REPORT TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON FINANCE
UNITED STATES SENATE

Improvements Needed In Medicaid Program Management Including Investigations Of Suspected Fraud And Abuse

Social and Rehabilitation Service

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

MWD-75-74

APRIL 14, 1975

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

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The Honorable Herman E. Talmadge
Chairman, Subcommittee on Health
Committee on Finance
United States Senate

Dear Mr. Chairman:

This is our report on Medicaid program management, including investigations of suspected fraud and abuse.

Our review was made pursuant to your August 6, 1974, request. As requested by your office, we have not obtained written comments from the Department of Health, Education, and Welfare or the State of Illinois. However, we discussed our findings with officials of the Department and the State, and considered their views in preparing the report.

As agreed with your office we have informed the Chairman, House Committee on Interstate and Foreign Commerce; the Chairman, Subcommittee on Labor-Health, Education, and Welfare, Senate Committee on Appropriations; Senator Charles H. Percy; and Senator Adlai E. Stevenson, III, that you will be providing them with copies of the report.

We plan no further distribution of this report unless you agree or publicly announce its contents. In this connection, we want to invite your attention to the fact that this report contains recommendations to the Secretary of Health, Education, and Welfare. As you know, section 236 of the Legislative Reorganization Act of 1970 requires the head of a Federal agency to submit a written statement on actions he has taken on our recommendations to the House and Senate Committees on Government Operations not later than 60 days after the date of the report and the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report. Your release of this report will enable us to send the report to the Secretary and the four Committees for the purpose of setting in motion the requirements of section 236.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

BHI	Bureau of Health Insurance
EPSDT	early and periodic screening, diagnosis, and treatment
GAO	General Accounting Office
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
SSA	Social Security Administration

COMPTROLLER GENERAL'S
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Social and Rehabilitation Service
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D I G E S T

WHY THE REVIEW WAS MADE

Because of numerous allegations of fraud and abuse in Illinois' Medicaid program, the Chairman, Subcommittee on Health, Senate Committee on Finance, asked GAO to

--evaluate the administration of the Medicaid program by the State of Illinois and by the Department of Health, Education, and Welfare (HEW) in that State and elsewhere;

--evaluate Illinois' system for paying claims under Medicaid;

--evaluate HEW's and Illinois' practices for conducting reviews of medical services furnished by institutions and other Medicaid providers; and

--determine the causes of existing problems in Illinois' Medicaid program.

GAO was also asked to obtain information on the administration of the Medicaid program in other States. This information came from HEW headquarters files and from work done by GAO in Indiana and Michigan.

FINDINGS AND CONCLUSIONS

States are responsible for administering their Medicaid programs. The Social and Rehabilitation Service of HEW is responsible for administering Medicaid at the Federal level.

HEW can withhold all Federal Medicaid funds or, under certain conditions, assess lesser monetary penalties if States do not comply with Federal requirements.

Between October 1, 1969, and September 30, 1974, HEW regions reported 2,300 instances in which States did not comply with Federal Medicaid requirements. However, HEW has not imposed monetary penalties against any State. (See pp. 19 to 22.)

Increased efforts needed to detect Medicaid fraud and abuse

Beginning in March 1974 numerous allegations of fraud and abuse in the Illinois Medicaid program

were reported by the Chicago press and other news media. One Federal agency, seven Illinois executive agencies, and four private organizations began investigations into the charges.

In September 1974 Illinois established a Medicaid Task Force to direct and coordinate a comprehensive investigation into the allegations.

As a result, in January 1975, three cases of potential fraud were referred by Illinois to the U.S. attorney--the first referrals since the beginning of the State's Medicaid program in January 1966.

One earlier case, out of 22 referred for prosecution at the State level, had resulted in a conviction in the State courts. Before the Task Force investigation Illinois had done little to investigate suspected fraud and abuse in its Medicaid program.

The Service has known since 1971 that Illinois' Medicaid plan and program operations have not complied with Federal regulations concerning the detection of fraud and abuse. However, the Service has not taken appropriate steps to insure Illinois' compliance with Federal Medicaid regulations.

At the request of the Subcommittee staff, a Medicare unit reviewed the procurement and use of drugs and laboratory tests at three Chicago Medicaid-Medicare nursing homes. Medicare, which is administered by the Social Security Administration, has a unit which investigates several thousand complaints involving possible fraud and abuse each year. The Medicare unit referred one case to the U.S. attorney as a result of this investigation.

The Service does not have a unit in headquarters or its regions to

--provide assistance to States in identifying potential Medicaid fraud and abuse,

--insure that States are complying with Medicaid fraud and abuse regulations,

--coordinate with Medicare on fraud and abuse matters, or

--investigate suspected Medicaid fraud and abuse cases.

Twenty States have never referred a suspected Medicaid fraud case to State or Federal law enforcement agencies for prosecution. (See pp. 10 and 11.)

Improved coordination of State Medicaid fraud and abuse investigations with Medicare is needed. A combined Medicare-Medicaid investigative unit should improve HEW's ability to investigate fraud and abuse under both programs.

Improvements needed in Federal management of Medicaid

The principal ways the Social and Rehabilitation Service has to monitor State Medicaid programs are

--testing State operations to determine whether programs are operating in accordance with Federal requirements,

--requiring States to submit financial and statistical reports which can be analyzed to assess program effectiveness, and

--conducting investigations and audits and hiring consultants to identify problems that need correction.

GAO found that the Service had not

--given sufficient attention to reviewing States' Medicaid operations,

--obtained or analyzed needed data to provide indicators of the effectiveness of State Medicaid programs, or

--given adequate consideration to recommendations made by consultants and the HEW Audit Agency for correcting program deficiencies.

For example, GAO believes the Service did not give adequate consideration to a HEW Audit Agency recommendation to review payments made to two Illinois institutions to determine whether services were provided to Medicaid patients in sections of those institutions which were not approved to provide services to Medicaid patients. (See pp. 25 and 26.)

Many of the deficiencies GAO identified in the management of the Medicaid program were also identified in a February 1970 report by the staff of the Senate Committee on Finance.

Improvements needed in Illinois' system for paying Medicaid claims

The system for paying claims under Medicaid in Illinois needs improvement. Manual processing, cumbersome work operations, and other management problems have delayed payment to Medicaid providers for long periods. The following problems in the system need correction

--lack of accountability of claims,

--unnecessary manual processing,

--ineffective use of computers,

--inaccurate files of those eligible to receive Medicaid, and

--insufficient provider and employee training.

All of these matters have been brought to the attention of

the director of the Illinois Department of Public Aid who informed GAO that the State had started corrective action.

Need to improve systems for reviewing the use of Medicaid services

Utilization review is a system to determine the appropriateness of medical care provided and to identify and prevent overutilization of medical services. States are required to have utilization review systems for institutional and noninstitutional (physicians, pharmacists, etc.) services provided under Medicaid.

Illinois' utilization review system for noninstitutional services did not provide a continuous evaluation of the necessity for and quality of services provided under Medicaid. Illinois did not routinely generate or evaluate profiles of services received by patients and profiles of services furnished by providers.

According to Illinois officials, the State now routinely generates and evaluates needed profiles. They said that Illinois planned to implement a Medicaid Management Information System which should improve the State's capability to perform utilization reviews. The cost of developing and installing such a system will be funded primarily by the Federal Government.

The 1972 amendments to the Social Security Act (Public Law 92-603) provided a penalty, effective July 1, 1973, for States' noncompliance with utilization review requirements for institutional services. In 1973 and 1974 the Social and Rehabilitation Service conducted evaluations and found that Illinois and many other States did not comply with all the requirements. The Service is currently analyzing the results of the 1974 evaluation to determine whether penalties should be imposed.

GAO believes that the Service should increase its assistance to States to develop effective systems for reviewing institutional and noninstitutional Medicaid services. The Service should also, before approving Medicaid Management Information Systems, insure that State proposals for such systems provide data needed to perform effective utilization reviews.

RECOMMENDATIONS

The Secretary, HEW, should direct the Administrator of the Service to

--insure that all States comply with Federal requirements for investigating suspected Medicaid fraud and abuse cases;

--insure that States coordinate their investigations

of suspected Medicaid fraud and abuse more closely with Medicare investigations;

--more effectively monitor States' Medicaid operations;

--revise State reporting requirements to include data that will provide indicators of the effectiveness of States' Medicaid operations;

--insure that HEW regional offices and States give adequate consideration to recommendations made by consultants and the HEW Audit Agency to improve States' Medicaid operations;

--assess financial penalties on States that do not take adequate steps to meet Medicaid requirements;

--increase technical assistance to the States to develop effective utilization review systems; and

--insure, before approving Medicaid Management Information Systems, that State proposals for such systems provide data needed to perform effective utilization reviews and provide for an efficient system for paying claims under Medicaid. (See pp. 36 and 44.)

The Secretary should also establish a single unit for the systematic, coordinated investigation of suspected fraud and abuse under both Medicaid and Medicare.

The Administrator of the Social and Rehabilitation Service should direct the Commissioner, Social and Rehabilitation Service, Region V, to review payments made to two Illinois institutions to determine whether services were provided to Medicaid patients in uncertified sections of those institutions. The Service should recover payments made for any such services. Additional work, if warranted, based on the results of the reviews at these institutions should be done at other institutions.

Also, to improve Illinois' system for paying Medicaid claims, GAO made several recommendations to the Administrator. (See pp. 36 and 37.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

In accordance with the Subcommittee's request, GAO did not request written comments from HEW or Illinois but discussed the matters in the report with HEW and State officials.

