

~~11501~~

110472

REPORT BY THE

# Comptroller General

OF THE UNITED STATES

RELEASED

*RESTRICTED — Not to be released outside the General Accounting Office except on the basis of specific approval by the Office of Congressional Relations.*

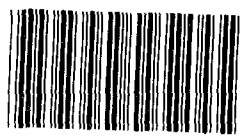
## Pennsylvania Needs An Automated System To Detect Medicaid Fraud And Abuse

RELEASED

Medicaid fraud and abuse can go undetected in Pennsylvania because the State does not have an automated claims processing and information retrieval system. More State funds are needed to complete the planned Medicaid Management Information System to identify potential fraud and abuse.

Although HEW approved Federal funds for Pennsylvania's Medicaid Fraud Control Unit, the State had not established required procedures for investigating and prosecuting Medicaid fraud. The State's criminal fraud statutes should be consistent with Federal Medicaid criminal fraud statutes.

This report was requested by Senator Richard S. Schweiker.



110472

~~507077~~  
110472

HRD-79-113  
SEPTEMBER 24, 1979



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

B-164031(3)

The Honorable Richard S. Schweiker  
United States Senate

Dear Senator Schweiker:

This report summarizes our review of Pennsylvania's efforts to control Medicaid fraud and abuse; you requested this review by letter dated December 4, 1978. We found that fraud and abuse can go undetected in Pennsylvania, primarily because the State does not have an automated claims processing and information retrieval system in full operation. ~~More State funds are needed to completely implement the planned Medicaid Management Information System (MMIS).~~ In addition to providing the State with an effective claims processing system, MMIS can analyze the claims data base to identify potential fraud and abuse.

Federal- and State-level investigations of Medicaid fraud have increased during the past year, but have led to few prosecutions. The Pennsylvania Medicaid Fraud Control Unit only recently took steps to comply with a Federal requirement to assure referral of cases for prosecution. We believe that HEW should review the Fraud Control Unit's actions.

Pennsylvania uses general criminal statutes (such as theft by deception), some of which call for lesser penalties than do the Federal Medicaid fraud statutes. To combat Medicaid fraud, Pennsylvania should establish provider and recipient fraud statutes consistent with the Federal statutes.

We performed our review at the Health Care Financing Administration and the Office of Inspector General (Department of Health, Education, and Welfare); Pennsylvania's Department of Public Welfare, the State Medicaid agency; the Pennsylvania Department of Justice's Medicaid Fraud Control Unit; Capitol Blue Cross (which provides Medicaid claims processing services); and offices of selected U.S. Attorneys, local District Attorneys, and Pennsylvania county boards of assistance. We interviewed officials and evaluated data from agency records. We also met with New York State officials to discuss estimated savings from a new Medicaid claims processing system installed in New York City.

THE PENNSYLVANIA MEDICAID PROGRAM

Under the Federal/State Medicaid program, the Federal Government pays about 55 percent of Pennsylvania's costs of providing health services to the poor. The State designs and administers its Medicaid program, and draws up the State Medicaid plan, which is the basis for Federal cost sharing. The Department of Health, Education, and Welfare's (HEW's) Health Care Financing Administration approves State plans that meet Federal requirements. It monitors State Medicaid operations to see that they conform to Federal requirements and the approved State plan.

The Medicaid program nationwide cost about \$18.9 billion (Federal share--\$10.7 billion) and served 21 million recipients in fiscal year 1978. Pennsylvania's Medicaid program cost the Federal and State Governments about \$1.2 billion and served about 1.1 million recipients in 1978.

MEDICAID CARDS

A person must obtain a Medicaid card before receiving a Medicaid service. Therefore, all cards should be accounted for so that they do not become a source of improper billings.

Pennsylvania's Department of Public Welfare administers the State Medicaid program. A county assistance office issues the initial Medicaid card, after determining that the individual is eligible. Thereafter, the State mails out Medicaid cards monthly, and undeliverable cards are returned to the county assistance office for disposal. The county assistance offices are responsible for controlling cards in their possession. A November 1978 State Medicaid agency report described the lack of security over controlled documents in one county office:

"The bulk of the controlled documents are kept in a 'security room.' \* \* \* This room could be easily entered \* \* \*. Inside this room, in open cartons, were 30,000 medical ID cards (blanks) \* \* \*. Several persons have a key to this room making it virtually impossible to maintain absolute control of these highly valuable forms."

B-164031(3)

Each county office developed its own controls over Medicaid cards until May 1979, when statewide control procedures became effective. The State agency now requires county offices to maintain records of issued cards and to provide for the physical safekeeping and destruction of cards. These requirements, if carried out, should make unauthorized persons less likely to get Medicaid cards.

MEDICAID MANAGEMENT  
INFORMATION SYSTEM (MMIS)

In 1972 the Congress authorized 90-percent Federal funding for developing and installing MMIS and 75-percent funding for its operation. MMIS has several subsystems. The claims processing subsystem pays the claims of medical providers. The utilization review and the management reporting subsystems consolidate data and generate reports to help control Medicaid spending. This utilization review subsystem is designed to identify unusual utilization patterns by providers and recipients.

