including 4 percent as ineligible and 1 percent as duplicates. Effective July 1974, these prepayment screens were eliminated, and nursing homes were told to submit their claims to local public aid offices. Local offices were given 5 days to review, approve, and forward the claims to the central office for payment.

This was to expedite payments and deal with incorrect payments on a postpayment basis. However, after the change in procedures, IDPA did not provide local offices with the postpayment information necessary to detect and correct any improper payments. For example, IDPA was supposed to provide the local offices with a postpayment list of claims for services to apparent ineligibles for identifying possible overpayments or, if eligible, to correct the central office eligibility files. However, the lists were never forwarded to local offices. Also, another list for identifying duplicate payments was not always provided, and one office we visited had received only about half its lists for the prior year.

During 1975 the HEW Audit Agency reported on IDPA's elimination of the prepayment screens and recommended that IDPA reinstate them. It also recommended that IDPA reimburse the Federal Government for its share of invalid payments made in the absence of computer screens. IDPA officials disagreed with the recommendations and expressed confidence in local office procedures because IDPA's Bureau of Internal Audits had not found any improper payments.

IDPA reinstated the computer prepayment eligibility test in April 1976 shortly after we initiated our review of nursing home claim processing procedures. Over 1,800, or about 6 percent of all nursing home claims, were rejected by the computer in the initial reapplication of this edit. However, IDPA had no plans for immediately reinstating the prepayment edit to detect duplicate claims or to determine improper payments made during the period that computer prepayment edits for eligibility and duplication were not used.

The Illinois MMIS is being designed so that the computer will edit all Medicaid claims before payment to assure that identical claims are not paid and that recipients of service are eligible.

REPEATED DELAYS IN IMPLEMENTING A MEDICAID MANAGEMENT INFORMATION SYSTEM

In 1971 HEW developed a model Medicaid Management Information System to help States improve their management information and claims processing systems to effectively administer Medicaid programs.

IDPA's MMIS is intended to be highly automated and sophisticated for achieving efficient claims processing and for providing data necessary for effective program management, audit, review, and reporting. Under the Social Security Amendments of 1972, States can be reimbursed by HEW for 90 percent of operating costs.

In August 1974, SRS approved IDPA's MMIS advance planning document for funding, and 3 months later approved a development grant for the system. On February 14, 1975, IDPA submitted a detailed implementation plan for its MMIS to HEW, Region V. Under this plan, full implementation was scheduled by March 1976.

In February 1975, at the end of our earlier review, IDPA told us they expected full implementation of MMIS by March 1976. In September 1977, IDPA officials informed us that:

--The only operational part of their MMIS was drug claims processing.

--They planned to award a contract by the end of 1977 to operate all aspects of the Illinois MMIS by January 1979.

--They would like HEW to participate in contract selection to speed HEW approval of this MMIS contract.

IDPA personnel said that MMIS implementation delays were partially attributable to slow HEW approval of MMIS components, inability to hire or contract for data processing staff, need to complete other higher priority data processing projects, and need to accommodate both provider needs and State legal requirements (such as accepting the design of drug claim forms), and the coordination with other State agencies for design and development of MMIS.

CONCLUSIONS

Although IDPA has improved its Medicaid claims processing system, it has been slow to implement an MMIS and to eliminate the other claims processing problems identified in our April 1975 report. IDPA needs to reduce extensive manual processing of Medicaid claims and the number of improper computer rejects, improve their accountability for processed claims, and control using override codes. Further, IDPA needs to speed implementation of its MMIS to improve its claims processing system, including installing prepayment edits to reduce payment of duplicate and other unallowable billings.

Until IDPA installs and uses prepayment edits to reduce paying duplicate and other unallowable billings, IDPA will spend much time on a postpayment basis trying to recover erroneous payments made.

Our April 1975 report contained several recommendations which IDPA officials stated they would either take or consider. We recommended that to improve the Illinois claims processing system, the Administrator, SRS, should direct the Commissioner, SRS, Region V, to insure that IDPA

--assigns control numbers to claims on receipt,

--provides preaddressed envelopes to providers submitting large volumes of claims,

--improves claims input through more intensive provider education and preprinted provider and recipient identification data.

Except for drug claims, IDPA did not assign control numbers to claims on receipt from providers nor did it provide preaddressed envelopes to providers, other than pharmacists, submitting large volumes of claims.

IDPA has, however, improved claims input through increased provider education and has conducted a study which showed that preprinted provider and recipient identification data is too expensive.

RECOMMENDATIONS

We recommend that the Secretary, HEW, direct the Administrator, HCFA, to assist IDPA in implementing its MMIS and to insure that IDPA

--reduces extensive manual processing of Medicaid claims,

--reduces incorrect computer rejects,

--controls the use of override codes, and

--installs prepayment edits to reduce payment of duplicate and other unallowable billings.

COPY

UNITED STATES SENATE

Washington, D.C. 20510

November 12, 1975

The Honorable Elmer B. Staats
Comptroller General of the
United States
Washington, D.C. 20548

Dear Mr. Staats:

Recent Senate Special Committee on Aging hearings on Medicare and Medicaid abuses indicate there are continuing problems with the Illinois Medicaid program. At the request of Senator Percy, the General Accounting Office (GAO) submitted a report on this matter to the Senate Finance Committee Subcommittee on Health on April 14, 1975. Allegations of efforts to withhold and alter information and generally impede the GAO investigation which produced the April report have come to our attention. We request that the GAO immediately undertake a follow up investigation of the Illinois Medicaid Program with particular emphasis on these charges that efforts were made to impede the earlier investigation.

In addition, we would be interested in a thorough review and evaluation of the responses of the Illinois Department of Public Aid (IDPA) to the April report. In its response, IDPA claimed to have instituted corrective actions to every problem cited. Is this accurate? Has IDPA in fact improved its system for paying Medicaid claims, strengthened its capabilities in dealing with Medicaid fraud and abuse, and developed a more effective utilization review system?

We look forward to your attention on this matter at your earliest convenience.

Sincerely,

/s/Charles H. Percy /s/Adlai E. Stevenson

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Joseph A. Califano, Jr.	Jan. 1977	Present
David Mathews	Aug. 1975	Jan. 1977
Caspar W. Weinberger	Feb. 1973	Aug. 1975
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION:		
Robert Derzon	Apr. 1977	Present
Don I. Wortman (acting)	Mar. 1977	Apr. 1977
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
Don I. Wortman (acting)	Jan. 1977	Mar. 1977
Robert Fulton	June 1976	Jan. 1977
Don I. Wortman (acting)	Jan. 1976	June 1976
John A. Svahn (acting)	June 1975	Jan. 1976
James S. Dwight, Jr.	June 1973	June 1975
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
OFFICE OF INSPECTOR GENERAL:		
Tom Morris	Apr. 1977	Present

(106080)