HEW officials generally agreed with the facts presented in this report. They said that the Service was in the process of (1) establishing a Medicaid unit to assist and insure that States comply with Medicaid fraud regulations, (2) increasing its staff to

evaluate States' compliance with other Medicaid requirements, and (3) determining which States should be assessed penalties for noncompliance with specific Medicaid requirements.

State officials also generally agreed with the facts in this report. However, in addition to corrective actions already mentioned, they also said that (1) Illinois was in the process of establishing an improved capability to identify and refer suspected cases of fraud for prosecution and (2) Illinois had substantially improved its system for paying Medicaid claims and planned to make additional improvements.

CHAPTER 1

INTRODUCTION

Because of numerous allegations of fraud and abuse in the Illinois Medicaid program, the Chairman, Subcommittee on Health, Senate Committee on Finance, requested in August 1974 that we gather information on investigations of the Illinois Medicaid program being conducted by various Federal, State, and private organizations.

We held discussions with and reviewed the data gathered by four private organizations, seven State agencies, and one Federal agency that were investigating various aspects of Illinois' Medicaid program and then met with the Subcommittee to discuss the purposes, findings, and comprehensiveness of these investigations. At the Subcommittee's request we agreed to review and evaluate

--the Department of Health, Education, and Welfare's (HEW's) and Illinois' administration of the Medicaid program;

--the Illinois Medicaid claims processing system; and

--HEW's and Illinois' practices for conducting utilization reviews of institutional and noninstitutional medical services under Medicaid.

In addition, we agreed to examine the causes of the problems in the Illinois Medicaid program rather than investigate potential cases of fraud. We were also asked to obtain information on the administration of the Medicaid program in other States. Most of the information we obtained on other States' programs came from HEW headquarters files and from work done in Indiana and Michigan.

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 who are unable to pay for such care. The Federal Government pays from 50 to 81 percent (depending on the per capita income in the State) of the costs incurred by States in providing medical services under the Medicaid program.

Medicaid authorizes health care coverage for persons entitled to public assistance under the Social Security Act. In addition, States can cover other persons whose incomes and other resources exceed State requirements to qualify for public assistance but which are not enough to pay for necessary medical care.

The services provided to Medicaid recipients vary among States. However, as a minimum, all States must provide inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing home services; home health services; early and periodic screening, diagnosis, and treatment (EPSDT) of those under age 12; family planning services; and physician services.

Administration of Medicaid

At the Federal level the Secretary of HEW has delegated the responsibility for administering Medicaid to the Administrator of the Social and Rehabilitation Service (SRS). The Administrator, SRS, has assigned the general responsibility for administering Medicaid to the Commissioner, Medical Services Administration (MSA).

Each State has primary responsibility for administering its Medicaid program. The nature and scope of a State's program are contained in its State plan which, after approval by an SRS regional commissioner, provides the basis for Federal cost sharing with the State. The regional commissioner is also responsible for determining whether the State program is being administered in accordance with Federal requirements and the State's approved plan.

The Medicaid program in Illinois began on January 1, 1966. The Illinois Department of Public Aid (IDPA) administers the program. IDPA is responsible for making policy decisions, establishing fiscal and management controls, and reviewing program activities. In addition, it is responsible for approving, disapproving, or cancelling the certification of providers to participate in Medicaid.

Cost of Medicaid

The cost of providing health care to the poor under Medicaid has increased greatly in recent years. During fiscal year 1970 the Federal Government spent about $2.5 billion to provide Medicaid health services to an estimated 15 million recipients. The same type of services are expected to be available to 24.7 million recipients at a cost to the Federal Government of about $6.8 billion for fiscal year 1975.

During the 3-year period ended June 30, 1974, the six States in HEW's Region V--Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin--reported payments of about $5.1 billion for medical services to Medicaid recipients. The following table shows, in summary for the six States and separately for Illinois, the reported number of recipients and the amounts paid for Medicaid services.

	1972	1973	1974
	(millions)		
HEW Region V:			
Number of recipients	2.9	3.3	3.6
Medical assistance payments	$1,346.4	$1,638.6	$2,127.9
Illinois:			
Number of recipients	1.0	1.2	1.3
Medical assistance payments	$449.9	$520.0	$657.4

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 age 65 and over. Effective July 1, 1973, the Social Security Amendments of 1972 extended Medicare protection to (1) individuals under age 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 under age 65 who have chronic kidney disease.

Medicare, administered by HEW's Social Security Administration (SSA), provides two forms of insurance protection. One form, Hospital Insurance Benefits for the Aged and Disabled (part A), covers inpatient hospital services and post-hospital 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 the IDPA office,

Springfield, Illinois. We also visited Lansing, Michigan, and Indianapolis, Indiana, and several contractors of IDPA, including the Illinois Department of Public Health and the Illinois Foundation for Medical Care.

At IDPA we examined the policies and procedures for management of the system for processing Medicaid claims for payment and the system for monitoring the quantity and quality of Medicaid services.

In addition, we reviewed the policies and practices of HEW headquarters and HEW's Region V office used in monitoring the Medicaid program. We also reviewed the Medicare fraud and abuse files of the Program Integrity Unit of SSA's Bureau of Health Insurance (BHI) in Region V.

As requested by the Chairman's office, we did not request HEW or IDPA to provide us written comments on the contents of this report. However, we discussed our findings, conclusions, and recommendations with officials of these agencies and their comments were considered in preparing this report.

CHAPTER 2

NEED FOR INCREASED STATE AND SRS ACTIONS TO IDENTIFY AND INVESTIGATE SUSPECTED MEDICAID FRAUD

SRS has been aware since 1971 that Illinois' Medicaid plan and its program operations have not been in compliance with Federal regulations concerning the detection of fraud and abuse. However, SRS has not taken appropriate steps to insure Illinois' full compliance with Federal Medicaid regulations. From the beginning of the Medicaid program in Illinois in January 1966 to December 31, 1974, no cases of potential fraud had been referred by the State to the U.S. attorney for prosecution. Three such cases were referred in January 1975. Twenty States have never referred a suspected Medicaid fraud case to State or Federal agencies for prosecution.

SRS has taken the position that, since Medicaid is a State-administered program, the primary responsibility for detecting suspected fraud and prosecuting providers who submit fraudulent Medicaid claims rests with the States. Consequently, SRS does not have a unit to investigate suspected Medicaid fraud and abuse or provide assistance to States in developing their capacity to investigate suspected fraud and abuse in the Medicaid program.

SSA does have a unit--called the Program Integrity Unit--which investigates several thousand complaints annually involving possible fraud and abuse under Medicare. However, because of the absence of a fraud and abuse unit in SRS, coordination between Medicare and Medicaid on matters involving possible fraud has been inadequate, even though many providers furnish services under both programs.

In our opinion, a combined Medicare-Medicaid fraud investigative unit would improve HEW's ability to detect suspected fraud and abuse under both programs.

FEDERAL PENALTIES FOR FRAUD

Persons successfully prosecuted for fraudulently obtaining payments under Medicaid may be subject to criminal penalties under statutes of either general or specific application. Sections 286, 287, and 1001, title 18, United States Code, provide for penalties of fines of up to $10,000, or imprisonment of up to 10 years, or both. Section 1341 of title 18 provides for fines of up to $1,000, or imprisonment of up to 5 years, or both when the U.S. mail is used in the process of fraud. The Social Security Amendments of 1972 specifically 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 together with the cost of the law suit.

SRS HAS NOT REQUIRED ILLINOIS TO COMPLY WITH FRAUD REGULATIONS

Since the Medicaid program is State administered, SRS has taken the position that States have the primary responsibility for detecting and prosecuting providers who submit fraudulent Medicaid claims. According to HEW regulations dated March 27, 1971 (45 C.F.R. 250.80), 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 there is valid reason to suspect that there has been fraud;

--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 will establish and maintain procedures for reporting promptly to SRS each case of suspected fraud which has been referred by a State or local agency to law enforcement officials and subsequently the disposition thereof by such law enforcement officials.

Since July 1970 SRS' Region V has had the responsibility for monitoring the six State Medicaid programs in the region. The region generally prepared annual reports on State Medicaid plans. The purpose of the reports was to identify areas of States' Medicaid programs that were not in compliance with Federal regulations. The reports were to serve as a means of bringing the deficient areas to the attention of the States and SRS officials. Region V prepared reports on the Illinois Medicaid program in 1971, 1972, and 1974. (See ch. 3.)

The 1971 report stated that Illinois' plan needed revision in order to comply with Medicaid fraud regulations and

that an operational problem existed concerning the handling and referring of potential fraud cases for prosecution. The 1972 report also stated that Illinois' plan needed refinement in the procedures for detecting suspected fraud. It stated that the plan did not designate an individual responsible for referring cases of suspected fraud and did not provide for informing SRS of fraudulent providers and the disposition of fraud actions. The 1972 report listed the fraud aspect of the plan as an SRS priority review area for 1973. However, SRS Region V did not prepare a 1973 report on the Illinois Medicaid program.

The 1974 report stated that the resources allocated to IDPA's fraud and abuse unit were grossly inadequate considering the size of the Illinois Medicaid program. The report stated that one of the State's activities which required SRS regional office technical assistance was the investigation of suspected fraud.

ILLINOIS MEDICAID INVESTIGATIONS

Beginning in March 1974 numerous allegations of fraud and abuse in the Illinois Medicaid program were reported by the Chicago press and other news media. Seven Illinois executive agencies and four private organizations reacted by initiating investigations into the charges.

In September 1974 a Medicaid Task Force was established by the director of IDPA to direct and coordinate a comprehensive investigation into the allegations of Medicaid fraud and abuse. Before this investigation Illinois had done little to routinely detect and investigate suspected fraud and abuse in the Medicaid program.