Twenty-four States now have an approved MMIS. New York State estimates--based on New York City's use of MMIS--that a statewide MMIS would save \$180-\$288 million--from 5 to 8 percent of the program's expenditures.

To improve Medicaid administration, Pennsylvania is developing and implementing MMIS--referred to in Pennsylvania as the Medical Assistance Management Information System. The Pennsylvania plan, sent to HEW in December 1975, cited a June 1977 date for implementing MMIS. Because of delays in both Pennsylvania's and HEW's approval processes, however, it was not until May 1977 that the State Medicaid agency began developing MMIS with an analysis of the then-existing system.

Pennsylvania began using the MMIS claims processing subsystem, but not the information retrieval subsystem, for podiatrists' claims in July 1978 and for dentists' claims in March 1979. To get the staff needed for processing dentists' claims on MMIS, the State dropped a program for identifying inappropriate drug claims. (See app. I.)

State budget cuts have delayed further development of MMIS. Testifying before Pennsylvania's senate appropriations committee in April 1979, the secretary of the State Medicaid

B-164031(3)

agency said that funding must be provided for completing MMIS because it is needed for controlling fraud and abuse. According to the agency's budget request for fiscal year 1980:

"Other provider groups will be placed into the system as resources permit. In order to continue expanding the coverage of [MMIS] to the larger provider groups, such as physicians, additional resources are necessary."

The State agency asked for \$1.8 million, which would permit Pennsylvania to fully implement MMIS during fiscal year 1980. A State official said, however, that the agency is reprogramming the amount appropriated for all agency programs because the overall amount is lower than requested. In mid-July the State official told us that the results of the reprogramming and its effect on extending MMIS coverage to larger provider groups had not yet been determined.

#### CLAIMS PROCESSING

Pennsylvania's present Medicaid claims payment process does not detect ineligibility, duplicate billings, inappropriate charges, or third-party liability. The HEW Inspector General's 1978 annual report noted that similar deficiencies in claims processing were found in 13 other States. Pennsylvania's MMIS is designed to provide an effective claims payment system when it is fully implemented.

Pennsylvania reimburses Medicaid providers by three methods:

B-164031(3)

<u>Method of reimbursement</u>	Fiscal year 1978 Medicaid payments (millions)	<u>Provider</u>
Health insurance premiums	\$ 10.4	Health maintenance organizations and Medicare
Reasonable cost	867.7	<u>a/</u> Inpatient hospital and nursing home care
State fee schedule	224.8	All other providers

a/Not including drugs provided to nursing home patients or inpatient physicians' services, which are billed separately and paid on a fee schedule.

#### Health insurance premiums

Pennsylvania enrolls Medicaid recipients in health maintenance organizations (HMOs) and Medicare. These insurance plans are primarily responsible for the recipient's health care; Medicaid is responsible for some services and payments not covered by the plans. A claims processing system should be able to determine whether a recipient is enrolled in a health plan before it approves an invoice for payment. Pennsylvania's claims system does not do this, except for podiatrists' and dentists' claims processed by MMIS.

#### Reasonable cost

Hospitals generally are reimbursed for the reasonable cost of inpatient services 1/ to Medicaid recipients. Before the State reimburses an institution, the county board of assistance must certify that the recipient was eligible, and a utilization review group must certify that the level of care provided was appropriate.

Nursing homes are reimbursed in the same way as hospitals.

---

1/Institutions' outpatient services are reimbursed on a fee schedule.

Medicaid reimburses institutions an interim daily rate; later, Pennsylvania makes a final cost settlement, during which full reasonable costs are determined and paid. We did not evaluate the adequacy of these cost settlements because an evaluation would have required a detailed institutional review. However, in May 1977, we reported 1/ that an institution incorrectly charged both Medicaid and Medicare for some services. As a result, duplicate charges to Medicare and Medicaid are now looked for during cost settlements, and such duplicate charges have been found at other institutions.

Pennsylvania's fee schedule

Pennsylvania reimburses physicians, laboratories, clinics, and pharmacies according to a fee schedule for services to Medicaid recipients. Claims processing is divided among the State agency (outpatient services) and two fiscal agents-- Blue Shield (inpatient physician services) and Capitol Blue Cross (drugs and medical supplies). The following table shows the number of invoices processed and disbursements made by each organization:

<u>Organization</u>	<u>Number of invoices</u>	<u>Disbursements</u> (millions)
State agency	7,212,000	\$150.5
Blue Shield	360,000	13.7
Capitol Blue Cross	12,000,000	60.6

These organizations process and pay invoices without determining whether the recipient was eligible for Medicaid or enrolled in Medicare or an HMO. Also, many claims were processed without determining whether the amount paid was correct or whether the claim had been previously processed and paid. Therefore, claims could be paid for ineligible, for services for which the State was not liable, or for services for which payment had already been made. (See app. I for additional details on Pennsylvania's fee schedule payment process.)