The director of IDPA agreed that before September 1974 IDPA investigations of alleged abuses by providers had been ineffective because IDPA lacked administrative rules and regulations which would provide a Medicaid vendor an opportunity to appeal an adverse action. The lack of such administrative procedures had rendered IDPA vulnerable to legal action by providers against whom it had taken action. For example, as a result of threatened legal actions, IDPA was required to reinstate two providers--the owners of two large pharmacies--because before suspending the providers for alleged abuses IDPA had not held hearings at which the providers could respond to the charges.

Our review of the documentation gathered by the seven State agencies and four private organizations during their investigations before the establishment of the Medicaid Task Force indicated that the State agencies had directed their

investigations toward individual allegations rather than patterns of abuse or possible fraud by Medicaid providers or program administration deficiencies.

Special investigation

To provide coordination and direction to the ongoing investigations, the Governor of Illinois, in August 1974, ordered the director of his Office of Special Investigations to assume control of all State investigative efforts and to establish an effective investigative process utilizing whatever State resources might be necessary to determine the extent of fraud and overutilization of services in the Medicaid program. As a result a Medicaid Task Force was established in September 1974 with personnel from the Illinois Bureau of Investigation, State Police, Department of Revenue, Department of Finance, and IDPA. This Task Force was under the daily operational control of a special counsel to the director of IDPA.

The special counsel reviewed the information that was collected during the State investigations and concluded that the previous investigative work was directed at isolated allegations and that the cases were not sufficiently developed and, therefore, could not be referred for either State or Federal prosecution.

Under the direction of the director of IDPA, the special counsel and IDPA staff developed computer programs to produce recipient and provider profiles so that utilization data from IDPA payment records could be used to

--investigate alleged fraud and abuse regarding the operations of factors (billing companies that buy providers' claims at a discount and then attempt to collect the full amount of the claims from the State Medicaid agency);

--detect unusual patterns of medical services provided to recipients by physicians, dentists, optometrists, and pharmacies; and

--detect instances in which providers submitted multiple billings for services which were performed once or which were never performed.

Through use of the information extracted from provider and recipient profiles, the special counsel referred the following three cases to the U.S. attorney for prosecution.

--An optometrist, who allegedly overprescribed glasses to Medicaid recipients, billed IDPA for glasses or lenses which were not furnished or replaced and billed IDPA for replacement of lenses because the initial prescription was intentionally incorrect.

--A pharmacist, who allegedly provided Medicaid cards to recipients to procure drugs, repurchased the drugs from the recipients for a nominal amount and then resold the drugs.

--A physician allegedly billed IDPA for medical services for a number of recipients to whom he did not provide service.

These were the first cases of potential Medicaid fraud ever referred by Illinois officials to the U.S. attorney for prosecution since Illinois' Medicaid program began in January 1966.

The special counsel told us that he was still investigating several other cases, some involving factoring organizations, which will be referred to the U.S. attorney for prosecution if warranted. He also said that the investigation had not been directed to reviewing potential fraud and abuse by institutional providers (hospitals, nursing homes, and intermediate care facilities).

The director of IDPA informed us that he has

--approved a reorganization of IDPA's Medical Programs Division to incorporate the techniques developed by the Medicaid Task Force into IDPA's daily operations;

--established a Medical Analysis Section to implement programs developed by the Medicaid Task Force and to increase IDPA's capability to analyze vendor utilization and billing practices; and

--established a Bureau of Medical Audit and Review which will review and audit, on a routine basis, provider records and billing practices. Twenty auditors have been provided training and have been assigned to the Bureau.

Medical Advisory Committee review

Since 1966 a Medical Advisory Committee has aided IDPA in reviewing the quality and necessity of medical care provided to Medicaid recipients. As of January 31, 1975, the Committee had

reviewed the medical care provided by 40 of the 200 physicians who received the highest payments for service to Medicaid-eligible recipients during 1973. No formal final reports containing the findings and/or recommendations of the Committee have been given to IDPA; however, preliminary reports suggesting inferior quality of medical services provided to recipients, inadequate records to support medical services billed to IDPA, and overutilization of laboratory tests have been provided to IDPA. The director of IDPA told us that he has taken no action on the preliminary reports and will not do so until the Committee submits final, formal, and complete reports and recommendations.

NEED TO ESTABLISH COORDINATED MEDICARE-MEDICAID FRAUD AND ABUSE UNIT

SRS does not have a unit to (1) provide assistance to States in identifying potential fraud and abuse, (2) insure that States are complying with Medicaid fraud and abuse regulations, (3) coordinate with BHI on fraud and abuse matters, or (4) investigate suspected fraud and abuse cases.

SRS has taken the position that States have the primary responsiblity for following up on allegations of fraud in the Medicaid program. SRS believes that Medicaid providers suspected of fraud should be investigated and prosecuted at the State level.

This concept has not worked very well, as demonstrated by the fact that many States have never prosecuted a case of Medicaid fraud. The HEW New York regional director expressed dissatisfaction over SRS' incapability to deal with Medicaid provider fraud cases and in October 1974 made the following statements to the Administrator, SRS.

> "* * * As you know SRS has neither an adequate capacity to assist States in the development of their capability to investigate and deter fraud and abuse by Medicaid providers nor the staff skills to provide support to the U.S. Attorney when a case is referred for Federal prosecution.
>
> "Since the inception of the Medicaid program, we have been confronted frequently with headlines in the media regarding provider fraud and abuse. While SRS has maintained that the responsibility for initiating recovery and prosecution rests with the State, not the Federal government, SRS has done very little to assist States in developing their capacity to police this program. Further, when a U.S. Attorney in Region II recently accepted HEW's request that a very substantial Medicaid

fraud case be handled as a Federal prosecution, SRS lacked the professional program integrity staff to assist the U.S. Attorney in the preparation of the case. In this particular case, the Regional Director's Office secured a one-time agreement for the BHI Regional Office to provide the needed expertise needed to direct and coordinate the investigation * * *."

From January 1, 1972, through December 31, 1974, 27 States referred 526 cases to State law enforcement officials, and 208 of these cases were prosecuted. Eighty percent of these prosecutions were in California. In addition, five of the eight cases prosecuted in Federal courts were referred by Oklahoma. Twenty States have never referred a case for prosecution. Before October 1974 Arizona did not participate in the Medicaid program and information was not available on fraud cases referred for prosecution by the remaining two States. Although the Medicaid program began in 1966, SRS did not have information on the number of cases referred and prosecuted before 1972.

Illinois referred 22 cases to Illinois county attorneys between January 1, 1966, and December 31, 1974. Only one of these cases resulted in a conviction. Before January 1975 Illinois had not referred any cases of suspected fraud to the U.S. attorney.

In view of the problems identified in Illinois and the absence of referrals for prosecution in 20 States, we believe there is a need for Federal oversight to insure that States have the capability to investigate all suspected Medicaid fraud and abuse cases.

Medicare Program Integrity Unit

To help maintain the integrity of the Medicare program, BHI has established a Program Integrity Unit, which has a staff of 151 persons, assigned to SSA's central office and HEW's regional ofices. This Unit's purpose is to develop and carry out a program for fraud prevention, detection, reporting, and processing.

Each year the Unit investigates several thousand complaints involving possible fraud and abuse under Medicare. Although most fraud complaints prove to be unsubstantiated, from the beginning of Medicare to June 30, 1974, 242 cases of suspected provider fraud were referred by BHI to the U.S. attorney for prosecution. Of these 242 cases, 118 were prosecuted in Federal courts and 102 convictions were obtained.

From the introduction of its Program Integrity Unit in 1969 until September 30, 1974, BHI, Region V, completed 3,536 investigations of complaints of fraud or abuse. We reviewed 598 BHI complaint investigations closed between January 1, 1972, and December 3, 1974. The types of complaints investigated included billings by doctors for services not rendered, duplicate billings for the same service, and improper billing practices. BHI took administrative actions, including suspending providers, as a result of these investigations.

In addition, as of February 1975 BHI, Region V, had referred six suspected Medicare fraud cases in Illinois to the U.S. attorney for prosecution. The U.S. attorney had obtained a conviction in one case, was still investigating two cases, and had declined to prosecute the remaining three cases because they lacked sufficient evidence.

Limited coordination between Medicare and Medicaid

BHI, Region V, provides SRS with a monthly list of physicians who BHI has suspended for suspected fraud or abuse and an annual list of the providers in Region V who received the most Medicare funds. In August 1974 BHI, Region V, pointed out to BHI's central office that State Medicaid agencies did not provide BHI with similar information, but BHI, Region V, was working to establish such agreements with State agencies. The need for better coordination between BHI and SRS is demonstrated by the following examples.

In July 1974 BHI, Region V, received a complaint of widespread abuses in ambulance services. BHI started an inquiry but determined that the allegations pertained to Medicaid rather than Medicare. However, BHI did not inform SRS of the complaint until October 1974 (after we had talked to BHI about this subject). In December 1974 an associate SRS regional commissioner told us that he followed up on the complaint but because of the lack of specifics supplied by the complainant he stopped pursuing the matter and referred the name of the Medicaid provider to IDPA.

The lack of coordination between BHI and SRS is described in a memorandum, dated October 18, 1974, to the Administrator, SRS, from the director, HEW Region II:

> "* * * Many of the providers under investigation by BHI are also providers of services under Medicaid. Such providers probably abuse both programs.... Yet the degree of coordination between the two programs has been practically negligible because of the absence of a program integrity expertise in SRS for BHI to work with.

"The consolidation of program integrity responsibility for both programs in BHI would give the Medicaid program an instant program integrity capacity while at the same time achieving coordinated and simplified management at minimal administrative cost and with maximum potential for program saving."

We believe that a consolidated fraud and abuse unit for both Medicare and Medicaid would help control abuses and improve the effectiveness of both programs.

Special nursing home review

In August 1974, the Subcommittee on Health, Senate Committee on Finance, requested BHI, Region V, to review the procurement and use of drugs and laboratory tests at three Chicago nursing homes which were authorized to provide medical services to Medicare and Medicaid recipients. The Subcommittee asked BHI to make this review because SRS did not have a unit to investigate alleged fraud or abuse. The three nursing homes reviewed purchased all of their patients' pharmaceuticals from the same pharmacy.

During the review BHI, Region V, compared pharmacy claims paid by IDPA with prescriptions on patients' medical charts and evaluated other nursing home practices and procedures.

A November 1974 BHI report indicated that:

--There were no prescriptions for 17 of the 363 claims which the pharmacy had submitted to IDPA for Medicaid reimbursement.

--In all three nursing homes, patients' funds had been withdrawn by third parties without showing that the withdrawal was used for the patients' benefit.

--The pharmacy paid $4,500 a month to a management company for services performed at four nursing homes, including one of the nursing homes reviewed. The management company was owned by the spouses of the owners of one of the nursing homes reviewed. BHI officials were told that the services performed were reviews of patients' charts to determine the accuracy of medications ordered and dispensed. However, BHI Region V officials believed that the payment may have been a form of "kickback" for the privilege of obtaining the nursing homes' drug business.

BHI Region V officials informed us in January 1975 that the U.S. attorney was investigating the propriety of the

pharmacy's $4,500 monthly payment to the management company. Also, the handling of patients' funds had been referred to SSA's Bureau of Old Age and Survivors Insurance because the funds involved social security benefit payments. In addition, the investigative branch of SSA's Office of Administration plans to make a criminal investigation of one of these nursing homes.

In January 1975 we discussed with the Commissioner, MSA, the need for establishing a special unit to investigate suspected Medicaid fraud and abuse. The Commissioner agreed that such a unit was needed and stated that he planned to hire staff for such a unit at headquarters. He also planned to establish units in the HEW regional offices to investigate suspected Medicaid fraud and abuse if the Congress authorized the 108 new MSA positions which HEW has requested.

CONCLUSIONS

Illinois' efforts to investigate and refer suspected cases of Medicaid fraud and abuse for prosecution have been inadequate. IDPA did not routinely and systematically investigate and refer for prosecution suspected cases of Medicaid fraud and abuse. Accordingly, the Governor established a Medicaid Task Force to investigate many recent charges. The director of IDPA told us that he has established a unit which will use computer programs and the procedures developed by IDPA's special counsel to identify suspected cases of fraud and abuse. These actions should strengthen the State's efforts.

SRS has not insured States' compliance with Medicaid fraud and abuse regulations. Twenty States have never referred a case of suspected fraud and abuse to State or Federal agencies for prosecution. SRS does not have a Medicaid fraud and abuse unit to insure that the States comply with Medicaid regulations. SRS plans to establish Medicaid fraud and abuse units in headquarters and the regions.

Although the planned actions should provide SRS with an increased capability to identify and refer suspected cases of fraud and abuse for prosecution, we believe that a single Federal Medicare-Medicaid fraud and abuse unit would be more efficient and economical than having separate units for Medicare and Medicaid. Many providers of medical services participate in both programs and a single unit could avoid unnecessary duplication of investigations.

RECOMMENDATIONS

We recommend that the Secretary, HEW, direct the Administrator, SRS, to

--insure that all States comply with Federal requirements for investigating suspected Medicaid fraud and abuse cases and

--insure that States coordinate their investigations of suspected Medicaid fraud and abuse more closely with BHI investigations of suspected Medicare fraud and abuse.

We also recommend that the Secretary, HEW, establish a single unit for the systematic, coordinated investigation of suspected fraud and abuse under both Medicaid and Medicare.

CHAPTER 3

NEED FOR IMPROVED FEDERAL MANAGEMENT OF THE MEDICAID PROGRAM

States are responsible for administering their Medicaid programs. SRS is responsible for insuring that States' Medicaid programs are operating in accordance with Federal requirements. If a State does not comply with Federal requirements, HEW can withhold all Federal Medicaid funds from the State or impose lesser monetary penalties.

The principal ways SRS has to monitor State Medicaid programs are to

--test State operations to determine whether the program is operating in accordance with Federal requirements,

--require States to submit financial and statistical reports which can be analyzed by SRS to assess program effectiveness, and

--conduct investigations and audits and hire consultants to identify problems that need correction.

We found that SRS had not

--given sufficient attention to reviewing and evaluating States' Medicaid operations,

--withheld Federal funds from States that were not in compliance with Federal requirements,

--obtained or analyzed data needed to detect potential problem areas in State Medicaid programs, or

--adequately considered recommendations made by consultants and the HEW Audit Agency for correcting program deficiencies.

PROBLEMS IN MEDICAID ADMINISTRATION REPORTED BY SENATE COMMITTEE ON FINANCE IN 1970

In February 1970 the Senate Committee on Finance issued a report entitled "Medicare and Medicaid Problems, Issues and Alternatives" (Publication No. 35-7190, 91st. Congress). This report concluded that there were serious and costly deficiencies in the operation, administration, and supervision of the Medicaid program. The report pointed out that

--payments to Medicaid providers were slow,

--there existed little effective effort to determine whether medical services provided to recipients were necessary, and

--there was general laxity in administration.

The report recommended that the Federal administration and supervision of the Medicaid program be strengthened to assure that States were fully complying with the congressional intent of the Medicaid statute. The report also recommended the establishment of a Medicaid fraud and abuse unit to coordinate State and Federal efforts to curb fraud and abuse and punish violators.

Our review showed that many of the deficiencies identified in the report had not been corrected by SRS or the States.

MONITORING ACTIVITIES SHOULD BE STRENGTHENED

SRS, Region V, has not effectively monitored States' Medicaid programs for compliance with Federal regulations.

In July 1970 SRS headquarters delegated to the SRS regional commissioners the responsibility for monitoring State compliance with Federal Medicaid requirements.

At that time regional officials requested SRS headquarters to furnish guidelines for monitoring States' Medicaid operations. However, SRS headquarters did not provide such guidelines until 1973, and then the guidelines were incomplete. The Associate Regional Commissioner for Medical Services, Region V, told us that he considered the guidelines--a series of checklists--too inflexible for use in reviewing State Medicaid operations, and he said that the region had used only one section.

SRS, Region V, prepared annual reports on States' Medicaid plans for fiscal years 1971 and 1972 without guidelines from SRS headquarters. According to the Associate Regional Commissioner, these reports were assembled from data gathered during the years but SRS staff did not conduct on-site visits at the State agencies to determine specifically how the States' Medicaid programs functioned. He told us that he did not consider the 1971 and 1972 reports to be very worthwhile.

We reviewed the Illinois reports for 1971 and 1972 and found that

--SRS had primarily reviewed Illinois' written description of how its Medicaid program was supposed to operate rather than conducting an indepth, on-site review at IDPA to evaluate the operations of the Illinois Medicaid program and

--five problem areas identified in 1971 were again identified in 1972, indicating that action had not been taken to correct those problems.

Region V had a small MSA staff (usually three or four persons) to monitor the Medicaid programs in the six States in the region.1/ The Associate Regional Commissioner informed us that the limited staffing has hindered any meaningful program reviews and that the MSA staff has been engaged primarily in resolving crises. Staff assigned to monitor State Medicaid programs in other HEW regions is also limited.

MSA's limited staffing contributed to its inability to thoroughly review the Illinois Medicaid program in 1971 and 1972. Also, according to the Associate Regional Commissioner, limited staffing was the major reason Region V did not evaluate State programs in 1973.

In 1974 the Associate Regional Commissioner, Region V, drafted review guidelines to assist the region in evaluating State Medicaid programs.

In October 1974 the regional staff used the draft guidelines and issued a report on Illinois' Medicaid program. The report was based on a 3-day on-site review at IDPA and on other information which the regional staff had accumulated on the Illinois Medicaid program during the year.

The 1974 report identified 12 problem areas needing further review. Several of the areas had been reported in 1971 and 1972, for example (1) monitoring the care of aged mental patients, (2) institutional medical reviews, and (3) Illinois' system for investigating suspected fraud (see ch. 2). On January 24, 1975, the Associate Regional Commissioner told us that the 1974 report had been forwarded to Illinois officials for comment and that he did not expect to develop an action plan to review all areas identified in the report until he received the State's comments.

1/Other HEW Region V staffs assist the MSA staff in monitoring a few selected Medicaid priority areas, such as institutional utilization review, long-term care, and EPSDT.

SRS headquarters personnel, in November 1974, refined the guidelines that had been used by Region V to prepare the October 1974 report on Illinois' Medicaid program. From December 9 to December 20, 1974, a review team consisting of seven persons from the SRS central office and three persons from SRS' Region V used the revised guidelines as a basis for reviewing Michigan's Medicaid program.

While in Michigan the team gathered information from the State Medicaid agency, local Medicaid offices, a private ombudsman organization concerned with the needs of long-term-care patients, a provider association, recipients, providers, and others. The purposes of the review were to

--evaluate the management of the Medicaid program in Michigan,

--learn the strengths of Michigan's program and the means by which these strengths were developed, and

--learn the weaknesses or problem areas of Michigan's Medicaid program and the causes of the problems.

The SRS review team's general observation was that the administration of the Michigan Medicaid program was better than the administration found in most States.

We did not evaluate the guidelines used by the SRS team to determine whether the scope and procedures used were adequate to make an overall evaluation of Michigan's administration of the Medicaid program. However, we believe that periodic evaluations of the operations of all States' Medicaid programs are necessary to identify weaknesses or problems and to improve the overall management of the Medicaid program. Strong points found in a State's program should be disseminated to other States, and weaknesses disclosed and solutions to problems could be brought to the attention of the States to help them avoid or overcome similar problems.