---

1/"Lack of Coordination Between Medicaid and Medicare at John J. Kane Hospital," HRD-77-44, May 6, 1977.

A claims processing system should at least determine whether there is a legal obligation to pay a claim. Yet Pennsylvania processed some \$225 million in Medicaid claims in fiscal year 1978, under the State fee schedule method of reimbursement, without making that determination.

#### UTILIZATION REVIEW

Title XIX of the Social Security Act requires States to safeguard against unnecessary utilization of care and services under Medicaid. HEW regulations require the Medicaid agency to implement a statewide surveillance and utilization control program to control the use of all Medicaid services and guard against unnecessary or inappropriate use of services and excess payments. The regulations require a postpayment review process that allows the State to develop and review recipient and provider profiles. 1/

Pennsylvania's utilization review for noninstitutional services is not adequate for guarding against the inappropriate use of Medicaid services or excess payments. An effective State review system must be able to process and analyze large quantities of data. Pennsylvania has a limited review capability because (1) it lacks mechanized claims processing and data analysis for most services and (2) the utilization review for those services that are computer supported lacks the staff necessary for handling the workload. Therefore, Pennsylvania cannot count on detecting Medicaid fraud and abuse. (See app. II for details.)

Pennsylvania's utilization review is primarily a manual operation--18 employees manually review a 5-percent sample of provider invoices and subjectively select providers to profile. Because the staff members review only a 5-percent nonrandom sample, an unknown number of program abusers escape detection. From January to March 1979 the staff reviewed over 141,000 invoices, recouped about \$446,000 through provider repayments and prepayment claims adjustments, and initiated 29 provider profiles.

---

1/Profiles are listings, for a specified period of time, of all services furnished by a provider or received by a recipient.



Pennsylvania employed no more than three persons to review the large number of recipient profiles generated by the computer that supported the prescription drug part of the utilization review. Blue Cross generated a monthly average of 7,600 profiles of drug recipients from July 1978 to April 1979, so it is unlikely that the small staff handling that workload could detect even all serious abuses.

Those identified cases of suspected drug abuse are placed in the State's restricted-drug program, which was initiated in November 1976 and under which a recipient must choose and use only one pharmacy. This program is to combat prescription drug overuse by notifying pharmacists that they will be denied payment if they dispense drugs to a recipient restricted to another pharmacy. Pennsylvania's auditor general, in a September 1978 report, concluded that the two staff members who handled the program were

"\* \* \* not adequate to handle the influx of drug profiles and a staffing increase should result in a greater percentage of abusers being restricted."

Since then, the number of restricted recipients has risen from 165 to 800 without a corresponding increase in staff.

The Secretary of Pennsylvania's Medicaid agency, in April 1979 testimony before Pennsylvania's senate appropriations committee, said "We can no longer rely on manual review \* \* \* and human recall to detect potential abuse." Another State official said that staffing considerations will be crucial to the success of both MMIS and the overall State system.

#### INVESTIGATIONS AND PROSECUTIONS

Investigations of suspected Medicaid fraud have increased, particularly over the past year. HEW's Office of Inspector General has begun two projects--one for developing detection techniques--that have identified potential provider fraud in Philadelphia. At the State level, the Pennsylvania Department of Justice established the Medicaid Fraud Control Unit (MFCU) to investigate provider fraud and requested certification from HEW in order to receive 90-percent Federal funding. HEW's

Health Care Financing Administration certified MFCU for Federal funding in August 1978 and recertified it in March 1979. <sup>1/</sup> Recipient and State employee fraud are handled by the State's special investigations unit. To date, however, few providers, recipients, or State employees have been prosecuted for Medicaid fraud. More prosecutions may be forthcoming as MFCU completes some of its investigations. (See app. III.)

Legislative criteria for certifying MFCUs

The Medicare and Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142) authorized HEW to pay a State 90 percent of the costs of establishing and operating a MFCU for the purpose of eliminating fraud in the State Medicaid program. To receive 90-percent funding, the MFCU must be certified by HEW as meeting the requirements set forth in the act and HEW regulations. One of these requirements is that the MFCU be a single identifiable entity of the State government. In a State like Pennsylvania, where the State's constitution does not provide for a statewide prosecutory authority, the MFCU must have HEW-approved formal procedures which assure that the MFCU

- refers suspected cases of criminal Medicaid fraud to the appropriate prosecuting authority or authorities and
- provides assistance and cooperation to such authority or authorities in prosecutions.

The regulations require the MFCU to submit with its application for certification a copy of whatever documents set forth these formal procedures.