PENALTIES NOT IMPOSED FOR NONCOMPLIANCE WITH MEDICAID REQUIREMENTS

Between October 1, 1969, and September 30, 1974, SRS regions reported over 2,300 instances in which States were not in compliance with Federal Medicaid requirements. This figure includes repeated violations--many States were reported not in compliance with the same Federal requirement on more than one occassion.

The Secretary of HEW has the authority to withhold all Federal Medicaid funds from a State that is not in compliance with Federal regulations. In addition, HEW can impose lesser monetary penalties against a State that (1) has not adequately provided for utilization reviews in institutions (see ch. 5), (2) has not implemented EPSDT programs, and (3) does not have family planning programs that meet Federal requirements.

As of March 1, 1975, the Secretary of HEW had not used his authority to withhold all Medicaid funds from a State, and HEW had not imposed other monetary penalties against any State. However, the Administrator, SRS, told us that he expected HEW to impose penalties against States for noncompliance with EPSDT requirements and utilization review requirements in the near future.

Authority to withhold funds

The Social Security Act authorizes the Secretary of HEW to withhold funds otherwise to be paid the State until such time as the Secretary is satisfied that the State is in compliance with the requirements of Federal law. The Secretary of HEW can withhold payments to States when (1) a State has submitted a plan for administering its Medicaid program that does not meet Federal requirements or (2) when an approved State plan is not carried out.

Even though SRS identified many instances in which States have not complied with Federal Medicaid requirements, SRS has initiated Medicaid compliance hearings only twice--in Missouri and Connecticut. In both instances the States came into compliance and funds were not withheld.

According to the Administrator of SRS, the compliance process is lengthy and cumbersome and generally ineffective. Also, the Commissioner, MSA, told us that SRS staffing in the regions and in headquarters has been inadequate to effectively monitor the Medicaid program and develop sufficiently the information needed to warrant holding compliance hearings.

EPSDT penalty

The Social Security Amendments of 1967 (Public Law 90-248) made EPSDT a mandatory Medicaid service and required implementation by July 1, 1969. The EPSDT program is designed to provide free physical examinations and medical diagnosis and treatment to children under age 21 who are eligible for such services under their State Medicaid programs. To influence

States to implement the EPSDT program, the 1972 social security amendments authorized HEW to impose a penalty--a 1-percent reduction of the quarterly Federal contribution to the aid to families with dependent children program--effective July 1, 1974, on States which had not made EPSDT services available to eligible persons or had not informed eligible persons of the availability of such services.

SRS regional offices evaluated each State's compliance with the EPSDT requirements. Region V completed its field reviews in November 1974, and the Acting Regional Commissioner, SRS, informed Michigan and Wisconsin that their EPSDT programs met Federal requirements. He informed us that a lack of provider participation in Ohio was not, in his opinion, the State's fault. An SRS Region V official told us that the other three States in Region V may be subject to a reduction in Federal funding because, as shown below, they had not implemented various Federal requirements.

State	Reason for possible penalty
Illinois	The State could not document that treatment had been arranged for children whose screening showed abnormal conditions.
Indiana	The State had not --established a procedure to inform eligible families that EPSDT services were available, --implemented adequate health assessment interviews to identify diseases or abnormalities, or --identified the specific screening services which were to be provided to eligible children.
Minnesota	The State had not --informed all eligible persons of EPSDT services, --begun to screen eligible children in July 1974, or --documented that screening, diagnosis, and treatment were provided.

In January 1975 the Acting Regional Commissioner told us that he intended to recommend that penalties be imposed against these three States.

The Administrator, SRS, said that HEW would impose penalties against States not in compliance with EPSDT regulations. He stated that, while 13 States had been identified as being possibly subject to the penalty, the number of States that a penalty would be applied to had not been determined.

Family planning penalty

The Social Security Amendments of 1972 also authorized HEW to impose a penalty--a 1-percent reduction of the quarterly Federal contribution to the aid to families with dependent children program--effective July 1, 1973, on States that failed to offer required family planning services. SRS, however, has not made the necessary reviews to determine whether States are in compliance with family planning requirements.

The Administrator, SRS, said that he has had limited manpower for that purpose and that other programs within SRS had higher priority. The Administrator stated that SRS recently started a survey to identify those States not offering the required family planning services. However, Region V officials said that surveys of States' family planning programs were not in process in Region V and such surveys were not planned because regional staffing was limited.

In responding to the question of imposing penalties, the Administrator, SRS, said that, in general, the threat of imposing penalties compelled some States to take action they otherwise would not take. He stated that the position of SRS was not to use penalties in a punitive way but to gain States' attention to achieve desirable program effects.

We agree that penalties are a serious matter; however, unless SRS imposes penalties when States fail to comply with Federal requirements, the deterrent effect of the penalties will lose its effectiveness.

NEED FOR IMPROVED STATE REPORTING

SRS requires that States submit to the regions three financial and five statistical reports pertaining to Medicaid. The reports include information on

--annual expenditures and projections and quarterly estimates and expenditures under the Medicaid program;

--annual and monthly statistics on medical care provided;

--annual statistics on recipients, payments, and types of services under the Medicaid program; and

--quarterly statistics on fraud investigations and hearings for providers of Medicaid services.

According to SRS Region V officials, the officials compare the States' current financial reports to prior reports for reasonableness and mathematical accuracy and send the reports to headquarters. SRS headquarters uses States' financial reports as the basis for the Federal Medicaid budget and in the quarterly computation of payments of Federal funds to States.

The five statistical reports are sent to HEW's National Center for Social Statistics where they are compiled on a national basis and are used in the preparation of analyses and forecasts. However, neither SRS headquarters nor Region V routinely analyze the statistical data to identify potential problems in State Medicaid programs.

At the request of the Senate Committee on Finance, the SRS Acting Regional Commissioner, Region V, on September 6, 1974, requested from each State in the region additional statistical data which would be useful in comparing trends in different States and might identify potential weaknesses in State Medicaid programs. However, some of the States in Region V could not provide even the most basic utilization data such as

--the number of admissions to institutions (hospitals, skilled nursing homes, etc.);

--the average length of stay in such institutions; and

--the average cost per prescription.

We believe this type of data is needed by SRS to effectively monitor and evaluate State Medicaid programs. The same data would also be useful to the States to monitor their own programs. SRS should provide to the States standard,

uniform guidelines on the data needed to effectively monitor the Medicaid program. SRS should also analyze this data to identify problem areas.

SRS HAS NOT ADEQUATELY CONSIDERED CONSULTANT AND AUDIT AGENCY RECOMMENDATIONS

The HEW Audit Agency periodically conducts audits which identify problems in State Medicaid programs and in SRS' Medicaid operations. In addition, SRS periodically hires consultants to identify problems in State Medicaid programs. Both the HEW Audit Agency and consultants make recommendations for corrective actions to SRS and the States. SRS and the States have not implemented several of the recommendations which, in our opinion, could result in substantial savings in Federal Medicaid funds.

Consultant recommendations

In June 1972, at a cost of about $375,000, HEW headquarters contracted with a consulting firm to develop and test a series of guidelines for conducting financial reviews of State and local governments' administration of grant programs authorized under the Social Security Act. By February 1974 the consulting firm had developed 26 financial review guides, including the following 9 guides for review of Medicaid grants to States: recipient eligibility, provider enrollment, provider reasonable charges, claims edit and processing, third party liability for services, utilization review of services, Medicaid buy-in of Medicare, fiscal agent management, and administrative and training costs.

The consulting firm field tested the draft Medicaid guides in Illinois. Three other consulting firms, at additional cost, field tested three of the guides--claims edit and processing, provider reasonable charges, and Medicaid buy-in of Medicare--in each of the other five States in Region V.

As a result of the field tests, the private consulting firms recommended improvements in Medicaid procedures and practices or further tests and evaluations in each of the States. Twenty-six recommendations were made to SRS, Region V, for IDPA procedural changes or for conducting further tests and evaluations.

We found that SRS, Region V, did not respond fully to most of the consulting firms' recommendations or insure that IDPA implemented the recommendations. For example, SRS did not:

--Perform additional tests of claims for long-term care paid in November and December 1972. Illinois had suppressed all computer edits for such claims during the 2 months, and the consultant firm estimated that the Federal share of improper payments was about $650,000.

--Review an unrestricted sample of calendar year 1972 drug claims. The consultant firm estimated that the Federal share of improper payments in the second quarter of fiscal year 1973 was about $8,000.

--Use additional procedures to identify potential third party payment sources and to recover such funds.

--Insure that IDPA periodically audits claims processed by outside contractors.

--Insure that IDPA develops procedures to compare provider claims with information in the recipient eligibility file for potential third party resources, such as private hospitalization coverage.

The SRS Associate Regional Commissioner, Region V, told us that SRS did not act on the consultants' recommendations because it did not have sufficient staff.

HEW Audit Agency recommendations

We reviewed four HEW Audit Agency reports regarding the Illinois Medicaid program and the actions taken by SRS on the reports' recommendations. SRS had not given proper consideration to implementing 8 of the 35 recommendations.

For example, the Audit Agency recommended that Illinois review claims paid for medical services which were provided to patients in uncertified sections of institutions. Institutions must be certified by the State as meeting Federal health and safety standards in order to participate in the Medicaid program. Some institutions are certified in total, while other institutions have only certain sections certified. The Audit Agency determined that Illinois made payments to some institutions for services provided to Medicaid recipients in sections which were not certified because they did not meet Federal requirements. The Federal share of these payments was estimated at $4.8 million. The State contended that a review of the payments was impossible because the certification of various sections of institutions had changed frequently during the period for which payments were made. The Acting Regional Commissioner, SRS, Region V,

accepted the State's position without obtaining sufficient information on which to base that decision.