HEW certified Pennsylvania's MFCU for 90-percent Federal funding in August 1978, thereby approving the formal procedures MFCU proposed to establish which consisted of a letter to be sent to local prosecutors throughout Pennsylvania after certification. Although the proposal letter did not discuss the specific procedures MFCU would use to refer suspected

---

<sup>1/</sup>Certification/recertification responsibility was transferred from the Health Care Financing Administration to HEW's Office of the Inspector General on April 15, 1979.

fraud cases or to assist and cooperate with local prosecutors, HEW approved the proposal as meeting the requirements of the law. However, the letter was not sent to local prosecutors, although certification had been granted. Furthermore, recertification was granted in March 1979, although no further action had been taken on the letter by that time.

A similar letter was sent to 66 of the 67 local prosecutors on June 11, 1979. An MFCU official stated that the letter sent to the local prosecutors was to fulfill the legal requirement for formal procedures and to acquaint local prosecutors with MFCU. The letter stated that MFCU is ready to help and get help from the local prosecutors with investigating Medicaid fraud and abuse; the letter also contains information on how MFCU attorneys would work with local prosecutors. In the interim between certification and the June 1979 letter, a formal agreement with one local prosecutor (in Philadelphia) was reached. The agreement dealt with cooperation between the Philadelphia prosecutor and MFCU attorneys when investigating and prosecuting Medicaid fraud. Internal operating procedures or regulations for referring cases for prosecution have not been completed or adopted.

The agreement with the Philadelphia prosecutor cannot alone meet the requirement for formal procedures because it cannot provide the assurances required by the law, since it only covers a part of Pennsylvania's Medicaid population and the regulations specifically require the MFCU's program to be statewide. The letter eventually sent to local prosecutors was not the same as the one on which HEW based its approval of MFCU. HEW should review it to see if it assures adequate coordination between prosecutors and MFCU, as required by the Medicaid law.

Stronger State laws are needed

In enacting Public Law 95-142, the Congress made fraud by Medicaid providers punishable as felonies and provided for suspending convicted providers from the program. Previously, those crimes had been classed as misdemeanors. The Senate Committee on Finance report (Senate Report No. 95-453) accompanying the Public Law's bill stated that the misdemeanor penalties seemed inconsistent with existing Federal criminal statutes that classified similar actions as felonies. The report concluded that the misdemeanor penalties had not deterred some providers from illegal practices.

Under Medicaid law, recipient fraud is a **misdemeanor**, and the State may restrict or suspend that person's eligibility for Medicaid.

Pennsylvania criminal statutes do not specifically cover fraud by Medicaid providers. Such crimes must, therefore, be prosecuted under various State statutes (such as theft by deception). These statutes carry various penalties, and some are not as severe as the Federal penalties. The lack of a single statute penalizing fraudulent Medicaid providers makes preparing and prosecuting these complex cases more difficult. This may be remedied, because a Pennsylvania Senate committee reviewing Medicaid intends to propose a State criminal statute to deal with fraud and kickbacks by providers and call for suspension from the program of convicted providers. (See app. IV for details.)

A Pennsylvania criminal statute makes fraud by recipients of Medicaid a misdemeanor, but the penalty is less severe than the Federal law, and the State law does not provide for suspending from Medicaid a recipient convicted of fraud. There are two bills pending in Pennsylvania's Senate that would strengthen the penalty for fraud.

In our opinion, State criminal statutes should be consistent with the Federal criminal statutes. At least one State has revised its statutes along the lines of Public Law 95-142.

Pennsylvania law provides for recouping overpayments to recipients, but does not cover overpayments to providers. In our opinion, if the State had a civil penalty for provider abuse, it would help recover overpayments to Medicaid providers, whether or not the overpayment was due to fraud. (Other States have established such penalties.)

#### CONCLUSION

Pennsylvania has a poor system for detecting Medicaid fraud and abuse. It does not have a utilization review program capable of detecting and preventing the inappropriate use of Medicaid and excess payments or of combating abuses by recipients and providers. The State recognizes these deficiencies, and it is taking steps, by implementing MMIS, to control Medicaid fraud. Success will depend on the proper implementation of MMIS, the appropriate criminal statutes, and the successful relationship between MFCU and local prosecutors.

① ~~Enactment of State Medicaid criminal statutes similar to Federal statutes would help Pennsylvania prosecute Medicaid fraud cases. Also, the relationship between MFCU and local prosecutors should be governed by the formal procedures required by HEW. HEW, in certifying Pennsylvania's MFCU for Federal funding, did not enforce its requirements adequately because MFCU had not worked out procedures with local prosecutors.~~

HEW AND STATE AGENCY COMMENTS

As requested by your office, we did not submit this report to HEW or Pennsylvania for comments. However, as agreed with your office, we did discuss its contents with HEW and State officials. The State Medicaid agency subsequently provided us a letter based on these discussions. (See app. V.)

The Medicaid agency's secretary said that our findings and recommendations coincided with results of its Medicaid program review. The secretary said that developing MMIS is a top priority, and she believed that the State's plan for reorganizing and upgrading its medical assistance program would make dealing more effectively with abuse, overutilization, and fraud a possibility.

HEW officials generally agreed with our findings and recommendations. We considered their comments in our discussion of MFCU's formal procedures for referring fraud cases for prosecution.

RECOMMENDATIONS

We recommend that the Secretary of HEW require the Inspector General to:

① ~~Reassess the procedures established by Pennsylvania's MFCU to determine if they provide sufficient assurances that the unit will refer suspected cases of criminal fraud in the State Medicaid program to local prosecutors and provide assistance and cooperation to them in the prosecution of such cases. If the Inspector General determines that the requirements have not been met, he should help Pennsylvania's MFCU meet the requirements.~~

B-164031(3)

*(Handwritten mark)*  
~~Encourage and assist MFCU in its efforts to have Pennsylvania enact statutes which will be consistent with Federal Medicaid criminal statutes as well as establish appropriate civil penalties.~~

*(Handwritten mark)*  
As agreed with your office, we will make this report available to Pennsylvania, HEW, and other interested parties in 7 days.

Sincerely yours,

*(Handwritten signature)*  
Comptroller General  
of the United States

OPERATION OF THE FEE SCHEDULECLAIMS PAYMENT PROCESSPENNSYLVANIA'S DEPARTMENT OF PUBLIC WELFARE

Except for podiatrist and dental claims, which are processed under MMIS, all claims received by the State agency are manually processed by 35 individuals. According to an HEW report, these individuals must review and process an invoice for payment in about 5 seconds. A review by the State Medicaid agency of a 5-percent sample of claims processed from January through June 1977 resulted in restitution of about \$58,000 primarily because payments exceeded the fee schedule or because duplicate payments were made. The extent of improper payments by the State agency is unknown; however, about 5 percent of the podiatrist and dental claims processed under MMIS are being returned to providers for various reasons, such as

- the individual is not eligible for Medicaid,
- the recipient was enrolled in an HMO or Medicare, or
- duplicate billings.

BLUE SHIELD

Blue Shield processes physician bills 1/ for inpatient services provided to Medicaid recipients. Provider invoices are checked for completeness; then they are coded and key-punched. Blue Shield's computer compares the medical procedure code against the fee schedule and determines the amount owed to the provider. However, since Pennsylvania does not furnish Blue Shield with a list of Medicaid recipients, Blue Shield cannot determine if the recipient is eligible or enrolled in an HMO or Medicare. Furthermore, Blue Shield can only identify duplicate billings if the billings are submitted within 30 days of each other.

---

1/The processing of podiatrist and dental claims for inpatient services has been transferred from Blue Shield to MMIS.

CAPITOL BLUE CROSS

Capitol Blue Cross processes billings for drugs and medical supplies. Like Blue Shield, Blue Cross checks the bill for completeness, codes and keypunches it, and automatically computes the payment. Although Capitol Blue Cross compares invoices with the State's Medicaid eligibility file, claims with Medicaid identification numbers which are not listed on the eligibility file are not rejected.

In September 1977 Pennsylvania instructed Capitol Blue Cross to reject claims which did not match the eligibility file; a large number of claims was rejected. A State review of about 34,200 rejected claims showed that 22 percent of them were for ineligible persons. Pressure from providers (primarily pharmacies) forced the State to revert to its policy of paying all claims. Capitol Blue Cross reports indicate that 6.7 to 7 percent of the 12 million claims it annually processes do not match the Medicaid eligibility file.

In December 1978 Pennsylvania started to manually review drug and medical supply claims which did not match the eligibility file. When a claim was made for an ineligible patient, Capitol Blue Cross was notified to adjust future payments to providers. During the 10-week period December 1, 1978, to February 8, 1979, 34,200 claims did not match the eligibility file. Of these claims, 7,485 (about 22 percent) worth \$47,000 were ultimately determined to be for individuals not eligible for Medicaid. However, this program was terminated in April 1979. According to an assistant State agency controller, the staff used for this review function was needed to help process dental claims under MMIS.

The drug claim review process also analyzed why claims did not match the eligibility file. This analysis showed that provider errors (primarily transpositions and omissions) were responsible for about 74 percent of the nonmatches. As a result of this study, the State Medicaid agency's controller office recommended that Capitol Blue Cross be instructed to reject claims which did not match the eligibility file and to return them to the provider. At a meeting with Pennsylvania officials in June 1979, a State agency deputy secretary stated that these claims would be rejected in the future, although that decision has not yet been formally announced.



UTILIZATION REVIEW IN PENNSYLVANIA'SMEDICAID PROGRAM

Pennsylvania's utilization review function is to assure that recipients receive the proper medical care at the proper time and place. The Pennsylvania public welfare department performs this function through a formal utilization review system.

One element of the State's review program involves identifying potential sources of program misuse (abuse and fraud). This misuse may involve providers, recipients, or both. Pennsylvania primarily identifies such abuse through an activity called "profiling." Profiling involves scheduling either provider or recipient invoice data over a specified time frame and analyzing that data for suspicious trends or patterns of program use. To be effective, the State system must be able to process and analyze large quantities of data over a period of time. However, Pennsylvania currently has a limited review capability because (1) it lacks a mechanized claims processing and data analysis system for most services and (2) review of those services which are covered by MMIS lacks adequate staff for handling the workload.