We noted that about $2.7 million was paid to two institutions. The Audit Agency believed that the majority of patients in these institutions were furnished care in uncertified sections. We believe that a review should have been made at the two institutions and, if warranted, efforts should have been made to recover Federal payments for services provided in uncertified sections. Additional work, based on the results of the reviews at these two institutions, could have been done at other institutions.

In addition, during other GAO Medicaid reviews of third party collections and hospital reimbursements, we identified many instances in which SRS had not taken adequate steps to insure that HEW Audit Agency recommendations were implemented.

CONCLUSIONS

SRS needs to (1) more effectively monitor States' Medicaid operations, (2) revise State reporting requirements to include data that will provide indicators of the effectiveness of States' Medicaid programs, and (3) give greater consideration to recommendations made by consultants and the HEW Audit Agency to improve State and SRS Medicaid operations. These steps would permit SRS to be in a better position to determine whether Federal funds should be withheld from States for noncompliance with Medicaid requirements. These steps would also permit SRS to evaluate the accomplishments of the Medicaid program and identify areas needing improvement.

SRS should also review payments made to two Illinois institutions to determine whether services were provided to Medicaid patients in uncertified sections of those institutions, and, if so, SRS should recover such payments. Additional work, if warranted, based on the results of the reviews at these two institutions should be done at other institutions.

RECOMMENDATIONS

We recommend that the Secretary, HEW, require the Administrator, SRS, to

--more effectively monitor States' Medicaid operations,

--revise State reporting requirements to include data that will provide indicators of the effectiveness of States' Medicaid operations,

--assess financial penalties on States that do not take adequate steps to meet Medicaid requirements, and

--insure that SRS regional offices and States give adequate consideration to recommendations made by consultants and the HEW Audit Agency to improve States' Medicaid operations.

Also, the Administrator, SRS, should direct the Regional Commissioner, SRS, Region V, to review payments made to two Illinois institutions to determine whether services were provided to Medicaid patients in uncertified sections of those institutions. SRS should recover payments made for any such services. Additional work, if warranted, based on the results of the reviews at these institutions should be done at other institutions.

CHAPTER 4

NEED TO IMPROVE ILLINOIS' SYSTEM FOR PROCESSING MEDICAID CLAIMS

Many of the problems in Illinois' Medicaid program have stemmed from its claims processing system. Manual processing, cumbersome work operations, and other management problems have delayed payments to Medicaid providers for long periods.

PAYMENT CYCLE TOO LONG

IDPA reports show that between March and September 1974 the average time to process and pay claims was 60 days for physician claims and 35 days for drug claims. However, these averages are for clean claims--claims that are legible, contain all necessary data, and do not have errors. During October and November 1974 we sampled claims that were being processed for payment and found that for physician, optometrist, drug, and ambulance claims which had to be reprocessed--regardless of the reason--the claims processing cycle averaged about 300 days.

During fiscal year 1974 IDPA processed about 22 million claims. In July 1974 IDPA had on hand 2.1 million unpaid claims, of which about 400,000 or 20 percent had been on hand for over 90 days. It took IDPA a long time to pay these claims because many of the claims entered into the IDPA computer were rejected because the claims were illegible, incomplete, or contained errors. IDPA reports show that about 1.2 million, or 14 percent, of all claims entered into the computer system from March through June 1974 were rejected--necessitating manual verification and correction before the claim could be reentered into the computer for further processing and payment. Rejection rates ranged from about 9 percent for nursing home claims to 25 percent for physician claims.

Delays by IDPA in paying Medicaid claims caused cash flow problems for some providers. To ease these problems some providers resorted to using the services of factors. Allegations were made that factors received favored treatment by IDPA which resulted in their receiving faster payment with less reduction of the amounts billed than could be obtained by providers submitting their bills directly to IDPA. The director of IDPA told us, however, that the Medicaid Task Force found that factors had a higher rejection rate for bills submitted to IDPA for payment and that the bills took longer to pay.

The special counsel in charge of the Medicaid Task Force said that the Task Force examined contracts used by factors and providers and found that providers pledged their accounts receivable from IDPA to the factors. The factors charged a set fee (a billing service charge) in the form of a percentage (usually 11 to 15 percent) of the total bills accepted from the providers. In addition, the factors generally did not advance funds based on the full face value (less the percentage) of the providers' accounts receivable but rather reduced the amount advanced by an additional sum (usually 15 percent) for bills which the factors estimated IDPA would not pay. This means that the billing service charge and the amount withheld against possible rejection of bills usually amounted to up to about 30 percent of the total bills submitted by the providers.

The Task Force also found that contracts between factors and providers usually provided that the factors could withhold additional amounts as a result of higher rejection of bills by IDPA than projected by the factors. In addition, if the factors resubmitted the bills previously rejected by IDPA they could charge an additional 15 percent billing service fee on those bills.

IDPA has recognized that its claims processing operation has experienced serious problems. IDPA created an advisory committee in September 1974 to develop and initiate a plan by November 1, 1974, to pay Medicaid claims within 15 days after receipt without relaxing internal controls over claims. This committee concluded that more employees and equipment were needed to reduce the backlog of unpaid claims and pay incoming claims within 15 days. At the committee's recommendation, the director of IDPA established a Production Control Unit to reduce claims processing time by production scheduling, monitoring of work flow, and attention to "bottlenecks" in the claims processing cycle.

The director of IDPA informed us that as of February 1975 IDPA had been successful in reducing the average processing time to 19 days for physician claims and 15 days for drug claims.

PROBLEMS IN CLAIMS PROCESSING

Lack of accountability of claims

Neither IDPA nor local public aid offices have procedures to account for claims as they are received and processed. This makes it impossible to know whether all claims received are processed for payment and makes it difficult to trace claims.

Present procedures require only that IDPA estimate the number of claims received and processed. There are no records to show how many claims (1) are returned to local aid offices for correction, (2) are received by local aid offices, (3) are turned over to specific caseworkers for action, or (4) are resubmitted to IDPA.

This situation could be improved if IDPA would assign a control number to each claim as it is received so that it could be traced through the various processing steps. At local public aid offices, records could be maintained to show the receipt, processing, and disposition of claims returned by IDPA for correction.

The director of IDPA said he was initiating major changes in the claims processing system which include assigning control numbers to claims upon receipt. A suspense file is to be established to control claims which are rejected by the computer for any reason. In addition, all claims will be microfilmed upon receipt.

Manual processing

To eliminate the need to sort claims by type of provider, IDPA in May 1974 obtained different post office box numbers for each type of provider (physician, pharmacist, institution, etc.). Eligible providers were notified of their applicable postal box numbers. However, our observations of the mailroom operations revealed that a considerable quantity of mail from providers did not contain post office box numbers. As a result, IDPA personnel must manually sort such claims by type of provider, thus increasing the overall time and cost to process claims.

If IDPA furnished preaddressed envelopes to providers submitting large volumes of claims, it would not be necessary to manually sort claims by type of provider. This should reduce the overall claims processing time.

After claims are sorted by provider type, they are manually screened, and those with errors are removed from the processing cycle and corrected. This procedure is designed to speed claims payment by reducing the number of claims rejected by the computer. However, IDPA records show that 15 percent of claims on their initial entry into the computer are rejected even though they have been manually prescreened.

In addition, we observed that IDPA was manually reviewing dental claims which already had been reviewed by the Illinois Dental Service acting under contract with IDPA. This

appeared to be a needless duplication since under the contract the Service checks all dental claims (about 34,000 a month) for reasonableness of charges, diagnosis, and treatment. We believe that IDPA should only review on a sample basis claims previously reviewed by the Illinois Dental Service.

Another example of manual processing and duplication involved manually kept records dealing with the eligiblity of providers to participate in Medicaid. Most of these records duplicated those kept in IDPA's computer files. IDPA officials agreed that the manually maintained card files duplicated existing computer files and were unnecessary.

The director of IDPA said that IDPA was evaluating the use 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.

Ineffective use of computer

IDPA's computer is not programmed to take full advantage of its capability. The computer is not programmed to identify and tabulate all errors on a claim before it is rejected. The computer is programmed to check each data item sequentially. As soon as an error is identified the claim is rejected. A claim can be rejected after checking only the first data item. This item is then manually corrected, and the claim is reentered into the processing system. The claim can be rejected again during subsequent data checks and we identified instances when this happened.

We believe that IDPA's processing of claims would be improved if the computer checked all data items on the claim and listed all errors before rejecting the claim. This would minimize the need for multiple reentry of claims.

Inaccurate recipient eligibility files

IDPA has not promptly updated or accurately maintained its automated recipient eligibility files. During a 9-month period in 1973 and 1974 about 1.4 million claims were rejected by the computer because of indicated recipient ineligibility. Many of these claims were submitted for services provided to eligible recipients, but IDPA files had not been updated to show that the recipients were eligible.

Before a provider's claim can be paid, IDPA must make sure that the recipient named on the claim was eligible to receive Medicaid services on the date the service was rendered.

Recipient eligibility data is maintained by IDPA on magnetic tape files which include a master recipient file, an alphabetic name file, and a medical eligibility file. These files are updated during the same computer application. The recipient's case identification number shown on a provider claim is compared to data in the medical eligibility file. The computer rejects claims when:

--There is no record of a recipient's case identification number in the medical eligibility file.

--The recipient was not eligible for medical services on the date that the service was provided.

--The recipient's name does not match or correlate with the case identification number.