HOW PENNSYLVANIA'S UTILIZATION REVIEW  
SYSTEM IS ORGANIZED AND OPERATES

Two separate State agency divisions perform a utilization review--the Utilization Review Division and the Division of Pharmaceutical Services. The Utilization Review Division, Pennsylvania's primary utilization review group, is responsible for reviewing the quality of health services rendered by all types of program providers, except pharmacies. The Pharmaceutical Division reviews pharmacy activities and oversees the State Medicaid drug and medical equipment program.

The Utilization Review  
Division and its functions

The Utilization Review Division has 81 staff members--38 full-time professionals, 17 clerical workers, and 26 part-time professionals--and performs several functions in Pennsylvania's utilization review system, including

- (1) reviewing selected hospital invoices for compensability and the quality of care, and contacting providers and recipients to verify the quality and accuracy of reported medical services;
- (2) reviewing or monitoring hospital admissions; and
- (3) identifying potential program abuse and fraud by developing and analyzing provider profiles.

Eighteen division personnel manually review a 5-percent sample of all provider invoices. This review includes a 100-percent review of all chiropractor claims and a 50-percent review of optometrist claims. When division personnel detect unusual treatment patterns or suspicious trends which suggest potential provider abuse, they may decide to profile the suspected abuser(s). The division personnel must use visual observation, subjective judgment, and memory when selecting providers for profiling because of the lack of computer assistance. They must also manually schedule the providers' invoices, because a claims processing historical payment data base is not currently available. Once developed, a profile serves as the basis for further division action. In the first quarter of 1979, division staff reviewed over 141,000 invoices, recouped approximately \$446,000 through provider restitution and prepayment invoice adjustments, and initiated 29 provider profiles.

Our review of 37 cases involving restitution and prepayment adjustments for a 3-month period showed that the majority involved administrative discrepancies which a mechanized claims processing system could discover. A division official stated that MMIS, when fully implemented, should significantly enhance profiling efficiency, because MMIS can automatically produce profiles for any provider or recipient.

#### The Division of Pharmaceutical Services and its functions

The Division of Pharmaceutical Services, in conjunction with Capitol Blue Cross, provides utilization review for Pennsylvania's Medicaid drug and medical equipment program. One of the division's primary activities is the Restricted Recipient Drug Program, which was initiated in November 1976. The program is to combat recipient prescription drug overuse by (1) identifying recipients who receive large quantities of drugs and (2) alerting pharmacists that they will not be reimbursed if they dispense drugs to a recipient who is restricted to another pharmacy.

As fiscal agent, Capitol Blue Cross provides computer support to the division and generates a variety of management information and data analysis reports, including recipient profiles. Capitol Blue Cross generates these profiles by programming several criteria into a claims processing data base. The division then uses the profiles to pinpoint potential recipient program abusers. The criteria are (1) a recipient obtains prescription or nonprescription drugs, medical supplies, or durable equipment 25 or more times in a 3-month period and (2) a recipient receives prescription or nonprescription drugs, medical supplies, or durable equipment exceeding \$250 in a given month.

Each month, division and Capitol Blue Cross personnel screen all recipient profiles and segregate them into two categories: (1) those recipients who visited six or more pharmacies and are tentatively considered to be the potentially more serious program abusers and (2) those recipients who visited five pharmacies or less and are tentatively considered to be the potentially less serious program abusers.

Division staff receive all the profiles and initially review the serious cases themselves while the less serious cases are sent to Drug Utilization Review committees. (See below.) For the serious cases, the division reviews the profiles to determine which recipients need immediately to be locked in--those who should be restricted to a single pharmacy of their choice. The decision to immediately lock in a recipient is a subjective one which considers the quantity of drugs used and other circumstances of the particular case. Profiles for cases not locked in are also sent to the Drug Utilization Review committees.

Once the division decides to lock in a recipient, it manually imprints a red "restricted" note on the front of the recipient's Medicaid card, and the name and address of the specified pharmacy on the back.

The Drug Utilization Review committees are regional committees of professionals. These committees receive from the division the profiles on the less-serious abusers and the more-serious abusers which the division does not lock in. The committee reviews these profiles and informs the recipient's physician in those cases where the committee believes the recipient has abused the program.

Currently, the division has locked in about 800 Medicaid recipients. In order to alert pharmacies about restricted recipients, Pennsylvania's Office of Medical Programs publishes the "Medicheck Restricted Recipient List for Drug Services." This list segregates recipients by county and shows both the recipient case number and the restricted pharmacy identification number. A division official estimated that approximately 10 to 15 percent of all restricted recipients are seriously abusing drugs.

Although Capitol Blue Cross generates considerable data for the division, its officials stated that inadequate staffing hinders their ability to use the data fully. For example, from July 1978 to April 1979 Blue Cross generated an average of 7,600 recipient profiles per month. According to a division official, these profiles are crucial elements in detecting potential recipient program abuse. However, a division staff member stated that the sheer volume of profiles produced each month makes it very difficult to screen and segregate all serious abuse cases. The staff member added that there is always the potential for human error when analyzing and identifying abusers.

The State auditor general, in a September 1978 report to the Governor of Pennsylvania, cited staffing inadequacies as a hinderance to effective lock in program operation. The report stated, in part, that "The existing compliment of staff is not adequate to handle the influx of drug profiles \* \* \*." The report also identified abusers who had not been restricted. At the time of the auditor general's study, the State agency had two staff members administering 165 restricted recipient drug cases; the caseload has subsequently expanded to about 800 without any appreciable program staffing increase.

THE MEDICAID INVESTIGATIVE PROCESS AND WORKLOAD DATAMEDICAID FRAUD CONTROL UNIT

Pennsylvania's Medicaid Fraud Control Unit (MFCU) was certified in August 1978 (retroactive to January 1, 1978) for 90-percent Federal funding by HEW. MFCU had 115 cases under investigation at March 31, 1979, according to the MFCU status report, and had closed 55 since its inception. MFCU had 26 investigators and six attorneys on its staff at the time of the HEW recertification review in early 1979. It has obtained one provider fraud conviction. The provider--a chiropractor--was fined \$2,610, ordered to pay restitution of \$2,610 and serve 30 days in jail (on weekends), and was placed on 36 months probation. He pleaded guilty to one count of theft by deception (third-degree felony), one count of tampering with public records or information (third-degree felony), and one count of unsworn falsification (third-degree misdemeanor).

Of MFCU's 170 cases, 68 (40 percent) were referred by the State's special investigations unit, 30 cases (17.6 percent) were referred by the State's program enforcement committee, and the remaining cases were received from other State agencies, private citizens, and others.

HEW, during its recertification review, examined why 46 cases had been closed and found that 5 cases had been closed because of insufficient evidence; 8 suspected-abuse and neglect-of-patient cases were closed during preliminary investigation in order to apply resources to more productive areas; 7 preliminary investigation cases were referred to other State agencies; and 26 cases in preliminary investigation were closed due to insufficient evidence, because prosecution was barred by the statute of limitations, or because other basic data were too old to substantiate continued investigation.

The State's program enforcement committee was comprised of representatives from various welfare department offices, and MFCU after its establishment. It was to evaluate provider abuse cases and to recommend such administrative actions as suspending or terminating the provider from the Medicaid program, collecting the provider's overpayment, or referring the case to MFCU. From 1972 through 1978 the committee permanently removed 42 providers and suspended 33 providers from the Medicaid program; issued warnings to 29 providers;

and required 150 providers to make restitution. With the committee's dissolution in April 1979, the State Medicaid agency's utilization review function will make all administrative decisions, with advice from the State agency's legal counsel. The committee was dissolved, according to an official, to simplify the State's program enforcement process.

The following table reflects MFCU's workload for the quarter ended March 31, 1979:

<u>Number of cases</u>	<u>Integrity reviews (note a)</u>	<u>Full-scale investigation (note a)</u>
Cases on hand Jan. 1, 1979	63	46
Received	<u>15</u>	<u>15</u>
Available for review	78	61
Completed	<u>20</u>	<u>b/4</u>
Ending balance Mar. 31, 1979	<u>58</u>	<u>57</u>

a/Integrity reviews are preliminary, and if questions of fraud arise, they lead to full-scale investigations.

b/From October 1, 1978, through March 31, 1979, the unit reported two cases referred for administrative action, one conviction, and five cases closed.

In Philadelphia, MFCU and the district attorney have agreed to investigate and prosecute Medicaid providers together. The district attorney convened a grand jury in conjunction with that agreement. Several district attorney staff members are assigned to and paid by MFCU. An assistant district attorney stated that MFCU attorneys lack courtroom experience, and that his staff would be better able to prepare these complex cases and process them in court. The agreement extends from October 1, 1978, through September 30, 1979, or the date the grand jury goes out of existence, whichever comes first.

An assistant district attorney stated that the priority enjoyed by Medicaid is in part due to the fact that the staff assigned to MFCU are paid by MFCU. He said that a second grand jury might be convened.

Under Pennsylvania's 1978 Investigating Grand Jury Act, MFCU may be able to get authority to prosecute Medicaid fraud cases. The grand jury act provides that the attorney general or his designee shall be authorized to prosecute a person indicted under a multicounty grand jury. The State's justice department petitioned the State supreme court for a statewide investigative grand jury in June 1979; if this is granted, MFCU could use this for prosecuting cases itself. A State justice department official said supplemental funding this year will provide resources to lay the groundwork for operating the investigative grand jury in the latter part of 1979. MFCU would have access to the grand jury in its pursuit of Medicaid prosecutions.