Claims rejected for recipient eligibility reasons are either routed to the appropriate unit at IDPA for resolution or returned to the provider--the latter is usually the case. The provider then usally sends the returned claims to the local public aid office where the recipient's eligibility is determined. The local office certifies the recipient's eligibility in most cases and returns the claims to IDPA for reprocessing. IDPA accepts the local office certifications and authorizes such claims to be processed for payment even though IDPA's medical eligibility file shows that the recipient was not eligible. According to an official in a local public aid office, it takes at least 30 days for a rejected claim to reach a local office for determination.

This entire process is cumbersome and time consuming and does not provide proper safeguards. For example, in visits to local public aid offices, we observed that some caseworkers certified the eligibility of persons whose claims had been challenged with little, if any, research of the person's records. According to office supervisors, certification of eligibility of returned claims carried a low priority and only a small number of persons had been declared ineligible.

Also, claims have been rejected for eligibility reasons because of ineffective communication between local public aid offices and IDPA. Local offices do not inform IDPA of the eligibility of persons at the time eligibility determinations are made but rather do so on a cyclical basis. This causes delays of up to 30 days or more in entering the recipient's eligibility data in IDPA's automated eligibility files and results in rejection of many claims. Also local public aid offices are not always timely in notifying IDPA that a recipient's eligibility has been terminated. For example, we

noted a case in which the recipient's eligibility was terminated in December 1973 on the records of the local office, but as of December 1974 the recipient's name was still on IDPA's medical eligibility file.

Rejections on the basis of eligibility have also been caused by inconsistencies in data in the three eligibility files maintained by IDPA. If these three files are not consistent, rejections will occur. For example, a claim was rejected because the medical eligibility file showed that a recipient's eligibility had been terminated in December 1973, yet the recipient was issued medical cards showing he was still eligible for medical services in April 1974. The medical cards are generated from IDPA's master recipient file. In another instance differences in the effective date of eligibility between the medical eligibility file and the recipient name file have caused problems in deciding whether a recipient was eligible on the date medical services were rendered.

The importance of accurate local office determinations of eligibility cannot be overemphasized because they are the basis on which IDPA pays claims in those cases where IDPA's records do not show the recipient to be eligible for Medicaid services. If the problems with eligibility files were corrected, processing of provider's claims could be expedited. If actions were taken to correct the problems mentioned above, fewer claims would be rejected by the computer for eligibility reasons and fewer claims would have to be processed by local public aid offices for eligibility determinations. By reducing the number of rejected claims, local offices should be able to more quickly process those claims needing a determination of the recipient's eligibility.

The director of IDPA informed us that he recognized the problems caused when IDPA eligibility information cannot be matched with such information on claims. He said that IDPA would merge its three eligibility files and changes would be instituted to insure that the IDPA file is maintained on a current basis. Such actions should reduce the number of certifications of eligibility that must be made by local offices.

In addition, the director stated that IDPA planned to furnish to Medicaid recipients either a card (with or without a photograph of the recipient) which could be used to imprint a recipient's name and identification number on provider claims or a card with recipient identification coupons to be affixed to provider's claims. This should eliminate two major errors now appearing on providers' claims--inaccurate

recipient name and number. Correcting these errors should reduce the number of claims rejected by the computer for eligibility reasons.

Need for training and assistance to alleviate problems in processing claims

As discussed earlier many claims submitted to IDPA were rejected from the computer and reprocessed because the claim was incomplete, inaccurate, or illegible. IDPA has conducted annual workshops to instruct providers in preparing Medicaid claims to reduce or eliminate these problems. Workshops have been held in about 12 selected locations throughout Illinois. Also, IDPA has installed toll-free telephones at its central office to respond to recipient and provider inquiries concerning Medicaid.

In addition to these measures, we believe IDPA should

--meet with and give assistance to providers who seem to be having the most difficulty in preparing acceptable claims,

--issue claim-filing information kits to providers, and

--notify providers of procedural changes in preparing and filing claims.

The director of IDPA told us that these measures were being addressed in his reorganization of IDPA's Medical Programs Division.

We also believe that IDPA could speed payment of claims by improving its internal operations. IDPA gives little emphasis to formal training of employees in the procedures to be followed in processing claims. Unit supervisors are responsible for providing new employees an overview of the unit's function, the specific procedures to be followed in processing Medicaid claims, and on-the-job training. Training, however, is based on each supervisor's acquired knowledge and interpretation of the unit's mission rather than on formal written operating instructions or training seminars. For example, handwritten instructions prepared by a former employee were the only operating procedures available to employees in one unit, and we observed that employees were sending claims to the wrong processing units, which delayed payments of those claims.

A formal training program and updated procedure manuals should help employees understand the program and the proper

procedures for processing and paying claims and should result in faster payment of claims.

According to the director of IDPA, actions are underway to establish a Vendor Education, Assistance, and Participation Section. This section is to conduct provider education programs, develop and disseminate provider handbooks, and deal with specific provider problems. He said that updated procedure manuals were made available to claims processing personnel in January 1975 and that major changes in the employees' training program would be implemented within the next 6 months.

Medicaid Management Information System

In 1971 HEW developed a model Medicaid Management Information System (MMIS) which was designed to help States improve their management information and claims processing systems so they could achieve greater effectiveness in administering their Medicaid programs.

The 1972 social security amendments authorize HEW to reimburse the States for (1) 90 percent of the cost of designing, developing, and/or installing mechanized Medicaid claims processing and information retrieval systems and (2) 75 percent of the cost of operating these systems when approved by the Secretary of HEW.

The Secretary has delegated to the Administrator, SRS, the responsibility for issuing regulations to implement section 235, approving the design of MMIS, and reimbursing the States for the costs of developing and operating MMIS.

In the fall of 1971 SRS officials began comparing State Medicaid operations to operations included in the model MMIS systems design. The purpose of these surveys was to persuade the States to adopt the MMIS design. SRS reviewed all available documentation concerning State Medicaid operations and conducted on-site reviews of State Medicaid systems, including the claims payment system.

The system survey of Illinois' Medicaid operations was made by SRS in October 1971. SRS recommended to Illinois in January 1972 several ways to improve its Medicaid operations. As of February 1975 IDPA had not implemented several of the recommendations.

In August 1974 SRS approved IDPA's MMIS advanced planning document for funding, and 3 months later SRS approved a grant to develop the system.

On February 14, 1975, Illinois submitted to HEW, Region V, a detailed implementation plan for its MMIS. According to the director of IDPA, many of the recommendations we have made regarding the Illinois claims processing system have been included in the plan. Full implementation of the system, under this plan, is scheduled to be completed by March 1976.

CONCLUSIONS

IDPA has been slow in paying providers for medical services rendered to Medicaid recipients because of an ineffective claims processing system. Delays in making timely payments to providers have caused some providers to discount their claims to factors in order to maintain sufficient cash flow. To speed payment of providers' claims, IDPA needs to (1) provide better controls over claims, (2) eliminate unnecessary manual processing operations, (3) take full advantage of its computer capabilities, (4) maintain accurate recipient eligibility files, and (5) improve the quality of claims input data. A better claims processing system would help detect fraud and abuse.

RECOMMENDATIONS

We recommend that the Secretary, HEW, direct the Administrator, SRS, to insure, before approving MMIS systems, that State proposals for such systems provide for an efficient claims processing system which will include elements such as (1) eliminating unnecessary prescreening of claims, (2) providing for computer programs which process claims so that all data items are checked for accuracy and all errors are listed before a claim is rejected, and (3) insuring that recipient eligibility files are accurately maintained.

Also, 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 upon receipt;

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

--revises the policy of manually reviewing all claims previously reviewed by the Illinois Dental Service, to reviewing such claims on a sample basis; and

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

CHAPTER 5

NEED FOR EFFECTIVE UTILIZATION REVIEW SYSTEMS

Utilization review is the system used to determine the appropriateness of medical care provided and to identify and prevent overutilization of medical services. Utilization review has two basic purposes: (1) to help insure that individuals receive high quality medical care and (2) to control program costs by preventing unnecessary use.

The Social Security Act requires States to have operational utilization review systems for all services provided by Medicaid and lists specific requirements for utilization reviews of institutional services. Our review of the utilization review system in Illinois showed that it had certain weaknesses which made the system ineffective. For example, Illinois did not routinely generate the type of utilization data necessary to review the utilization of noninstitutional (physicians, pharmacists, dentists, etc.) services and its utilization review system for institutional services did not meet all of the requirements of the Social Security Act. However, according to the director of IDPA, IDPA now routinely generates and analyzes utilization data for noninstitutional services.

SRS has not vigorously enforced the utilization review provisions of the Social Security Act as they relate to Medicaid when States have been found not in compliance with Federal regulations, and SRS has not imposed financial penalties on any State for failure to comply with institutional utilization review requirements--as provided for by the act. SRS should increase assistance to the States to develop effective utilization review systems and impose penalties on States that do not take appropriate steps to implement such systems.

ILLINOIS UTILIZATION REVIEW SYSTEM NEEDS STRENGTHENING

Section 1902(a) (30) of the Social Security Act requires States to have methods and procedures to review the utilization of care and services provided under the State Medicaid plan to safeguard against unnecessary utilization. HEW's implementing regulations require States to have statewide surveillance and utilization control systems to safeguard against unnecessary or inappropriate utilization of the care and services provided under Medicaid and to provide a basis for assessing the quality of these services. The utilization review system must provide for continuous review

of care and services which includes an ongoing evaluation, on a sample basis, of the necessity for and quality of these services and a postpayment review process.

According to HEW regulations, this program should provide for:

--Summarizing claims data to develop profiles of services provided or received and to screen and identify providers and recipients deviating by specified margins from prescribed parameters or norms of performance.