#### HEW

HEW's Office of Inspector General initiated two projects-- Integrity and Crackdown--directed at detecting provider fraud in major U.S. cities--including Philadelphia. Project Integrity began in 1977 and was aimed at developing techniques to be used by States for detecting and preventing fraud and abuse in the health care field--including Medicaid. In Philadelphia, 15 physicians and 19 pharmacies were identified for review. An HEW official stated that 12 physicians and 12 pharmacies are under investigation; the remaining 10 cases are under consideration for administrative action only. The official stated that no prosecutions have resulted as yet in these or their other Medicaid-related cases.

Project Crackdown was initiated in about August 1978 because Philadelphia newspaper stories alleged widespread, systematic illegal use of the Medicaid program to obtain narcotic and dangerous drugs. The stories also alleged that unscrupulous physicians, pharmacies, and recipients were involved. The project identified 31 physicians for review, of which 12 were already under investigation. These investigations were expected to tie into pharmacies, laboratories, and other providers. An HEW official stated in May 1979 that these cases soon would be turned over to Pennsylvania's MFCU, the Federal Bureau of Investigation, and others.

SPECIAL INVESTIGATION UNIT

The Pennsylvania welfare department's special investigation unit is responsible for investigating recipient and employee Medicaid fraud and abuse, and was responsible for investigating provider fraud and abuse before that responsibility was transferred to MFCU. The unit is also responsible for investigating suspected fraud and abuse in two public assistance (welfare) programs and the food stamp program. Unit officials stated that Medicaid investigations are a low priority because of limited resources and the difficulty of developing such cases. Few recipients and employees have been prosecuted.

The following table reflects the unit's Medicaid workload at March 31, 1979:

<u>Number of cases</u>	<u>Provider</u>	<u>Recipients</u>
Cases on hand Jan. 1, 1979	33	4
Received	<u>-</u>	<u>19</u>
Available for review	33	23
Completed	<u>3</u>	<u>2</u>
Ending balance Mar. 31, 1979	<u>30</u>	<u>21</u>

The provider cases were carried over because the special investigation unit was developing them before MFCU was established. From October 1, 1978, through March 31, 1979, the unit reported to HEW that three providers had been convicted, one recipient case was referred for administrative action, and two recipient cases had been closed. The following sentences were imposed on the three convicted providers:

- A physician was ordered to pay a \$1,000 fine and court costs and was terminated from the program.
- Another physician received 2 years' probation, 90 days in jail (on weekends over 2 years), and was ordered to pay a \$12,000 fine and make restitution of \$2,546. This physician was also terminated from the program.
- A pharmacist received 7 years' probation, was ordered to pay court costs and make restitution of \$13,534.38, and was terminated from the program.

The providers had been charged with billing for services not rendered, duplicate billings, and/or generic substitution.



PENNSYLVANIA'S CRIMINAL STATUTESAND PROSECUTORY ACTIVITYINCONSISTENCY BETWEEN FEDERAL  
AND STATE CRIMINAL STATUTES

Public Law 95-142 strengthened the criminal penalties related to Medicaid provider fraud, and provided that providers be suspended from the program if convicted of Medicaid- or Medicare-related crimes. The Federal criminal penalty for a provider is now a felony--upon conviction, fined not more than \$25,000 or imprisoned for not more than 5 years, or both--and extends to persons involved in kickbacks, bribes, or rebates in providing such services. In the case of a recipient, the penalty is a misdemeanor--upon conviction, fined not more than \$10,000 or imprisoned for not more than 1 year, or both.

Pennsylvania law provides a criminal misdemeanor penalty for Medicaid recipients for assistance criminally received in excess of \$300--upon conviction, a fine not exceeding \$1,000 or imprisoned for a term not exceeding 1 year, or both. The penalty for fraudulently receiving assistance of less than \$300 is, upon conviction, a fine of not more than \$200 and imprisonment not exceeding 60 days, if repayment is not made. State Senate Bill 587, entitled "An Act to consolidate, editorially revise, and codify the public welfare laws of the Commonwealth," would strengthen the misdemeanor penalty for recipient fraud to require payment of a fine not exceeding \$5,000, imprisonment not exceeding 2 years, or both, and restitution of any moneys received under the crime. However, the law does not provide a criminal penalty--misdemeanor or felony--for providers or those engaging in kickbacks, bribes, or rebates. It does not provide for suspension from the Medicaid program of recipients or providers convicted of such crimes. State senate bill 589 would amend the public welfare code by providing that a recipient convicted of giving false information be ineligible for cash or medical assistance for a period of 1 year, but it does not address provider fraud.

When prosecuting a provider for suspected fraud, the State must rely upon other statutes (such as theft by deception, tampering with the public records and information, and/or unsworn falsification). A Medicaid Fraud Control Unit official said a criminal provider fraud statute is needed, including provisions extending to cases involving kickbacks, bribes, or rebates.