--Reviewing and investigating deviations to determine whether medical care or services had been appropriate or whether overuse has occurred.

--Implementing appropriate corrective measures in cases involving overuse.

Utilization review of noninstitutional services

The Illinois utilization review system does not provide a continuous, ongoing evaluation of the necessity for and quality of the services provided under Medicaid. IDPA has not routinely generated recipient profiles of services received and provider profiles of services furnished. IDPA has a limited utilization review system for noninstitutional services which consists of

--following up on complaints of fraud and abuse,

--instructing claims reviewers to be alert to identify unusual claims,

--reviewing the providers which receive the highest amount of Medicaid payments annually, and

--contracting with the Illinois Dental Service to make prepayment reviews of dental claims and postpayment tests of the quality of dental care.

IDPA officials recognize that their noninstitutional utilization review system needs to be improved and that recipient and provider profiles are needed to improve the system. The director of IDPA informed us that provisions for improving the utilization review system were an integral part of the State's MMIS implementation plan. He also said that IDPA planned to establish an MMIS which will provide data that can be used to control the use of noninstitutional

Medicaid services. IDPA's MMIS advanced planning document and implementation plan include a provision for profiles of recipient services and provider payments and for post-payment review. For example, pharmacy exception reports will identify excessive numbers of claims for one patient, excessive costs of prescriptions, and duplicate claims. The director of IDPA stated that the computer programs developed by the Medicaid Task Force have been used since January 1975 to routinely produce provider and recipient profiles.

Utilization review of institutional services

The 1972 amendments to the Social Security Act added section 1903(g) which set forth specific requirements for utilization review of services provided in institutions. The law provides that as of July 1, 1973, States must have institutional utilization review systems which provide that

--the physician certify at the time of admission that the patient requires inpatient institutional services;

--the physician recertify every 60 days that the patient continues to require inpatient institutional services;

--medical and professional personnel not directly responsible for the care of the patient and not employed by or financially interested in any similar institution conduct a utilization review of the necessity for admission and the continued stay of each patient;

--the medical review of the care of patients in mental hospitals, skilled nursing homes, and intermediate-care facilities is reviewed and evaluated at least annually by independent professional review teams; and

--utilization reviews in hospitals and skilled nursing homes meet the requirements of the Medicare system unless the Secretary of HEW waives this requirement because the State has a utilization review system better than Medicare's system.

The law provides that if these requirements are not met HEW is to reduce Federal payments to the State by one-third for the cost of institutional care provided to individuals for more than 60 days during a fiscal year (90 days in a mental hospital). The reduction is to be made unless the State makes a satisfactory showing to the Secretary, HEW, that the State has an effective system in operation.

IDPA has hired contractors to monitor the services provided by hospitals and long-term-care facilities (skilled nursing facilities and intermediate-care facilities).

The State presently uses Medicare's utilization review procedures for hospital and skilled nursing homes. The State also uses the Hospital Admission and Surveillance Program to control the length of hospital stays by Medicaid patients. IDPA has requested a waiver to Medicare's utilization review system. The request states that the Hospital Admission and Surveillance Program is superior to Medicare's system.

Illinois was without a satisfactory medical review plan to control Medicaid services in long-term care facilities until July 1974. At that time IDPA entered into a contract with the Illinois Department of Public Health to review Medicare and Medicaid services provided in skilled nursing homes, mental institutions, and intermediate-care facilities.

According to Illinois Department of Public Health officials, a medical team--consisting of a physician, a nurse, and a social worker--makes an annual review at each institution. The department sends a report on each inspection to IDPA informing it as to whether the patients are receiving appropriate care and recommending the transfer of patients where appropriate.

In 1973 and 1974 SRS surveyed the institutional utilization review programs in all States. The 1973 survey of Illinois' program listed the following deficiencies:

--Recertifications by physicians were haphazard and the State needed closer surveillance of the requirement.

--Physicians were not on site during all medical reviews.

--Medical reviews were not conducted in institutions for mental diseases.

The 1974 SRS survey in Illinois listed these weaknesses:

--About 18 percent of the intermediate-care facility cases reviewed were not in compliance with the recertification requirement.

--About 17 percent of the intermediate-care facility cases reviewed had not had their plans of care updated for over 60 days.

--Some of the hospitals and nursing homes surveyed had utilization review plans for Medicaid patients which did not meet all the requirements of Medicare.

--Utilization review in intermediate-care facilities did not meet the independent professional review requirements.

--Physicians were not on site during all medical reviews.

Federal payments to Illinois for institutional services were not reduced after the 1973 survey even though the State had not complied in full with institutional utilization review requirements. Because of the improvement in the State's utilization review program between the 1973 and 1974 surveys, Illinois was not cited for noncompliance after the 1974 survey.

HEW NEEDS TO ENFORCE UTILIZATION REVIEW REQUIREMENTS MORE AGGRESSIVELY

The SRS regional offices submit quarterly reports to SRS headquarters on States' compliance with Medicaid requirements. We analyzed the quarterly reports for all States and found numerous instances of States not in compliance with utilization review requirements. The following table lists for the quarterly reports submitted between April 1, 1970, and December 31, 1974, the issues reported and the number of States out of compliance.

Issue	States out of compliance
Utilization review procedures	25
Medical review procedures	43
Verification of services	4

We determined that the States were reported out of compliance for an average of 4.2 quarters with a range of from 1 to 15 quarters. No compliance hearings were ever recommended or held for noncompliance with utilization review requirements.

We analyzed 186 HEW Audit Agency reports issued between March 1, 1969, and April 30, 1973, dealing with State Medicaid programs. Sixty-four of these reports covering 38 States pointed out deficiencies in the States' utilization review systems. Over this period the HEW Audit Agency issued 2 reports in each of 13 States, 3 reports in 5 States, and 4 reports in another State dealing with utilization review deficiencies.

The Social Security Amendments of 1972 require that HEW survey States' institutional utilization review procedures to determine whether the one-third reduction in Federal payments for extended institutional stays should be imposed. SRS established institutional utilization review as a special initiative and established special units in headquarters and regional offices to evaluate State compliance. SRS conducted the first such evaluation from October to December 1973 although the penalty provision was effective on July 1, 1973. A second evaluation was conducted from July to September 1974. The results of these evaluations are presented in the following table.

Legal requirement	Number of States not in compliance 1973	1974
Physician certification	9	5
Physician recertification	32	7
Plan of care	15	6
Facility utilization review	26	23
Medical review by State	11	5

The Administrator, SRS, informed us that SRS had limited capability with respect to validating the effectiveness of State institutional utilization review systems in 1973. He stated that the 1973 evaluation was a preliminary sample of States' systems to allow SRS to refine its techniques for evaluating State compliance. According to the Administrator, SRS did not penalize any State as a result of this sample because SRS criteria for compliance were not specific. However, SRS obtained commitments from States to improve their systems when evaluations disclosed problems.

The Administrator, SRS, said that calendar year 1974 evaluations made by the regions to identify States not in compliance with requirements for institutional utilization review programs were being evaluated by SRS headquarters to determine whether penalties should be imposed against States. The institutional utilization review regulations (45 C.F.R. 250.19 and 20) became effective February 1, 1975, (19 months after the effective date of the legislative requirement). The Administrator stated that the regulations provided SRS with more specific criteria to evaluate whether States were complying with the legislation and that it was likely that 10 States will be penalized for not complying with the utilization review requirements.

CONCLUSIONS

Illinois did not have an effective utilization review system primarily because IDPA did not routinely generate and evaluate data that could be used to detect and prevent overutilization of medical services. The lack of recipient and provider profiles was a serious problem. SRS should assist Illinois in developing an effective system and insure that Illinois' proposed MMIS will provide the data necessary for implementing an effective utilization review system.

The compliance problems relating to utilization review reported by the regions and in numerous HEW audit reports indicate a lack of SRS action to insure that States have effective utilization review systems. HEW's delay in issuing regulations and its failure to impose penalties has delayed the effective implementation of utilization review systems in the States. SRS should move rapidly to assist the States in improving their systems to protect against unnecessary and inappropriate utilization and thereby reduce Medicaid costs and improve the quality of care provided under Medicaid. Improved utilization review systems should also help detect and control fraud and abuse.

RECOMMENDATIONS

We recommend that the Secretary, HEW, direct the Administrator, SRS, to

--increase technical assistance to help States develop effective utilization review systems;

--insure, before approving MMIS systems, that State proposals for such systems provide data needed to perform effective utilization review; and

--assess penalties on States that fail to comply with utilization review requirements.

PRINCIPAL HEW OFFICIALS RESPONSIBLE FOR ADMINISTERING ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Casper W. Weinberger	Feb. 1973	Present
Frank C. Carlucci (acting)	Jan. 1973	Feb. 1973
Elliot L. Richardson	June 1970	Jan. 1973
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
ASSISTANT SECRETARY FOR HEALTH:		
Dr. Theodore Cooper (acting)	Feb. 1975	Present
Dr. Charles C. Edwards	Apr. 1973	Jan. 1975
ADMINISTRATOR, SOCIAL AND REHABILITATION SERVICE:		
James S. Dwight, Jr.	June 1973	Present
Francis D. DeGeorge (acting)	May 1973	June 1973
Philip J. Rutledge (acting)	Feb. 1973	May 1973
John D. Twiname	Mar. 1970	Feb. 1973
Mary E. Switzer	Aug. 1967	Mar. 1970
COMMISSIONER, MEDICAL SERVICES ADMINISTRATION:		
Dr. Keith Weikel	July 1974	Present
Howard N. Newman	Feb. 1970	July 1974
Thomas Laughlin, Jr. (acting)	Aug. 1969	Feb. 1970
Dr. Francis L. Land	Nov. 1966	Aug. 1969